Keeping head above water: social presence in the transitions of Brazilian women to motherhood

Comparing experiences in Brazil, France, Portugal and Sweden

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I dedicate this thesis to the memory of Odete Fernandes de Souza, my adoptive grandmother who I did not have the opportunity to meet but who keeps feeding my myth of origin.

"And that, you see, is my dilemma this afternoon. Both reason and seven decades of life-experience tell me that reason is neither the being of the universe nor the being of God. On the contrary, reason looks to me suspiciously like the being of human thought; worse than that, like the being of one tendency in human thought. Reason is the being of a certain spectrum of human thinking. And if this is so, if that is what I believe, then why should I bow to reason this afternoon and content myself with embroidering on the discourse of the old philosophers?"

(Elizabeth Costello's quote in J.M. Coetzee's essay "The Lives of Animals")

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LIST OF ABBREVIATIONS

SUS: Sistema Único de Saúde

PBF: Programa Bolsa-Família

ESF: Estratégia de Saúde da Família

RC: Rede Cegonha

PAISM: Programa de Atenção Integral à Saúde da Mulher

AP: Attachment Parenting

CMC: Computer-Mediated Communication

MDS: Ministério do Desenvolvimento Social e Combate à Fome

MPS: Ministério da Previdência Social

MTE: Ministério do Trabalho e do Emprego

SPM: Secretaria Especial de Políticas para Mulheres

MEC: Ministério da Educação

DGSS: Direção Geral da Segurança Social

CAS: Centre d'analyse strategique

DREES: Direction de la recherche, des études, de l'évaluation et des statistiques

CNAF: Caisse nationale des allocations familiales.

ABSTRACT

Keeping head above water: social presence in the transitions of Brazilian women to motherhood. Comparing experiences in Brazil, France, Portugal and Sweden

The main objective of this thesis was characterizing and analysing social presence in the transition(s) of Brazilian women from privileged classes to motherhood, in Brazil, France, Portugal and Sweden, in recent years. As a final goal, it intended to contribute to de-construct the hegemonic model of "good motherhood" in Brazil, which is established from the experiences of middle-class white Brazilian women. As methodological strategy, it focused on Brazilian mothers' experiences of presences, using Computer-Mediated Communication and three methods in parallel: a documentary research on official reports of perinatal health and family policies, biographical interviews and recording of daily diaries, articulated through a phenomenological perspective. Therefore, in my fieldwork I searched, in a spiral drifting, how certain moral rhetorics associated to gender, class and racial norms are reproduced by privileged mothers in maternal transitions. Beyond of this process of reproducing hegemonic representation of motherhood, I also found generating hesitations and ethical enactment among these women towards marginalized mothers such as racialized, single and poor ones. Finally, this thesis discusses how care ethics raise from daily parental relationships and how improving responsive social presence is quite significant for the promotion of such ethics beyond of feminine care work.

Keywords: social presence; care ethics; perinatal health; family policy; immigration; intersectionality.

SUMÁRIO

Com a cabeça fora d'água: a presença social em torno da transição de mulheres brasileiras para a maternidade. Comparação de experiências no Brasil, na França, em Portugal e na Suécia.

O principal objetivo desta tese foi caracterizar e analisar a presença social na(s) transição(ões) das mulheres brasileiras de classes privilegiadas para a maternidade, no Brasil, na França, em Portugal e na Suécia, nos últimos anos. Como objetivo final, este trabalho pretende contribuir para desconstruir o modelo hegemônico de "boa maternidade" no Brasil, que é estabelecido a partir das experiências de mulheres brancas da classe média. Como estratégia metodológica, o estudo foi focado em analisar as experiências de presença das mães brasileiras, através de Comunicação Mediada por Computador e três métodos em paralelo: uma pesquisa documental em relatórios oficiais de políticas de saúde perinatal e em políticas familiares, entrevistas biográficas e gravação de diários, articulados através de uma perspectiva fenomenológica. Por isso, em meu trabalho de campo eu procurei, numa deriva em espiral, como certas retóricas morais associadas às normas de gênero, classe e raça são reproduzidas por mães privilegiadas no cotidiano durante as transições maternas. Além deste processo de reprodução da representação hegemônica da maternidade, eu também encontrei hesitações criativas e enação ética entre as mulheres em relação à mães marginalizados, tais como as mães Afro-descendentes, solteiras e pobres. Finalmente, esta tese discute como a ética do cuidado emerge a partir de relações parentais e como melhorar a responsividade da presença social é bastante significativo para a promoção de tal ética para além do trabalho de cuidado exercido pelas mulheres.

Palavras-chave: presença social; ética do cuidado; saúde perinatal; políticas familiares; imigração; interseccionalidade.

INTRODUCTION: TRANSIENCE BY AND DESPITE MOTHERHOOD

This thesis follows the patterns of Portuguese PhD programs but also tries to converge with French academic outlines since this work is affiliated to two different institutions in both countries and is part of an interdisciplinary Erasmus Mundus programme. Therefore, it was a great challenge not only writing in accordance to both supervisors' expectations but also pursuing a field research in four different countries, despite using Computer- Mediated Communication. All the challenges and advantages in articulating those differences during this four years' work period were exhaustively exposed in the following chapters, although I insisted in concentrating the corpus of the text on the research's goals and findings. Still, it is here, in this introduction, that I further express my situated experience as a Brazilian PhD candidate working in Europe, where I lived as a migrant, mother and married woman. Subsequently, I present what should be expected to each part of the thesis, summarizing the content.

As suggested by Patricia Paperman (2013), this work is a result of the interlocution with my collaborators' standpoints and experiences – therefore, it is not a response to previous hypotheses, since those hypotheses had been transformed along with the effort of inquiring and writing. This means that I underwent intense transformation of my perceptions regarding the transition(s) of motherhood and the politics involved in that during the entire enterprise. Thus developing a phenomenological aptitude (Morais, 2013) towards the feminist and maternalist web that served as the first doors for my fieldwork, and in peering attentively at the experiences lived by my collaborators, I took a step back to observe my own experiences. I followed Paperman's recommendations for constructing a body of knowledge coherent to the ethics of care:

> Cela requiert des méthodes et une épistémologie féministe différentes, inspirées de l'épistémologie féministe du point de vue: c'est-à-dire une manière de produire des connaissances qui intègrent des protagonistes qui en seraient normalement absents, qui élargit son public, et explicite (ou revendique) son caractère politique. (Paperman, 2013, p. 47)

One example: my first research project was focused on associative parental childcare centres, since I thought they should be an interesting alternative for Brazilian mothers sharing childrearing while also profiting from their children's physical presence – influenced by the motherhood ethos of a "hedonistic injunction" (Martiskainen de Koenigswarter, 2006) I myself reproduced at that time. But, then, one of my first readings of Motherhood Studies captivated my attention to an invisible dimension of this ethos, placing me in confrontation with my own naturalizing perceptions. As well observed by Maurice Merleau-Ponty, reading can be an incendiary, two-way moving experience between reader and author, from which we cannot be left unscathed:

> Ainsi je me mets à lire paresseusement, je n'apporte qu'un peu de pensée – et soudain quelques mots m'éveillent, le feu prend, mes pensées flambent, il n'est plus rien dans le livre qui me laisse indifférent, le feu se nourrit de tout ce que la lecture y jette. Je reçois et je donne du même geste. J'ai donné ma connaissance de la langue, j'ai apporté ce que je savais sur le sens de ces mots, de ces formes, de cette syntaxe. J'ai donné aussi toute une expérience des autres et des événements, toutes les interrogations qu'elle a laissées en moi, ces situations encore ouvertes, non liquidées et aussi celles dont je ne connais que trop l'ordinaire mode de résolution. Mais le livre ne m'intéresserait pas tant s'il ne me parlait que de ce que je sais. De tout ce que j'apportais, il s'est servi pour m'attirer au-delà. À la faveur de ces signes dont l'auteur et moi sommes convenus, parce que nous parlons la même langue, il m'a fait croire justement que nous étions sur le terrain déjà commun des significations acquises et disponibles. Il s'est installé dans mon monde. (1969, p. 30)

"I also brought an entire experience of others and of events" (Merleau-Ponty, 1969, p. 30, free translation): this means that I also opened my perceptions to the past plans that were fully presented in my research habits. Therefore, reading, starting my fieldwork and writing this thesis constituted an intense exercise of comprehension of my own story whereas it also promoted a widened perception towards diverse experiences of motherhood.

Here is a quick summary of my story: I am a Brazilian born from Northeastern parents – a mother born in Bahia's backlands and irregularly adopted by a poor family, and a father born in Paraiba from an ascendant middle class family. I grew up in Rio de Janeiro as an "outsider", since in Brazil Northeasterners' migration to the Southeast is historically depicted as the cause for poverty in urban centres. During the 1980s and 1990s, Northeastern women and men were generally disregarded and discriminated in Southeast cities such as Rio, while also participating in the growing process of democratization and urbanization of the region – which my parents certainly did, my mother as a housewife trying to build a career and my father as an engineer, both politically engaged in left-wing movements and both members of the Workers' Party.

Despite the "unjust family" (Okin, 2008) we belonged to, with a rather traditional division of labour and gender imbalance, even after my parents' divorce, we did not have the common middle class lifestyle. As far as I can remember, my mother did not enjoy being fully dedicated to childrearing and did not like to have domestic workers at home, since she tried to transit through feminist, naturalist, anarchist movements; whereas my father was quite distant, even abusive, but creating a argumentative environment with his Marxist-inspired speeches against the bourgeois middle class. At the time, my three sisters and I profited from unusual freedom and fluidity among different "grand narratives" (Lyotard, 1979) and we transited through quite different territories of the city: among *favelas*, big condominiums and private clubs, political protests, the party's office and Christian churches, households of military families and hippie communities... In summary, I grew up with this sense of being a misfit in my own

city and social class, enjoying a bizarre sensation of freedom, unbelonging and disconnection – which brought me to an acute interest for "Brazilian citizenship" as a research object that I investigated during my undergraduate studies and Master's Degree. That was the "good citizen"[1] in Brazil: an individual (with no race) well-identified in the "nice girl" or "nice guy" models[2], inspired by the shared nationalist project. "Brazil, love it or leave it"[3] – that was one of the most diffused slogans by the Brazilian government during the former military dictatorship that definitively ended when I was about six years old[4]. After all, how should one love a country?

I went about studying Psychology, mainly Social Psychology, which has given me the tools and partners to understand what it meant to be a Brazilian individual. By that, I understood how Psychology contributed to the rising of the "psychological individual" as a Brazilian middle class model (Dimenstein, 2000). Thus, I turned to Public Health – one of the most influent fields in the country's political system and social structure. In Public Health institutions, I have worked as a clinical psychologist but also as a researcher of public policy analysis – an unusual path among my undergraduate colleagues, which is indeed becoming increasingly common in the country through a recent sub-area called "Political Psychology" (it seems that almost everything must be labelled and assimilated in a disciplinary logic).

Finally, I suppose, I do not love Brazil, in so much that I do not have the feeling of belonging projected by the nationalists (from left and right-wings parties) for my generation. I belong to a generation that wished for globalization, being "global citizens", transitioning between borders and pretending they don't exist. I am from a generation that does not get the sense of "grand narratives". However, still, I reproduce a mode of existence that is historically situated, therefore, produced by the permanent rhetoric of crisis, the constant menace against democracy, and the endless feeling of risk (Latour, 2012; Mendes, 2002). Loving my country is not a question or an order, as it used to be for my parents; but fearing what can happen to us as Brazilians, yes it is. The experience of being a Brazilian woman can be quite determinant in my temporal and spatial experience, since I am a privileged but unfitted citizen in a peripheral position. Brazil has this "spatial schizophrenia" – as many of the "third world" territories under the "fable of globalization" (Santos, 2000). And it is, indeed, from that position that I intend to contribute to the contemporary construction of knowledge suggested by Milton Santos for "another globalization" (Santos, 2000). Finally, after all this path of 15 years of studying, researching, working

[1] "Cidadão de bem" is a common expression in Brazil that opposes the ideal citizen to the stereotype of "layabouts".
[2] "Moça de família" and "Homem de família" are both common expressions in Brazil that reinforce the role of gender and family as core categories for the ideal model citizenship.
[3] "Brasil, ame-o ou deixe-o"
[4] Officially, military dictatorship ended in 1985; however, the first direct and democratic election took place in 1989.

with themes related to Brazilian citizenship, I am quite unworried about co-existing with uncertainty and transience.

However, before that, I became a mother and started questioning my habitual transience, since this condition put me under an intense pressure to fulfil the "good family" ideology from Brazil's chauvinist past. After all, how does a country invade one's love for one's child?

In late 2012, I had a quite modified family arrangement, since we had moved to Portugal and later to France with my salary and my husband's savings; I was decided to not be captured by the "good family" model – although I was probably incapable of performing this role. In that period, my husband was the one who did most of the domestic duties and took care of our three year-old daughter the most part of the time; he profited from a temporality he had never experienced, and liked it for a while. At that time, the injunctions related to the project of "chosen motherhood" were not exactly clear for me, since I was able to persist in my professional goals while profiting from my daughter's presence – I had almost forgotten the dark side of my first two years as a mother. As Martiskainen de Koenigswarter (2006) had found on her research with early and experienced mothers, this "forgetfulness" is part of the "hedonistic injunction" of motherhood, a contemporary ethos related to women's conquest of reproductive autonomy.

Still in Portugal, while I developed my research project, the mothers' situations – instead of associative childcare – started to be at the forefront of my mind. While living there, as a mother, I realized some significant differences regarding the "presences" for childcare. For instance, we could not find a part-time preschool or crèche in the regions where we lived. I noticed that, since the majority of mothers and fathers worked in a full-time basis, the childcare institutions did not perceive an advantage of offering a 4-hour shift – the general pattern in Brazilian preschools. Later, while living in France, we also realized interesting cultural differences regarding parenting practices. I came to live in the same city as a quite well-known militant mother, Marlène Schiappa, who edits a website, writes books and actively participates in the political system since 2014 as a member of the Socialist local government of Le Mans[5]. Unlike a large part of left-wing militant mothers in Brazil, she stands for the rights of "active mothers"[6] in France, including claims for full-time childcare centres and sharing household duties with men. In

[5] Marlène Schiappa was elected as *"adjointe du maire"* in 2014 and is known as a lobbyist for working mothers' rights in France. For a recent and full profile, see *Le Figaro*: http://madame.lefigaro.fr/societe/marlene-schiappa-140915-98208

[6] "Mères actives" expresses the category of women who have children and keep active in their professional lives.

Brazil, I had approached activists who used the term "active mothers"[7] in a quite different sense: they identified themselves as being active in mothering, arguing against the "outsourcing of motherhood", therefore handicapping the agenda for public full-time childcare in the country and preferring to defend longer maternity leaves. Thus my interest in motherhood came to be related to the differences and similarities of social presences around childbearing, including, but not limited to, associative devices. The international comparison could help me understand how national boards can also become determinants in social presences.

Furthermore, in reading about motherhood in Nordic countries, which is usually perceived as the best places for becoming a mother in the world, I realized that there was something similar despite all cultural and political differences with Brazil. As commented by Elvin-Nowak and Thomsson (2001) in their work with employed mothers in Sweden, the conflicts related to families' time-balance keep burdening mothers in that country. Comparing French and Finish mothers' conversations, Heini Martiskainen (2011) also concluded that long parental leaves developed in the Nordic countries by the rhetoric of "children's best interest" can reinforce a quite contemporary dilemma in mothers' transitions to motherhood: "children are more desired and valued than ever, but their presence strongly limits adults' autonomy" (Martiskainen, 2011, p. 14, free translation). Thus the decisions, responsibilities and moral injunctions associated to the sharing of childcare duties are usually part of mothers' experiences with time and presence, even in the countries acknowledged for having strong "gender-equality discourses" (Elvin-Nowak & Thomsson, 2001).

Therefore, I decided to analyse social presence in the transition of Brazilian mothers who lived in Brazil, Portugal, France and Sweden for two main reasons: the pertinence of the three European countries in the organization of the PhD programme I am enrolled in, and the interesting comparison they can favour because of their different welfare system patterns despite their commonalities in perinatal assistance and global health rhetorics. These countries are influenced by different feminist movements, different histories of family policy and childcare policy, but they are under the common influence of Public Health as a globalized field.

Through this initial inquiry and personal pathway, I realized that when closely addressing *real* situations experienced by *real* mothers, one witnesses a common academic discourse concerning the mismatch between moral references for the transitions of motherhood and the actual experiences of "becoming a

[7] The term "mães ativas" and, more commonly, "Maternidade ativa" expresses the engagement of mothers in the project of nurturing children, generally in a domestic basis.

mother". While one cannot assert this mismatch as a universal experience, one can observe it in various studies conducted in different countries:

> À la lumière de ces indicateurs objectifs, la transition à la maternité apparaît comme un carrefour dans la trajectoire de nombreuses femmes. Il peut ainsi paraître surprenant que l'ampleur et la nature des bouleversements apportés par une naissance semblent méconnus de nombreuses 'jeunes' mères : qu'il s'agisse des conséquences physiques de l'accouchement ou de celles inhérentes aux modes de vie après la naissance, parmi lesquelles l'accentuation de la division sexuée du travail. En témoigne une caractéristique récurrente des expériences de mères, observée dans les entretiens tant en Finlande, en France et en Angleterre qu'aux États-Unis. En effet, les recherches mettent en évidence un sentiment récurrent d'impréparation ainsi qu'une collision entre les attentes a priori (fondés sur des espoirs personnels et des imaginaires collectifs) et les réalités sociales, auxquelles la naissance d'un enfant donne lieu pour les femmes. (Martiskainen, 2011, p. 5)

In this sense, I saw this "recurrent feeling of unpreparedness" as a clue for analysing the incongruences between the temporality of childcare and the pressures of a maternal solitary presence – a pressure that is not only culturally constructed but physically perceived during the transition to motherhood (Capponi & Horbacz, 2007). Therefore, women's perceptions of presence in this transitional period produce habitualities, paralyzing and generating hesitations (Alia Al-Saji, 2014), which reinforces their privileged positioning regarding more vulnerable women and in some cases produces ethical responsiveness towards non-normative experiences of motherhood. From that, I addressed the debate around ethics of care and "gendered temporalizing" (Bessin & Goudart, 2009) – which refers to a structural process in capitalist societies regarding the organization of labour as a social structure and subjective experience. Marc Bessin and Corinne Goudart's text was the first one that I had read with this rather interesting perspective of time as an experience, and an experience related to the reproduction of gender structures. In commenting on the strategies of homemakers facing men's absence in care activities, the authors mentioned the well-suited expression "keeping head above water", in inspiring this thesis' title:

> Mais ces « arts du faible » constituent bien souvent de faibles armes, la disponibilité permanente et la flexibilité inhérentes à ce registre temporel ne laissant bien souvent pas d'autres marges de manœuvre que celles qui sont mobilisées pour tenter de maintenir la tête hors de l'eau. (Bessin & Goudart, 2009, §17, their quotations)

Thus, from this perspective, "social presence" is not limited by physical presence; it embraces moral dispositions and injunctions to care. That is why "rhetorical analysis" became an interesting method, which will be discussed further in the methodological chapter of this thesis. As one may have already noticed, this is not a traditional Psychology or Motherhood Study. Mostly situated in Public Health, this study is fundamentally interdisciplinary – or, as I would prefer, a *transdisciplinary* work. Ever since I took my first steps in Academia, I was seduced by this controversial proposal by Edgar Morin (1971) of

producing a *transdisciplinary* science. I understand that some criticism can be coherent in resisting this "new" label for articulating different standpoints over a scientific object, since, I agree, we cannot succeed in hiding our main academic filiations under an alleged capacity of dealing with an infinitude of scientific and philosophical concepts. Therefore, I stand for the interdisciplinary perspective, whereas also emphasising this almost utopian horizon of *transdisciplinary* research. Here I do not separate a sociological analysis and a psychological one to finally articulate them; here, the focus is not a specific logic from a disciplinary field, but research questions and problems form the common thread, and for that I articulate psychological, sociological and philosophical concepts together.

THE THESIS' STRUCTURE

The chapters of this thesis are presented by a somewhat different sequence than the usual in Portuguese academy, because I tried to conciliate it to the traditional formatting of French Social Sciences thesis. Therefore, instead of separating the methodological chapter, I integrated it to Part One, in which I present the whole framework, epistemological, theoretical and methodological.

In Part One of the thesis, I explain and discuss my point of departure, considering the fields mentioned before and revising the most basic assumptions of traditional Motherhood Studies. In doing so, I do not mean to evaluate the social policies commented in the text, neither to embrace all the history and ethical implications of Public Health, Psychology and Feminism, but to identify specific debates, concepts and paradigms related to mothers' health and rights, including immigration and Human Rights, that are quite important for the broader contextualization of this work. I also describe my pathway as an "implicated researcher" (Merhy, 2011), the process of defining my research questions, the contextualization of the participants' profiles and the methodology that guided it. Besides, I assume my interest in analysing social presence from a serious consideration of women's bodily experiences, by attempting to surpass the dichotomist view of "nature" *versus* "culture", thus addressing an *"alternaturalist"* view (Hoquet, 2015). From this interest, I explore some of the most important concepts of Feminist Phenomenology applied to the analysis of my fieldwork, such as "presence", "situation", "experiences", "gender", "agency" and "intersectionality".

The discussion of the research's findings is not structured by a classical comparative analysis of the countries' systems. Since the analysis follows the experiences of presence lived by Brazilians, the international comparison was made from the "unities of senses" revealed in the fieldwork by those mothers' narratives, which are strongly anchored in Brazilian cultures of birth, social class hierarchy and political participation. Therefore, rhetorical analysis of official reports also followed the themes presented in the

unities of sense, which revealed the importance of childbirth and early childrearing for the participants' experiences of presence in subsequent periods. Then, from Part Two, the chapters are organized through a temporal logic presented in the collaborators' narratives, but also related to my own research interests. The specific themes discussed as sub-chapters were also part of my conversations with them and appeared as the most significant in order to understand their experiences, especially for comprehending experiences of habitualities, paralyzing and generating hesitations (Al-Saji, 2014; 2004) mentioned above. However, as one may notice, I did not separate a specific chapter to discuss the theme of the fathers' presences/absences; however, it is clearly an important analytical index for me, since gender structure is transversal to this whole enterprise. Therefore, instead of dedicating a chapter for this issue, such as the one focused on "grandmothers' presence", I decided to approach it transversally. For instance, one can read about male presence in the decisions regarding prenatal care and childbirth in Part Three.

In Part Two, I start to deeply discuss the fieldwork findings by presenting the first "unity of sense" of women's experiences with social presence in the transition of motherhood: the desire of presence. It is indicated as first unity because this desire and the correspondent non-desire(s) (of presence and of motherhood) seemed connected to the establishment of habitual presences and absences on the participants' first months and years as mothers. The desire of presence is related to a search for fluidity in the "own body" experience and it is intensified by gender oppression on women's motility (Young, 2005). Therefore, the text addresses gender embodiment in the earlier transitions of motherhood such as the process of planning and/or choosing to be a mother, which is influenced by moral rhetorics on "chosen motherhood" found in participants' narratives and the documentary research. Therefore I could discuss how the desire of presence is a motor for the development of aesthetic experiences (Gumbrecht, 2010) in contemporary culture of middle class motherhood, characterized by the expansion of body disciplining from space to temporality (Moreau & Vinit, 2007), and favoured by Computer-Mediated Communication. Finally, Part Two points to "human development" as a common ground to feminist, maternalist and sanitarian rhetoric of chosen motherhood, configuring a therapeutic culture of motherhood that influences social policies for families and pregnant women. At that point, I suggest that the excessive influence of liberalism in Feminism produces a quite problematic contradiction to motherhood-related issues, especially for racialized and poor women.

Part Three develops the problem of the contradiction found in the previous part, focused on one of the most important events of the transition of motherhood according to the narratives of the majority of participants: searching for "humanization of childbirth" configures the second "unity of sense". This

unity of sense arose from women shifting from the desire of presence to the consumption of psychologising and scientific information on birth and breastfeeding to face over-medicalization of perinatal systems. Therefore humanization is part of searching for one's own body fluidity and plays a core role in the morality of "human development", catalysing women's attention and also producing a growing politicisation of motherhood in Brazil (Meyer, 2005). However, the text explores how this politicisation does not cope with "universalization" and does not revert the perinatal paradox (Diniz, 2009) where it exists, because of the liberal rhetoric on humanization as a "personal good" and a "conquest" when women follow certain patterns of consumption from which racialized and poor women are excluded. In analysing the official rhetoric on humanization and perinatal health in Brazil, I could discuss how social presence in perinatal health is constructed through a growing process of privatization nurtured by a culture of fear regarding vaginal birth (Barbosa et al, 2003). When comparing the women's experiences in the other three systems, I was able to identify how immigrant Brazilian women negotiate birth decisions and change their "mentality" regarding motherhood in this process. Then in this part of the thesis, I analyse how each country presented specific trends in perinatology that contributed to quite different experiences among the participants regarding the Brazilian culture of fear around birth.

In Part Four, I analyse whether habitualities enacted in the early childrearing phase, especially the first year after birth, favour hesitation and ethical responsivity (Al-Saji, 2013; 2014). This part is related to the third unity of sense, which is the injunction of "giving time" for children. Along with the process of desiring presence, searching for humanization and caring for children in the early stages, the presence of male partners and other relatives can contribute to hesitation and creative agency, but can also prompt to the injunctions of therapeutic motherhood if motivated by a child-focused rhetoric. Also, the presence of certified, institutionalized caregivers, such as child-minders and childcare centres, can contribute to women's trust in shared childrearing, and dedication to other activities that increment autonomy, such as their career. Or they can encourage the exploitation of subordinate women such as domestic workers, reproducing the domestic structure of Brazilian inequality (Sorj, 2014). Therefore in this part, the rhetorical analysis of documentary research focused on policies for "parenting and family support" in each country, especially the ones related to parental leaves, employment protection and childcare. But the chapters were not structured according to the national differences – as in the part on perinatal health – for two reasons: France, Sweden, Portugal and Brazil display huge differences in terms of rhetorical productions for family policies (the complexity and historicity of the four systems of family policies could not be justly analysed by this thesis), besides, it was not exactly the different national borders that triggered different experiences among the participants with this injunction for "giving

time", rather, it was the process of being *otherized* (Al-Saji, 2013; Dorlin, 2005; Leite, 2013) as a migrant in Europe, as single and homosexual parents, or being black that significantly marked important hesitations *vis à vis* the Brazilian model of "good motherhood". I was able to realize that moral rhetoric related to the stereotypes of the "good mother" are confronted with the actual experiences lived by participants in establishing the *habitualities* of childrearing during the first transition to motherhood. In some situations, I could observe the rising of ethical responsiveness towards a broader politicisation of motherhood, in which structural problems can be better visualized, such as gender oppression, racialization and discrimination of non-heteronormative families.

In the following chapters, all the quotes of the interviews' narratives are identified by pseudonyms that replace the respective speaker's real name, and the names of their family members were replaced by the initial letter. The sociological marks of their respective situations can be visualized with the aid of Table II in chapter 1.3.a, but are somehow remembered each time the participants' stories and quotes are cited. The quotes were translated into English, but are also presented in the original language in the Annex of this thesis. I used bold letters to emphasize speaking fragments I judged as essential for the understanding of the unities of senses analysed.

Part one: Setting the framework

This thesis is an outcome of a research developed in dialogue with three fields of knowledge: the first one is Public Health, specifically the domain of public policy analysis in the health sector; the second one is Feminist Studies, which can be understood not only as an autonomous academic field with which I dialogue but also as a transversal critical approach that permeates this whole enterprise; and the third one is Psychology, understood as a Social Science with clinical and ethical concerns.

In this first part of the thesis, I explain and discuss my point of departure, considering the three fields mentioned before and revising the most basic assumptions of traditional Motherhood Studies. In doing so, I do not intend to evaluate the social policies commented in the text, neither to embrace all the history and ethical implications of Public Health, Psychology and Feminism, but to identify specific debates, concepts and paradigms related to mothers' health and rights that are quite important for the contextualization of this thesis.

In the first chapter, I discuss Public Health as an interdisciplinary and globalized field from which many rhetorics and policies around motherhood are present, being a privileged source for social presence in the transition of motherhood. After discussing some aspects of Brazilian Public Health and its relationship with family policy and global health, I describe my pathway as an "implicated researcher", the process of defining my research questions and the contextualization of my fieldwork. I also introduce the core concept of this thesis: "social presence", which is part of a broader debate on "care crisis" and "care ethics".

In the second chapter, I assemble the philosophical and sociological framework that attempts to deconstruct the traditional approach of research about motherhood, which is generally based on biological facts or psychological theories of human development. I discuss the difficulties of Academic Feminism in embracing motherhood as a specific subject because of the resistance to the naturalization of women's identities. Therefore, I develop a multifaceted debate on Feminist Phenomenology and feminist considerations on "nature" and "human condition", in order to construct an alternative epistemological approach that converges to an "epistemology of resistance" and an ethical outcome of this research situation. I assume my interest in analysing social presence from a serious consideration of women's bodily experiences, and proceed to explain some of the most important concepts applied in the analysis, such as "social presence", "situation", "experiences", "gender" and "intersectionality".

I.1 RESEARCH PATHWAY: PUBLIC HEALTH AS A *SITUATION CHARNIÈRE*

In this chapter, I present the interdisciplinary nature of this thesis, discussing the context of Public Health and Welfare, focusing on maternal and women's health within Brazil and at a global level. I also discuss Brazilian immigration to Portugal, France and Sweden, while introducing the context of family policies in those countries. Furthermore, I introduce the research questions that motivate the theoretical framework and methodological approach that will be subsequently discussed.

Public Health is fundamentally multi- and interdisciplinary, because health is a multifactorial and complex outcome. The World Health Organization (WHO) has largely contributed to conform it as a global and political multi-disciplinary field, acknowledging that health "is a state of complete physical, mental, and social well-being, and not merely the absence of disease" (WHO, 2006, p.1). Therefore, the WHO favoured the emergence of discordant definitions of well-being, individual and community health in Academia and political systems worldwide. Scholars and political actors have to resort critical theories from Social Sciences beyond the traditional health sciences to forging the great debates introduced in the last decades and enjoy Gender Studies and Academic Feminism as important interlocutors. Thus, WHO performance is related to the "globalization of gender" (Le Renard, 2013), producing contradictory outcomes for women, such as the invisibility of health concerns that are not directly assimilated in the consensus between nations or are not emphasized by scholars who feed those debates.

I.1.A THE PROBLEM OF THE MATERNALIST RHETORIC OF BRAZILIAN SOCIAL POLICIES

In Brazil, the "Health Reform" project was constructed under this innovative health consciousness of embracing economic, ideological and political dimensions, including feminist contributions to the debate on reproductive rights (Scavoni, 2000; Leite, 2014). Political and social movements influenced the implementation of this project, seeing it as a model and a motivation for other social changes in the country, encouraging social participation to consolidate the recent democracy that was being established in the 1980s after a long period of military dictatorship (Almeida, 1999; Baptista, 1997). The Health Reform in Brazil was strongly motivated by Latin American and local social movements displaying left-wing tendencies, such as the "Collective Health Movement" (Saúde Coletiva), the "Anti-asylum Fight" (Luta Anti-manicomial), the "Popular Education Movement" (Educação Popular), which emphasized the relationship between health, social equality, autonomy and citizenship. They all had quite an important influence in subsequent years of Brazilian social policies, despite a political system marked with a strong heritage of capitalist dictatorship (Pombo-de-Barros, 2009).

Later, in the 1990s and 2000s, the injunctions of economic stabilization and neoliberal rhetoric promoted an expansion of the Brazilian Unified Health System (SUS: Sistema Único de Saúde) permeated with contradictions (Almeida, 1999; Leite, 2014; Menicucci, 2007). It became increasingly mixed with great participation of the private sector and out-of-pocket budget, and with great regional disparities, despite the law that asserts SUS as a "universal system". It has also reinforced the leadership of sanitarian discourses with a maternalist approach in the incipient field of family policies influenced by a global rhetoric on "social investment and human capital" (Jenson, 2011). This rhetoric can be identified in different recommendations and agreements by international organizations, which has an important influence in the improvement of children's and women's rights from poor and developing countries, but also in obstructing a broader agenda on gender equality:

> Il nous faut d'ailleurs noter que, à la fois en Europe ou dans les pays du Sud, les politiques d'investissement social, quand elles s'intéressent aux femmes adultes, se préoccupent de plus en plus des questions relatives à la maternité et à leurs liens avec la croissance démographique. Ainsi, les féministes ont une autre évaluation de la convergence entre la perspective d'investissement social et la conscience de genre. Elles sont beaucoup plus sceptiques sur le fait que cette perspective, particulièrement en raison de la place centrale accordée aux enfants et au capital humain, pourrait avoir des conséquences positives sur leur objectif d'égalité des sexes. (Jenson, 2011, p. 31)

Despite the important participation of health activists in the movement for reproductive rights in Brazil, who also fight for the decriminalization of abortion, this matter was not easily articulated into the agenda of maternal health and social investment – until now they seem contradictory in the Brazilian public spheres (Leite, 2014; Diniz, 2009).

The use of a public health budget by the Federal Government to strengthen the "Family Grant Program" (PBF: Programa Bolsa-Família) in the 2000s is one example of the country's priorities when "family" and "health" appear in the headlines. Fed by a broader view of health but limited view of gender equality, the PBF is a strategy for cash transfer idealized to be the first step for a minimum revenue policy in the country, but designed with the support of World Bank and other international agencies to reduce extreme poverty (Pombo-de-Barros, 2009). It uses the rhetoric on the necessary role of biological mothers in family health, because it imposes some compliances to the beneficiaries: the mothers, who are the large majority of beneficiaries, must ensure their children's school attendance and up-to-date vaccination records, as well as provide proof of receiving pre-natal medical assistance when pregnant, in order to be entitle for the grant; but those mothers live in "subnormal habitations"[8] or remote rural are-

[8] "Subnormal habitation" is a classification by Brazilian Statistics and Geography Institute (IBGE) which characterizes the *favelas*. See in:
http://www.ibge.gov.br/home/presidencia/noticias/imprensa/ppts/00000006960012162011001721999177.pdf

as, where public services are not adequately present. However, the use of the state health budget to finance and expand the PBF to the detriment of better public health structure distribution, in the 2000s, contributed to join different political parties and representatives in conceding that reducing poverty was an urgent goal, thus favouring the governability of the first Workers' Party (PT: Partido dos Trabalhadores) president Luis Inácio Lula da Silva, and fitting with a "global consciousness" among politicians (Pombo-de-Barros, 2009).

The main criticism by scholars regarding the expansion of PBF concerns the concurrence of the program *vis à vis* a broader "social investment" in education and infrastructure (Lavinas, 2007). It is also targeted by different criticisms on its limited role in promoting gender equality; some analyses show that it has positive outcomes in the well-being of poor women, but not sufficient for emancipation through better working conditions (Lavinas et al, 2012) and reveal negative effects on the participation of men in domestic and childcare duties (Meyer et al, 2012). In a previous research studies on the social representations of citizenship among Brazilian politicians in the social policy agenda, I perceived "global consciousness" and the PBF as articulated and central elements, while historical inequalities such as racial and gender imbalances have not occurred:

> A exclusão dos negros e das mulheres é citada apenas como exemplo extraído do passado.(...) A consciência global une-se à solidariedade a fim de reforçar uma nova visão de Estado e cidadania, que retira do primeiro a função de provedor e coordenador da integração social, colocando-o como facilitador e incentivador da solidariedade. Por um lado, esta dinâmica amplia as possibilidades de participação dos eleitores e de grupos historicamente excluídos na esfera pública. Por outro lado, este projeto de Estado casa-se com uma representação de cidadania no Brasil que mantém a visão de desigualdade entre os cidadãos, e dificulta a implantação de projetos políticos que pretendam superá-la de fato. (Pombo de Barros, 2009, p. 117, 121)

Then, the expansion of the main family policy on the country was anchored on the global rhetoric of women's role in fighting against child poverty and for child health, thus requesting a specific kind of solidarity without clear concerns on gender and racial inequalities, and confirming the core role of globalized rhetoric. More recently, some official reports from international and national organizations reveal tension between mothers' well-being and the ideals of global public health. Usually, the proposals that try to overpass this tension subsume changes of women's behaviour and much less in institutional rules and men's behaviour (Boyer & Nicolas, 2015; Nicole-Drancourt & Jany-Catrice, 2008; Pailhé & Solaz, 2009). The approach of social investment related to cash transfer strategies is trying to respond to the immediate needs of poor mothers, but reclaiming from them much more dedication to childcare than from fathers. The rhetoric on "human capital" which sustains those policies is related to two processes: an a-critical appropriation of psychological concepts of human development produced and diffused by

the WHO since the 1950's[9] and the stigmatization of poor, racialized and non-nuclear families reinforced by power imbalances in national public spheres. Moreover, it is clear that to potentialize their positive outcomes, those policies should be better contextualized by feminist and intersectional studies.

> Health, in this context – and to a large extent, in the emerging 'global health' discourse more generally – was positioned as addressing a set of natural and 'scientific' problems. In this sense, 'health' represents a series of challenges that can be easily solved simply through the adequate devotion of economic and technological resources. Similarly, by focusing on maternal health, the initiative emphasizes the 'natural' processes of reproduction, which are likewise constructed as a-political. Like 'democracy' and 'human rights' we are all for women's health. Unlike 'political' gender issues, this is constructed as a 'women's issue' on which we can all agree. In this way, the politics surrounding issues related to women's health recede out of view (Robinson, 2014, p. 99, her quotations)

Concomitantly, in Brazil the Primary Health System was developed with "community agents" and multidisciplinary teams as the cornerstone for assistance in subnormal neighbourhoods, thus promoting a broader conception of health care than the one centred on medicalization and hospitals. This last strategy, called "Family Health Strategy" (ESF: Estratégia de Saúde da Família), also has family-focus rhetorics and contributed to the improvement of children's health indexes, but it was expanded in parallel with a huge increase in the consumption of medication favoured by a public policy centred in a medicine supply chain supported by the Federal Government (Machado et al, 2011). Also, the "reproductive health" and "family planning" agenda, constructed in the 1980s and 1990s with a strong participation of feminists and the black women movements, was gradually gulped by another policy with maternalist rhetoric, the so called "Stock Network" (RC: Rede Cegonha). Stock Network was launched during the first government of President Dilma in 2011 with "childbirth humanization" as a cornerstone, playing down the right not to bear children and the integral assistance of women's health conquered during the first period of Brazil's democratization (Pimentel, 2014).

Stock Network has been debated and analysed by feminist activists and scholars through different standpoints, because it tries to face the "C-section epidemic" in the country (Leal et al, 2012), but without articulation with historical social movements engaged in the Integral Assistance to Woman's Health Program (PAISM: Programa de Atenção Integral à Saúde da Mulher). The construction of RC shows progress by the Federal Government towards a political coalition with key actors of the "maternal-infant health" movement, who profess conservative arguments on reproduction and maternal roles, but it also shows the rising of political participation of middle and upper class women, who are claiming better conditions to resist over-medicalization of perinatal health in private institutions.

[9] The most influent and representative reports of this WHO's rhetoric in the Twentieth Century are the ones on "Maternal care and mental health" by John Bowlby in the 1950's and Ainsworth et al in the 1960's.

> Nesta perspectiva materno-infantil, a que a Rede Cegonha estaria vinculada, a concepção de política de saúde de assistência às mulheres se estabelecia no entendimento de mulher enquanto reprodutora, ou seja, a política de saúde para as mulheres seria constituída a partir do binômio mulher-bebê, portanto, excluiria aquelas mulheres que não desejassem filhos. Em outras palavras, as mulheres que optam pelo abortamento não estariam incluídas neste tipo de política de assistência à saúde das mulheres. (Pimentel, 2014, p. 87)

During the 1980s, the PAISM resulted from the coalition of feminist movements, black movements, and interests of left wing parties, marking the consolidation of a public agenda on family planning in Brazil, and making way for contraception and abortion to be discussed as a public health matter. During that period, illicit caesarean sections were being performed to justify a subsequent tubal ligation procedure in women who used SUS facilities but were not allowed free access to sterilization. This common albeit informal procedure was used as a bargain for votes in local elections and configured a perverse framework that gradually began to change (Correa, 1993). However, it contributed to a strong domination culture by physicians over women's sexuality and the use of fertility as a political bargaining chip (Carvalho & Brito, 2005). Nowadays the Family Planning Law allows physicians to refuse to sterilize women or assist abortions based on their "conscious objection", even in cases in which the woman has the legal right to access these procedures[10] (Diniz, 2013).

Furthermore, the persistent criminalization of abortion can be related to the high rate of female sterilization, even after the legal regulation of this practice in 1997, promoted by physicians in public and philanthropic institutions as one of the most common birth control methode (Scavone, 2000). In 2011 Brazil still figured as the third country in South America with the highest rate of female sterilization, used as birth control by 29.1% of women who were married or living with a partner, while the same indicator in Argentina was 5.8%, Bolivia 6.5% and Uruguay 5.4% (UN, 2013)[11]. Despite the absence of consistent demographic data about those women, one knows that, historically, the majority of them are black and poor (Roland et al, 1991).

In light of women's historic demand for fertility control, the movement towards childbirth humanization offers very few answers. While the Brazilian state reinvests in the "maternal-infant" rhetoric through RC, studies that feed the humanization agenda focus on the main problems of the Complementary Health System. An important example of this trend can be observed in the recent national survey *"Nascer no Brasil"*[12], conducted between 2011 and 2012 and considered the most important initiative for evaluating the perinatal healthcare system in the country (Leal, 2015; 2014). The inquiry has contributed to

[10]Legal and assisted abortion is a right granted to pregnant women who have been raped, or whose lives are at risk or whose foetus' lives are at risk.

[11] See: http://www.un.org/en/development/desa/population/publications/family/contraceptive-wallchart-2013.shtml

[12] This report is part of the documentary research of this thesis and will be further analysed in Part III.

consolidate a political agenda on the quality of perinatal care, using WHO's reference parameters to struggle against "epidemic caesareans" (more than 80% of deliveries in private facilities and more than 40% in public ones) (Domingues et al, 2014; d'Orsi et al, 2014). However, although it revealed that 45% of the interviewed pregnant women did not have planned pregnancies, the inquiry did not analyse further the high percentage of them who wished to have surgical birth because it would facilitate their access to sterilization. In other words, the articulation of the desire to not have children and the access to medicalization during pregnancy and birth is not being conducted by the contemporary analysis of Brazilian perinatal health – which could contribute to the understanding of various problems related to this field. This lack seems to express a class divergence regarding women's interests in feminist social movements.

Thereby, receiving much attention from public budget and political agendas in the last fifteen years, PBF, ESF and RC contributed to the consolidation of a rhetoric on "maternal presence" in Public Health agendas in Brazil, converging interests of different ideological groups such as the capitalist investors of health sector, the conservative parties and some left-wing movements – in which Feminism has a peripheral role. At this point, comparing maternal and infant health, one can assert a "perinatal paradox": while we assist a great improvement of infants' health indicators, the increase of breastfeeding among all social classes and better access to neo-natal technologies (Brasil, 2009), maternal mortality rates remain startlingly high due to unsafe abortion, inequality in the distribution of maternity facilities and vulgarization of caesarean sections (Mello & Galli, 2009; Diniz, 2009; Leal et al, 2012; Brasil, 2009).

At the same time, it is clear that changes in the Brazilian Welfare system since the 1980s produced positive outcomes for poor women, who have been acquiring more autonomy in conjugality and inside communities because of better access to revenue and primary health care (Giffin, 2002). The number of female-headed families has been significantly rising in the last decades, accounting for 33% of households in 2007, and 37% among the poorest families (Mariano & Carloto, 2009). The Ministry of Social Development asserted that 93% of the PBF's beneficiaries are women who head their families, 68% of them being black (Brasil, 2014). This means that one can assume a gradual emancipation of the most vulnerable women in the country, however, it also comprises another conflicting aspect: a significant number of them are single parents and are accumulating a great responsibility as breadwinners and family caregivers in very difficult conditions. As Giffin (2002) asserts on the Brazilian "gender transition":

> Dados mais recentes de áreas urbanas de baixa renda no Brasil mostram que com a dificuldade crescente dos homens garantirem uma renda familiar adequada, ou mesmo manter um trabalho

> minimamente estável, estamos passando por uma 'transição de gênero' em que as mulheres não somente 'ajudam' como também começam a ser responsabilizadas, e a se considerarem responsáveis pela provisão de renda, mesmo (ou, principalmente) tendo filhos menores. Essa atualização ideológica dos gêneros, na figura da 'nova mulher independente' que controla sua fecundidade, trabalha fora e tem seu dinheiro 'próprio', permite o ocultamento do aprofundamento da dupla jornada, da exploração e da forma em que estas estratégias contribuem para a reprodução da desigualdade em nível de gênero e de classe social. (Giffin, 2002, p. 105, her quotations)

Thereby, the most important social policies in the country led to two negative consequences: the reinforcement of a conservative ideal of "motherhood" based on the binomial mother-infant, and the weak investment in historical requests of feminist and black women movements such as: a) public and full-time day-care centres; in 2010, only 24% of children under three years old attended childcare centres, and the goal to rise this percentage to 50% announced by the Federal Government in 2011 are far from being reached, according to Cruz et al (2014), b) and a strong policy in reproductive health, including assistance for safe abortion. This phenomenon can be also explicated by the lack of interest of privileged groups in universalizing those rights, since they can pay for the respective services in the private sector. For reproductive health, perinatal and post-partum assistance, middle-class and upper-class women profit from private health insurances and facilities, including access to expensive and illegal abortion clinics, higher rates of surgical childbirth but also better access to "humanized childbirth". In fact, middle classes are not really targeted by social policies in the country although they have a growing influence in the political agenda acting as healthcare and social workers, political activists and influential academics. Therefore, one can identify the paradoxical reproduction of neoliberal logics of privatization and medicalization of health and motherhood in recent years in Brazil, with the influence of global health rhetoric (Jenson, 2011; Leite, 2013).

In light of this complex context, some authors are working with different hypotheses to explain why the SUS could not overcome historical inequalities and truly universalize the healthcare rights in an integrated perspective – a hypothesis that emphasizes external reasons, such as Federalism and fiscal constraints, and internal reasons related to the interests of social movements towards health reform. I profit from those readings to identify how these hypotheses seem related to the exclusion of intersectional feminist priorities from the implementation of social policies in Brazil despite the focus on women's social roles. Basically, I assume the following reasons as pertinent to explain this failure: a) the "excluding universalization" of SUS, which consisted in the expansion of the system without the participation of middle classes as beneficiaries of public services (Faveret & Oliveira, 1990), b) articulated to an individualistic and conservative ideology of motherhood and family, supported by international agreements and maternalist movements, and not sufficiently faced by Academic Feminism (Jenson,

2011; Leite, 2014). Those processes favoured the advancement of an ideological actualization of "gender transition" with the invisibility of class conflicts in a "new politicisation of motherhood" based on maternal-infant health (Leite, 2013; Giffin, 2002; Meyer, 2005).

In summary, the expansion of Public Health in Brazil allowed dynamic articulations between various scientific disciplines, democratizing knowledge and expanding social rights, but also defying the deconstruction of gender and class inequalities, because of the reification of motherhood as a static landscape for children and family well-being, and because of the invisibility of historical matters such as racial and economic inequalities among women, in the political agenda. This "new" form of motherhood politicisation then is charged by old and conservative ideals and concomitantly has an important heritage of the Public Health Reform movement and profits from the democratic development of political institutions in the country.

> De uma forma geral, essa politização da maternidade é incorporada e difundida pelas políticas de Estado, pelos manuais, revistas, jornais, televisão, cinema e publicidade. E o modelo da mãe cuidadosa – que cuida e se cuida – triunfa e, ao mesmo tempo, se democratiza (...) A discursividade que produz e sustenta esse processo de politização também articula, explícita e intensamente, problemas sociais contemporâneos (em especial de educação e de saúde) a certos modos de sentir e de viver a maternidade. E essa operação permite descolar tais problemas dos contextos e processos sociais mais amplos em que eles são gerados para vincular sua solução a determinados tipos de relação mãe-filho e ao exercício de uma determinada forma de maternidade. (Meyer, 2005, p. 82)

At this point, I understand Public Health as a never completed field of knowledge, but as a complex body of knowledge that is open to recurrent reviews – a situation that reminds me of the characterization of Social Psychology as a *"science charnière"* by Jean Maisonneuve (1973). With this author we can say that a field in a *"situation charnière"* intents to be specific but not autonomous, because it is nourished by theories and methods from other specific disciplines depending on the subject that is on focus and on the social context from which the knowledge emerges. In the following chapters, I will discuss my position as a researcher in this arena, deepening the analysis of the social context of Brazilian and European Public Health, Feminism, immigration and family policies.

I.1.B THE RESEARCH QUESTIONS AND THEIR CONTEXT: CHOOSING "SOCIAL PRESENCE"

The asymmetry between social classes and race in Brazilian maternal health and the weakness of gender issues in the global health discourses has drawn my attention. From my first impressions as a recent mother working in the Public Health field as psychologist and researcher, I realized psychologized and sanitarian discourses that serve to separate women between "good mothers", "bad mothers" and "bad women"; what I called hegemonic representation of the "Universal Mother" (Pombo, 2013). This representation hides the differences between mothers and mothering styles, assuming that all women have the same biological and/or psyche equipment to correspond to a childrearing ideal, an ideal constructed by privileged groups. I suspected that the invisibility of those differences in public spheres obstructed the development of universal childcare systems, family policies and family planning services in Brazil, favouring the maintenance of mothering as a private and domestic matter. What kind of rhetoric on motherhood do privileged Brazilian mothers produce? To which extend does sanitarian and globalized rhetoric contribute to those mothers' experiences in the transitions of motherhood? To which extend do they reproduce the class and racial inequalities when undergoing these transitions? When living as immigrants in different European countries, those women have different experiences and produce more emancipating rhetoric on motherhood?

FROM DEMOGRAPHIC CRISIS TO CARE ETHICS AT THE TRANSNATIONAL CONTEXT

Here I discuss the recent debates on immigration and welfare in Europe that lead me to choose social presence as a core concept of my research. This study is not focused on immigration, but emerges from the debate on the outcomes of contemporary transitions between Brazil and Europe; and in doing so it must be aware of the contradictory effects of the internationalization of the rhetoric influencing women's and mothers' rights, such as the rhetoric on demographic and care crisis. Regarding immigration, the political regime of Human Rights contributes to international immigrants' rights but is confronted by the fear of weakening national sovereignty, producing paradoxical reactions by developed countries facing foreign residents (Brito, 2013). Those reactions are not determined only by economic crisis, but are related to the history of modernization and national projects in each country.

Europe contributes to the emergence of Human Rights as a global reference for a myriad of social matters while simultaneously producing harsh criticisms on the globalization of capitalism and its consequences for labour markets, the environment, healthcare, ageing population, and different social rights, which seem threatened by "negative individualism" (Castel, 1999) and the expropriation of National States (Bauman, 1999). Thus, one can identify different rhetorics from scholars and politicians by right-

or left-wings movements assuming a misgiving *vis à vis* international migrations or even promoting anti-immigration discourses. In this context, Fausto Brito (2013) asserts that the articulation of national sovereignty and Human Rights rhetorics is not a solved debate, especially concerning international migrations. In fact, the conflicts and superposition of discourses on this matter show how political polarization cannot help understand it.

Whereas, in Portugal, Brazilian immigrants represent the largest foreign group (SEF, 2013) , and whose relationship is marked by historical colonization, in France, they are the largest group of American nationalities but are less numerous than African and European migrants (Ined, 2008). Sweden, despite being one of the European countries with the highest rate of foreign residents (15%), does not have relevant data on the Brazilian migration; therefore they are considered a minority (DSED, 2014). Generally, Brazilian immigration to Europe is drawn from middle and upper classes and represents a qualified workforce that transits due to academic and/or economic reasons; albeit showing different levels and forms of integration within different societies. However, the trend of feminization of migratory fluxes is observed internationally. For instance, in Portugal, women are already the majority of migrants from Brazil consisting in 56% of the total flux, and they also represent more than 25% of the female migration to Portugal (Gomes, 2013).

Concerning health and family rights, Sweden offers a universalized system, with low levels of medicalization in childbirth, long parental leaves and high quality of childcare facilities, leading global rankings in terms of children's and mothers' well-being. On the other hand, women are still the main caregivers at home (King et al, 2011; Elvin-Nowak & Thomsson, 2001), while fathers use less than 25% of the leave's total time; this inequality is even higher among migrants (Nyberg, 2012; Mussino & Duvander, 2014). Surveys investigating parents' knowledge about parental-leave rights have found indication that immigrants' knowledge of how to efficiently use the leave is low in the country, compromising their presence in the labour market (Mussino & Duvander, 2014). In Portugal, specific problems in the access to information on social rights and health care among Brazilians have been identified (Almeida & Caldas, 2013). In this country, the great efforts to improve family policies and healthcare for mothers and babies in a universalized system have been strongly challenged by the economic crisis of the 2000s, rising unemployment and worse social conditions among migrants and promoting an important change in the flux between Brazil and Portugal (Nunan & Peixoto, 2012). Thus, the fertility rate is also declining among migrants, who usually tend to have more children (SEF, 2012).

In France, there is a growing trend since 1997 of women requesting public financial benefits to stay out of the workforce and caring full-time for their children under six years old, which is more common among foreign residents (Grosset, 2004). Childcare centres are mostly public but not sufficient to face families' demands, constraining many women who do not have full-time jobs and long-term careers to remain fully dedicated to childrearing, which means that the immigrants' situation is worse than that of women born in France (Crenner, 2011). In this country, fertility and family policies are constantly related to the debates on national identity because of the historical effort of constructing a modern National state based on nationalization and naturalization of filiation (Fassin, 2009). However, in the three countries, immigrant women represent a rather important workforce in domestic and care work in *crèches* and households.

Generally, many demographic inquiries are indicating low fertility and ageing as serious causes of the recent "care crisis" in Europe, and seek to motivate women into choosing to become mothers while reconciling their domestic duties and professional career. The Organisation for Economic Co-operation and Development (OECD) recognized families as the "cornerstone of society" and "nuclear organizations" that play a central role in the economy and mentioned in recent reports the "changing family context" with demographic and social aspects such as ageing and fertility decline (OECD, 2007, p. 07). These changes are associated to the erosion of the male-breadwinner/female-homecare family model – which has being interpreted as the principal cause for a "demographic crisis" in developed countries (Philipov, 2011). One can note an international consensus according to which National states should intervene for the improvement of fertility in Europe while trying to promote gender equality in workplaces. That's why it is not surprising to read the question posed by the Max Planck Institute for Demographic Research in 2006 and published by Demographic Research in 2011: "Should governments in Europe be more aggressive in pushing for gender equality to raise fertility?" On the other hand, in this debate, the need for state intervention in gender equality is not questioned; the need for action targeting fertility is doubted by Tolemon (2011) and denied by Guerda Neyer (2011). Philipov (2011), in turn, affirms the need for gender-neutral family and fertility policies, insisting that gender equality policies can significantly interfere in population control. Livia Ohlá (2011) defends gender equality as an efficient policy to raise fertility, assuming that the changes in family and work organization are here to stay.

During this debate, Gerda Neyer (2011) discussed the ideological implications of considering a consensual and international concern about low fertility. She affirmed that those who claim that fertility is too low and needs to be raised usually neglect gender implications of their proposals, then she declared "myths" what they call "problems". For her, the "myth" of European superiority is the basis of these

proposals, and gender is used as a marginal variable, as a tool for population control, articulating immigration and fertility in an oppressive way: on the one hand, with the concept of "replacement migration" viewing migrants "merely as an economic or demographic resource (and not as human beings with their own needs and individuality)" (Neyer, 2012, p. 234), and on another, warning of the supposedly detrimental consequences of compensatory immigration, introducing a "hierarchical distinction between 'us' – i.e., the people of supposedly 'indigenous origin' – and 'others', i.e. all those who are declared not to be of this origin" (p. 235). According to Neyer, this kind of rhetoric of European superiority is contemplated by maternalist perspectives; as examples she comments on the maternalist systems of France and Germany. She also asserts a different interpretation of Nordic countries' fertility rates, which, according to her, are not promoted by "aggressive" gender equality policies but by a gender perspective presented transversally in Nordic Welfare Systems.

Therefore, Neyer's criticisms seem quite interesting to the understanding of the general resistance of social policy managers against gender as a structural dimension and temporality as a gendered structure. It implies overcoming the separation of Sociology of family and Sociology of work (Tripé, 1997), private and public spheres, Human Rights and national borders. The research questions that motivate this thesis are mostly in the interface of theses spheres, trying to point out the political aspects of "care ethics". Feminist scholars worldwide are articulating the debates on Human Rights, transnationalism and globalization by an ethical analysis on the "transnational care", through the recognition of "transnational families" (Baltassar & Merla, 2014) and the importance of thinking the place of care in many global issues such as "security", "diplomacy" (Robinson, 2014; 2011) and the "reproduction sphere" that includes the "reproduction of cultures and structures of belonging" (Gedalof, 2009, p. 82). This theoretical framework brings interesting and innovative questions to the more traditional and dichotomist debate, converging to the contemporary development of the theory of care ethics started by Carol Gilligan (1985) in the field of Psychology and Moral Philosophy in North America. The political and epistemological development of this theory is being deeply expanded in Europe by feminist scholars such as Sandra Laugier (2011), Patricia Paperman (2013), Pascale Molinier (2010), Fabienne Brugère (2013, 2011) and others, and it is also growing in Brazil by the work of Helena Hirata (2014), Nadya Guimarães (Guimarães et al, 2011) and others.

Thus, the contemporary development of the care ethics theory responds to the debate on the "care crisis" discussed by scholars and politicians for the last fifty years, including the problems related to globalized capitalism. Robert Castel (2012) had recently welcomed the feminists' criticism on his theory, recognizing that he left out the role of gender in the study of the labour market and wage society,

pointing out that other contemporary researches should develop such criticism. One of the authors who dialogue with Castel's theory in locating gender as a central issue is Marc Bessin (2014; 2009), who refers to the concept of "social presence", a concept forged in French sectors of social work and appropriated by the Sociology of care: *"sociologie des interventions pour autrui"* (Bessin, 2009, p. 3). Responding to the need of revising theories and classical questions on "care crisis", "social crisis" and "demographic crisis", Marc Bessin proposes a phenomenological approach of gendered temporality (Bessin, 2014). He argues:

> Il me semble que cet élargissement à l'analyse morale des temporalités s'impose pour affronter le double défi de mobilisation des individus dans la société post-salariale (...) En découlant aussi des questions plus classiques sur la manière d'articuler un système de droits pour s'adapter à une question formulée à partir des besoins et des situations concrètes et singulières. (Bessin, 2012, p. 267)

Converging with Bessin's proposal, other scholars are surpassing traditional dichotomies on their analysis in locating gender as a transversal matter. For instance, the distinction and hierarchy between "ethics of justice" and "ethics of care" have been replaced by an integrated approach which visualizes the intrinsic relationship of moral affections and "universal" ethics in caring relationships (Paperman, 2013). Also, the classic organization of social services focused on patterns of social identities, such as "man" and "woman", "young" and "elderly", is being criticized by scholars who prioritize "cycles of life" and "life courses", recognizing different temporalities and needs of care (Nicole-Drancourt, 2007; Nicole-Drancourt & Jany-Catrice, 2008). The debate on the balance of family and working life is also being revised by scholars who show the important role of enterprises and childcare centres in what we are used to consider a private problem (Tripé, 1997; Michel & Mahon, 2002; Pailhé & Solaz, 2009).

In addition, as a normative standpoint, I consider the "right to have a family"[13] rather than concerning with a crisis in certain family models– which means that I am attentive to the recent Social Sciences debates on the politicisation of parenting and family life led by different scholars such as Eric Fassin (2009, 2013) in France, Gerda Neyer (2011), Mussino & Duvander (2014) in Sweden, Dagmar Meyer and colleagues (2005, 2012) in Brazil and Karin Wall and colleagues (2013) in Portugal, who invert the place of evidence-based research in social policy analysis, questioning to which degree do those policies fit reality. Those authors contribute to the understanding of filiation and family as multiple realities not restricted to biological and national citizenship, equalling the right to have a family to others already considered "unconditional rights", independent of gender identities and nationality. It opens the discus-

[13] The construction of "parental leave" in Sweden is one of the most illustrative policies as a result of this principle, since, in this country, parental leave started to be conceived as an individual's right, not only entitled to the biological mothers as it was prior to the 1990's (Nyberg, 2012;).

sion to *real* experiences of migrants, children living in the streets, recomposed, mono-parental and adoptive families, homosexuals, bisexuals and transgender people who are parents, contributing to the denaturalization of filiation as fundamentally biological and as a classist and nationalist matter; as asserted by Fassin (2013): "le droit de vivre en famille ne serait pas soumis par exemple à des contraintes de ressources, de taille de logement, de langue, mais vivre en famille serait un droit inconditionnel soit au même titre que se marier". This broader conception contributes to more flexible definitions of family policy beneficiaries, despite the constant effort of most programs to educate members of nuclear families into certain conviviality patterns.

At first, my research questions and the consideration of the general context of Brazilian immigration in Europe led me to what seemed to be two opposite inquiry approaches: the first one being sociological, focused on the recent history and construction of "motherhood" in the public spheres, and other psychological, focused on the subjective and single experiences of mothers inside those systems. However, aware of the recent debates influenced by Feminism, gender and immigration studies, I reached the theory of social presence, which is a sociological enterprise with a clear interest in singular experiences (Bessin, 2014). Correspondingly, social presence helps me think of mothers' presence related to the project and routine of motherhood and of fathers', institutions', informal networks' and others' presence for maternal health and childbearing, propitiated or not by social policies. "Presence" is a concept that is *"charnière"* itself, in a scientific culture that privileges scission and hierarchy of knowledge fields. I can just identify my questions in Hans Gumbrecht's "desire of presence":

> Ao contrário, perguntar-se por que me sinto tão tocado pelos fenômenos de presença e pela possibilidade de refletir sobre eles, isso conduz a analisar a situação cultural do presente: em um nível primário, os efeitos da presença tem sido tão completamente banidos que agora regressam como um intenso desejo de presença – reforçado ou até iniciado por muitos dos nossos meios de comunicação contemporâneos. (Gumbrecht, 2010, p. 42)

Gumbrecht mentions a "primary level" of presence as his focus, which I understand as an interest in intense experiences that are not dependent on reflectivity, such as some religious sensitivity like epiphany, for which: "the passage of time will not be lived as a producer of a distance *vis à vis* the past" (2009, p. 17, free translation). Another concept that can be related to Gumbrecht's reflection consists in the "own body" by Merleau-Ponty (1945). Undergoing experiences of presence offers subjects the sense of immanence and the potential to experience transcendence – which means that the "own body" from a first person's perspective differentiates a human's presence from an inanimate objects' presence:

> Mais ce fait ne prouve pas que la présence de mon corps soit comparable à la permanence de fait de certains objets, l'organe à un outil toujours disponible. Il montre qu'inversement les actions dans lesquelles je m'engage par l'habitude s'incorporent à leurs instruments et les font participer à la structure originale du corps propre. Quant à lui, il est l'habitude primordiale, celle qui conditionne toutes les autres et par laquelle elles se comprennent. (Merleau-Ponty, 1945, p. 125)

During my readings I could identify different dimensions, focuses, and "levels" of those "phenomenons of presence" among philosophers', psychologists' and sociologists' theories, despite the same "desire". In my turn, I decided to research social presence as part of intersubjectivity, situated in time, space and power relations, privileging bodily experiences, such as the "desire of presence", habits and hesitations, regarding aesthetic objects and human relationships.

I choose to use the expressions "transition of motherhood", "transition into motherhood" and "transition to motherhood", interchangeably, although I recognize they have originally specific purports. The three prepositions (of, into, to) help me *complexify* the traditional view of motherhood as an individual and definitive life-changing experience of all "normal" women after childbirth. I switch between prepositions when discussing "transition" followed by "into" – which conveys a sense of a permanent future – or followed by the variability subsumed in "of" and the relationality of "to". Transition contains time as an index in its definition; it necessarily implies change, movement, processes within the duration of a certain period, but a period that is lived sometimes as ruptures and sometimes as temporary stages conditioned by surrounding presences. Beyond that, even if one can find the "radical fragmentation of time" as the only possible condition to live through "experiences of presence" in their primary level, as mentioned by Gumbrecht (2010), I assume that this condition is not "essential" but constructed by the same scission that intensifies this desire and that configures contemporaneity. I suppose that experiences of presence, in different levels, depend on temporality as social structure (Bessin, 2014).

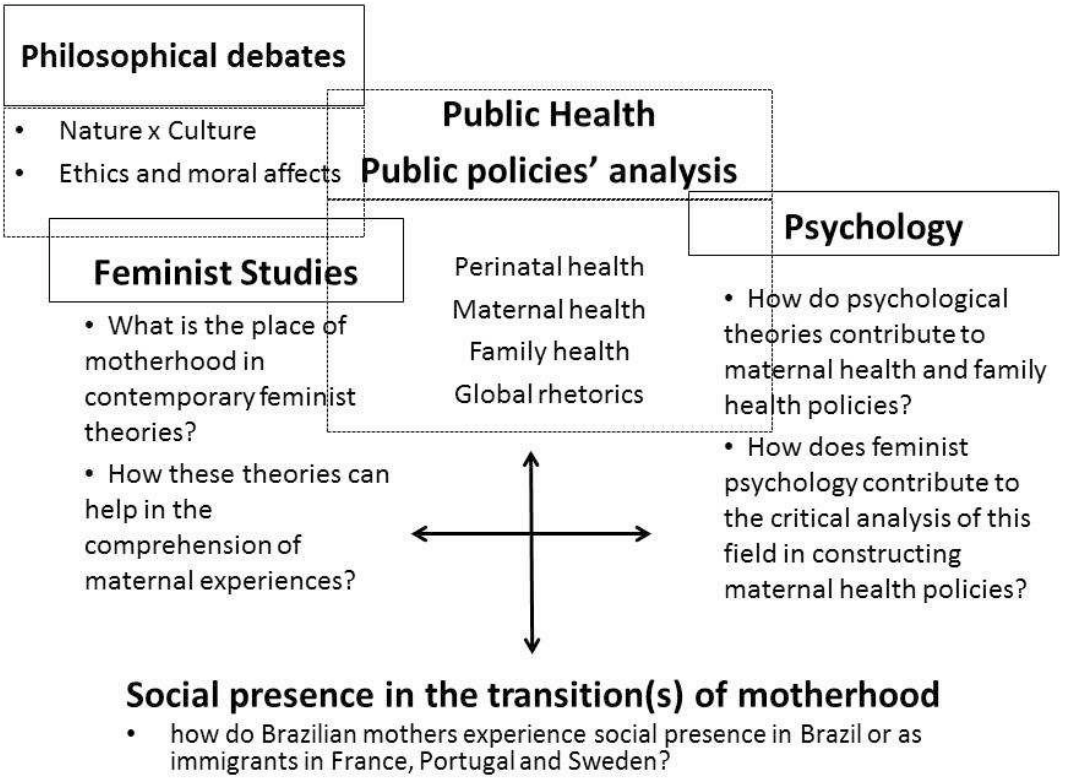
Considering that this research has a chronological and a geographical frame to "transition", I hope to be able to analyse different experiences of presence, in a primary level but not exclusively, which are articulated to the processes of "becoming a mother". Therefore, when I decided to analyse social presence in the transition to motherhood from this pivotal position in Public Health, Psychology and Sociology, two movements seemed fundamental: a) a philosophical review that contributed to a critical approach of the dominant dichotomist epistemology, which has important ethical aspects that I discuss further in this thesis b) a strong motivation to understand and use (when applied) Feminist Studies of motherhood and mothering to contextualize psychological concepts. Such studies are mainly from sociologists and philosophers; and some scholars in the field of Clinical, Developmental and Social Psychology are also working in the approximation with feminist theories, calling "Feminist Psychology"

which would be the specific trend of those studies (Rutherford et al, 2011; Nuernberg et al, 2011; Corbeil, 1990; Burman, 2009). In being part of this recent movement, I have the clear intention to contribute to a broader and ethical conceptualization of "maternal experiences" in Psychology – close to what motivated Faya-Robles in her thesis:

> Il devenait primordial de partir de l'expérience et non pas d'une idée, un grand mot, déterminant la vie des personnes. Il s'agissait de ne pas définir a priori le contenu de "la maternité", mais de la déconstruire pour voir ensuite comment les femmes construisent leur maternité. (Faya-Robles, 2011, p. 16, her quotations)

Finally, to clarify for me and my interlocutors the theoretical drifting I have performed to arriving in my actual research's questions, I profit from the suggestions of Marie-Noëlle Albert (2009) on the strategy of systematizing and publishing the research processes by "visualization tools". This exercise corresponds to "first of all, the need to describe and understand experience (...) [which] is done from an immediate, comprehensive and experiential intuition" (Albert, 2009, p. 209, free translation). Thus, Table I shows the first questions and theoretical articulations I did in dialoguing with the academic fields where I am situated. The superposition of the boxes illustrates the pervasiveness in between the fields, and the dotted borders show how I see Public Health (and public policy analysis) as an open but robust body of knowledge.

FIGURE I: THEORETICAL QUESTIONS AND CONTEXT



I.2 NATURE IS NOT BINARY: EPISTEMOLOGY FOR STUDYING CORPOREITY IN MOTHERHOOD

As already suggested in the first chapter, from here one moves towards deconstructing the dichotomy strongly impregnated in the epistemology of Health and Social Sciences – despite knowing that it is a "perilous" form of pursuit (Arruda, 2003). For this study, nature is not considered a determinist entity or a dischargeable concept. It is important to resort to this sentence as we are about to discuss "motherhood" – a category that is constantly used to split women's experiences into two "inevitable" determinants: nature and society.

It might be suggested that biological mothers have biological facts of reproduction, pregnancy and childbirth as the core basis of their experiences, which would produce universal bodily experiences, rendering biological mothers as the primary and essential presence for young children. This essentialist view on mothers' presence for children contributes to maintain male presence and childcare institutions as secondary matters, thus formatting a normative parenting model based on a static view of reproduction and sex differences. This normativity intimidates the narratives of mothers who do not want or can-

not be fully present for their infants and of fathers who do want to be more than secondary caregivers – which defies the development of alternatives for social presence during the transition into parenthood.

Feminist studies have shown that the assumption of biological facts as static essences structures the discrimination against divergent maternal experiences, for instance of adoptive mothers (Haslanger, 2005), "refrigerator mothers"[14] (Douglas, 2014), even working mothers[15] (Fine, 2008), categorized as "unnatural" and submitted under social and health interventions which aim to re-establish the ideal relationship between mothers and children. Even so, during some decades, motherhood has not been treated as a main concern for the Academic and State Feminism. This is mostly due to a strong resistance of the second wave of the movement against *essentialization* of women's identities bringing biology to the fore (Kawash, 2011; Knibiehler, 2000). In general, the issues related to mothers' health, parental leaves and childcare were appropriated by pro-nativist and maternalist discourses which have conservative trends on gender relations. Furthermore, until recently, motherhood remained a paradox for the feminist movement. According to this paradox, Feminism must be implicated in free women from the biological destiny of motherhood, and do not prioritize better pregnancy, childbirth and parenting conditions, as I discussed in the Portuguese context of 1980s and 1990s State Feminism (Pombo de Barros, 2013) and as Mariana Leite discussed in the Brazilian context of recent policies for the reduction of maternal mortality (Leite, 2014; 2013).

Nevertheless, researchers in the field of Women's History, Sociology and Gender Studies have published important works about motherhood, family and public policies in different countries, mainly since the 2000s (Wall et al 2001; Wall & Amâncio 2007; Kawash 2011; Knibiehler, 2000; Okin, 2008/1989; Bock, 2010; Faya-Robles, 2011). But the bodily experiences of mothers in their diversity was not sufficiently analysed, neither in Motherhood Studies nor in Women's Studies in general. The most outstanding gender theory in current Anglophonic and Brazilian Humanities has a poststructuralist approach that defies the analysis of corporeity and materiality of women's experiences (Stoller, 2009; Vasterling, 1999; Lennon, 2014; Young, 2005). Moreover, updated disputes around dichotomies, including the dichotomy between gender and sex, has contributed to antagonize topics directly related to biological

[14] According to Patty Douglas, "refrigerator mother" is a common expression in North America to designate mothers who are viewed as being "cold" with their babies, and because of that they would be blamed for the autism of their children. The author shows how the psychoanalytical and after the scientific discourse about the origins of autism contributed to this discrimination and blaming of women who did not seem to express their affection for children as *naturally* expected.

[15] Cordelia Fine denounces the recent publication and popularization of books supposedly based on neuroscience which defend the essential difference of women's and men's brains as an explanation to many social problems. In one of them, for example, the working mothers read that they are "struggling against the natural wiring" of female brains and biology (Fine, 2008, p. 70).

conditions of most women to more "progressive" topics, as if in studying bodily experiences we would reinforce gendered normativities (Bock, 2010; Stoller, 2009). These gaps and internal disputes in the Academy have weakened the influence of feminist perspectives on health and demographic researches, in which a progressive use of gender, fertility and maternal mortality as globalized and "disincarnated variables" (Le Renard, 2013), without proper contextualization, influences political agendas. As Fausto-Sterling comments, "many feminist, queer, and critical theorists work by deliberately displacing biology, hence opening the body to social and cultural shaping. This, however, is the wrong move to make" (2000, p. 26).

As a biologist and a feminist scholar, Fausto-Sterling cannot just displace Biology. In the pursuit to comprehend the phenomenons and subjects she has to deal with in her fields, she has chosen the systemic approach, remaining in a Mobius strip without the certainty of a destiny (2000, p. 24)[16], renewing our comprehension of human biology and giving feminists more reason to adopt a phenomenological perspective. Thus the point of this chapter is to demystify Modern Biology as the source of biological mothers' experiences and at the same time to open a way of naturalizing divergent non-normative parenting, from a non-determinist and complex notion of nature and culture. Here, I propose that we have to take a deep account of the new understandings on the non-binary sex and reproductive systems to surpass this historical dichotomy and to conduct an innovative study of social presence in motherhood.

[16] "The Mobius strip is a topological puzzle, a flat ribbon twisted once and then attached end to end to form a circular twisted surface. One can trace the surface, for example, by imagining an ant walking along it. At the beginning of the circular journey, the ant is clearly on the outside. But as it traverses the twisted ribbon, without ever lifting its legs from the plane, it ends up on the inside surface." (Fausto-Sterling, 2000, p. 24)

I.2.A BIOLOGY, GENDER AND SEX: NEW CONSIDERATIONS TO OLD ISSUES IN MOTHERHOOD STUDIES

Generally, the word "nature" is used as a synonym for "Biology". And as a result of an essentialist view of Modern Biology, nature is also seen as something inevitable, and not constructed, in opposition to cultural and social constructions. Additionally, there are also those who assume a deterministic relation between nature and culture, usually based on a much equivocated view of natural evolution – also exemplified in some of the evolutionary neuroscience and psychology approaches which associate, in a deterministic sense, genes, brain functions and gender behaviour (Fine, 2008; Dupré, 2013).

However, the "in between" nature and culture of maternal bodies continues to be theorized by feminist scholars, who make a great effort in showing what was repressed or ignored during the most influential feminist wave after the 1960s: that maternal experiences are neither only culturally nor biologically determined. Emily Jeremiah, who has greatly contributed to feminist, queer and motherhood research, discusses the epistemological difficulties of the latter, suggesting an important non-dichotomist ethical standpoint. Her consideration of ethical constraint seems a quite resourceful intuition from which one can develop an attentive look to maternal bodies performing maternal care:

> Such an idea of attachment allows us also to understand the maternal subject as engaged in a relational process which is never complete and which demands reiteration, that is, as performatively mothering a child or children. This mothering involves what might be termed 'choice' or 'effort', what I would prefer to call 'ethical constraint', where that constraint is not to be understood as purely and simply constructed, but as constituted in and codified by discursive and material practices. This 'maternal ethics' then, is not fixed (...). (Jeremiah, 2006, p.28).

Contrary to what dichotomist theories affirm, I want to emphasize here that including gender equality in the political agenda does not mean struggling against nature. Rather, I would say *binarism* is a battle against nature and has a very negative ethical effect. Because biological mothers are not the only ones under natural constraints, since every human being is "naturally" dependent on others in the need to survive – despite this reality having been excluded from the representation of the "liberal individual" (Brugère, 2013), ideally we should all deal with the ethical constraints of the responsibility for our offspring. However, the ethical constraints are not equally experienced and do not represent the same kind of demands for all human beings, as gender theories have shown, partially due to a misguided comprehension of human nature, including a wrong understanding of human reproductive development.

THE COMPLEXITY OF REPRODUCTIVE DEVELOPMENT

The science philosopher John Dupré (2013) asserts that, contrary to what was assumed until the 1950s, reproductive development is not a Mendelian system[17] composed of dominant and recessive genes which always define a phenotype and a sexual pattern. Indeed, most human genes do not work like that, but Genetics continues to be influenced by a pursuit for "receipts" of human patterns, which are not neutral but traversed by the politics of gender. I quote professor Dupré in his lecture on "A Postgenomic Perspective on Sex and Gender": "the application of genomic information is part of a process in which the genome is a dynamic participant and which is highly sensitive to external influences" (2013). Thus, reproduction is profoundly influenced by environmental and diverse chemical interactions in and around human bodies in specific life cycle timings. As Fausto-Sterling (1993; 2000; 2002) and others scientists are showing, one cannot say that the combination of XX or XY chromosomes are the only possibilities that determine sexual development and, even in the majority of bodies that carry one of these combinations, the results on physical characteristics are not completely predictable. Quite the opposite: one can be surprised by the multiple possibilities of sexual hormone, organ and genetic combinations (Peyre & Wiëlls, 2015). This actually means that a determinist science regarding sexual differences is wrong, and we should face nature in its richness and complexity, not as a deposit of static essences or receipts, even if one continues to match nature to Biology. In fact, the atomic view does not serve Biology and Genetics, because living beings are constantly changing; thus the interest of these sciences should be focused on understanding how these changes are connected, how they create cycles and causalities between different states of life in different environments, instead of searching for immutable essences (Dupré, 2013; Morin, 1987; 1971).

According to Edgar Morin (1987; 1971) who developed a method to articulate biological sciences and the Humanities, life is a constant organisational system based on the logic of complexity. As a matter of fact, this author asks for a rehabilitation of the concept of "human nature" in Anthropology, which rearticulates humanity to natural environments through a paradigm of complexity that can be resumed in Morin's following assertion:

> a nova consciência ecológica deve modificar a ideia de natureza, tanto nas ciências biológicas (em que a natureza era apenas a seleção dos sistemas vivos, e não o ecossistema integrador desses sistemas), como nas ciências humanas (em que a natureza era amorfa e desordenada). (...) A proposição tem uma enorme consequência teórica: a relação ecossistêmica não é uma relação externa entre duas entidades isoladas; trata-se de uma relação integrativa entre dois sistemas abertos, em que cada um deles é parte do outro, embora constitua um todo. (Morin, 1987, p. 10)

[17] Which means that it does not function according to the logic of Mendel's genetics theory.

Therefore, according to the systemic perspective of nature, "our bodies are too complex to provide clear-cut answers about sexual difference. The more we look for a simple physical basis for 'sex', the more it becomes clear that 'sex' is not a pure physical category" (Fausto-Sterling, 2000, p. 4). That is why some biologists are working through this systemic view, with a Developmental Systems Theory (DST)[18]. If nature is a complex systematic construction, sex is a developing system, constructed by multifactorial connections.

SEXUAL REPRODUCTION AND THE PROCESS OF HIERARCHIZING HUMAN EXPERIENCES

Nonetheless, the spectrum of sexual patterns in human development is not fully considered by dominant scientific standpoints yet. Atypical sexual developments, such as intersex bodies, are commonly called "disturbances" and suffer radical interventions such as surgeries and hormonal treatment at a very early stage (Fausto-Sterling, 1993; 2000; Dupré, 2013). These medical decisions are made with humanitarian intentions to relieve what they believe to be the suffering of people who do not fit perfectly into the "female" or "male" categories in a binary gender system[19]; but by doing so they can reinforce gender politics which produce a worse environment for human diversity. Insisting on separating humanity into two genders cannot be considered as an evolutionary natural necessity any longer, as Serge Moscovici already debated in his book *"La société contre Nature"* in 1972. The author acknowledges that, since the hominids, sexual reproduction started to have an autonomous goal beyond the species' adaptation to the environment: "of being a reproduction of division between human groups, a separating reproduction" (1994/1972, p.166, free translation). The main goal of this reproduction was to perpetuate certain patterns related to the new nutrition techniques; and the specialization of such perpetuation has become so stable that it can appear as an essential division not related to inventiveness, as stated by Moscovici (1994/1972).

We already have many elements to affirm that the exhausting division of people into two sexes, from foetus ultrasounds to ageing health care, is not a reflection of how things are in the natural world but a transversal politics which influences almost all of our social policies. Medical technologies are being used to reinforce that influence (Dupré, 2013). This use challenges the statistical knowledge of atypical

[18] DST scholars do not have direct affiliation to the paradigm of complexity proposed by Edgar Morin, but one can be easily related to the other, one more linked to biological studies and the other to the fields of social sciences and humanities. In the field of neuroscience and cognitive science, the systemic approach is largely developed, and Francisco Varela is one of its most representative scholars. He proposes the concept of "enaction" in the human perception, which means that cognition is embodied: sensory experiences are necessary for the production of knowledge, in an open pathway (Varela, 1998).

[19] Fausto-Sterling shows how societies became more repressive to those differences throughout the centuries.

sexual development in societies[20], because it constrains humans since the beginning of life to a constant bodily and behavioural adaptation to the dichotomist pattern of sexes – which consists in the process of gendering. Thus, gendered policies based on essentialist Biology and a-critical Medicine render the spectrum between the dominant patterns invisible, by transforming diversity into abnormality; they create demands for public health, feeding a growing therapeutic system with pharmacological paraphernalia, surgical techniques and psychotherapies, instead of incorporating the growing knowledge of complexity into a better comprehension of human bodies and more inclusive healthcare systems: "Ironically, a more sophisticated knowledge of the complexity of sexual systems has led to the repression of such intricacy" (Fausto-Sterling, 1993, p.4).

Recognizing the diversity of human development does not mean that we have infinite possibilities. It does not mean that we have to ignore that "there are hormones, genes, prostates, uteri, and other body parts and physiologies that we use to differentiate male from female, that become part of the ground from which varieties of sexual experience and desire emerge" (Fausto-Sterling, 2000, p.22) – this reality is frequently dismissed by social researchers who do not provide a theoretical framework to a feminist analysis of bodily materiality in our societies. However, it means that, in practicing science, we have to fully consider all the processes of those bodies as "natural" (including the processes which seem to escape from the dominant standards of reproduction such as the biological mothers' breasts that do not produce milk[21]) and of the situations considered sexually abnormal such as intersexed bodies. Like all natural beings, we also have patterns and generalities; but we are the living beings with the most powerful ability to create and maintain patterns for our biological cycles – as far as we know. There is no all-inclusive category, thus "nature" will be always described as excluding what is not considered natural. In these terms, I am not proposing we consider everything to be part of nature, but I believe in including diversity and the complex relation to culture(s) as a dynamic source of definition for this category, which means to get along with its openness[22]. In conclusion, we need to recognize divergence as part of our nature not as a dysfunction and to consider the relation between nature and culture as a complex continuum more than a radical friction.

Concerning ethics, avoiding conceptual disputes like sex *versus* gender and Culturalism *versus* Naturalism, Carol Gilligan (2003) insists on analysing "human nature" – why not say "essence" of human

[20] In 2000, Melanie Blackless and five other researchers estimated that the frequency of deviation from the ideal male or female sexual development of the fetus was around 2% of live births (Blackless M et al. 2000).
[21] The work of the science historian Londa Schiebinger (1993) shows how the classification of "mammals" was created from a very limited selection of characteristics present in some animals, emphasizing the nurturing capacity of some female bodies as a turning point to the human's taxonomy in detriment of divergent characteristics or other similarities.
[22] For scientific and political purposes, it is similar to the use of "women" as an identity (Vasterling, 1990).

nature – but without appealing to the classical division between body and soul, and constantly referring to cognitive scientists who work through the systemic approach. From that, it is not surprising that some feminist scholars have criticized this author as "essentialist", as they avoid to pursuing the interesting path she opened in the 1980s. In spite of the risk of *essentializing* human experiences, Gilligan's ontological search asserts a new ethical standpoint from a feminist perspective, for which "human" is also characterized by relational aspects usually categorized as "feminine" and inferior, such as the (inter)dependency on intimate bonds with others, caring, love and pleasure from authentic connections (Gilligan, 2003; 1989). In fact, she defends a normative standpoint to contradict the dichotomist and excluding logics of patriarchy – what she sees as a cultural phenomenon that strongly influences human development and defies the full accomplishment of democracy:

> Dans une société et une culture démocratiques, basées sur l'égalité des voix et le débat ouvert, le *care* est par contre une éthique féministe: une éthique conduisant à une démocratie libérée du patriarcat et des maux qui lui sont associés, le racisme, le sexisme, l'homophobie, et d'autres formes d'intolérance et d'absence de care. Une éthique féministe du *care* est une voix différente parce que c'est une voix qui ne véhicule pas les normes et les valeurs du patriarcat ; c'est une voix qui n'est pas gouvernée par la dichotomie et la hiérarchie du genre, mais qui articule les normes et les valeurs démocratiques. (Gilligan, 2009, p. 77)[23]

The historical process of hierarchizing bodies renders the subordination of care work and the rationalization of moral sentiments invisible, not only in (de)colonized societies but also in Europe. This happens because moral sentiments are historically amalgamated to the female gender and other subaltern otherness, such as racialized ones (Gilligan, 2011; Paperman and Laugier, 2011) – an amalgam that was constructed with the patriarchal norm of hierarchizing and separating nature *versus* culture, women *versus* men. The naturalization of care as a female/feminine and moral duty accompanied the way that Western societies theorized the evolutionary function of culture in the history of colonization and industrialization (Amancio, 2003). That is actually an important reason to once again defy the dichotomist approach.

As Moscovici (1994/1972; 2004) discussed, the development of modern Social Sciences was built from the view of culture as a second degree of the evolutionary process apart from biological evolution, even if some sciences have used biological explanations to account for sociological facts. The modern project consisted in hierarchizing human rationalities (Jovchelovitch, 2007) and reinforcing social reproduction after the logic of separation (Morin, 1971). In doing so, this historical process led societies

[23] In subsequent parts of this thesis, I return to this subject on human development and democracy, aware of the paradoxical consequences of certain rhetorics on the superiority of democracy and humanism in social movements related to maternalism and maternal feminism. But I do appreciate the contributions of the ethics of care to the epistemological framework of my research mostly regarding the overpass of binarism.

to a radicalization of differentiating humans and nature: "society is radically a counter-nature" (Moscovici, 1994/1972, p. 25, free translation). Thus, nature was conceived as a pre-ordained world from which human nature should be freed through the power of culture, but paradoxically human biology can be also used to determine the hierarchy of gender, races, mental and physical disabilities with discourses as Eugenics and Malthusianism.

> É neste contexto que o recurso à biologia, como fonte e fundamento da masculinidade e da feminilidade, se torna sinal da modernidade (...) para remeter as mulheres para o cumprimento de um destino, a maternidade, as confinar ao espaço privado e as excluir do contrato social. (Amancio, 2003, p. 703)

Related to the "disenchantment of the world" in Weberian theory, the hierarchy of rationalities reinforces moral sentiments as submitted to the aegis of nature and opposed to reason – a concept of reason which dislocates affection and relationality, from the universalized ethics of justice (Brugère, 2013; Laugier, 2011).

Since the 18th Century, the ethics of justice has helped states combine the expansion of capitalism with the development of "societies of individuals", which was crucial to the emergence of democracy and liberalism. However, it also produced the devaluation of moral sentiments as these would not be efficient for the production of marketable commodities and for the application of a universal conception of justice (Brugère, 2011). I do not consider that care is an inefficient product for marketization; on the contrary: nowadays, we not only have an expansive services sector including care work, as moral sentiments are appropriated by the logic of mass consumption; as an example, one can point out the new market of reproduction in Spain, as Elena Pérez analysed in her research (2011). But the exclusion of moral sentiments from public spheres, including economy and justice, was part of the initial capitalist development.

In parallel to their own specific constitutions, European Welfare states inherited the idea of "love for humanity" preached in the 18th Century, in which philanthropy was built after the French Revolution (Lynch, 2003). But this "love" could not be based on a biblical interpretation, for states should be constructed in opposition to the promiscuous religious charities. This fraternity should be a civic duty, a deliberate and rational recognition of every individual to a fraternal and egalitarian society, illuminated by the principle of rationalism. This rationalist equation engendered a paradox, as it justified the exclusion of women, children, slaves and racialized individuals from the category of citizens, also conflicting to the spontaneous solidarity systems structured through the dynamics of families and communities until then. Thus, although the ethics of justice stands as a very important paradigm to the liberation of

public spheres from the power of religion, it also reinforces the reproduction of dichotomies and hierarchies in social structures. Because it was not developed as a "sensitive ethics" from the observation on how people care and act for fraternity, rather as theoretical universal paradigm which should be followed by everyone and ruled by states (Laugier, 2011).

This historical change is discussed by the historian Katherine Lynch (2011; 2003), who recognizes the role of churches and philanthropic institutions in ancient communities of different European countries. According to her, the growing power of states pushed towards the centralization of marriages in family arrangements and to a gradual reorganization of women's situation in their communities. She shows, for instance, that before this centralization of states, the average age of marriage in Northern European countries was higher and women enjoyed a more autonomous position regarding land ownership (Lynch, 2003). Lynch (2011) demonstrates how modern development, with the political and industrial revolution between the 16th and 19th centuries, did not provide direct and significant improvement in the quality of women's life. The debate among historians on the possible causes for higher mortality rate among girls from 5 to 20 years old throughout more than three centuries[24] illustrates this contradiction (Lynch, 2011). As a matter of fact, Lynch (2011) denies that there is sufficient evidence to prove voluntary infanticide of girls by mothers in Europe and considers it most likely that the urban labour market, increasingly demanding and unhealthy, associated to the disadvantage of girls in the use of economic resources, produced greater vulnerability for this gender. Thus, the construction of modern states initially produced worse conditions for women and children. Later, in recognizing their vulnerabilities, instead of adapting the labour market, urbanization and citizenship to the specificities of female bodies, states romanticized the "maternal role" and included women in the welfare system from a sexual differentiation based on motherhood (Khnibiehler, 2001).

Likewise, contemporary Public Health and Education institutions in democratic countries, envisioning the ethics of justice, demand mothers to promote healthy child development, through the adoption of universal patterns of childcare paradoxically based on an essentialist view of maternal bodies. In addition, it demands mothers to submit themselves to specialists' surveillance; since they can intervene in the moral sentiments that women would naturally invest in motherhood, moderating the ambivalences of their "love" (Garcia, 2011). Medicine, Psychology, Education and other fields of knowledge prescribe universal forms of taking care of young children and generally target women as their main audience,

[24] The mortality difference among girls and boys in this age range could reach as twice as much according to Lynch's revision of demographic historical data.

contributing to fixing primary care under maternal bodies, reproducing motherhood as a subaltern situation in front of experts, by moral reasons.

This logic of subordination is also presented in how societies value the care work beyond the maternal one, by which the caregiver who deals directly with dependent individuals must respond to an authority – someone who can guide, oversee and pay (generally inadequately) for the work (Brugère, 2011). It seems that Fabienne Brugère (2011) is right when recognizing that the more bodily the relationship between caregiver and the one who is cared, the more controlled and economically undervalued the work will be. This assumption brings us back to the question of temporality: I suppose that this undervaluation happens partially because we are used to underestimating bodily experiences of caring; then the maternal experiences need to be analysed from a phenomenological perspective that contrasts to chronological definitions of development.

GENDER POLITICS, SCIENCE AND THE PRODUCTION OF BODILY EXPERIENCES

Thus, when conducting psychosocial research, how can one understand bodily experiences without being trapped by the dichotomy nature *versus* culture or without using one as a determinant of the other? In practice, do we have a way of analysing corporeity in social phenomenons? Fausto-Sterling (2000) follows the new orientation of feminist biologists and gender theorists who recognize that scientific language on the bodies and specifically on the sexes is gendered, but she goes beyond that criticism and suggests that the body itself is modified, designed, and sensible through and to gendered language. She exemplifies such idea with the scientific discovery of sexual hormones:

> I show how in the period from 1900 to 1940 scientists carved up nature in a particular fashion, creating the category of sex hormones. The hormones themselves became markers of sexual difference. Now, the finding of a sex hormone or its receptor in any part of the body (for example, on bone cells) renders that previously gender-neutral body part sexual. But if one looks, as I do, historically, one can see that steroid hormones need not have been divided into sex and non-sex categories. They could, for example, have been considered to be growth hormones affecting a wide swath of tissues, including reproductive organs. (2000, p. 28)

This kind of scientific classification produces certain ways of perception, speech and caring of the bodies in different spheres of societies. “Hormones” seems to be a very powerful word which literally flows through our bodies, gives meaning to various events of women’s life cycles and ends up being part of militant speeches on Feminism, Maternalism and related social movements. For instance, oxytocin has been receiving plenty of attention in French and Anglophonic (but also Latin American) scientific fields

as the "love hormone"[25], the one which would prove to be the biological basis of maternal instinct. Despite that, after a prolific historical and technical analysis, Odile Fillod (2014) shows how those who advocate the oxytocin effect in maternal bonding are based on misinterpretation and over-extrapolation of research findings with non-humans. In fact, since the early years of the 21th Century, the effort of finding conclusive causal association between oxytocin levels in the brain and what they called "maternal behaviour" has failed – even between rats and sheep the presence of this hormone can vary greatly (Fillod, 2014). But, still, we can ask if public attention to this scientific effort of proving biological basis to maternal instinct, even without solid results, can produce specific bodily experiences.

Synthetic oxytocin is already present in many instrumental deliveries as an inducer for labour contractions[26]. The popularization of this clinical procedure is inscribed in contemporary perinatal systems worldwide, to assisting, controlling and motivating parturients during labour. Moreover, there is also a recent debate within the natural birth movements and in the field of evidence-based medicine about the efficacy of this intervention, by arguments about the harm of unnatural hormones in childbirth in contraposition to the benefit of "natural oxytocin". Indeed, as far as gendered language is concerned, this hormone is also defined by a dichotomist classification on nature and culture, approximating an ideal female body to the first one in opposition to the second. A recent article in the Journal of Midwifery and Women's Health introduces its discussion in the following terms:

> Although endogenous oxytocin is well known for its role in labor and lactation, a large body of evidence documents numerous oxytocin-mediated molecular and endocrine pathways that buffer stress reactivity, support emotional and mental well-being, and promote prosocial and bonding behavior. These behaviors are critical for the successful transition to motherhood. Given the predominance of synthetic oxytocin in clinical practice, research is needed on how synthetic oxytocin may affect the intrinsic regulation of endogenous oxytocin and subsequent oxytocin-related outcomes. In this review, we examine the hypothesis that exposure to synthetic oxytocin during childbirth may play a role in maternal stress reactivity, mood, and mothering behaviors (including lactation)." (Bell at all, 2014, p. 35)

The paper makes a big mistake when assuming a causal association between endogenous oxytocin and pro-social and bonding behaviour while simultaneously proposing that stress, mood and reactivity of mothers can be *caused* by the exposure to the synthetic hormone. In contrast, in his books and seminars, Michel Odent alerts that endogenous oxytocin will only be activated if the parturient can be in what he considers a "natural ambience" – which would be constituted by a calm, silent domestic room, weak

[25] Michel Odent, a renowned figure in the natural birth movement worldwide, wrote a book entitled "The scientification of love" in which he affirms that oxytocin is the "hormone of maternal love" (Odent, 2001).

[26] A national representative study in Brazil estimated that 36% of parturients received synthetic oxytocin as a medical intervention to induce or accelerate labour in 2011 (Leal et al, 2014), and the European Peristat Report concluded that, in 2010, 27% of labours were induced in France and 13.7% in Sweden (Zeitlin et al, 2010) mostly with oxytocin.

lighting, with no video-camera and preferably with no male presence – the opposite of a hospitalized ambiance where parturients have induced onset of labours. This is in fact a way to somehow consider environment in hormonal function, but still in a deterministic and essentialist way[27].

From a systemic perspective, the hormone could be considered, at most, one of the factors implicated in specific events experienced by some mothers (not exclusively), in which uterus and breast are physically stimulated, but it cannot be considered the cause, the essential source or proof of a maternal instinct exclusively present in "well-succeed transitions to motherhood" – whatever it means. Nevertheless, instead of completely dislocating Biology and considering oxytocin just as a result of linguistic monism (Vasterling, 1999)[28], we should have tools to analyse how the vulgarisation of oxytocin, in perinatal practices and militant discourses, are related to *real* experiences of *real* mothers. Based on my field research, I suggest that the bodily experiences in pregnancy, delivery and post-partum in hospitalized environments and medicalized assistance also contribute to the appropriation of this linguistic category by women.

Veronica Vasterling (1999; 2003) helps us to understand reality as a complex and continuous process of co-presences, from a phenomenological perspective especially influenced by Merleau-Ponty. From this perspective, corporeal experiences constitute the subject's presence, which is possible through the contours and materiality of the body, and does not depend only on language but also on "unintelligible corporeity". According to Judith Butler (2006, 2003, 1997), the body's materiality demands for language – it is the basic source of performativity as a necessity. In this process subject repeats the social representations of gender, reinforcing the constructed categories for the intelligibility of the body. Despite we normally assume those representations as characteristics of women and men, as if they were biologically determined – and in doing so, we are capable of designing certain limits of a shared reality – Butler helps us to understand how they are naturalized while we perform them persistently but still insufficiently, repeating the same necessity at the same time acting to resist it. In doing so, we exclude

[27] In October 2010, I had the opportunity to attend a conference of Michel Odent for Brazilian mothers and doulas in Rio de Janeiro, where he defended the hypothesis of his book emphasizing the harm of contemporary cultural conditionings to the natural oxytocin function. He affirmed that presence of others than the doula or midwife during labour can intimidate the "primitive brain" of the parturient, and the well function of the "primitive brain" would be the most responsible for a pleasant natural birth and for the initial maternal bonding including a successful breastfeeding. At that time I had recently become a mother and a natural birth militant, still not very aware of feminist critics on this kind of social movement. However, in that occasion, I raised a question which today I found truly intuitive: why can we not consider cultural conditioning as part of the labour event instead of keeping in search for a perfect supposedly natural birth? I then wrote a post about that in my weblog of the time: http://www.whatmommyneeds.com/2010/10/questoes-para-michel-odent.html

[28] Vasterling has been writing critics on the limits of the post-structuralist theory of Judith Butler for feminist analysis of women's experiences, and one of the differences she noticed between phenomenology and Butler's theory is that for this one "there is no access to reality without language" (1990, p. 22) – which she calls "linguistic monism".

of our habitual perceptions the bodies that are not intelligible in hegemonic reality, as the non-*heteronormative* ones (Butler, 1993). But Vasterling (1990) adds that beyond language, corporeity emerges from an unintelligible but accessible body, which means that some experiences will always scape from language but still playing an important role on the subject's "experience of presence" (Gumbrecht, 2009). This process constitutes the subject's perceptions, which are habitual and at the same time creative.

> Manifesting itself as a demand in and for language, the unintelligible body may mobilize us to articulate new meanings and new discursive practices with respect to the body. The signals of the unintelligible body and their demand may, if we are responsive to them, initiate an effort of articulation that is not only creative but also critical insofar as it challenges oppressive norms that regulate the intelligibility of the body. (Vasterling, 1990, 25)

For Gumbrecht (2009) the language itself can produce this presence that is not enclosed in "meaning" but is also "physical reality", being an important connection between us and the "things of world", between the culture of presence and the culture of senses:

> Como uma realidade física, a linguagem falada não só toca e afeta nosso senso acústico, mas também nossos corpos em sua totalidade. Assim percebemos a linguagem em seu modo menos invasivo — isto é, muito literalmente — como o leve toque do som em nossa pele, até mesmo se não nos for possível entender o que supostamente suas palavras significam. (Gumbrecth, 2009, p. 13)

EXPERIENCE AND AGENCY IN THE TRANSITION TO MOTHERHOOD

Moreover, Silvia Stoller (2009), a feminist phenomenologist, is responding to poststructuralist critics on the concept of "experience", reinforcing the role of creativity within it. Indeed, the discussions produced by phenomenologists such as Stoller, Vasterling and Iris Marion Young (2005) contribute to opening the *Butlerian* concept of "agency" to the analysis of embodied intentionality in conservatism and transformation of feminist and women's movements, which converges to the proposal of Saba Mahmood (2001) to: "think of agency not as a synonym for resistance to relations of domination, but as a capacity for action that historically specific relations of subordination enable and create" (p. 203).

Biology can be included in what Young calls the "embodiment as a mode of being-in-the-world" (2005, p.7), considering the "physical facts" that play a part in the "lived body", and not only as an illustration of the gendered texts about bodies. Nevertheless, it does not mean that those biological facts are the same for every woman interviewed for a research about the same thematic, if we consider them by the complex paradigm already discussed. Stoller (2009) reminds us that intentionality includes the consideration of perception as creative, active, limited but not determined only by language or by the body. As explicated in this Merleau-Ponty's (1945) assertion about sexuality:

> Il y a une "compréhension" érotique qui n'est pas de l'ordre de l'entendement puisque l'entendement comprend en apercevant une expérience sous une idée, tandis que le désir comprend aveuglément en reliant un corps à un corps. Même avec la sexualité, qui a pourtant passé longtemps pour le type de la fonction corporelle, nous avons affaire, non pas à un automatisme périphérique, mais à une intentionnalité qui suit le mouvement général de l'existence et qui fléchit avec elle. (p. 201, his quotations)

There are complex reasons why the debate about oxytocin is incorporated by women and health workers outside conclusive scientific findings. Odent and other researchers with determinist arguments on Biology and maternal experiences have taken part in social movements against the over-medicalization of childbirth, some of them articulating biological facts to feminist rhetorics with the aim of improving women's emancipation – the rhetoric on "humanization of childbirth", "empowerment" and "autonomy" of mothers in the production of family health is part of it (Meyer, 2005; Faya-Robles, 2011; Pérez, 2011). Odile Fillod (2012) also affirms that the biological cause between the hormone and some maternal behaviours is a powerful argument used by contemporary privileged women in their choices to be fully dedicated to motherhood without the need for them to reflect on the social constraints associated to those decisions. Since the demand on "chosen motherhood" – an important demand from the earliest feminist movements – we are testifying nowadays the rising of an unpredicted phenomenon related to the use of scientific arguments on maternal experiences: the injunction of a "successful motherhood" firstly based on choice (Filod, 2012).

Another movement related to scientific discourse abusing biological misinterpretation to defend a kind of "maternal empowerment" is Attachment Parenting (AP). According to the AP lobby, the first three years would be a "biological window of opportunity" for brain development, which restricts the possibility of adequate development of the brain's functions during life and demands special attention from parents towards young children in avoiding stress and frustration – materialized in the "stress hormone" cortisol (Bruer, 2011). Besides being scientifically incorrect, this assumption is used to explain social problems such as violence among teenagers as behavioural problems rooted in bad parenting in early stages (Bruer, 2011). With this kind of discourse, AP has promoted in the public sphere the legitimation of a more proximal parenting style, which includes on-demand breastfeeding, co-sleeping, home schooling, public programs for parental education, etc. Moreover, this lobby for preventing bad parenting also uses extrapolations of Epigenetics' findings, a scientific field that aims to understand how health exposure during pregnancy can prevent terrible DNA mutations on foetuses. Recently, Sarah S. Richardson and colleagues (2014), who research developmental origins of health and disease (DOHaD) alerted, in an online Natures' article that:

> Headlines in the press reveal how these findings are often simplified to focus on the maternal impact (...) We urge scientists, educators and reporters to anticipate how DOHaD work is likely to be interpreted in popular discussions. Although no one denies that healthy behavior is important during pregnancy, all those involved should be at pains to explain that findings are too preliminary to provide recommendations for daily living. (Richardson et al, 2014)

However, as a phenomenological exercise, I question, if the existence of "natural oxytocin" *versus* "artificial oxytocin" and other dichotomist and determinist disputes involving scientific findings can be articulated to the desire of some economically privileged women to enjoy more physically the presence of their children. In conflict with the temporality of professional and remunerated activities, this desire is performed as a "scientific truth", which they can use in the search for intelligibility of their corporeal experience in the hegemonic reality of over-medicalization. On that topic one can raise a question about the place of this "comprehension" that surpasses intelligibility, described by Merlau-Ponty: how do women, in searching for certain bodily experience with motherhood, address certain scientific arguments about their bodies?

"Chosen motherhood" in contemporaneity accompanies an expectation of "enjoying motherhood", which appears as a "hedonistic injunction" in Heini Martiskainen de Koenigswarter's (2006) research on French and Finish mothers' talk. Obviously, the hedonistic choice is not free from constraints and it is not all satisfying (as Martiskainen has showed), but it is easily justified by scientific explanations that reinforce mothers as the natural and primary caregivers of babies, while simultaneously appears as a feminist agency towards a more emancipated maternal experience – contributing to contradictory outcomes, in an unexpected way. The high rate of caesarean surgeries in Brazil even when most pregnant women declare their desire to have vaginal births can be an example of the complex relationship between women's desires and scientific discourse on motherhood. The social movement for the humanization of childbirth in this country uses biology and evidence-based medicine as main sources of arguments to influence the public agenda. One of the recent outcomes of this lobby is a national law that validates fathers' presence (or other companion of women's choices, such as doulas) during labour because it would provide a more familiar ambience to hospitalized births – which contradicts Odent's defences at the same time it is an indirect result of his influence in Brazilian movement for natural childbirth.

What Martiskainen (2006) did not deal with in her thesis was the bodily intentionality of the "hedonistic injunction", which Filod approached in her text: "Besides, presenting the rising of a flourishing maternal sentiment after delivery has the advantage of reassuring women who are anguished by the injunction of 'succeeding motherhood'" (Fillod, 2012, free translation). Still, the reiteration of an apparently legiti-

mated explanation of this injunction constructs a horizon in which it is possible for those women to be bodily engaged in daily childcare, habitually, hiding the contradictory effects it may bring. Therefore, I suggest that the main problem, in this case, is not viewing the rising of maternal sentiment after birth as a natural process, but to understand natural not as a developmental complex process, which in fact includes the presences and absences women perceive during the early transitions of motherhood. Their corporeity is engaged in this kind of perception – a perception which is contextual, not only biologically determined.

The analysis on racial experiences from Sally Haslanger (2005) can contribute to the understanding of how corporeity is not only a product of normative discourses but a daily construction of ritualized co-presences socialized in a certain way. As a white adoptive mother of two African-American children, in the United States, she wrote in search of theoretical tools to analyse race not only as social but bodily constructions:

> there are important components of racial identity, I want to argue, that are somatic, largely habituated, regularly unconscious, often ritualized (...) Individuals are socialized to become embodied subjects, not just rational, cognitive agents; so race and gender socialization isn't just a matter of instilling concepts and indoctrinating believes, but are also ways to training the body (Haslanger, 2005, p.277)

The example of oxytocin raises a philosophical question that is far more important than the answer itself: how do we naturalize maternal experiences? One hypothesis is related to the rhetoric on maternal autonomy rooted in biological determinism; which suggests that for women with children the condition to be fully entitled to health and social rights should be the fulfilment of a successful transition into motherhood according to the view of a naïve rationalist model of health policy-making process.

In fact, the definition of what we consider natural is an ethical one, just as the decision on what we consider human (and consequently human development). As an ethical decision, it is always open to different contexts; it has certain stability and limits conformed by language and materiality, but defining what is natural requires performance and presence – which is reminiscent of Jeremiah's (2006) assertion on the ethical constraint of maternal performativity. Therefore, the problem with classical Naturalism is not the interest in what can be conceived beyond linguistic monism, but in taking "nature" as a stable fundament from which hormones, sex, and other biological processes would emerge as stable results (Hoquet, 2015). By studying the transitions of motherhood, considering the biological processes implied, I assume that parental and care relationships are under various forces, biologically and culturally articulated. Those processes have certain stability in time and in spaces, producing certain patterns of experiences and behaviours, but not immutable, and never completed. Thus, as researcher, I as-

sume, converging with Tierry Hoquet, an uncomfortable position: "the consideration of diversity of natural mechanisms and the needed contingency of biological conceptualisation" (Hoquet, 2015, p. 51, free translation). What we may perpetuate as natural practices in health and parental care is an ethical and political decision grounded on the ethical responsivity towards different modes of existence. In fact, this shows an effort that would lead to an *Alter-naturalism*[29], a way to seriously consider a democratic relationship with nature:

> Distinct de l'attitude naturaliste telle qu'on peut la caractériser à partir de Descartes, cet alternaturalisme éprouve un type de solidarité ou d'affinité élective, entre la vie démocratique et l'impératif de modifier nos rapports aux choses naturelles en les prenant au sérieux, c'est-à-dire en considérant enfin les moyens comme des fins (Hoquet, 2015, p. 48).

If nature is a complex system in which we, as humans, are profoundly implicated but not limited to, we should, as a precaution, analyse each dilemma as they deserve. For instance, new technologies, specially used to solve health problems, must be observed and analysed in duration and in relation to other aspects of life beyond their medical focus. In the case of the "love hormone", before defending an antagonism between the synthetic and the endogenous oxytocin, should we not ask ourselves how individuals experience labour under or free from medical interventions, in history and in different contexts?[30] Considering maternal experiences implies taking a step back in the common assumptions of a universal maternal body and to consider parturients as active presences in childbirth. Researching presence means attention to the body but also to the situation of the body, in duration of time, in a certain space and in relation to others, from a phenomenological and sociological perspective.

[29] Tierry Hoquet proposes the label *"Alternaturalisme"* to his critical positioning concerning Naturalism, advocating, however, a different position from constructivist or post-structuralist scholars, from a very similar view on nature to what I am discussing here, with clear ethical intentions.

[30] Later in this thesis, I will discuss the questions on over-medicalization and privatization of the recent reforms on perinatal systems in the four countries focused by this study; these reforms reinforced a paradox in the assistance of parturients and mothers dealing with their bodies mainly as "objects" for medical intervention and as childbirth vehicles, defying in different levels the full consideration of their subjective and socialized experiences.

I.2.B TEMPORALITY AND GENDER IN SITUATED EXPERIENCES

I discuss here the general context of gender as a fundamental index of social structures, including the process of hierarchizing based on a modern assumption of moral sentiments as derived from nature and the ethics of justice as an outcome of cultural evolution. This theoretical discussion feeds the analysis of social presence around motherhood in post-salarial societies.

WOMEN'S SITUATION AND SOCIAL PRESENCE

As Stoller (2009) has discussed, "situated experience" is a phenomenological concept that defines human perception always related to a horizon constituted of historicity and spatiality. Indeed, we do not perceive only the object/subject that is directly focused by our voluntary attention but we also presume others parts of the object, its location in space and in time – the embodied intentionality discussed before. It means that the subject's presence is habitual and historical, thus the body is also a vehicle and not only an object of perception. The human subjective experience is constituted by the connections in which s/he is situated, which Merleau-Ponty defines as a "connection of existence" in opposition to a classic "human essence". By saying that, he conciliates subjective experience with a non-essentialist approach: it is in the sense of a "foreign spectator", with an external conscience as mine, in the same moment when I experience my existence that "other" can be more than a mere word (Merleau-Ponty, 1945; 1969). This is a fundamental paradox: it consists on my co-existence with another, who realizes my materiality and shows me how my individual conscience is weak and dependent. Therefore, when presenting his theoretic project in opposing the Cartesian philosophy, Merleau-Ponty (1945) brings "situation" as the condition for intersubjectivity.

> Pour qu'aurai ne soit pas un vain mot, il faut que jamais mon existence ne se réduise à la conscience que j'ai d'exister, qu'elle enveloppe aussi la conscience qu'on peut en avoir et donc mon incarnation dans une *nature* et *la* possibilité *au* moins d'une situation historique. Le Cogito doit me découvrir en situation, et c'est à cette condition seulement que la subjectivité transcendantale pourra, comme le dit Husserl, être une intersubjectivité. (p. 18, his italics)

Stoller (2010) discusses the criticism of Butler to a "pre-existence" of the subject and then an essentialist conception of "expressivity" of gender; she also comments Butler's proposal of "performativity" as the co-construction of subjective experiences and language – which would structure gender. By agreeing with this author on the critique of a subject who would express language, considering that language itself constitutes subjective experience, Stoller shows how Merleau-Ponty's conceptual efforts were exactly in the same direction as Butler's. However, as she discusses in another text, there is a difference of goals between both approaches (Stoller, 2009). Certainly, when interested in experiences, we have to

consider a sort of "pre-existence" that is not an essence from which other experiences emerge, but a "connection of existence" related to the "sense of immanence"; it means to consider time and intersubjectivity as bodily experiences. Therefore, by Phenomenology, subjective experience can be seen as the articulation of habits, memories and History:

> Il s'agit de comprendre comment par sa propre vie et sans porter dans un inconscient mythique des matériaux de complément, la conscience peut, avec le temps, altérer la structure de ses paysages – comment, à chaque instant, son expérience ancienne lui est présentée sous la forme d'un horizon qu'elle peut rouvrir, si elle le prend pour thème de connaissance, dans un acte de remémoration, mais qu'elle peut aussi laisser 'en marge' et qui alors fournit immédiatement au perçu une atmosphère et une signification présentes. Un champ toujours à la disposition de la conscience et qui, pour cette raison même, environne et enveloppe toutes ses perceptions, une atmosphère, un horizon ou si l'on veut des 'montages' donnés qui lui assignent une situation temporelle, telle est la présence du passé qui rend possible les actes distincts de perception et de remémoration. (Merleau-Ponty, 1945, p.51, his quotations)

Merleau-Ponty is not defending the subject's immanence, but the sense of immanence as a subjective experience which pushes one to perceive "the other" while sustaining conscience's continuity. Indeed, this author was not concerned with gender as structuring and structured in experience, but as one of the generalities he assumes in his text. He idealized a general human situation, without realizing the trap of conceiving the sense of immanence as necessary as intersubjectivity in a society profoundly structured by power. Therefore, the assertion by Simone de Beauvoir about the situation of women, faced by a phenomenological-existential perspective, is extremely important to bring gender as a structural part of women's situation:

> Quand un individu ou un groupe d'individus est maintenu en situation d'infériorité, le fait est qu'il est inférieur, mais c'est sur la portée du mot être qu'il faudrait s'entendre : la mauvaise foi consiste à lui donner une valeur substantielle, alors qu'il a le sens dynamique hégélien : être c'est être devenu, c'est avoir été fait tel qu'on se manifeste ; oui les femmes dans l'ensemble sont aujourd'hui inférieures aux hommes, c'est-à-dire que leur situation leur ouvre de moindres possibilités : le problème est de savoir si cet état de choses doit se perpétuer. (Beauvoir, 1986, p. 27)

From a critical perspective of Phenomenology, Young (2005) suggests we use the concept of gender mostly to analyse the structure of social inequalities, and "lived body" to comprehend the subjective dimension of gender. But, in my turn, I would argue that gender remains an interesting concept to do both, understanding that to "have a gender" or to be "identified as a gendered person" is not only related to how societies are organized but it is also an *intersubjective*, situated experience. By considering situated bodily experiences, we can discuss gender as part of the power structure of societies without

being trapped by the dichotomy sex *versus* gender[31]. Therefore, I propose to face it as a powerful index of social structures that are part of the horizons of subjects' perceptions – not statics and not closed but embodied. Social structure can be a useful concept to understand the generalities related to inter-subjectivity in a research situation in which I am with other women, considering social presence not as result of a subject's expressions during interviews or a previous structure that determines their narratives, but as a quite important component of their situated experiences as mothers – in a "spatial-temporal enigma" (Bessin, 2014) that I want to resolve.

TEMPORALITY AS SOCIAL STRUCTURE OF GENDERED SITUATIONS

We can thus assume that social structures are formed by the historical confluence of institutional rules, collective resources, geographical spaces, in relation to which individuals act. Social actions are important in the reproduction of social structures as Max Weber (1904/2000) theorized; the social theory of this author gives us a panorama on how institutions and senses are connected throughout social actions. Such a panorama seems interesting to view gender as relational, related to individual actions while reproducing[32] social structures in micro and macro levels. These structures are relatively stable in time and also contribute to individual identities (Young, 2005) – which are a psychosocial phenomenon. But gender is not fixed in subjects' bodies or identities, rather it is a social relation: "Gender refers to a social relation, and not a property of concrete individuals, and this relation, which is marked by asymmetry in terms of meaning and defines a context of domination, is socially constructed" (Amancio, 2003, p. 702, free translation). According to this view, gender is a relation of domination based on a dichotomist division of sexes, embedded in social representations which are anchored in the individuals' social actions.

Therefore, in a situated experience, an individual reproduces normativities related to gender and also contributes to transform them. I agree with the idea of performativity as a necessary process in the reiteration of gender and paradoxically in its transformation (Butler, 1990/2005)[33]. This paradox is presented in Feminism, as a social movement, which has developed associated processes of differentiation and homogenization of social identities, motivating the emergence of different sub-groups and a universalist agenda. They resort to gender as an important index to understand and modify power structures

[31] The direct consequence of understanding gender as a cultural structure in opposition to sex as a radically separate biological fact is the view of gender equality policies as a "fight against nature" (Dupré, 2013) and its opposition to the agenda of maternal health.

[32] In the sense of "repeat" by a Deleuzian perspective..

[33] This assertion is influenced by Judith Butler's theory, especially clarified by a materialist comprehension of *queer* theories and movement in the interview of Gabriel Girard with Elsa Dorlin (2007)

but paradoxically reinforce some of its structural basis (Amancio, 2003; Arruda, 1997). Angela Arruda points out, for instance, how Brazilian eco-feminists in the 1990s took stand in a "double filiation", assimilating female gender as a fundamental difference for the group's empowerment facing male domination and nature as an argument for the unification of all women in a universal identity – propelling a violent effort to render invisible some differences among women. This process is also related to the debate discussed by Marc Bessin and Elsa Dorlin (2005) on the generational renewing of Feminism. With a contemporary generation of feminists playing a central role in Gender Studies and in the dialogue between Academia and political institutions, the movement is running the risk of keeping the experiences of marginalized women invisible:

> Parallèlement, on assiste à une invisibilisation et une dévalorisation de la production théorique issue des lieux non institutionnels, qui subissent une conception académique du savoir en étant désormais exclusivement considérés, si ce n'est relégué, comme 'militants' (avortement, contraception, violence conjugale, aide aux victimes, etc.). Les rapports asymétriques entre activités de solidarité, ancrées dans les pratiques sociales, et activités intellectuelles, fournissant aux mouvements les théories sur lesquelles s'appuyer, ne sont pas nouveaux. On sait d'ailleurs qu'ils font partie de ces bicatégorisations hiérarchisées qui participent des rapports de domination, en particulier de la construction du genre. (Bessin and Dorlin, 2005, § 9)

Thus we need to recognize that social structures related to gender are also permeated by other power relations institutionalized by norms such as *heteronormativity* (Butler, 2006), but also racialization, classism and temporality (Bessin and Dorlin, 2005; Dorlin, 2012). That is why contemporaneous feminist and *queer* activists are claiming for a "renewed materialism" from the influence by diverse political identities, which radically defy institutional rules that separate and hierarchize sexes, sexualities, nationalities, racial identities and skin colours, in different contexts. Those institutions need to be confronted with the aim of resisting the undifferentiating process that in certain contexts leads to invisibility and subordination among women themselves. As Elsa Dorlin affirms: "There is no classism, racism and then sexism: the three social relations do not superimpose, they nourish one another. Therefore, this configuration is decisive for the fights" (Girard, 2013, p.57, free translation). This author argues for a materialist *queer* and a "phenomenology of domination", for which the materiality of bodies, in the way they are produced by power relations, are main concerns.

Simone de Beauvoir (1986) criticised the difficulties of historical materialism in giving tools to the understanding of women's subordination, even though she agrees that economic structures are decisive in women's situation. However, she states that their "total situation" cannot be conceived strictly as an economic outcome. In fact, as Marc Bessin highlights, one should be aware of how the institutionalization of specific norms such as chronological temporality is dominant in economy and democracy, caus-

ing women's work to be undervalued and economically vulnerable. Many gender and feminist studies contributed to the visualization of inequalities on time-use between men and women, but still from a "chronological semantics [that] refers to a male temporality, tough from the experience of the dominant" (Bessin, 2014, p. 4, free translation).The author argues that this way of conceptualizing time, in calculating it, is not sufficient for rendering intelligible care work and temporal availability of care workers – mainly female workers.

Here, I propose to comprehend maternal duty also as a subaltern condition, constrained by temporal normativity that is related to biological cycles, which pathologizes the variety of mothers' experiences. If Beauvoir recognizes that giving birth cannot be directly imposed but can be an outcome from difficult women's situations by which motherhood is the "only way out" (1986, p.78, free translation), I would argue that assuming almost all responsibility for children's development is not a forced labour either, but it can be the outcome of a conflicting situation in which temporality and gender are strongly implicated. These conflicts are mostly perceived if we question the chronological logics of economy and democracy.

The definition of the transition to/into motherhood in the perinatal, medical, psychological and correlated discourses is based on a chronological logic that does not correspond to the reality of human bodies. It is a product of the dominant temporality, restricting "transition" to a very limited period between two stable states – as if women should experience the same linear evolution regarding the changes in their bodies and reach a satisfactory parental identity in the end. This process could prevent "bad parenting" if lived according to the expectations of perinatal norms. However, none of the human bodies are like stable objects that only change because of disease or exceptional events; the body is in constant movement, acting, drifting, ageing, even if constantly repressed. Therefore, I cannot conceptualize the transition of motherhood as a passage from one point to another in a linear chronology, but as a process of intense changes, when habits and rhythms can be re-organized, when past can be present with a unique intensity, and hesitations can confront existence – or not. The transition to motherhood exists in intersubjectivity, when I ask the question: "how was your transition experience into motherhood?"

The temporality of maternal care is not restricted to a chronological one, despite family policies insisting in standardized maternal leaves, particularly in Brazil. Those policies seem to assume the reduced duration of parental leave as a sufficient standardized period for all families to organize their new care routine after childbirth, ignoring the continuity of time-demand that surcharges mothers, not mobilizing a broader reorganization of the labour market, nor favouring men's presence for children or in the

childcare system. Maternal care in Brazil is still very limited to the domestic environment, while formal and remunerated work mostly occurs outside the household, according to a male-breadwinner / female-caregiver model. This gendered division between maternal presence in the domestic sphere and paternal presence outside sustains another hierarchy: the relationship between privileged mothers and child-minders, baby-sitters, house cleaners and domestic workers in general as a private and affective matter. The informality and isolation of domestic and care work from public spheres make quite difficult for legitimating labour rights for this workforce (Sorj, 2014). While non-domestic professions have clear regulations that define the space and time to be present at home and at work, domestic employees are under time fluidity in-between those spheres, because of a moral expectation according to which they should always be caring attention to the others.

Despite the illusion of a "domestic problem", the situations regarding hierarchy between fathers, mothers and domestic workers are strongly related to care systems that are relatively stable and invisible – part of the very landscape of daily life. However, the concept of social presence deconstructs the dichotomist separation between public and private sphere, when it adds to the social question theorized by Robert Castel and other sociologists – as also the concepts of "social crises" and "care crises" – the dimension of time, space and affections (Bessin, 2009; 2012; 2014). According to this view, presence is not only a subjective experience; it is a sociological problem.

I.3 THE PHENOMENOLOGICAL METHOD: INQUIRING EXPERIENCE(S) OF PRESENCE(S)

While analysing Brazilian mothers' experiences of presences through Computer-Mediated Communication (CMC) tools, I applied three methods in parallel: a documentary research on official reports of perinatal health and family policies, biographical interviews and recording of daily diaries, articulating them through a phenomenological perspective. Therefore, in my fieldwork I searched, in a spiral drifting, how certain moral rhetorics are reproduced by the mothers in their daily life.

According to the rationalist paradigm of policy analysis, the sole discovery of scientific evidences would be enough to rationalize political efforts and to have positive outcomes in the daily life of public services, as if social policies did not have a complex "life cycle". This rationalist approach is largely used by health and family policy analysts, who contribute to the weak presence of gender issues in it. The concentration of studies on the association of policies and health rates, when ignoring contextual and situational variables, obstructs the understanding of contradictory outcomes such as the one exemplified in the "perinatal paradox" (Rosenblatt, 1989). Therefore, as "life" of policies I mean values, ideas, interests and perspectives of the people involved in the decisions, implementations and usufruct of rights and respective services, which includes but surpasses the institutional rules and the official planning (Pombo de Barros, 2009). Thus, policy life needs to be faced in practice "on what is said, by whom, and on whether others find their arguments persuasive (...) then we require a framework of ideas that addresses the role of language, argument and discourse" (Russell et al, 2008, p.41). Russell and colleagues argue for policy analysis in Public Health by rhetorical analysis, defining this method as a tool for the understanding of "practical reasoning" (2008, p. 43). This practical reasoning includes discourses, affection and temporality experienced in daily life by regular people, not only in the official spaces of public debate such as public hearings, state congresses, association assemblies, etc.

From a phenomenological point of view, finding out if someone considers a political argument persuasive cannot be limited to analysing expressed opinions, because persuasion occurs while people incarnate and perform – even if with resistance – the moral arguments of those official discourses (Brown, 1978). I follow the definition of Jaana Vuori on the rhetorical analysis method: "The key question in rhetorical analysis concerns the relationships that the speakers (or writers of texts) construct between themselves and the audience with their texts" (2012, p. 1); but I add to this assertion a serious consideration of language as part of subjective and bodily experiences (Young, 2005).

I.3.A THE FIELDWORK: METHODOLOGICAL STEPS OF AN IMPLICATED SUBJECT

A "phenomenological aptitude" (Morais, 2013) was taken from the beginning of the inquiry and took me to the reassessment of my situation as a researcher in Public Health, a feminist, mother and migrant in Europe, to then clarify the design of my fieldwork. It is a pathway that allows me to objectify my relationship with the field and research themes as an implicated but also an "epistemic subject", out of a naïve rationalist intention – which can be well represented in Emerson Merhy's (2015/2011) text:

> Estamos, mesmo, é diante de situações nas quais não é possível ter tão nítido a possibilidade de construção do sujeito epistêmico como um a priori, como garantia da cientificidade do empreendimento que busca construir um saber. Por exemplo, como em situações nas quais o sujeito que propõem o que será conhecido está tão implicado com a situação, que ao interrogar o sentido das situações em foco, interroga a si mesmo e a sua própria significação enquanto sujeito de todos estes processos. Enquanto sujeito da ação, enquanto sujeito interessado e que aposta em certas direções para ela e não outras, enquanto sujeito que ambiciona ser epistêmico mas que quer produzir conhecimentos e sistematizá-los para si e para outros, implicado com o seu lugar na ação sob foco. (...) Ou mais, ao saber sobre isso mexe no seu próprio agir, imediatamente e de maneira implicada; chegando ao ato de intencionar o conhecimento através de um 'acontecer nos acontecimentos', como algo que, como um processo, emergisse no silêncio do instituído, provocando 'ruídos' no seu modo de dar sentido ao 'fenômeno' e a si mesmo (...) O que o faz colocar sob análise os fenômenos que lhe interrogam, a sua implicação e o seu próprio agir enquanto, e ao mesmo tempo, diferentes tipos de sujeitos. (2011, p. 9, his quotations)

From now, I will discuss my pathway through this implication mentioned by Merhy.

The transitional experiences of motherhood in my socio-economic class have been portrayed in weblogs, books and magazines, to which I have access as a reader and an author. Such spaces are useful in revealing moral rhetoric and social representations that can influence policies and institutions, but also subjective experiences related to them. Sometimes, they are explicitly engaged in the policy-making process, especially maternalist and gender politics related to Feminism. Brazilian women's participation in the Internet grows significantly, and equals the participation of men in terms of time spending (Braga, 2005); motherhood is one of the main themes women discuss online (Sales, 2011). This indicates that the web is a more workable public space than other traditional media for people who are not traditionally represented in the political system (Casilli, 2010), such as women who are in charge of childcare. In my experience transiting in virtual spaces, I see different contents and political debates around maternal experiences that are clearly gaining attention from politicians and governments[34], but yet with a tendency to obscure asymmetries and differences in a universal label of being a mother.

[34] Recently, President Dilma Rousseff had been intensifying her presence in virtual spaces to dialogue with social movements and to the great public; some examples of this tendency are: the inclusion of virtual communities in her project of political reform and the replacement of television by virtual social networks such as Twitter and Facebook to publish official statements in 2015 Mothers' Day and Workers' International Day.

I created a personal weblog six months after the birth of my only daughter and five months after the conclusion of my Master's thesis, in 2009, seeking to maintain contact with the world "outside", while I was living mostly at home and occupied with domestic duties. I also participated in virtual theme groups (mailing lists and Facebook communities) in which I introduced myself as a mother and sometimes as a Public Health psychologist with the intention of creating a fine representation of myself – I was experiencing a transitional period, in which many of my certainties about career and family were being tested by my new situation. Later in 2012, the PhD intensified my desire to dialogue with other women from feminist groups – in some of them there were also PhD students or young researchers, and I needed to talk about my research topics almost as an exercise to better differentiate which were my own personal questions and which were the ones that could be important to Feminist Studies and Public Health movements. This interest is coherent to what Ruben Mattos and Tatiana Baptista (2011) assert in a consistent body of reflections on the analysis of policy-making processes, recognizing the importance of researchers in dialoguing with different actors engaged in the entire life of the policy.

After the beginning of my PhD, during the second phase of browsing feminist and maternal material online, I started to introduce myself also as a researcher in order to develop another type of approximation and distance with the persons and groups concerned – more at a position of "curiosity" rather than of activism, with more questions than personal narratives. This process confronted me with a new "hesitation" facing the debates raised by the thematic groups, which was not planned but caused by the strangeness that my theoretical pathway was getting me into. While trying to raise questions about motherhood, in particular on the theme of health policies and the lack of social policies related to parental leaves and equality in domestic duties, I realized the resistance of an important part of the groups and its coordinators. This resistance was primarily based on a categorization of the activism around mothers' rights as an "essentialism" to be strongly avoided by third wave feminists. Discourses that opposed "subversive identities" to conservative ones (mainly identified in the heterosexual biological mothers' identities) produced a dynamic of exclusion and marginalization of the issues brought by us (me and other mothers who were also trying to mobilize the groups around those questions). This reminds me of Faya-Robles' criticism to her own approach in a previous research she conducted, in which she classified mothers' representations into two dichotomist patterns:

> allant de celles plus proches d'une idéologie patriarcale à celles menant à l'émancipation. Sans l'expliciter véritablement, ces deux pôles recouvraient finalement la sphère d'une autre polarité: celle entre 'tradition' et 'modernité'. Et, sans le vouloir, je tombais dans le piège de mes propres préjugés de jeune femme de classe moyenne argentine (2011, p. 16; her quotations).

The strangeness I felt was not only theoretical of course, but related to my own experience with the first transitions of motherhood and the sanitarian discourses. I was gradually intensifying my implication in the Feminist movement, because of the need of new references as a Public Health militant and also as a mother. I was an "implicated subject" (Merhy, 2004) although I did not have a professional membership in any specific feminist group. When I had to be submitted to an expensive and unsafe perinatal system, when I had to stay out of the labour market for a while against my plans, when I had to depend economically on my daughter's father, beared lack of full-time childcare centres and started employing another vulnerable mother to take care of my own child during my absences, in order to improve my chances of returning to the labour force, then I could certainly say that feminist activism should be very important to face mothers' matters. When I had to immigrate with my family to another continent to pursuit my career goals, then, the use of virtual tools and the transit in feminist virtual spaces should be a solace – something familiar and at the same time linked to the personal and theoretical questions I was raising.

But then, I realized that it was not easy to find a virtual welcoming space to express those expectations without being classified by some kind of moral judgement[35], such as the following: a) biological mothers are basically "conservatives" because they "choose" to be submitted under the patriarchal logic of reproduction, b) heterosexual mothers are performing *heteronormativity*, which oppresses *queer* people, c) "maternal feminism" should state the right to choose full-time dedication to mothering as a priority since the capitalist labour market is the "true" problem of mothers who are constrained to fulltime dedication to work. Those arguments produced great debates in the groups I participated in and reflected the different historical relations between maternal demands and Feminism in different countries (Scavone, 2001; Kawash, 2011; Knibiheler, 2001). I was comprehending that the disputes around the subjects of a "third feminist wave" were not only in Brazilian Internet and did not solely involve the questions of motherhood; many themes are intensifying the spread of different and opposing feminist movements since the 1990s (Dorlin & Bessin, 2005), related to the visibility of *queer* and marginalized women, but also in reviving the dichotomies debated by Gisele Boch (2010) and others, such as: nature/culture, work/family, public/private, sex/gender, equality/difference, integration/autonomy. Con-

[35] Those kinds of arguments can be easily visualized in the online debate produced by readers and authors of the text by Lilian Gusmão and Iara Paiva, "Largar seu emprego para ser mãe em tempo integral é provavelmente uma má ideia" in the Blogueiras Feministas weblog (translation of the Erin Gloria Ryans' original post in the north-American website Jezebel). Blogueiras Feministas is a website, Facebook Fanpage and mail listing important for the diffusion of feminist thinking in the Brazilian internet and public sphere (including Academy and great international mobilizations such as the Sluts Walk). See in: http://blogueirasfeministas.com/2013/09/largar-seu-emprego-para-ser-mae-em-tempo-integral-e-provavelmente-uma-ma-ideia/

cerning the "new" dichotomy sex/gender constructed from the old nature/culture as a political strategy of resisting the reductionism in feminist movements, Boch (2010) asserts:

> Cependant, il s'agit simplement d'une attitude défensive et certainement pas d'une avancée intellectuelle. On devrait plutôt penser qu'aucun progrès ne verra le jour, au niveau intellectuel, historique et politique, tant que des idées intellectuelles et historiques seront rejetées pour des raisons qui sont davantage dictées par les antiféministes que par l'expérience des féministes et des femmes elles-mêmes. Mary Midgley a ainsi avancé l'idée que ce que l'on appelle 'déterminisme biologique' n'est 'pas plus une attaque contre la liberté que le déterminisme social ou économique accepté dans toutes les branches des sciences sociales'; pour elle, ce qui est vraiment dommageable, c'est 'le fatalisme, la croyance erronée que les problèmes dont nous avons le contrôle se trouvent hors de notre sphère d'action et sont insolubles' (p. 67; her quotations, emphasis added)

Thus I remained attentive to my experiences while trying to dialogue with privileged and marginalized mothers, and I understood that if we could not find spaces to express and incorporate diverse experiences in becoming mothers and caring of our children in Feminism, then maternal matters would be appropriated by maternalist, demographic and sanitarian movements, which contribute to the construction of social policies for us but while reproducing old stereotypes and exclusions. I did not accept that important problems related to maternal experiences should be out of the feminist agenda because of a political strategy. I decided to analyse more deeply those experiences in their diversity, defying the limits imposed by dichotomies such as conservative/subversive, nature/culture, seeking for different biographical and theoretical references.

While I was being confronted with those dichotomies in my own experience as a feminist activist and a mother, I planned my fieldwork. That was a crucial moment in which I realized that the difficulties and richness of the virtual spaces where I tried to move could be an indication for the definition of my research methodology. After the first year of theoretical research, I decided to incorporate Computer-Mediated Communication (CMC) in my fieldwork and radically changed my habitual presences in some virtual spaces to be able to contact different women, not only those who are habitually in virtual feminist groups. I decided to stop writing for a specific feminist weblog and reduced my exposure in other groups in which motherhood was focused by feminist or maternalist trends. I retained synchronized and desynchronized contacts with participants of those groups, publishing more theoretical essays on my own new website and in different blogs to which I was invited as a researcher and an author, in the intent to diversify my contacts with different readers and possible volunteers for the fieldwork. This process was quite similar to the experience of Adalene Sales (2011) in researching maternal narratives in a maternalist community of the social network Orkut:

> O distanciamento em relação à militância (...) permitiu ressignificar essa experiência como mãe 'orkuteira', defensora da amamentação, mas, especialmente, permitiu romper com as pré-noções

> ou preconceitos para fazer (...) a contestação decisória e metódica das aparências, quebrando as relações mais aparentes e familiares, para fazer surgir o novo sistema de relações (Sales, 2011, p.15)

COMPUTER- MEDIATED COMMUNICATION FOR A TRANSNATIONAL RESEARCH

The specificity of Computer-Mediated Communication (CMC) caught my attention: the web can be viewed as an innovative human institution, but with social dynamics common to traditional institutions and related to political and historical contexts in which members are inserted (Díaz de Rada, 2010). Virtual groups certainly do not form communities such as those analysed by classical Anthropology, but they have their own dynamics and interaction codes, anchored in the previous experiences of their members with their local communities – something not completely new (Braga, 2005). For instance, feminist virtual groups are not "classless" and immune to the social inequalities and political disputes presented in non-virtual life. They are part of it.

Refusing to deny the radical changes that CMC is producing in contemporary sociabilities, Antonio Casilli (2010) critiques the common opposing approaches on their conceptualization: one "utopic" on the positive outcomes of communication technologies and the other pessimist and mistrustful regarding their outcomes in social and political life. In fact, the growing expansion of CMC is related to profound modifications of borders usually taken for granted by sociologists and psychologists, as the border between home and workplace, relatives and strangers; and it can be better understood if conceptualized as part of contemporary sociabilities rather than as a new world of new communities, with diverse and also unpredictable effects. Through his research, Casilli (2010) shows how, in favouring a longer permanency inside private spaces (as homes and individual offices) rather than direct socialization (without technological devices), CMC does not produce a feared process of emptying the political participation in traditional spheres such as political parties, associations, referendums, elections etc. In fact, the Internet is functioning as a complementary space for politicians and citizens, more open to issues related to personal motivations and intimate problems, which are also important in political agendas (Casilli, 2010). In entering intimacy, being part of the domestic appliances, inside bedrooms, fitting in one hand when the user is lying in bed, personal computers connected to the web produce situations that cannot be opposed to "non-virtual" communication but is profoundly linked to it – which should be more scrutinized by academic researches. This comprehension contributed to my decision of fully incorporating CMC in my fieldwork.

Besides, the questions related to a comparative curiosity confronted me to a geographical limitation: I would not be able to compare the experiences of mothers living in different countries if I had to inter-

view each participant using the traditional method – geographically co-present. But I knew I could be co-present with my collaborators through technological mediation, such as Skype, Google Hangouts, and Facebook's video chat, by the so-called "synchronized online communication" (Casilli, 2010). And to complement this tool, I also envisaged incorporating my "desynchronized communications" by web with the research participants and in the maternalist and feminist virtual groups with which I shared some familiarity.

CMC groups favour different kind of "presence" and "absence" dynamics. When I realized that my identity as a mother was not well integrated in a feminist group, I could decide to completely withdraw myself from its virtual spaces, since I did not feel the same injunction to "belong" to the group as I experienced in other kind of interactions; but I cannot deny that not being integrated in it as a mother did, in fact, bother me and moved me to reflect on my own identity and experiences with the transitions of motherhood. I was confronted with an ambivalent movement between presence and absence, and more than that, I was intrigued by the capacity of exercising different forms of presences: I could participate in the mailing list and figured in that as a member through a chosen interface (an e-mail created for this purpose, for instance) and only express my opinions to specific interlocutors; I could represent myself as a person I am not in *real* life, with different name and narratives; I could use many e-mail accounts to create different personas pretending they all agreed with me, etc. I did not pursue those ideas, because I insisted in experiencing the virtual interactions as serious parts of my activism and research. But I knew that the presence and absence allowed by the Internet could be significantly diversified.

Basically, my presence depended on my interests when entering these virtual communities and the consequences that I tried to predict with my virtual moves – something not so different from the Weberian theory on "social interactions". To be virtually present did not mean that I was not truly present; on the contrary, the fragmented traces of my body, the personification that I used in those interfaces, indicated a lot about my true interests. The main question is: how social presence is also constituted by virtual interactions and how physical distance does not impede it– in some cases it renders it possible, as in the "transnational care" of transnational families (Baldassar and Merla, 2014) and in this transnational research.

> Je viens de prononcer le maître mot des communications numériques, présence. En mettant en scène son corps, un usager arrive à être présent dans un échange en ligne (on dit aussi "téléprésent"). (...) Il s'agit d'une incarnation faite de pixels, bien sûr. Mais derrière celle-ci, il y a toujours le soi en chair et en os de l'usager qui cherche à exprimer ses exigences, ses goûts et ses dispositions. (Casilli, 2010, p. 124, his quotations)

Therefore, one of the focuses of my analysis turned to social presence through CMC. I am interested in the CMC employed by mothers who live in Brazil and mothers who emigrated to France, Portugal and Sweden in order to be present, absent and to profit from the presences and absences of their relatives, partners, activist groups and institutions related to the process of becoming a parent.

THE RECRUITMENT AND SELECTION OF PARTICIPANTS

I profited from my previous experiences and presence in the Internet to the recruitment and selection process of the research collaborators. In November 2013, from my residence in France, I firstly sent out an online socio-economic survey on a website[36] and in my virtual networks written in Portuguese, and I started distributing it to virtual groups and thematic websites on motherhood and/or Brazilian immigration. Additionally, I emailed and made phone calls to Brazilian associations in France and in Portugal (I did not find a similar association in Sweden).

The preliminary conditions to answer the questionnaire were being a Brazilian mother who had a child the past five years in Brazil, France, Portugal or Sweden. Contacts within groups and websites proved to be more efficient for recruiting respondents and constituted the main source of volunteers. From a pool of 72 volunteers who answered the survey, I selected 31 to interview. Thirteen of these mothers volunteered from the diffusion of the research in virtual groups, 6 were indicated by other participants of the survey, 5 were recruited by my personal contact in non-virtual spaces, 3 I contacted directly on their weblogs (since they fulfilled the core conditions to participate and represented marginalized characteristics in the sample), 3 were indicated by others who were unrelated to the research, and 1 mother responded to a call in one of my own social media profile. Thirty of them are biological mothers (which means they experienced pregnancy and childbirth of their children), and only one is an adoptive mother of a ten year-old daughter. Thus, I decided not include the narratives of the adoptive one to the data analysis because I would not be able to deal with this specificity in this thesis, although our conversations did nourish some of my reflections.

The questionnaire was mainly used to understand time availability of respondents to participate in the qualitative phase of the research and also to have some socio-economic information in advance, such as: social class, individual financial resources, work and profession, number of children, age and nationality of the children, racial identity, family arrangement and sexual orientation. The profiles of the women who answered the questionnaire were fairly homogeneous, as almost all of them self-identified

[36] The website *Com a cabeça fora d'água*, in the URL www.matempo.net, was created to diffuse the research, the theoretical discussions related to it and the questionnaire.

as “middle class”, had one or two children, and were 24 to 42 years old. From there, I selected participants who formed a group as diverse as possible, primarily taking into account the criteria of country of residence, family arrangement, sexual orientation and racial identity. The fact that all of them belonged in some level to a privileged class (economically and in years of formal education) is unsurprising, since it is clear that having CMC as a frequent means of interaction is already a limitation to the group’s configuration. As I specified in this chapter, one of my main concerns was in understanding to what extend privileged women reproduce or dispute the dominant rhetoric on motherhood.

However I had to actively seek black mothers who wished to participate in my fieldwork, because among the first 21 women, who I had interviewed until June 2014, only 1 identified herself as black and 5 identified themselves as mixed-race (“parda”, “miscigenada” and “mestiça” in their own words). It is known that Brazilian immigration to Europe is massively formed by middle and upper classes because of the economic weight of this geographic transition; and the Afro-descendent and indigenous population (self-identified as “negra”, “preta”, “parda” and “indígena” in the statistics of Brazilian official registers) still ranks as the minority in those classes (30% and 17% respectively, in the year 2006) (Osorio, 2009). In Brazilian racial configuration, regarding differentiation among black and white people, it is not ethnic origin that matters most; instead, it is skin colour. *Colourism* is a historical outcome of a “whitening idealization” in the country (Munanga, 2004). However, the Brazilian government has recently constructed affirmative policies for Afro-descendants grounded on self-identification and heredity, which destabilizes this *colourism*, reviving the debate on racial identity and discrimination based on skin blackness. In this context, since the whitening idealization constrains Brazilians to not self-identify as Afro-descendants, public policies have used an inclusive definition of “black race” that includes mixed-identifications such as “brown”, with the aim of encouraging a positive black identity (Munanga, 2006).

Despite those affirmative policies in the field of Education, Celi Scalon and André Salata (2012) showed that the black population had the least social mobility inside middle classes from 2000 to 2010 on a study that uses different variables beyond family budget to configure social classes. For these authors, the conception publicized by the Brazilian governments in the last decade according to which Brazil is becoming a “middle class country” has to be problematized, because in terms of racial and consumption patterns the inequality persists, with few improvements:

> No interior das classes médias, os profissionais e administradores se destacam por sua renda elevada, alta proporção de indivíduos com nível superior e pequena proporção de negros. (...) Nesse sentido, ao invés de falarmos de uma nova classe média poderíamos ponderar, talvez, sobre uma parcela da classe trabalhadora que, em relação a certas características, quase exclusivamente os rendimentos, estaria se aproximando dos setores mais baixos das classes

> médias. Torna-se uma importante questão, portanto, verificar até que ponto essa aproximação em termos de rendimentos (e poder de consumo) poderia levar a uma aproximação, ou até mesmo a uma assimilação, no campo social." (Scalon and Salata, 2012, p. 404)

Finally, from the 30 collaborators of my field research, 10 were not white, 5 of whom declared themselves "black", 3 as "brown" and 2 as "mixed" – therefore, I decided to include "mixed-race" in "brown" category, since in Brazil the term "parda" figures in official Statistics whereas "mixed" does not. Therefore, the group of participants that I selected to be interviewed was not inconsistent with the composition of Brazilian international migration and middle classes; but my goal was not exactly to match that composition but to find possible relationships between privileged classes, racialization processes and family arrangements related to social presence, demystifying an alleged homogeneity of experiences in becoming a mother. The following assertion by Beatriz Padilla and colleagues (2012) can be also applied to studies on maternal experiences:

> Não obstante, devemos salientar mais uma vez a importância que teve a criação de algumas categorias de análise no campo de estudos da imigraçao brasileira, não para as defender eternamente, mas para as situar cronologicamente. Muitas vezes, a criação de categorias tem um valor prático e simbólico, especialmente no avanço do conhecimento. É para isso que servem, especialmente quando transitamos de estudos ou considerações macro, para estudos e considerações micro. Se no início se partiu da categoria 'os imigrantes', para logo passar à categoria 'as imigrantes', e posteriormente a 'imigrante mulher brasileira', esta última indica um estágio evolutivo. O importante é salientar que no presente não é possível falar do imigrante universal, como se ser homem ou mulher, heterossexual ou homossexual, pertencer a uma categoria etnico-racial ou diferentes classes sociais fossem situações indiferentes. Pelo contrário, sabemos à partida que tanto a situacionalidade como a contextualidade são fulcrais e marcam as experiências migratórias, de adaptação e de inserção. A perspectiva da interseccionalidade ensina-nos que são muitas as categorias e marcadores que modelam as experiências migratórias. (Padilla et al, 2012, p.4)

On the following chapter I better contextualize the participants' profiles, discussing the social markers of their experiences as mothers and migrants, aiming to answer the questions related to the feminist approach of intersectionality. "The benefit of intersectionality is its analytical emphasis on situated inequality and embedded structural relationships" (Johnson, 2014, p. 36) a) from a phenomenological point of view, in analysing the "experiences of domination" (Dorlin, 2012) and b) from a sociological perspective on the "variable geometry" (Hirata, 2014) of those markers, asking if some of them are preponderant in the social presence around those women.

THE PARTICIPANTS' PROFILES

To correctly identify the participants' social class I articulate three references: a) the interviewees' answers to the questionnaire, b) family budget levels based on the criteria established by the Commission for the Definition of Middle Class in Brazil (Comissão para definiçao da classe média no Brasil), from

the Secretariat of Strategic Studies (Secretaria para Assuntos Estratégicos) of the Federal Government (Brasil, 2010), and c) the typology of the international comparative research by Elísio Estanque (2003) based on the theory of Erik Olin Wright (1985).

In the questionnaire, I asked with which social class the mothers identified their families considering the country where they actually live, giving the following options: lower than middle class, lower middle class, middle class, upper middle class, upper class. Twenty-six respondents stated they belonged in the middle class in their country of residence; 1 reported to belong to the upper middle class and 3 to the lower middle class. After the biographical interviews, I compared their answers to the official definition of the Federal Government in relation to their family budget[37]. It is important to clarify that none of them experienced significant social mobility through immigration, even the ones who pursued their studies in the actual country. In fact, the majority of them had suffered an important break in their professional career after the geographical transition and after becoming mothers, without significant loss to the family budget. Thus, according to the official definition of "middle class" in Brazil, 17 of the mothers classified as "upper class", with a family budget of at least R$1,020.00 per capita; 10 are part of the "upper middle class" with at least R$641.00 and up to R$1,019.00 per capita; and 3 of the "middle-middle- class" with at least R$441.00 up to R$641.00 per capita. In summary, one can say that the majority of these mothers have the subjective experience of belonging to an economically less wealthy group than they actually do.

The typology developed by Estanque (2003) based on Wright (1989) helped me better qualify this categorization. According to it, the following criteria are combined in the experience of belonging to a social class: self-identification, ownership of production means, educational and qualification resources, and access to authority positions in the labour market. Twenty-eight mothers who participated in the research had completed a university degree, out of which 18 had earned post-graduate degrees including Master's, Doctoral and Postdoctoral studies. However, only 11 out of 30 women were employed in a full-time basis in their field of qualification, mainly due to a career "pause" due to childbearing and immigration. Only 2 had already been owners of private companies, most had never held leadership positions in the labour market, and 23 significantly reduced their paid workload and individual income after having children. Therefore, the women of this research have privileged educational resources compared to most middle class women in Brazil, and their household incomes range in the upper

[37] The information regarding family budget was calculated as an estimate concerning the family members' professions and employment status during the research period; some of the participants actually mentionned their specific budgets during our meetings.

middle class or in the upper class, but they are at a disadvantage in relation to men according to criteria of self-identification, ownership and authority in the workforce.

Estanque (2003) asserts that the middle class is an "intermediary set" that articulates economic but also relational resources, including social representations, ambitions and expectations related to consumption and lifestyle. Therefore, it can be activated as a source of personal identification even by individuals who do not objectively own a middle class budget, in configuring a very inclusive category that functions as a "safeguard zone" for class conflict (Estanque, 2003, p.26). Taking into account class relations in the Brazilian context, where huge social inequality is seen as a "natural landscape" and differences are suppressed by a "racial democracy" rhetoric (Arruda, 2002; Munanga, 2004), the interviewees' self-identification with the middle class can be understood as the subjective experience of being part of this "safeguard zone" while it reverberates gendered inequalities in the workforce.

However, while educational resources did not seem to improve the professional status of those mothers during the first years of motherhood, they were clearly related to their presence in the web at the same period. Internet was born under the dominance of men's work and presence, but nowadays, women have spent more time than men in it, and some of the main themes are "motherhood" and "health information" when they approach virtual communities and online search tools (Sales, 2011). This indicates that means of CMC that require writing and reading skills have been used by middle and upper classes in planning and experiencing motherhood, as the search/production of information is an important motivation.

Furthermore, CMC favours the construction of more flexible public spaces that include private and domestic problems as "political" or at least collective ones (Casilli, 2010), so they have been used by mothers to learn and speak out about pregnancy, birthing, breastfeeding, childcare etc., but still with typical tensions directly related to gender structures and social classes. That is why, after conducting research in the field of Cultural Psychology, whose object was a "breastfeeding" virtual community, Adalene Sales concludes:

> o uso e a apropriação das redes sociais virtuais por parte das mulheres, ao mesmo tempo em que lhes permitem ocupar o espaço público, as mantêm na esfera privada; o teor dos diálogos do fórum Pediatria Radical indica que essas mulheres transferem para o ciberespaço temas que dizem respeito ao papel historicamente delegado à mulher: cuidar da casa e do bem-estar da família. Nesse sentido, os debates podem tanto favorecer mudanças individuais, quanto reforçar valores, normas e costumes, perpetuando mitos sobre a maternidade, sobre a mulher e sobre a feminilidade. (2011, p. 104)

Likewise, 15 mothers who participated in this research had regular presence in the web as authors in weblogs and sites and/or as owners/mediators of fan pages and virtual communities[38]. They include all the 11 participants who lived in Brazil. These had "motherhood" as core subject of their writings from their personal experiences and/or the rhetoric of social movements and ideologies such as Feminism, Attachment Parenting, humanization of childbirth and maternal entrepreneurship. Three of them used online tools to publish contents related to their professions and jobs. In addition, 2 bloggers lived in France and 2 others in Sweden, writing about their experiences on immigration and parenting in a country other than Brazil. The other 15 mothers were less regular in the web but also participated as readers in forums, blogs and websites.

Besides, 21 mothers were somehow engaged in social movements related to Feminism, Maternalism and/or parenting ideologies, using the Internet to first approach those movements and/or to improve social participation, having more or less presence in this innovative dimension of public sphere, sometimes producing moral rhetoric about motherhood and maternal care and constituting social presences for other women and parents. For instance, 11 of them reported to be part of the movement for the humanization of childbirth. It was not only the most quoted movement by the interviewees but it also seemed to be quite influent on the rhetoric used by the great majority of them when discussing childbirth. It reflects the expansion of this movement's presence in virtual spaces.

Regarding the country of residence, aside from the 11 mothers living in Brazil, 9 were in France (including one who had children in Portugal, moved one year later to Brazil and after to France, and another who had children in France, moved to Brazil and then went back), 6 in Sweden (including one who had children in Sweden, moved to Australia, and then went back) and 4 in Portugal. Among the immigrants, there are 6 who formed French-Brazilian couples, 4 formed Swedish-Brazilian couples, and 3 Portuguese-Brazilian couples. Three who were living in Brazil were not married, 1 of whom declared to be bisexual and, later, a lesbian. Another one, also in Brazil, is homosexual and married. The remaining others declared themselves to be heterosexuals. Among black and mixed-race women, 5 lived in Brazil, 1 in Sweden, 4 in France.

In Table I, below, the social markers of the participants' profiles can be visualized, including "presence in the web" (which means presence as an editor/author or moderator of weblogs, websites or virtual

[38] Many of them have more than one kind of space, such as blogs and virtual communities, but to the categorization in the next table I considered "professional website" as the preponderant space before "personal weblog" and "virtual group moderator" subsequently. In the data analysis I will fully consider all the presences of those women in the web that were indicated in our conversations.

groups), “graduation field” and “education level”. As one can see, the group is almost homogenous in terms of educational level, sexual orientation and social class. But some, albeit marginal, differences appear and they will be consistently analysed. Likewise, it is important to emphasize that the categories in the following tables cannot express the relationality and temporality of the respective markers; they are only indexes of the situations in which these women are found. The indexes are important to provide a previous notion of the subtle diversity of an apparently homogenous group. Some categories also serve to contextualize others; “official social class” can be confronted to the category of “current occupation”, indicating the actual economic situation of those women: the minority of them have a full-time job in a qualified professional position. On the other hand, these indexes contribute to further analysis of different experiences of domination, such as the complexity of the experiences in being economically dependent because of gender while exploiting the care work of racialized and poor child-minders and domestic workers – which will be discussed in others chapters of this thesis.

TABLE I: MOTHERS' PROFILES

Alias	Country	Race	Official class	Work status	Current occupation	Educational level	Expertise	Online presence
Luise	Brazil	White	Upper class	Autonomous	Out of work	Undergraduate degree	Visual Arts	Virtual group moderator
Letícia	Brazil	White	Upper middle class	Autonomous	Part time job	Undergraduate degree	Journalism	Virtual group moderator
Sofia	Brazil	Brown	Upper middle class	Autonomous	Part time job	Undergraduate degree	Philosophy	Personal weblog
Raquel	Brazil	White	Upper middle class	Autonomous	Part time job	Graduate degree	Journalism	Professional website
Renata	Brazil	White	Middle middle-class	Autonomous	Out of work	Graduate degree	Journalism	Personal weblog
Simone	Brazil	Black	Upper middle class	Qualified worker	Full time job	Graduate degree	Education	Professional website
Cristina	Brazil	Black	Middle middle-class	Qualified worker	Full time job	Undergraduate degree	Music-therapy	Professional website
Luciana	Brazil	White	Upper class	Autonomous	Full time job	Undergraduate degree	Physiotherapy	Personal weblog
Fátima	Brazil	Black	Upper class	Qualified worker	Full time job	Graduate degree	Communication	Video channel
Luna	Brazil	White	Upper class	Supervisor	Full time job	Graduate degree	Music Production	Personal weblog
Carla	Brazil	Black	Upper Middle class	Supervisor	Full time job	Graduate degree	Health Management	Virtual group moderator
Célia	France	Brown	Middle middle-class	Semi-qualified worker	Full time job	Secondary education	General	Not regular
Antonia	France	White	Upper class	Qualified worker	Out of work	PhD	Engineering	Not regular
Ana Lúcia	France	White	Upper class	Supervisor	Out of work	Graduate degree	Law	Personal weblog
Isabely	France	White	Upper class	Qualified worker	Out of work	PhD	Economics	Not regular
Lidiane	Portugal, Brazil, France	White	Upper Middle class	Semi-qualified worker	Out of work	Undergraduate degree	History	Personal weblog
Marcela	France	Brown	Upper class	Employer	Full time job	Graduate degree	Physical Education	Not regular
Eliane	France, Brazil	Black	Upper Middle class	Qualified worker	Out of work	Undergraduate degree	Letters	Not regular
Natalia	France	Brown	Upper class	Supervisor	Full time job	PhD	Education	Not regular
Francine	Portugal	White	Upper Middle class	Student	Out of work	Secondary education	General	Not regular
Virginia	Portugal	White	Upper Middle class	Qualified worker	Out of work	Graduate degree	Nutrition	Not regular

Helena	Portugal	White	Upper Middle class	Qualified worker	Out of work	Graduate degree	Psychology	Not regular
Vanessa	Sweden	White	Upper class	Supervisor	Out of work	Graduate degree	Business	Not regular
Olivia	Sweden	White	Upper class	Qualified worker	Out of work	Graduate degree	Psychology	Not regular
Flávia	Sweden	White	Upper class	Employer	Part time job	Graduate degree	Physical Education	Personal weblog
Viviane	Sweden, Australia	Brown	Upper class	Qualified worker	Out of work	Graduate degree	Law	Not regular
Michele	Sweden	White	Upper class	Qualified worker	Full time job	Undergraduate degree	Economics	Not regular
Marina	Sweden	White	Upper class	Qualified worker	Full time job	Undergraduate degree	Social Work	Personal weblog
Aline	France	White	Upper class	Qualified worker	Part time job	Undergraduate degree	Psychology	Not regular
Rebeca	France	White	Upper class	Autonomous	Out of work	Graduate degree	Marketing	Not regular

I.3.B THE DOCUMENTARY RESEARCH

Just as Martiskainen (2006; 2011) was interested in the rhetorical analysis of mother talk using a documentary research on magazines and books on the theme of "motherhood" articulated to the mothers' narratives, I am interested in articulating mothers' narratives to texts that directly contribute to (and are products of) social policies. This goal was consolidated when I conducted the politicisation of motherhood – a process that approximates women to political texts, including government texts, and their common words and expressions.

According to Merleau-Ponty's arguments on the experience of reading, there is neither an author nor a reader dominance:

> La lecture est un affrontement entre les corps glorieux et impalpables de ma parole et de celle de l'auteur. Il est bien vrai, comme nous le disions tout à l'heure, qu'elle nous jette à l'intention signifiante d'autrui par-delà nos pensées propres comme la perception aux choses mêmes par-delà une perspective dont je ne m'avise qu'après coup. Mais ce pouvoir même de me dépasser par la lecture je le tiens du fait que je suis sujet parlant, gesticulation linguistique, comme ma perception n'est possible que par mon corps. (1969, p. 32)

Reading is an opportunity for "decentralizing" while also "transcending" (Caldin, 2011), which means that the reader can experience a subjective drifting from space and time, positioned at a specific situation with the author, feeling "unique" and at the same time part of a collective world, a kind of experience that Adams and Van Manen called "the space of the text" (Adams & Van Manen, 2006). One can say, for instance, that a space created by the encounter of a World Health Organization (WHO) report on maternal-infant health and the mother who reads it cannot be determined only by the original goals of the Organization, although its goals represent an important contribution to the experience of this mother. Because of the bodily situation of the reader, the space experienced by her in the process of reading this report can be quite different to what other woman or even she can have in a different situation.

The possibility of accessing this kind of document online is also an element to be considered: one can reflect about the feeling of being part of the "global community" represented by the WHO and propitiated by the web. At the same time, personal computers offer a feeling of immediacy and the possibility to immediately react to the text, they can also ride the power relations among legitimated authors, who they represent and their readers. At this point, with a critical perspective, I am aware of the historicity and intersubjectivity of reading experiences and agree with Virginia Moreira (2004) when she tries to develop a critical tool for Psychology with Phenomenology:

> A busca do significado é a tarefa fundamental para o pesquisador fenomenólogo que conta com um método que se presta a alcançar uma compreensão dos múltiplos signficados da experiência

> vivida, que tem, por sua vez, múltiplos contornos. A busca de um significado mundano da experiência vivida inclui uma visão de ser humano em mútua constituição com o mundo, com a história, com a cultura. (p. 454-455)

This meaning of lived experience mentioned by Moreira surpasses what we are used to consider as "meaningful" when doing Social Sciences, because it includes "experiences of presence" that are not all reflexive, such as aesthetical experiences (Gumbrecht, 2009), which drives me to be attentive to the narratives' elements that conform "human formation" (Morais, 2013). In other words, in pursuing my field research, I had to be attentive not only to the repetition of themes (if they appeared recurrently in the narratives) but primarily to the themes that were strongly related to temporality, corporeity, spatiality and relationality of the mothers' experiences – the elements that compose "human formation" according to Van Manen (1990).

Considering that beyond the complicity between author and reader (Caldin, 2011), there is agency, including docility and resistance (Mahmood, 2001) produced with their encounters, I was led by a paradoxical drifting between my own reading of the documents and the mothers' readings, to finally choose texts related to the themes present in our meetings. It is also coherent to the critical perspective defended by Moreira (2004) and Merhy (2011), when they argue for the clarification of the researcher's hypothesis and situation instead of feigning neutrality. The ambition of searching for essences of experiences without any previous hypothesis is the reason for many criticisms on the phenomenological method – criticisms that suggest a lack of political perspective on the theory because it seeks "essentialism". Formerly, taking a critical perspective of phenomenology means keeping my own position clear in this research situation as already discussed; resorting to different methods and fields of knowledge to contextualize basic categories such as "family" and "filiation". It implies being open to *interdisciplinarity*, just as many feminist phenomenologists stand (Simms & Stawarska, 2013; Vasterling, 1999, 2003, 2010; Stoller, 2009, 2013; Al-Saji, 2013, 2014, 2004, 2007):

> Feminist phenomenology is interdisciplinary as long as it intersects the methods and approaches of reflective and empirical disciplines, and ties theoretical study with practical relevance (such as in therapeutic practice, or in concerns about the ethical and political backdrop, and implications of phenomenological claims). We believe that feminist aspirations are well served by interdisciplinarity, and that a thematic and a methodological openness go hand in hand. (Simms and Stawarska, 2013, p.8)

Therefore, the documentary analysis searched for a moral rhetoric that converged or conflicted with the recent debates on filiation, family, maternal health, etc. at the same time it was limited by the themes found important in the temporality, corporeity, spatiality and relationality of the mothers' experiences in the early transitions of motherhood, such as: perinatal health, parental leaves and childcare.

For instance, after realizing that childbirth planning and event itself were cited by the interviewees as major themes in the transition to motherhood, and knowing that those themes can be confronted with the debate on "the right to have a family" because of the tension between biological and cultural arguments on birth, I made a decision to use "perinatal health" as one of the focuses for the documentary research. The other focus was on "family and parental supports" because of the relevance of this kind of policy to the conformation of mothers' first habits in being absent or present for their children during the first year. Although they did not mention this specific field of policies in their narratives, it appeared to me that having maternity, paternity or parental leaves, paid or not, produced certain contingencies to their presences, including the time mothers engaged in the preparation for childbirth and breastfeeding.

As mentioned in the previous chapter, I also realized that the participants used to read online about those themes, sometimes even resorting, during our meetings, to terms used on national and international online documents, showing the configuration of a specific *grammar* on childbearing and early childrearing related to the politicisation of parenting in middle and upper classes. Those documents are generally reports on public policies and/or health indicators, having general population, Academy and the Press as readers, turning the senses of national bills more accessible. Finally, as I was interested in comparing social presence between Brazil, France, Portugal and Sweden, and I was interested in CMC tools, I added some criteria of searching on the web for those official reports: a) they should have been produced by or with the support of national governments of Brazil, France, Portugal and Sweden, and b) they should have been published on the Internet from 2004 to 2014, included.

In the theme of "perinatal health", the encountered and analysed reports were mainly published with consolidated data from 2006 to 2011. To complement the analysis, the following online databases were consulted: DATASUS (Brazil), PORDATA, INE (Portugal), and The World Bank Data Site, in many occasions during 2014, 2015 and 2016. The documents are listed below:

a) Brazil: executive report, summary, scientific articles and a short documentary published after the survey *"Nascer no Brasil: inquérito nacional sobre parto e nascimento"* (Leal, 2014), conducted in 2010 and 2011 by researchers from *Fundação Oswaldo Cruz* (FIOCRUZ) and funded by the Brazilian Federal Government. It is the first national report in perinatal health which consolidates data from every region of the country with institutions from public and private sectors.

b) Portugal: a national and consolidated report of perinatal health was not found for the period but the country is contemplated by the European Perinatal Health Report 2010 from the Europe Peristat Project (Zeitlin et al, 2013). In addition, the following documents were analysed: a presentation of the Ministry

of Health about the recent outcomes of the maternal and infant health system (CNSMN, 2007), the report of a survey conducted by the regulatory health agency of the Federal Government (ERS, 2007), and an agreement from different professional organizations signed in 2010 (DGSS/APEO/OE, 2010).

c) France: the national report on perinatal health from 2010 was analysed and its press release conducted by the *Institut National de la Santé et de la Recherche Medicale* (INSERM) (Blondel & Kermarrec, 2011), the national report on the maternity units from the *Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques* (DREES) from 2010 (Vilain, 2011), one survey on caesarean sections conducted by the *Fédération hospitalière de France* (FHF, 2008), and the guideline *"Organisation de la prise en charge et de l'accompagnement des femmes en situation de précarité ou de vulnérabilité"* published in 2014, after the national inquiry on perinatal health, by the *Commission nationale de la naissance et de la santé de l'enfant*. In addition, I considered the European Perinatal Health Report 2010 from the Europe Peristat Project (Zeitlin et al, 2013). The document *"Contribution commune : la filière physiologique en obstétrique"* by the *Collège National des Sage-Femmes* (CNSF, 2015) was not included in the rhetorical analysis because it was published in 2015, however, it was used for clarifying specific aspects of French context.

d) Sweden: the national report on birth registers from 1973 to 2010 was analysed, as well as annexes 1 and 2, elaborated by the National Board of Health and Welfare from the National Government (OSS, 2012), and the report from the Swedish Association of Local Authorities and Regions (SALAR) (SALAR, 2010). Besides, some scientific papers written by the main authors of the reports and related to the theme were referred. Complementing the information on caesarean sections among immigrants, I analysed one of the texts in the document "From women's health to gender medicine – An Anthology" promoted by The Swedish Council for Working Life and Social Research (FAS) (Abrahamsson et al, 2011). Sweden was also contemplated by the European Perinatal Health Report 2010 from the Europe Peristat Project (Zeitlin, 2013).

In the theme of "family and parental supports", I referred to OECD Family Database and analysed the following documents:

a) Brazil: There is no national report on "family policies" or "policies for families" or "parental support" in Brazil; the programmes targeting "families" are from the Ministry of Social Development and Fight against Famine (MDS – Ministério do Desenvolvimento Social e Combate à Fome). Paid leaves in general are ordered by the Ministry of Social Security (MPS – Ministério da Previdência Social), and the protection against discrimination based on reproductive issues in workplaces are part of the responsibil-

ities of the Ministry of Work and Employment (MTE – Ministério do Trabalho e do Emprego[39]). For the purpose of this research, I analysed the report *"Síntese das Pesquisas de Avaliação de Programas Sociais do MDS"* published in 2014[40], developed by consortiums of academics and the Federal Government from 2011 up to 2014. I also analysed MTE's website, but there was no official document focused on the usufruct of parental leaves or on employment protections for mothers and fathers, during the period of fieldwork. There was, however, a document by the Special Secretary of Policies for Women (Secretaria Especial de Políticas para Mulheres – SPM) on gender and poverty published in 2005 (Melo, 2005), which does not account parental leaves, but will be commented further in the analysis. In addition, I analysed the paper: *"Histórico e evolução recente da concessão de salários-maternidade no Brasil"* by MPS researchers (Ansiliero & Rodrigues, 2007). Childcare, including childcare centres, is one of the responsibilities of the Ministry of Education (Ministério da Educação – MEC). In MEC's website one can find various normative publications targeting teachers, institutional caregivers and local managers, but the report evaluating "educational practices" including vacancies in institutions for children under three years old is restricted to rural areas. The only reports including national representative data were produced in collaboration with UNESCO and international funding. Thus, I analysed one of those documents, entitled *"Educação infantil no Brasil: primeira etapa da educação básica"*, from 2011 (Nunes et al, 2011).

b) Portugal: I examined the website created by the *"Observatório das Famílias"*, an academic project funded by the Federal Government of Portugal, and I have specifically analysed the following documents: *"Políticas de Apoio Económico às Famílias Em 2013: Policy Brief"* (Wall et al, 2013) and *"Principais Desenvolvimentos das Políticas de Família em 2013"* (Wall et al, 2013), in addition to articles previously published by the coordinator of the project with national and international data from 2002-2003 (Karin & Amâncio, 2007). I also examined the documents: *"Guia da parentalidade: maternidade, paternidade e adoção"* by the Social Security General Directory (DGSS – Direção Geral da Segurança Social) from 2013 (DGSS, 2013) and *"Recomendação: a Educação dos 0 aos 3 anos"* by the National Board of Education (Vasconselos, 2011).

c) France: quite unlike Brazil, France places family policy as a central theme to other social policies and produces periodic surveys in the theme "family and parental supports" by different governmental insti-

[39] After the fieldwork and during the writing of this thesis, Brazilian Ministries have changed; in its place, the Ministry of Work and Employment joined the Ministry of Social Security in October 2015.

[40] This synthesis was not focused on family and parental support, but embraced all the scope of the MDS, which is much more related to the policies for social inclusion and fighting against poverty. From there, I could identify specific authors and researches in the thematic of this thesis.

tutions. For this research, I decided to analyse the most recent and strategic documents that have the potential to reach parents by CMC. Then, I analysed the normative document *"Aider les parents à être parents: Le soutien à la parentalité, une perspective internationale"* by the *Centre d'analyse strategique* (CAS) of Federal Government (Hamel et al, 2012), the paper *"Prendre un congé parental total : une décision qui dépend essentiellement du nombre d'enfants et de l'emploi occupé auparavant"* (Crenner, 2011) produced after the survey by the statistics agency from Federal Government *Direction de la recherche, des études, de l'évaluation et des statistiques* (DREES) *"L'offre d'accueil des enfants de moins de 3 ans en 2012"*, and the national report *"La petite enfance: l'accueil du jeune enfant en 2010"* by the *Observatoire national de la petite enfance"* coordinated by the federal institution in charge of social security for families, *Caisse nationale des Allocations familiales (Cnaf)*.

e) Sweden: this country also has various publications on the theme "family and parental supports", however, in a more integrated form than France, because one can find statistics, research reports and other documents focused on different interlocutors, such as citizens, service managers, politicians, and researchers in the same website. Family Policy is analysed as a specific field, in a periodical basis, and with the collaboration of university researchers and governmental Social Insurance Agency, *Försäkringskassan*, but less ofen than in France. For the purpose of this thesis, I analysed the last report on Family Policy in Sweden found on the *Försäkringskassan* website, which is from 2008 with statistical data from 2005 and 2006 (Duvander, 2008). This report includes mainly parental-leave and child-related benefits; in addition, I analysed the working paper "Parental leave benefits and employers' additional compensation: Does additional compensation from the employer influence the parental leave length for men and women with low and high income?" also published in *Försäkringskassan* website, from 2009 (Lindblom, 2009), and the comparative document on Nordic countries "Fathers' use of paternity and parental leave in the Nordic countries" (Haataja, 2009) with the support of the different Nordic countries.

I.3.C THE INTERVIEWS AND DAILY DIARIES

In addition to the documentary research, I conducted biographical interviews in two phases: first an individual interview and the voice or video recording of personal diaries during at least five and up to seven days of a regular week. An interview, from a phenomenological perspective, is motivated by the description of experiences, so it does not have a closed and standardized script, but it is propitiated by an intimate ambiance. For this research, this ambiance was created by CMC with video cameras, when the participants were alone in a private room chosen by them.

The first interview was structured by the question: "how was your experience with the transition into motherhood in the country where you live?" The diaries' recording occurred by synchronized and/or unsynchronized video calls, which means that the participants were free to choose if they wanted to record it on their own and send it to me or if they wanted to meet online and do it with my company. Twenty-five of the mothers agreed to complement their interviews with the journals, only 9 did it completely by themselves.. I mostly managed to conclude with a conversation about their participation in the research and their contact with me. All those materials were included in the analysis, comprising about 72 hours of conversations.

I also chose not to previously define all the topics of the interviews so the respondents would have autonomy to steer the conversation and indicate the most important subjects related to the transition. My interventions were mainly meant to clarify some points and to ask about some of my interests in CMC and the intersectional aspects I discussed in the previous chapter, including one question on how the father (when applied) had participated or not in the transition, when the mothers did not mention it spontaneously.

The recording of those intimate diaries was inspired by the Day Reconstruction Method (DRM) (Khaneman et al, 2004; Krueger & Schkade, 2007; Krueger et al, 2008); a method created with an experimental and cognitive approach in Psychology and Behavioural Economics. In a large comparative survey in the USA and France, Krueger and colleagues (2008) found that French mothers reported less life satisfaction than the Americans but a significantly higher level of pleasure when taking care of their children. The authors suggested that this result could be related to the broader welfare system in France which includes universal and full-time public schools. I was inspired by the potential of this method in capturing the temporal dimension of subjective experiences related to social policies, despite my criticism on the limits of its epistemological approach. In fact, one of the most interesting characteristic of the DRM is the preparation it requires from the respondents: the inquirer has to ask them to

write confidential daily journals before the completion of the objective questionnaire in which they categorize their activities and associated moods, with the aim of facilitating the memorization of "facts" (Khaneman et al, 2004). Thus, the use of DRM for that research intended to "reveal" how subjective well-being of mothers were affected by the health and social devices they have available during a standardized time. However, this method does not include the complex experience with time and its relationship with moral and ethical concepts of motherhood, human development, gender, and the presences socially constructed around childcare.

Actually, the redesign of my methodology accompanied the evolutions of my research questions during the first steps of the project, just as Patricia Paperman (2013) suggests for the construction of a "feminist epistemology", for which the resonances of women's experiences have to be integrated into the research design: "which means a way of producing knowledge that integrates protagonists who would normally be absent, which expands its public and explicit (or claims for) political role" (Paperman, 2013, p. 47, free translation). My hypothesis thus evolved with the comprehension of social presence as a co-producer (in a retroactive drifting) of a care ethics and "moral facts" (Martiskainen, 2011) that are "bodily lived" by mothers (Young, 2005; Merleau-Ponty, 1945) in the present, but a present historically and gendered constructed, with certain presences that are bodily perceived and memorized, and others that are not.

Therefore, instead of categorizing levels of "subjective well-being" I had intended to use intimate diaries to capture how, during daily life, habits and situated hesitations renew and/or deconstruct moral rhetoric identified during the individual interviews and documentary research, because of the "crisis of temporality" (Deleuze, 1993; Al-Saji, 2004). This crisis consists in a permanent paradox: while past is a "whole" that needs to be repeatedly re-presented by psychosocial processes like social representations and "moral facts", the past is also dependent on the ruptures produced in the present. For instance, "Universal Mother" as a hegemonic representation (Pombo, 2013) points to a form of conceiving motherhood as an ontological category, which remains almost stable in women's experiences with childbearing at the same that it is partially/gradually deconstructed by moments of hesitation in daily maternal care. Therefore, the use of personal diaries as a complementary method had the main objective of identifying processes of hesitation, intuition and production of differences, confronting the daily experiences of the participants with their narratives of "becoming a mother".

I.3.D THE MATERIAL ANALYSIS

In operational terms, the analysis of the material involved the following steps: a) transcriptions of the interviews and locating "unities of sense" in the narratives, based on the "human formation", while debugging the documentary research; b) writing of temporal *paraboles* from the biographical narratives, based on the method of "phenomenological reduction" that I explain further; c) locating the relevant argumentative strategies in the analysed documents; d) reassessing the diary records and returning to the participants with their respective *paraboles*, when they remained available to be contacted.

During these processes I was aware of the resonance of my own experience impose the participants' and to the encounter of our "pasts", just as Al-Saji discusses in analysing Deleuzes' and Bergson's theories: the meeting of persons is a meeting of pasts (Al-Saji, 2004). During those encounters, not only hesitation but intuition played important roles, and the fieldwork's conclusion became the feedback of some participants on their *paraboles* and further experiences with motherhood.

According to a Merleau-pontyan perspective of researching experiences, "phenomenological reduction" consists in an effort of the researcher to disrupt his/her familiarity with the world to see it through the others' perceptions – a task that is always incomplete but necessary to the comprehension of our "engagement to the world" (Merleau-Ponty, 1945). Therefore, as phenomenologists our task is not to search for an "idealistic essence" but for a "factual existence" that includes the unreflective intentionality of the situated body and its contours (Moreira, 2004; Young, 2005; Vasterlig, 1999, Stoller, 2010). Thus, in writing the *paraboles*, I was attentive to those elements. As already mentioned, it is not possible to find the others' total experiences but it is plausible to search for them, knowing that discourses are not only vehicles of narratives but producers of experiences.

Searching for "experiences of presence" means searching for how the past, present and future are lived by the subjects referring specific events and objects of perception (such as "the baby", "childbirth", etc.), with attention to structural elements such as gender, class and racialization. It is also related to a "desire of presence" discussed by Gumbrecht (2010) for whom we are living a time dominated by a "culture of senses", when aesthetical experiences are constrained or diluted by ethical normativities. For him, in this context, the desire for intense experiences of presence becomes increasingly common, but is not being significantly analysed by Social Sciences and Humanities because of the dominance of a Cartesian epistemology. Therefore, during my first steps of researching, already discussed on the first chapters of this thesis, I realised that this critique on the "culture of senses" could converge with my own intuitions searching for maternal experiences from a feminist perspective.

Therefore, confronting biographical narratives to the diaries helped me find this "desire of presence" in the transition of motherhood, but also hesitations and intuition. Hesitation forms a specific type of experience that interpose the paradoxical moving in time, contributing to break rhetoric that seem coherent and stable, affecting the foreseeing of caring habits and mothers-baby bonds. According to Al-Saji, "paralyzing hesitation" can conduct to interiorize objectification such as theorized by Iris Marion Young (2005) – who discusses the inhibited intentionality in women's bodily experiences – but hesitation can be productive if allowing improvisation and "responsivity". Intuition in its turn can be an experience of presence that allows fluidity after a moment of hesitation, being favoured by co-presence and intersubjectivity.

> Intuition is the attunement to a plane different than that opened up by my body and corresponding to my rhythm of duration. Intuition will not simply deliver a past different in content, though this may be its consequence. It involves remembering differently, according to the configuration and affective tonality of another plane, and hence from another perspective and at a different intensity than my own. (Al-Saji, 2004, p. 226)

Finally, the quest for experiences of presence with this critical phenomenological approach contributed to the finding of how certain patterns of social presence propitiate mothers' responsivity towards other women who do not have the same kind of presences and are not influenced by the same relationship to globalized rhetoric on "human development" and "maternal-infant health" they found in online spaces they transit, especially the ones who are racialized and from poor classes. That is the link that helps me politicize the discussion on maternal experiences and care ethics, conducting the intersectional approach presented in the last chapters. The processes I just described can be understood as part of subjective agency (Mahmood, 2001; Butler, 2006; Stoller, 2010) related to the repetition and/or transformation of gender and class structures, in considering not only the construction of senses that structures those categories but the performance of lived experiences through them.

Part two: Desire, presence and the choice of motherhood

In the second part of this thesis, I begin to discuss the most important findings of the field research, introducing the core dimension of the majority of participants' experiences in the transitions of motherhood: a desire for intense experiences of presence, which is related to the "unities of sense" I will discuss further in the next parts.

Here, I discuss how the desire of presence (Gumbrecht, 2010) and the project of the interviewed mothers in "choosing motherhood" was articulated to a quest for the "own body" fluidity – which is defied by gender socialization (Young, 2005) and by a therapeutic culture that tries to control biological cycles and constrains mothers' presence towards children in early stages (Moreau & Vinit, 2007). But this process has a paradoxical temporality that re-presents some past imageries related to gender, race and class domination and confronts mothers with an ethical constraint on "human development" that points to a preponderance of the future. Thus, I discuss "choosing motherhood" as an ambivalent category in the mothers' experiences of presence, converging to feminist but also to classist and sexist agency.

In accordance with phenomenological methodology, the presentation of cases and excerpts of the participants' speeches follows the analysis of this desire of presence as a fundamental "unity of sense" in the experience of transition to motherhood. Thereby, the analysis of systematic differences or similarities between countries, including in perinatal and post-natal care are presented in relationship to this desire, not having the ultimate intention of deeply evaluate the devices although contributing to express their contradictions[41].

II.1 DESIRING PRESENCE AND (NOT) CHOOSING MOTHERHOOD

Young (2005) points out that, in patriarchal societies, women are constrained to experience their bodies as external objects of the conscience and not as vehicles of transcendence, because of a historical separation of public and domestic spaces, which is related to gender structure. This ambivalent experience

[41] Unlike the unity of sense « searching for humanization », that will be discussed further in Part three, « desire of presence » does not express much difference regarding the countries where the participants live. However, the presence or absence of this kind of desire and its fullfilment will be contextualized through the trajectory of those women, including their transit in different countries.

with the body can be more conflicting during pregnancy, while intense physical changes are experienced at a "first person" perspective but objectified by technologically sophisticated health systems.

> In feminine existence, however, the projection of an enclosed space severs the continuity between a 'here' and a 'yonder.' In feminine existence there is a double spatiality, as the space of the 'here' is distinct from the space of the 'yonder.' A distinction between space that is 'yonder' and not linked with my own body possibilities and the enclosed space that is 'here,' which I inhabit with my bodily possibilities, is an expression of the discontinuity between aim and capacity to realize the aim that I have articulated as the meaning of the tentativeness and uncertainty characterizing the inhibited intentionality of feminine motility. The space of the 'yonder' is a space in which feminine existence projects possibilities in the sense of understanding that 'someone' could move within it, but not I. Thus the space of the 'yonder' exists for feminine existence, but only as that which she is looking into, rather than moving in. (Young, 2005, p. 41, her quotations)

Formerly, in many analysed cases of this research, pregnancy appeared as an opportunity for mothers to search for their "own body" fluidity, through the expectation of intense experiences of presence that could connect the body to the objects as parts "of a field of primordial presence, from a perceptive domain over which my body has potency" (Merleau-Ponty, 1945, p. 136, free translation). Seeking to transcend this limited female motility through "feminine" events such as pregnancy and child labour converges to feminist rhetoric that denounces patriarchy, but also converges to a "therapeutic culture" that propagates the liberal rhetoric of choice and the centrality of "informed choice" as agency towards autonomy. This culture also extends the disciplining of the body from spatiality to temporality (Moreau & Vinit), which intensifies the tension between the desire of presence and the reflexive intentionality, in mothers' experiences. After all, the intensity of primary experiences of presence cannot be planned nor predicted – it has in itself the aspect of unpredictability (Gumbrecht, 2010) and unintelligibility (Vasterling, 1999). According to Gumbrecht (2010), one can only choose to be "open" to this kind of experience, like the athlete who becomes "lost in focused intensity" (Gumbrecht, 2010, p. 133, free translation), but this author observes: "there is no sure way of producing intensity moments, and there is only a small possibility that we can grasp or prolong them" (p. 127, free translation).

For Fátima, a script supervisor working for a Brazilian television channel, mother of a three year-old daughter and pregnant at the moment of the interview, the desire of motherhood was part of an emotional healing related to her experiences of *"femininity"* and *"sexual-affective relationships"*. In trying to explain this to me, she stated that it is something she *"feels"* more than *"understands"* despite her effort in *"reading"* and *"studying"* this matter, mentioning Clarissa Estés' book "Women Who Run With the Wolves" (1992) – in which the psychoanalyst analyses female archetypes in legends and ancient

tales[42] . She states that femininity has been *"excessively domesticized"* and maternity would be a way to surpass this domestication because it has a *"savage"* side:

> "But the conversation I started about having a baby was while we were still dating. In fact **it was a wish that was sort of distorted on my emotional health**. Because I started to understand that I really projected motherhood on sex-affective relationships, **it was actually a way for me to deny myself the wish of being a mother, because, initially, it is a very feminist claim that I had**, not wanting to confess to this feminine side of me, and gradually I started organising it in my head and it coincided with this relationship (...) **Still today I try to study and understand, but sometimes I can feel more than understand, right?** I don't know if it's a very pretentious analysis of mine, but I think that there is excessive **erotic stimulus in general, especially over the image of femininity, the woman, and I think that motherhood is the closing of the cycle**. In theory, sex exists to generate life and I think this ended up contributing to make this emotional mess... so much erotic stimulus, of all the sex I had, none of which... in many of them... life was not generated, I did not get pregnant, **I think it also brings to an excess of domestication, as I read in 'Women who run with the wolves'**. She keeps saying that femininity started getting very domesticized and there is a wild side which I think is related to this desire I have, desire of motherhood, and now with my second pregnancy." (Fátima)

This savage aspect is described as *"animalistic"* by Sofia, a philosopher and journalist in Brazil, who also created a weblog to write about her experiences, when after eight months of intense corporal dedication to her daughter, found out again that she *"had a knack"* for writing. Recently she has decided to make an important change in her career with the rising of *"scientific interest"* on childhood: to leave the editorial market in which she worked with adult and children Literature and back to University to study Pedagogy. This change was also motivated by old frustrations with her profession, but she explained that this interest came from the *"animalistic"* experience with motherhood:

> "If I stay in the field of Literary Criticism, about Literature, I won't be able to get there (...) **I'm not going to really understand what I think I'm looking for at the end: who is my daughter, how I deal with it, what kind of human being she is, etc.** And I started to find these creatures pretty interesting; since I got pregnant I started to find the child a really interesting creature. I don't know, scientifically quite interesting indeed! I don't think pregnancy is cute... it's not about this mummy thing. **Actually, I think it pretty animalistic**, pretty interesting, the mother and the child." (Sofia)

Although this exact expression – desire of presence – was not mentioned by the mothers, it translates in few words what I heard in many encounters when they tried to trace a beginning of their transition into motherhood. Because what I heard during the interviews were not rationalized explanations about "why I wanted to have children" but explanations based on existential quests the women lived at the time they got pregnant – queries directly influenced by the female gender, for which motherhood seems always to be a possibility but challenged by the *"biological clock"* (Luise; Natalia). This can be visualized in the following narrative by Natalia, a mother of a three year-old son, working as a professor in France:

[42] This book was mentioned by five other participants besides Fátima.

> "How was the entry into motherhood? That's a broad question... I don't know **... I guess it was sort of in the process of things happening bit by bit. I was writing my thesis for a while already, at that stage you still don't know if you're grown up or not... when will you start your life for real** ... If you're going to be able to have other plans apart from the thesis ... and then I had a friend who was trying to have a baby for a long time and couldn't ... and it sort of worked by the story in the sense that I realized: well, my life is trapped in the thesis but I can't stay in this story ... Let's start trying because it might be that if it takes too long and I can't suspend all my projects because of this, right? (...)It was in 2010, I was 31 years old ... in that stage you don't know ... **I had had an appointment at the gynecologist, she gave me an earnest**: not having children is easy, but having children is not always easy, you have to start paying attention if you want to, and age also influences. Then there was a time when I knew I wanted to have children, that was certain to me ... and I said: **well, I'd rather run the risk of getting pregnant now, even if the timing is not ideal, if I'm still in the thesis, I'm not working... than running the risk of not being able to have children because I waited too long.**" (Natalia)

II.1.A CHOSEN MOTHERHOOD AS MARK OF SOCIAL CLASS

In many analysed cases, while the right time to get pregnant is suffering tension because of professional and family contexts, the control of fertility, with its ritualized and privatized habits, is an implicit fact, a capacity that is not in doubt. Although it can be viewed as an important outcome of Feminism, this access to individualized family planning among middle and upper classes has also an excluding side in Brazil, as one of the intersectional dynamics of domination among women. Because, while for privileged classes' fertility control is part of their self-caring routine, it is not an easily accessed experience for the poor. The difficulty of poor women in preventing pregnancy and performing safe abortions does not threaten the "chosen motherhood" culture – on the contrary, it happens to be a mechanism of differentiation among social classes. Thus, "chosen motherhood" is not only an individual choice, it is already a "culture" strongly linked to the status of middle classes in societies where health facilities are not equally delivered. It is also related to the spread of an easy access to health technologies on birth and death, accompanied by an "urgency" to decide on those events among privileged groups, which is part of a "therapeutic culture" discussed by Vinit and Moreau:

> De même, le temps de latence, entre la prise de décision (vouloir un enfant) et le résultat (la grossesse effective) tend aujourd'hui à devenir « anormal » ou difficilement tolérable. Si le corps ne répond pas à l'injonction du désir, la consultation médicale s'impose de plus en plus rapidement. (Moreau & Vinit, 2007, p. 39, their quotation)

As expressed by Marcela, a mother of a 15 days-old infant who lives in France, this urgency is strongly related to the desire of presence with motherhood, which is under the pressure of *"biological clock"*:

> "**My daughter was super, master, mega planned and desired** (...) When I decided to stop taking the pill, I talked with my husband, we made a deal, and then we said: it's now! That's the time we're going to have a baby. **And I was completely fanatic in order to get pregnant soon**. I stopped taking the pill in December and got pregnant in April, which was very long to me, but people say it was quick, **but my desire to get pregnant was such that for me it was a long time**." (Marcela)

In a paper written by Pombo de Barros and Fernandes (2016), we did an articulation between my field-work and Camila Fernandes' – she conducts an ethnographic research in a *favela* in Rio de Janeiro with mothers and caregivers who work in the neighbourhood. She observed that one of the most important themes of those women's narratives is the quest for preventing pregnancy, even while they are pregnant, because many of them have great difficulty in accessing medical facilities to receive other contraceptives than first generation progesterone – which produces very unpleasant symptoms (WHO, 2007) – or male preservatives – which reinforces their disadvantages in negotiating with their sexual partners. Thus after two, three or four children, and failing to find responsive family planning services, they hope for definitive methods such as sterilization[43]. In Fernandes' research, public managers, judges and directors of childcare centres say that offering more places with this kind of service and offering social benefits such as PBF will only further encourage poor women's "uncontrolled sexual behaviour".

On the other hand, one observes middle- and upper-class women coping or struggling with over-medicalization of reproduction, focusing on the right of choosing birth timing and onset, ignoring contraception as a real matter. The gender structures that cross both classes are reproduced by the rhetoric of choice as the way of controlling the body, with the preponderance of individual rational choice, which is used as justification for the lack of public services to assist family planning, pregnancy and motherhood. The problem is that "the concept of choice, which is so central to liberal feminist thinking, insinuates equality among the options, full autonomy to choose and unrestricted individual agency" (Neyer & Bernardi, 2011, p. 170). As discussed by Neyer and Bernadi, with the spreading of Artificial Reproductive Technologies (ARTs), "choice has turned into a eugenic obligation which women cannot forego without being termed irresponsible towards themselves and towards society" (2011, p. 171). Pérez (2011) articulates this "new" culture of motherhood to the logic of mass consumption in the capitalist system, emphasizing that they are constructed by the participation in the reproduction market with all the options it offers – including ARTs and the international adoption system. They both would be part of a complex phenomenon that reviews what we considered natural in human reproduction but also reiterates old gender assumptions, because of the concept of choosing motherhood as the most important project and event of a woman's life.

One of the stories that most fully exemplifies the paradox of "chosen motherhood" in searching for one's "own body" fluidity is by a black mother of a two year-old son, Simone, who is engaged in maternalist and feminist social movements in Brazil, and who experienced expressive social mobility during

[43] As already commented in other chapter, 30% of pregnant SUS patients in Brazil who wish for being submitted to a surgical birth, actually declare it with the aim of undergoing sterilization.

her life, having lived in a *favela* until the age of 27. Nowadays, Simone is part of the "upper middle class", and tries to conciliate her kinship's history with her present, resorting memories related to this social mobility, such as the experiences in a renowned public school – where she had better access to formal education but also experienced racism and classism. She told me her story of transition starting with a desire that became more important with ageing, which reminded her of the will to become a *"full-time mother"*. She mentioned, without highlighting it, that years ago she had undergone an abortion of an unwanted pregnancy, emphasizing that now she wanted to be a *"present mother"* for her son. During the interview she told me:

> "And then I organized myself for that. **Because I've always wanted to be a mother, and I'm a pedagogue, so I studied Education a lot**, working for an NGO for eight years with educational projects, so I've always been **pretty disappointed with the school, did not believe in this system**, and one thing I already knew was that I wanted to be intensely present with my son at least for two years after birth. (...) **So this relationship with my mother has really boosted me...** talking about how my father was around, reminding me of my childhood, about the care, the network that my family belonged to, which nowadays people don't have anymore, right? **There were my aunts, and everyone helped each other, and there was no such thing as going to school so early, because mothers didn't work outside**, because my aunts were all housewives and only began to work after their children had grown up, so the memory of all the cousins together, and that early childhood in the yard, right? **All that was constructing me... and I have remembered who I was, and it has made me stronger...** and when V was born everything was quite solid, you know?" (Simone)

Simone remembered who she actually was by an encounter with her mother's and aunts' past; a past in which she could feel embraced by an ambiance free of racism. However, she does not express an agency of deconstructing the gender and class inequality that her female ancestors lived whereas they were housewives without institutional resources such as family planning, day-care centres or individual incomes – for instance, she mentioned briefly that her mother had a caesarean section for the fourth child in order to be sterilized. Thus, Simone stood her ground against oppressive education but did not recognize the link between her voluntary exit from *"the system"* and the compulsory exclusion of poorer women from the same system due to structural inequalities. This paradoxical ambivalence appeared in many mothers' narratives, expressing a common experience of time in the early stages of motherhood, much determined by the intersection of social class and gender.

Alia Al-Saji (2004, 2007, 2013, 2014) develops a theory of racialization from Feminist Phenomenology, identifying that there is a "closure in the past" in the experience of racialization, because the body's schema can be situated in a history that it actually did not experience – a "representation of history" told and naturalized by Western society structural racism, dominated by the role of white Europeans. She analyses Martinican psychiatrist Frantz Fanon's book "Black Skin, White Masks" in the effort to understand how racism can be an embodied experience of time, and she discovers the paradox of ex-

istence under an "invisible domination". I try to draw a parallel with the processes of transition to motherhood as lived by a performativity of a "universal" history about human development, in which the mother is almost a mythological figure anchored in a dichotomist view on nature that demands an extemporal maternal presence.

At these terms, the "present" of intense experiences in mothering is repressed by the domination of the past and future, and the narratives of becoming a mother may suffer intense alienation because of the hegemonic representation of the "Universal Mother" and because of the social presence that delegitimates the tension and particularities experienced by women: "The closed past (...) is instituted and inhabited; it is a lifeworld of habitualities and not merely a representation" (Al-Saji, 2013, p. 7). Thus Al-Saji identifies a "feeling of lateness" that:

> (...) cannot merely be understood in terms of the pre-existence of the world, a pre-existence which characterizes our phenomenological experience of the intersubjective world. The feeling of coming to a world that was always already there, that contains meanings sedimented through other lives, gives us the sense of that world as real. But this intersubjective world is not perceived as a completed reality; indeed, it is felt to be inexhaustible and only incompletely given, open to the creation of new possibility (2013, p. 7, 8)

Habitualities constitute certain planes of memories in which specific habits are associated to specific periods of "life cycles", which is also determined by social and historical structures (Al-Saji, 2013). Although one observes an invisibility of gender and class oppressions lived by the foremothers in Simone's narrative, on the other hand, in her experience, being *"very dedicated"* to motherhood during her son's first years is a strategy to resist the *"system's oppressions"* represented by public school – an institution where she found her bodily experiences, such as the need for caring and presence, repressed by racist and sexist orders. With the project of "chosen motherhood" she can create a "new possibility" to this reality. Therefore, she decided, while still pregnant, not to put her son in a childcare centre, creating a parental association in her own household with the support of her husband and some friends, shrinking her individual income to one-third of what she used to earn before motherhood, but claiming to get *"natural satisfaction"* from it. Finally, she found motherhood *"easy"*, a role into which she *"fit quite well".* Shortly after our first conversation, Simone wrote about it as a guest author in a feminist blog, bringing to the forefront her past as a student and the will to respect her child's *"life times"*, with a text illustrated by pictures of children and parents in her associative day-care:

> "The school space enabled me to make many discoveries, many encounters and experiences, but it didn't welcome me during my crisis and self-discovery. In the first days of school, when coming down the favela and crossing the neighbourhood, I made numerous discoveries. (...) **I realized that there was a world beyond my family**. (...) **In this place, I also found out that I was black and poor**. (...) Then I went to University, where I learned about curricula, didactics and the History of Educa-

> tion. (...) I started to transit in the South region of the city [richer region of Rio de Janeiro], working there, and **I found myself experiencing racism and sexism every day**. **However, despite all these discoveries, I only reaffirmed myself as a black woman and educator way after school. Because school, with its rigid structure and knowledge compartmentalisation, did not prepare me for any of these transition**. (...) **During this work and search for alternative forms of education, I sought a technical dance course, because I wanted to appreciate the body that school ignored my whole life**. (...) We built a school that created a space in which we all participated as educators and educated, where we can turn into reality a world view which says it is possible to creatively join education and childcare. **It is about synchronizing vital time periods** and learning, through creation, play, experience and research." (Simone)

Transiting within a different society where racism is reproduced with unfamiliar mechanisms can also propitiate an agency towards a more emancipated experience of corporality and resistance, while women incorporate the local middle class culture. Eliane is a black mother of two French-Brazilian children living in France and works there as an English teacher. Married to a white man, she explained to me how it is *"much easier"* going out with him in the street in France compared to Brazil *"because of how people stare"*. In Brazil, she felt discriminated many times by people she never knew, such as in restaurants, where some reacted as if she was a prostitute and her husband a tourist. Because of that, in those situations she insisted on paying the bill. In France, she felt less noticed, which made her more relaxed when walking in the street; sometimes she even senses *"admiring looks"* as *"French people seem to admire the eccentric couple"* they form. But the situation is quite different in family settings. Whereas in Brazil, she sees *"hypocrisy",* in France she suffered great difficulty to finally be respected by her husband's relatives, who were clearly mistrustful towards her, accusing her of marrying him because of money. Her priority in the new country was to *"be integrated to the culture and learning the language"*, with which she did not have much trouble seeing as she completed a Master's degree in Language and Literature.

However, Eliane has a long-standing habit of receiving constant attention regarding her own behaviour in all kinds of settings to *"accomplish more"* and *"do better"* with the aim of being recognized in a positive light. During her whole life, she heard from her mother, who is also a black woman, that she should never depend on men as being a house maid – she asserted that *"this concern is part of my identity"*. Then she said: *"I grew up with this conscience that black people have to dress well and show that being black represents something positive. When you are black you are born with it. I observe gestures, how people walk... I like to sit where I can see everybody".* During the first years of motherhood, this concern expanded to the way she disciplined her children, and she found herself being *"strict"* out of the fear that any occasional undisciplined behaviour of her children would be faced as a racial index and as her failure as a mother. This strictness pressured her to an intense fatigue, whereas she had to work

outside home and wanted to be more present to her children. She struggled with a constant feeling of not being the mother she *"wanted to be",* trying to find explanations to the behaviour of her children on her own conduct, barely referring to their father as also responsible for them. She told me that learning about Attachment Parenting Theory from some friends from Brazil helped her question this guilt when her children were "badly behaved" while also causing her to be guilty of not being as *"attached"* as they might need:

> "**I feel guilty about not being able to maintain this attachment after six months... For me, it's like I've given up**. (...) Because Z didn't sleep immediately. I let her cry in her crib many, many nights. **So, that's my fault. Will be? I really wonder... Because Z had many nightmares. So I wonder if I shouldn't have had that attachment after six months, if I shouldn't have held on a little more... being more available to Z** (...)When she began to show many fears, nightmares with the cartoons, I said: Damn, I gave up too soon! I should have continued, I should have been, I don't know, a year without sleep, as a friend of mine was (...) without working and breastfeeding... breastfeeding ... even though I had reached my limit. Then I got questioning me: man? (...) Because when I found this theory of attachment parenting that said prank makes part of it, that prank is like this anyway, you don't have to go nuts, so I started to change my relationship with Z (...) because as I was telling you, I am quite strict. That's why I don't want to have another child, because I don't want to live this phase of educating children again, you know what I mean? Because I think, I know that is boring... **We wonder how we want our children be, right? I want my children well-educated; I don't want to feel ashamed at restaurants, supermarkets... I do remember of that, that I did not want to feel ashamed with the children squirming in supermarkets, you know?** So, I have this rigidity with things.... You know, this thing of keeping saying: no, that you can't, you can't do this, sit properly, hold on your fork properly... you know? This I don't want anymore. It made me quite tired." (Eliane)

Therefore, choosing motherhood is a social class marker, which is quite important to the agency of women who are struggling against specific forms of domination. However it pressures them to assume full responsibility for the caring and education of their children as a "natural" consequence, even when this entitlement conflicts with their identities and habits including racial experiences. It is also a middle-class culture that defies the advancement to a universalist agenda on fertility controlling and family planning, which could better contemplate structural inequalities among women.

II.1.B THE COMPLEXITY WITHIN CHOICE, PLANNING AND DESIRE OF MOTHERHOOD

However, the choice of having children is not as rationalized in women's narratives as it seems in the "chosen motherhood" culture. Thirteen of the participants of this research did not plan their pregnancies, although nine of them expressed motherhood as a desire and expressed a desire of presence in having the child. In fact, the most part of the participants, including the ones who planned their pregnancies, reported *"it was not the right moment to get pregnant"* (Alice, Sofia, Simone and Natalia used these exact words), albeit emphasizing that it did not stop them from wanting to. In many cases, they could not find a clear justification for the decision of keeping the child, describing it as *"a desire to have*

other projects in a period when life seemed stuck" (Natalia), accompanied by *"the rising volition of being a mother"* (Luise) when they were getting along with friends or relatives who were becoming parents.

Pérez (2011) interprets the desire and the choice of motherhood as part of the "narcissist" logic of consumption, which pressures many women who do not correspond to the hegemonic model of femininity to procreate in the same model, such as lesbians and single mothers. As for Faya-Robles (2011), she ascertains the "incarnation" of a maternal role by women from popular classes in Northeastern Brazilian even when they do not plan their pregnancies, because of the influence of a sanitarian discourse in SUS's facilities. Both researchers found a child-centred conception of maternal presence, which places the well-being of children as the cornerstone of families and maternal-infant bonding as the main source of mothers' satisfaction. However, as I could observe in my fieldwork, this relationship between desire, choice and incarnation of motherhood can be much more complex, including the capacity of women to use this process as a mechanism of resistance to specific relations of subordination while reproducing old structures of class, race and gender inequalities; an agency performed through "docility" and resistance, such as discussed by Mahmood (2001).

Renata, a blogger and writer who created different virtual groups on the theme of Feminism and motherhood in Brazil and who became a lesbian after becoming mother, told me that her decision to have a baby was a *"compulsory"* one, although it was a decision related to an *"old desire to see a human consciousness being formed"*. Therefore, she intuits a cultural index of her desire while identifying a bodily unintelligible intentionality with motherhood which rose after feeling *"controlled"* by her mother and ex-boyfriend, configuring an ambivalent agency:

> "Then pregnancy happened and it was a shock. **I was not prepared, it was not planned, I wanted to have children, we talked about that, but it wasn't the right moment (...) Then I got super confused, I thought of having an abortion, so the decision was really a decision, however a compulsory one**. I suffered a lot, but what counted most for me at the end of day was the fact that I always have seen myself in educating, you know? I always planned that for me. Maybe, most likely, it is due to the condition in which we are submitted, but also for the possibility of seeing a human consciousness in development. Then I told myself: no, I will assume this baby. And I thought I would have some support, right? But I had depression, and then I realized that I was not having support. (...) **Because my mother started calling... in the beginning of pregnancy, it became pretty weird because she dominated the situation. And then she got more controlling over me, over my body, my experiences...** everybody was giving hints about my decision of having or not the child, and it was at that moment that I was having depression." (Renata)

Lidiane lived in Portugal when she had her son, then moved to Brazil for one year and went to France, where she participated in the research. She has a peculiar history that can contribute to the under-

standing on how the project of motherhood can conflict to the desire of primary presence with pregnancy, and how this process is situated in certain cultural atmospheres that constrains those women to not assume this conflict between desire and reality, incorporating guilt and sometimes a child-centred discourse to compensate it. Lidiane reported that she had *"always wanted to be mother, since childhood"* comparing it to her difficulty in deciding for a specific professional career. She wanted to be a writer or psychologist but majored in History, thinking of writing a historical novel. Just after graduation in Brazil, she moved to Portugal to marry her husband – a Brazilian who worked there. Her first plan in the new country was to get pregnant, but her husband had already had a vasectomy and they decided to revert the procedure. The first attempt in the private health system failed, and Lidiane decided to start an undergraduate course in Psychology because she *"could not stop her life"* while she continued trying to get treatment in the public system. Finally, she was told she had a *"risky pregnancy"* and was restricted to *"bed rest for three months"*. She told me:

> "**Because I had a high-risk pregnancy** (...) I did the treatment, I found out that I was pregnant, but I thought in my head that I was going to take the pregnancy until the end and that when I was at the end **I would have him and it would be also the ending of College tests, right? (...) But when I was doing the test, it was the day of my birthday, I loved my birthday, nothing bad could happen to me (...) and when I went to the bathroom I was completely in blood, blood everywhere**! I don't know how that did not trespass the dress (...) Then I thought I had lost it (...) We went to the hospital, a pretty rude doctor didn't let him to entry with me, didn't let him even talk to me, she made me feel guilty because we had have intercourse... because when you're doing treatment, there are a lot of women who stand a myth like this: Oh I can't have sex whatever... But there is no reason for it, you know? Usually in these groups they avoid to have sex because they take so long to get the opportunity [of getting pregnant], you know, that in fact they can't have it naturally, so sometimes they deprive themselves even from sex for the whole pregnancy, right? You can find women who do that. (...) **Then the doctor made me feel quite guilty**; and she give me a face like it would not worth it, she said: oh you can have the resting to want! Because he was still alive but with the amniotic sac completely detached, only a small peace attached. **And she told me: you can have all the rest you want, but I don't believe it's going to work.(...) Then I stopped my whole life, and I was quite active. (...) In resume, I kept three completely months resting**, only got up to pee, to wash myself, and to back to bed, laying the entire time." (Lidiane)

Nevertheless, after childbirth, Lidiane did not feel what she expected, and wrote on her anonymous weblog that she *"hated being a mother"* and that she did not love her son as she loved her husband. As a response she received many comments in her blog by readers who judged and condemned her and by other mothers who reported feeling the same way. She felt *"depressive"*, like she had lost her *"identity"*, therefore living *"in a vacuum"*. Despite all this tension, Lidiane breastfed and was the main caregiver of her son during the first year, because she *"felt responsible"*. Her husband worked full-time out of the home, and every day, before leaving the house, he prepared all her meals and left them close to the bedroom, since Lidiane was not able to leave the bed. She kept most part of daily routine close to the child, lying, and doing the least caring duties she thought he should need. As for the baby, *"he cried*

a lot", which intensified Lidiane's suffering. During a walk to the health centre for visiting the child's paediatrician, she even briefly considered leaving him in the garbage disposal. His father knew about this situation but *"he didn't understand the gravity of it"*. The only person who was able to get Lidiane out of bed was her mother-in-law, but she lived in Brazil and could not stay longer. Lidiane's own mother was ill, undergoing chemotherapy in Brazil, but visited the family in Portugal and interfered many times in Lidiane's decisions regarding childcare in a way that made her feeling worse.

Of course Lidiane's transition to motherhood is characterised by a complexity that cannot be analysed solely under the focus of the "desire of presence", but her story can contribute to understanding how planning and choosing motherhood, sometimes, contradicts the search for one's own body fluidity, even when there is an expectation that this fluidity should occur. One problem, we can see, is the invasive presence of health systems, family and a general culture of motherhood which constrains, once again, women's motility, and keeps them from being spontaneous and publicly honest about their experiences. At this point, one can understand why weblogs and virtual communities become so present in some mothers' lives. Lidiane can use an anonymous avatar and a private virtual group on Facebook, in which she connects with other women with similar experiences, in order to finally express her frustration with motherhood and feel authentic again. Through this experience, she approached feminist virtual groups and read about gender and racial discrimination, remembering how she also felt discriminated as a Brazilian woman in Portugal. Thus this conflicting experience with motherhood brought Lidiane to search for alternative spaces online, in which there were rhetorics other than child-centred ones.

> "**Actually, when he was born I felt I had lost my identity**. I didn't feel as a mother but didn't feel as a girl either, I don't know, as young, woman, and **I was in a vacuum like that because I couldn't find myself in any role** (...) Because, at the beginning, the weblog was a way of putting my feelings, and on. At the beginning, infertility was the reason, and later this question of F having been born and I didn't have felt that identification, **at any moment I felt that identification, that thing people say: oh what a love!** That thing that I don't know from where it comes, you know? I never felt that. **And I think it was one of the things that made me quite depressive, and I drown even more because I felt guilty**, because people.... all that we see in social medias, you know, people keep in full bloom, showing that happiness, wanting to show they are plenty, right? And for you, as a woman, having a child, it is seen as "oh God" like you have found the nirvana, you know? And I didn't feel anything like that and I couldn't talk to anyone." (Lidiane)

After a while, Lidiane suspected that she had post-partum depression, and started online therapy with the same psychologist she had in adolescence. The psychologist, in turn, used his own experience as an adoptive father to legitimate Lidiane's reported experiences, which aided the process of demystifying the expectations associated with motherhood and the guilt it can bring. About this process, she told me:

> "And when I came back again, I had a few sessions with the same therapist I had have for my entire life, from fifteen years old until I moved to Portugal. And he talked to me like that... he has a humanistic approach; **he always tried to take the blame away when I said: but I don't feel it! I was punishing me, and he spoke: but why do you have to feel it?** He always told me so, but you know, he was also a man, right? I don't know what would be a woman's approach. But he always told me how being a mother is just one of the roles that we have, right? You are daughter, niece, goddaughter, godmother ... anyway ... and you're mum! Of course that being a mother you have greater responsibility, obvious, huh? **Because you are responsible for nurturing... you and the father actually. But it's not that supernatural. So he was the one who helped me a lot in thing of having sincerity about myself too.** Because he adopted two boys, and he said one of the boys had a trauma so great with abandonment that he could scream and cry, sometimes for about a hour without stopping (...) and he admitted that sometimes he had thoughts... that he had feelings of killing! But of course he wasn't going to do that. **Feeling is one thing, doing is another. We can feel... It doesn't mean you're a monster because you feel something that isn't admited or appropriated in our society**." (Lidiane)

Nowadays, mothers' feelings regarding children are constantly submitted to scrutiny, used as a variable to explain children's emotional states and future behaviours – which is reified by the diagnosis of post-partum depression. Despite the advantage of giving visibility to mothers' needs of support during early motherhood, generally this support is understood in terms of medical care for the mother rather than in improving social presence for the family, for instance in encouraging fathers to take early parental leave. In this context, the desire of presence with motherhood can be replaced by a subaltern position facing medical and family presence and a strong alienation towards one's own experiences; since the main concern is centred around the children whereas the main responsibility is assigned to the biological mother. That is the reason why Lidiane struggles with the cultural idea according to which she is a *"monster"* because she did not have *"that identification"* with her son. The possibility of having the presence of a therapist with a clear empathetic attitude, instead of a scrutinizing one, was very important for Lidiane to *"be honest"* with herself and create another kind of action to overcome this depressive state and "feeling of unpreparedness" (Martiskainen, 2011). As an aesthetic experience, writing and reading personal weblogs can contribute to the conciliation of both experiencing dimensions, through this tension between "feeling" and attributing senses.

According to Gumbrecht (2010), aesthetic experience can be seen as a contemporary mode of living the tension between the desire of presence and reflexive intentionality. And I did observe in my fieldwork that this kind of experience plays an important role among privileged Brazilian mothers, since motherhood has been culturally linked to choice and intensity, albeit expressing motherhood-related aesthetics. This role is also favoured by CMC because these ones can constitute a "domestic door" to public spheres, having an emotional appeal with visual rhetoric. Visual rhetoric, as the creative use of images and objects to consciously communicate to an audience is, in some cases, the only pertinent

strategy to communicate the dynamics of human action because of its multidimensionality (Fox, 2004). This strategy is currently used on the Internet, from mainstream media to Cyberfeminism, to speak on women's bodily changes (Olson, 2009). As Casilli (2010) identified, one can observe the rising of a "truth about the body" on the Internet, in which images of diverse corporality have been exposed. From this perspective, pregnant women and real mothers' images have created a "counterculture" of the feminine ideal, while also reinforcing motherhood as a quite important mode for women being-in-the-world.

Writing and reading *per se* requires a "multi-aspectival" space, proportioning a complex space-time experience (Adams & Van Manen, 2006). Regarding online writing and reading, this complexity can be felt in an even more intense way, since one can interact almost immediately to another, having the sense of immanence while potential experiences of transcendence in this process. Thus, for Lidiane, such as reported by another participant, Vanessa, the possibility of connecting to the Internet can be a way of *"being absent without leaving the room"* (Vanessa), trying to conciliate this complex space-time to the infant's needs of presence.

> We need an undisturbed space of time where we can dwell in the timelessness of the space of reading. And the space of writing. § So, once you have found this phenomenological space conducive to reading or writing, you are ready, so to speak, to enter that other space, the space of the words that transports you away from your everyday reality to the reality of the text. When you have entered this world of the text then you are somewhere else. (Adams & Van Manen, 2006, p. 4)

Luciana, a blogger and professional athlete living in Brazil, told me how her weblog inspired on the book by Clarissa Estés (1992) began to have "motherhood" as its central theme after her "*entry"* into *"the world of motherhood"*. After participating in virtual groups and a yoga class for the preparation of childbirth during pregnancy, she *"wished to be an activist"* for the childbirth humanization, participating in a televised reality show, in which childbirths were exhibited. During the first year as a mother, she also published personal testimonies and pictures of her daily life with her son in the weblog, Facebook and Instagram profiles – which expresses aesthetically her transition from desire to the intentional *"diving"* in motherhood-related subjects. She told me:

> "Then, I found out I was pregnant by surprise... **I wasn't in the world of motherhood. I already had a desire of being a mother...** and actually I was wondering, when I did the test. Then I cried like a desperate, only so, in anytime I had doubts if I would have it or not, I knew I would have it. Anyway, my entry into motherhood was a punk entry... Like, what's going to happen to me now? **But I don't think I had too much sense of how difficult it was. In the first year, I was so I submerged in the world of motherhood ...** I stood there, trying not to getting in, but I think when I finaly got it, I relaxed and said, no, now I want to know all about it. **And I think even the blog is a reflection of this, because I liked it, right?** ... because I think it was generating fruits as well, because of all that I Googled, I began to read, what I experienced and such." (Luciana)

Moreover, some of the participants experienced the transition into motherhood as an act of *"diving",* starting by the preparation and experiencing of childbirth – transforming their background's presences in potential aesthetic objects, including the baby. With the same predisposition as Luciana, another eleven participants wrote about their childbirth or breastfeeding stories on the Internet, generally illustrated by pictures of the events. During these processes, political and ethical concerns arise and, in some cases, are related to the search for intelligibility of primary presences. Carla, a black mother who lived in Brazil and worked as Health Manager in a municipal Health Secretariat, had an experience in one of the few public birth centres in Brazil while supported by a private liberal doula, and narrated her story with childbirth on a weblog in which other similar stories are published. She wrote remembering aesthetic objects, such as *"Preta Velha's"* image, a female symbol from the African-Brazilian religion *Umbanda*, relating them to caring presences such as her mothers':

> "I arrived with 4 or 5 cm of dilation (I don't remember well) and then they settled us in the room. Upon arriving in the room, the first emotion: it was the room where I had done my last appointment on Wednesday, two days before, and it had a picture of a *Preta Velha* that deeply touched me. I found it a good sign because my mother always told me that during my birth she received care and comfort by a *Preta Velha* during her labour, soon, as there are no coincidences. Another thing I noticed was that the watch that used to be in front of the bed wasn't there anymore, which I thought great because it would help me turn off time and plunge the head in my delivery. I turned on the MP3; I connected the sound boxes and played black music again making me dance among the contractions." (Carla)

Van Manen sees the parenting care as states of "attentive intensity" that include the "intense experiences that stand out" but also "mundane and common moments" that conform a habitual background (Van Manen, 2000, p. 317). Those specific memorized experiences of care are somehow articulated to a "heedful attunement" (Van Manen, 2000, p. 318), which configures a perception over backgrounds fulfilled of presences: the infant's presences, the childcare objects' presence and other caregivers' presences. The relationship of self-perception, specific objects and the caring background can contribute and at the same time defy the feeling of "being-in-the-world", as generally mothers are not "allowed" to stay completely concentrated on certain activity while caring for their children because of external and intrinsic demands of behaving in accordance to certain moral patterns. While childbirth and breastfeeding can be seen as important opportunities to experience this desire of presence, the first years of mothering, if lived in a great solitude, strongly confronts that expectation.

While participating in the research, Flávia, a Physical Education teacher and blogger, living in Sweden, sent me a video of her week in the company of her three year-old daughter. She explained that her husband was abroad, working in Norway for fifteen days, while she cared for the child, tried learning Swedish and worked in a part-time job, and decided to make a movie for him. The movie is full of mundane

moments of both of them together, going to school and back, playing in the snow, eating, taking baths, going to sleep. Of course none of the stressful moments she had undergone during the week while alone with the child was in the movie. However, during one of our meetings by CMC, she began the conversation by expressing irritation towards her sister, who had called her but could not talk because of the presence of Flávia's child. She told me:

> "I was talking a while ago with my sister, because she called and wanted to talk to me, but B kept all time attached on me, and I told her, look, I can't talk right now. Then she said: Damn, B doesn't give you peace, huh? Damn! Think about it, you put yourself in B's place! She is a child at three year old, she has no one here! The father is out of town, she's alone, she only has her mother, there's no grandma, no uncles, it's snowing like hell ... She's not going to stick on me?! Of course she will. **She's not overattached, it is the situation that I'm giving to her, okay**?" (Flávia)

Despite that, Flávia said in the interview: *"the most important thing Sweden has given me until now is that first year"* referring to the period in which she got a full-time parental leave. She reported feeling a deep sense of loneliness during that period, which was quite hard but also important to overcome the bad experience she had undergone with pregnancy and labour. As I see, in trying to deal with mothering as a way to being-in-the-world, because of an oppressive situation – in which she is constrained to be the only familiar caregiver of her child – but also because of a desire of presence, using video and writing as aesthetic tools, she tried keeping her head above water. Not only above the difficult routine to which her temporality and space were limited by the child's presence and needs, but also above solitude, including the lack of empathy from her sister and/or other adults – such as her husband who was only present in certain celebrating moments such as the ones in the movie – who could not understand this *"situation"* Flávia felt as she was *"giving to"* her daughter. Therefore, while motherhood appears as an opportunity to feel emancipated, it can put women under social scrutiny and demanding absence – mainly the fathers' absence – which captures the desire of presence under an intense and uncertain *"diving"*.

II.2 SEARCHING FOR INTELIGIBILITY IN THERAPEUTIC MOTHERHOOD

Aesthetic experience with motherhood is historically and culturally situated, bringing this expectation of subjective transcendence strongly anchored in the bodily motility that surpasses "comprehension" at the same time it generates new "scientific" or "scholastic" interests. The search of these mothers for new language as scientific and therapeutic responds to the need of creating senses to intense experiences, since "the unintelligible body may mobilize us to articulate new meanings and new discursive practices with respect to the body" (Vasterling, 1999, p. 25). Thus, highly educated and with a regular presence in the web, they resort to the most legitimated knowledge in contemporary societies to under-

stand their experiences. Even if they cannot find a complete sense to comprehend the most bodily dimension of it, they perform new engagements with gender, career, domesticity, family, affections, etc. while trying to do so. This process of knowledge construction is propitiated by contemporary modes of communication, discussed by Mocovici (2004), Jovchelovitch (2008; 2004), Pombo de Barros & Arruda (2010) and Jodelet (2011), such as "cognitive polyphasia" and "social representations".

In another text, Pombo de Barros and Arruda (2010) apply Winnicott's theory of emotional development to identify the place of affection in the construction of social representations. On that text, we were able to show how the constant paradox of objectivity and subjectivity, typical of contemporary modes of subjectification, creatively contributes to the appropriation of social representations by individuals, thus resorting to reified and traditional knowledge propitiated by cognitive *polyphasia* to the understanding of relevant social phenomenons in their groups. For instance, affections related to "self" integration can motivate individuals to search for group commitment, using legitimated sources of information in its social class and community to reinforce its bonds or to produce new paradigms from it. In being creative in this interchange, subjects also need to recognise a "consensual universe" in which hegemonic representations play an important role (Moscovici, 2004).

Furthermore, the majority of mothers who participated in this research reported that reading and studying were important practices to create a sense/understanding of their experiences of presence in earlier transitions of motherhood. It was also propitiated by the closeness of CMC, which are felt as another space though still inside the house. They reported the participation in virtual groups as a way of learning and also *"teaching"* others from their own experiences, searching for *"being prepared"* for motherhood. If initially this searching could bring certain feeling of belonging, it also produced tension for the fulfilment of a correct way of doing things, including a moral pressure for *"being an activist"* for motherhood-related subjects. Comparing the two pregnancies she had, Luna, a white mother of two in Brazil, asserted the importance of preparing herself by reading weblogs and participating in virtual groups; however, she also emphasised that this habit produces a *"tension"*, which becomes less intense through experience:

> "**I think it's good you chase information and see, read, read, read blogs, mailing list, now you have these Facebook groups**. I think, on the one hand it's very good, but on the other hand it makes you tense as the second son didn't. Then, you go much more intuitively. **Of course, experience is the best thing, right? It is the best teacher, experience is the best teacher**." (Luna)

Francine, a mother who lives in Portugal, narrated how she discovered the *"labour without pain"* in Portuguese public system and became quite impressed by her experience with childbirth because in

Brazil she thought she would be undergoing a caesarean. Despite the fact that she had few friends in the city and kept most of her time at home taking care of her 8 month-old child, she discovered a portal in the web focused on themes related to childbearing where she liked *"going to",* and started to participate in its thematic forums to clarify doubts, talking about her experience with vaginal delivery and informing other women on the *"right to epidural"*:

> "**I like to go in the Babycenter forums to have questions cleared up, to see the tips, supporting natural childbirth, because I saw that it's a good experience, right?** I saw that I didn't need to end up in having a caesarean. (...) As I did not have my mother for whom to ask, I had to find somewhere, right? (...) I don't talk to a lot of people. I just read the threads, and I created a topic about vaginal childbirth without pain, in which I talk about my experience. And there is people who asked me how I had access to epidural, how I had a baby without pain, whether it was a right, so I had to research, and I found out the law of the Ministry of health, I don't know exactly resolution, so I could talk what was about it... That's all ... I'm reading, and if I see that someone has any questions about anything I did, that I can help, I answer ... It is the time I have, my time to read it's a quick one, while she sleeps, she takes a nap." (Francine)

II.2.A FROM SCIENTIFIC TO THERAPEUTIC MOTHERHOOD

The construction of Child and Maternal Health as important fields of Public Health worldwide, since the beginning of the 20th Century, was consolidated with the "scientific motherhood" discourse adopted by the press, physicians and politicians, which converged with women's and feminists' demands for the access to formal Education (Freire, 2008; Apple, 1997). This discourse insists on the need for mothers to search for scientific information and specialized help in order to care for their children, rendering them targeted consumers of knowledge on children's health and development. It expresses how public spheres started to recognize the importance of domestic care for communities but ignoring the mothers' body as "first locus of intentionality" (Young, 2005, p. 35) and "primordial habits" (Merleau-Ponty, 1945), asking them to deal with their pregnant bodies, childbirth and breastfeeding practices as scientific external objects. Therefore, mothers have been faced as essential "state partners" for the health of children and communities in Europe and Brazil (Knibiehler, 2000; Faya-Robles, 2013; Meyer, 2005) – as the manipulation of their bodies in the direction of healthy family "lifestyles" could easily integrate their presences in an intimate domestic situation, thus also subordinating their performativity to external presences by physicians, psychologists and midwives. Nowadays, with the spread of CMC, one can observe that "scientific motherhood" is encompassing a therapeutic culture (Moreau & Vinit, (2007), which stimulates the individual agency towards health decisions but also creates new mechanisms to discipline maternal bodies, such as the confluence of maternal aesthetic experiences to child-centred rhetorics.

For instance, Renata reported that during pregnancy she had *"physical and emotional memories"* of a child abuse she had suffered and in which her mother had not believed. She was feeling depressed and found this memory as the explanation for her symptoms, after developing a special attention to the body as a vehicle of being-in-the-world and with her readings on *"psychology of pregnancy"*. Thereby, this was not only an intense experience, but a *"hook"* that brought up a new interpretation of the relationship with her mother and generated different choices and care habits, such as a cyberfeminist activism. She wrote about this process, publishing pictures of the child's home birth on blogs and web magazines, having an important aesthetic experience that marked her transition to motherhood. She decided to become fully dedicated to childrearing while intensely improving her presence in feminist and maternalist online movements, to which *"studying psychology"* was crucial:

> "**It was just a hook right? To face the truth... My body, it was clear to me, it was a fact that traversed my body, which was not an imagistic memory you know? It was a physical memory. It was a functional memory that I couldn't understand with words**, I couldn't understand why I wanted to be just lying in a dark room without contact with anyone... It was out of my reach. Then I realized: wait, what's going on? This is not normal! This is not normal! And then I went right for help ... man, **I need to understand the psychology of pregnancy. It was the keyword**, it was the keyword, then I started to study, then I discovered that pregnancy can produce *re-experiences*, you know? (...) So, I've understood and told: well, I have to cure myself, how can I cure myself? So, I hold on childbirth, right? And there it was: childbirth can be empowering, really, it was quite empowering, really (...) an experiencing of appropriation, ownership (...) before I got pregnant, one day it appeared at my timeline: Orgasmic Birth. I said to myself: wow, amazing, delivery in the bathtub, the lady with a great facial expression, really unperturbed, awesome, I've never seen that. And I told myself: it's not for me, huh? It's for people who have money and such. At the meanwhile, that became more present in my timeline because of Feminism, with few things that someone had shared, and **there I began to desire a humanized childbirth, which for me was the natural childbirth. At that time, it was not humanized childbirth, I thought it was beautiful, I did not think about it in a scientific way, but when I got pregnant and I started to deal with everything that I was dealing with alone I told myself : Damn I'm going to have to fight for it!** And then I started studying about childbirth, Caesarean, and Psychology (...) but before I was totally lay." (Renata).

On breastfeeding, she said that despite intense fatigue she will hold on to her child spontaneous weaning because she did not want him getting the same *"emotional scars"* she had, trying to negotiate their mutual limits:

> "I want breastfeeding to be... if not natural, if I couldn't have it natural, if it is not possible, right, for any reason.... but I want it to be respectful and not abrupt. (...) **Natural weaning means he stop to suck, stop to wanting more, it is him to have his own process, without the minimum interference by me**, because he doesn't use pacifier and baby bottle (...) But I do not want to wait until he's seven years old like my cousin did, you know? I'll know and it coming to my limits, then that's why I say not abrupt." (Renata)

The category of "risk" in the sanitarian speeches meets the category of choice and desire from Psychology and Psychoanalysis to configure a stronger rhetorical tool for valuing family bonds as important

to every individual but also for increasingly blaming individuals for health and social problems. Thus the field of social policies approaches therapeutic culture in reinforcing parental, mostly maternal, engagement in a healthy lifestyle that includes constant anticipation to the risks of getting emotionally sick or having emotionally sick children, which would compromise the communities' wellbeing. Commenting on Foucault's discussion on the body's disciplining by medicalization, Moreau and Vinit assert:

> Or cet « objet corps » dont s'emparent le discours et la pratique médicale s'inscrit dans une conception de plus en plus idéologique de la santé, où la maladie est conçue comme la punition d'un écart par rapport aux normes en vigueur, normes biologiques, socioculturelles, voire morales. L'existence contemporaine tourne ainsi de façon prédominante autour de la recherche constante d'un bien-être physique et psychique, d'une sécurité intérieure et relationnelle, dans une culture thérapeutique imprégnant l'ensemble du social. (2007, p. 35, 36)

There is not a consolidated field of "Family Policy" in Brazil (Sorj & Gama, 2015), and the recent reports that use the category of "family" evaluate social programs focused on "at-risk" families, such as the beneficiaries of PBF, promoted by the Ministry of Social Development and Fight against Famine (MDS – Ministério do Desenvolvimento Social e Combate à Fome) (Jannuzzi & Quiroga, 2014) and on "paid leaves", promoted by the Ministry of Social Insurance (MPS – Ministério da Previdência Social) (Barbieri, 2012; Guimarães, 2011). The MDS' report is defined as a "technical-scientific publication" that has the aim of informing public managers and professionals, the academic community, journalists, and society in general. The report resorts to the rhetoric of "empirical evidence" in its introduction but one can observe a broader approach that surpasses the rationalist conception of policy-making, because it mentions a complex methodology in which discourse analysis and other qualitative methods are applied and articulated to quantitative data, with the intention of reflecting on political contexts and social problems related to policy implementation in specific themes and cities. Moreover, it approaches the consideration of the "right to have a family", showing concern with social conditions that render it hard or impossible to create family bonds in various situations.

Despite that comprehensive approach, under this concern with family bonding as a right, there is a recurrently matrilineal and child-focused logic fed not only by the recognition of mothers as the main caregivers of children in daily life but also supported by psychologising trends of social work. As asserted by Meyer and colleagues (2012), the flexibility of the definition of "family" in social policies, which included single-parent families articulated to this logic, produces an unexpected contradiction:

> Um aspecto importante que temos destacado é que um dos efeitos de poder (não esperado) da incorporação (reivindicada e desejada) de noções mais abertas e flexíveis de família, nesses programas, parece ser a 'naturalização' da ausência de um homem-pai nos núcleos familiares mais pobres e, sobretudo, sua 'desresponsabilização' pela vida das crianças que o integram. Isso tem se traduzido, por um lado, no posicionamento do Estado no lugar de autoridade conferido ao

> pai na família mononuclear moderna e, por outro, na sobreposição de uma parte significativa dos deveres até então definidos como 'paternos' (sobretudo aqueles vinculados ao provimento do lar) aos já consagrados 'deveres maternos'. (Mayer et al, 2012, p. 444, their quotations)

The Brazilian report even recognizes that the psychologising trend in some specific social programs such as the Service for the Protection and Integral Assistance of Families (PAIF – Programa de Atenção Integral às Famílias) is a problem because of the persistency of old disciplining and moralizing methodologies used by social workers (Jannuzzi & Quiroga, 2014).

The same comprehensive methodology can be seen in the French report promoted by the Strategic Analysis Centre of the Federal Government (CAS - Centre d'Analyse Stratégique) (Hamel et al, 2012). The French report shows policies in the United States and Europe that focus specifically on "helping parents be parents" emphasizing "good practices" that politicians and social workers should adopt in France. It asserts an effort of consolidating a specific field of "parenting support policies", not only adopting a transnational perspective but also analysing a "genealogy" of this field. It prioritizes Psychology (including Psychoanalysis and Child Psychiatry) as one of the three fields of knowledge that contribute to the understanding of "parenting policy genealogy", and attempts to reinforce the distinction between biological and social parenthood. While it conducts towards a deconstruction of what one normally considers "natural" regarding parental roles, such as sexual division of domestic tasks, it reinforces the importance of helping parents assume childrearing and education as a social role. In doing so, it asserts the "logic of social investment" as a fundamental reference (Hammel et al, 2012, p. 3), which reinforces the need of economic justifications and global agreements for family policies. It asserts:

> Protéger les enfants, assister les parents : tels sont les deux fondements ou les deux pivots des programmes qui, un peu partout dans le monde développé, sont menés au nom de ce que l'on traduit par soutien à la parentalité. L'idée force, illustrée à travers les pages de ce rapport, est que les PPP (les Programmes de parentalité positive – pour adapter une expression anglo-saxonne) paient. Ces Programmes performants de parentalité (un autre PPP) peuvent répondre aux inquiétudes et besoins des parents. Ils peuvent atténuer des tensions et des difficultés. Ils peuvent mieux assurer le quotidien et les trajectoires des enfants. Bref, investir dans la parentalité (comme la politique familiale, traditionnellement, investit dans la famille et, plus globalement, les politiques sociales dans le capital humain) cela peut rapporter. Les conditions de la réussite sont cependant exigeantes. Dans le cas français, où prolifèrent (sans nécessairement prospérer) les initiatives de toute nature et de toute envergure, il y aurait toute raison de se lancer dans des programmes dits evidence-based, pour savoir ce qui est vraiment efficace, et à l'aune de quels objectifs. (Hamel et al, 2012, p. 175)

Ana Lúcia, a white mother married to a Brazilian man, who immigrated to France with the desire of being mother, spoke on her transition, explaining that the meeting of French culture and perinatal system lead her to a *"profound mentality transformation"*. In seeking to comprehend the health facilities related to vaginal birth and breastfeeding in the country, she ended up finding the *"positive parenting"*

rhetoric, which completely changed her expectations of presence with motherhood. In Brazil she believed *"everything could be practical"* but then she realized that to be a "positive parent" – according to her, different of the majority of French mothers – she should be *"studying"* and intensely engaging her body in caring for her child. As Sofia, she also decided to change her career, giving up on Law and thinking of becoming an *"assistante maternelle",* dedicating herself to study Montessori's theory and publishing it on a weblog. She said:

> "**Everything that I thought... it was a deconstruction, it was a deconstruction. I thought, I don't know, I thought things would be practical**, you have a baby, you get a baby, you hire a nanny, you let the baby with the nanny and you give it beby bottle anyway. **But then I got here, I became... mother, and all I understood that would be better was totally different right?** I mean, B slept with us, was breastfed, caried out, and I do have the books that... until these days I keep in this way, you know? So on motherhood's subjects I have this author that I really like called Catherine Dumonteil-Kremer, who, nowadays is a reference for a different education, different mentality, her books help me quite a lot. Anyway, her book is called *Élever son enfant autrement,* educating your child by another way. It is a manual so you know? Manual? It's not a manual! I don't know how you say that in Brazil, but it approaches the developmental steps and such, but she always goes that way: babysling, breastfeeding, *parentalité positive*, *non violence*, and I still participate (...) **As I told her, to Catherine, in the meeting, me, as a Brazilian, because of the cultural shock, because of the way I chose to follow, she is the French woman who thinks differently, whose books helped me a lot, you know?** She is the French who really thinks differently (...) because, generally, French women are... the girl who was sharing room with me in the maternity, she had the baby and soon gave it baby bottle, you got it? So, that's the mentality of the majority of them here" (Ana Lúcia)

Catherine Dumonteil-Kremer introduces herself in her website and magazine as a "Montessori Educator", an author and conference speaker on "non-violent education" and "conscientious parenting", suggesting that her parenting style is "a different way of educating children" and offering support to parents who "wish to respect their children".

Therefore, in this culture of "therapeutic motherhood", one can observe a pressure on pregnant women to have the "perfect baby" and sometimes to consent on the foetus' subjective existence (Neyer & Bernardi, 2011), as Leite (2013) has discussed on the field of maternal mortality rhetoric in Brazil. In France, this search for perfect foetuses has motivated medical decisions on abortions by therapeutic reasons with conflicting justifications, including physicians' and midwives' judgements on aesthetic, psychological and social conditions of pregnant women, including conceptions of the women's desires (Membrano, 2001; Weber et al, 2008)[44]. Jean Christophe Weber and colleagues (2008) highlighted the conflicting position of those health professionals in suggesting, authorizing or refusing tardive therapeutic abortions:

[44] The high rate of therapeutic abortion with weakening regulation on France causes this country to have one of the highest neonatal mortality rates in Europe (Euro Peristat 2013)

> L'appréciation de « la détresse psychologique » et de « la situation sociale » (femme seule ou en couple, milieu social favorisé ou non) intervient dans le jugement porté sur la demande parentale et la prise d'une « bonne » décision. Ainsi, les répercussions sociales anticipées par le médecin sur la foi d'expériences antérieures peuvent influer sur la décision : « elle va l'abandonner... (si l'IMG n'est pas acceptée par le centre). Donc après forcément t'as une indication dans le sens où t'as une détresse du couple ». Cette détresse (qui renvoie au registre de l'IVG) est en quelque sorte légitimée par ce qu'un médecin qualifie de « maladie de notre société, qui est la réification du produit de conception : l'embryon, on le veut le plus beau, le plus smart, le plus présentable, le plus intelligent ». (Weber et al, 2011, p. 109, their quotations)

II.2.B ETHIC OF DESIRE AS A MARK OF SOCIAL CLASS

Early Developmental Psychology was built in parallel to sanitarian interventions in Western countries with the aim to produce a "quality population" (Burman, 2003) – quality measured by psychological tests that evaluated educational and moral performances, which are still present nowadays in the use of evidence-based medicine and Evolutionary Psychology in Education. In this perspective, children are conceived as potential "psychological individuals" who should develop certain patterns of thinking, with rationalism as the great model: "this model in turn reinscribed the gendered and racialized privilege of the cultural masculinity of the West" (Burman, 2003, p. 16). Based on tendentious interpretations of Darwinian evolutionary theory, many scholars from the Nineteenth and Twentieth centuries, including Freud and Piaget, subscribed to this hierarchical view of human development as a universal pattern in the direction of a rational individual, ignoring the central role of variability to Darwin's observations (Burman, 2003).

Although Erica Burman's ground-breaking book (2003) accounts Psychoanalysis as an interesting alternative to the normative production of Developmental Psychology, she recognizes this statement cannot be made in institutional contexts other than Anglophonic ones, such as Latin American and African continents – and I complement this by remembering that the French context was considerably influenced by Psychoanalytical discourses (Garcia, 2006; Castel, 1978). If Psychoanalysis had a huge role in criticizing the dominance of rationality in an individual's development, confronting the use of intelligence tests, it fully participated in the construction of the modern "psychological individual" in which "unconscious desire" plays a fundamental role and is valued higher than the conscious ability to choose. Hence, beyond the ethics of justice, the social presence in the transition of motherhood in different countries such as Brazil and France is also produced by "ethics of desire" or "ethics of the subject". As described in the following quote by Scotti (2011), the ethics of desire is one of the most important landmarks in Psychoanalysis:

> A ética tradicional por sua vez, segundo Lacan, trata do serviço dos bens, ou seja, a ética do ter que mede a estatura moral do sujeito segundo suas posses ou segundo a depreciação do desejo, a modéstia, a temperança, ou seja, a moral do poder, do status quo, que quanto ao desejo, segundo Lacan, vocês podem ficar esperando sentados. (Scotti, 2011, p. 2)

However, in some cases analysed in this research, desire just appeared after the discovery of an accidental pregnancy and confrontation with "choice", showing that there are different registers in mothers' narratives, although often equated to psychologising, feminist and mainstream discourses. As one can see in Sofia's experience:

> "And it was pretty cool to get pregnant, on the one hand, because I was in a death register, of loss, of sadness, of recovery, and suddenly I was in a life registry, of future, so it was pretty cool. But I would never done that decision, I was unemployed, I was sick, I had no place to live, Oh I'm going to get pregnant! I would never take that attitude. **So it was great getting pregnant without having to think about it, because otherwise I wouldn't have had it and I wouldn't be here where I am, right? Pretty cool to get pregnant... So it wasn't nothing really planned**, and from the moment I thought I was pregnant, when I went to do the blood test, I already knew that I really wanted to get pregnant, but **it wasn't a conscience inside the fact, I had no idea that I wanted so much to get pregnant**."(Sofia)

Sofia confronted choice and desire when she felt discriminated as a *"single mother"* and started writing a personal weblog, criticizing psychologising discourses found in popular books and maternalist posts on the Internet which over-demand mothers with their motherhood desire. She mentioned certain empathy to poorer mothers who attended public health centres, where most families who go are poor, but which also offers child vaccination, one of the few health services that are truly universal in the country. When she found herself a "single mother", started to face poor mothers as "similar" to her as she identified a discriminatory mechanism in the psychologising rhetoric of motherhood:

> "**That's my experience and that's it! I sort of fell down in my life to start living it, I stopped looking at it from above**. And it was at that time I also started getting pretty upset with Laura Gutman, whose texts I had read a lot, like everyone else, right? I back to read her texts and said: man, this woman is tripping! I don't know, man, there is nothing to do... **Then I started to think, not Laura Gutman herself, but the Laura Gutman's army, this immediate repercussion of her speech, you know, I started to think of that as discriminatory of realities like mine and other mums' that I could meet at the public health centre too**... So I started to piss me off with all that speech, all that readings that over-naturalize the mother! ... I didn't thought of motherhood as cute, and, mainly, I didn't thought of that as a choice. In my case, it was not a choice! I was thrown on that situation!" (Sofia)

Laura Gutman is an argentine author of popular non-fiction books and widely present in the Internet, who uses psychologising rhetoric on mothers' identities and experiences to sell a therapeutic method called "human biography", and declares herself a feminist. Although she is not really a psychologist, but has studied Learning Sciences in France, this author declares herself a "therapist" and disciple of François Dolto and Michel Odent, and was also identified as an influential "pop psychologist" in Spain

by Pérez (2011). In mentioning the "savage" aspect of motherhood, Gutman encompasses an unconscious dimension of maternal desire as an ancestral foundation for child development, deconstructing the rationalist approach of reproduction while she reinforces a hedonistic injunction (Martiskainen, 2011) for mothers' experiences with pregnancy, childbirth and childrearing. She uses a very attractive rhetoric for upper-class women who are experiencing the first transitions of motherhood and do not recognize themselves in over-medicalized health systems nor are able to confront it to social class structures. However, as one can see in Sofia's critiques, when reconfiguring "choosing motherhood" as part of a female unconscious desire, Gutman naturalizes motherhood in such a way that she pathologizes divergent experiences and normalizes gender oppression.

Luise, white, heterosexual and married woman is another participant for whom Gutman's books made quite an important impact. Living in Brazil, after an intense experience with childbirth and breastfeeding, she felt lonely and depressed but was not able to ask for her husband or other relatives to improve their presences for their child nor liked the idea of leaving him in a childcare centre. Instead, she used psychological explanations to comprehend the *"floodgates"* motherhood has opened, referring to her memories as a child and to the painful experiences with labour. She explained:

> "Because I read Laura Gutman's book and I realized that motherhood had opened several floodgates. So it's amazing how we start remembering things from our childhood! I don't know, **I found it pretty nice not only to understand the birth, after all that happened, but also to understand, as a mother, which kind of mother I want to be for him**, and all those things." (Luise)

As one can see, *"the mother I want to be"* in Luise's narrative is not a rational choice, but something she has to *"understand"* from reading certain texts, which means that her decision can only be made in the search for this intelligibility rather than on actually choosing her mothering habits. Meanwhile, her husband engaged in Attachment Parenting Association, started to give parenting advices on a weblog, a virtual and non-virtual thematic group, based on popular literature associated to Attachment Parenting rhetoric – although he did not seem to be very present in the caring routine of their child and did not have any credentials on Psychology or related fields. One of the references he used on his weblog was *"Baby Bonds"* by Sophie Moullin, Jane Waldfogel and Elizabeth Washbrook (2014) – political scientists and marketing specialists working for Sutton Trust, an important lobbyist for "positive parenting" in England. The discriminatory view of popular classes is explicit in this report, with the justification that its goal is to support early intervention programs for "disadvantaged mothers and fathers", which would stop the reproduction of poverty (Moulin et al, 2014, p. 7). Using the rhetoric of risk, the authors correlate social problems such as future unemployment to "insecure attachment" in early developmental

stages, also suggesting that it is a universal theme, mentioning findings of other researches from other countries:

> Children with insecure attachment are at risk of the most prominent impediments to education and upward social mobility in the UK: behavioural problems, poor literacy, and leaving school without further education, employment or training. Behaviour problems are a particular concern for the UK where the gap in such problems between the most disadvantaged children and their peers is larger than in Australia, Canada or the US. (Moulin et al, 2014, p. 4)

This psychologising trend among privileged Brazilian families is also part of what Magda Dimenstein (2001) identified as an individualistic and elitist culture of Psychology in Brazil, in which structuralist Psychoanalysis plays a core role. The author presents the de-contextualization of this theory in Brazilian psychoanalyst practices as the main reason for the mismatch between professionals' and patients' expectations in public health services (Pombo-Barros and Marsden, 2008). One of the mismatches is the effort of those professionals to notch the patients' narratives in a subjective model in which the bodies and their political situations are completely ignored in the profit of a structuralist approach of the psyche, which was already identified by Castel in the French context (1978). Jurandir Freire Costa (1989), a psychoanalyst but also an activist of the Collective Health social movement in Brazil, conveys how the structuralist approach based on "desire" was not able to understand that those narratives revealed a "psychosomatic strategy" of the lower class patients in surviving with the ambivalent relationship with the Brazilian state.

As a matter of fact, applied to the mother-infant relationship the ethics of desire was a paradigm for the advocacy on the legalization of abortion in France, and at the same time, it contributed to *pathologize* "unwanted motherhood" and to maintain the access for abortion out of public health insurance (Garcia, 2011). For some pro-choice movements analysed by Sandrine Garcia, the goal was not women's choice and their emancipation as desiring subjects, but their desire in being mothers as a *sine qua non* condition for children to become healthy individuals; a position assumed by Françoise Dolto, a child psychoanalyst who played a central role in the debate on abortion laws in France. With psychoanalytical arguments, Dolto declared to be against free access to abortion because it should have a financial price as a "symbol" of the cost of ending a life; she stated that during a televised interview commented later by Christine Delphy and other feminists including Simone de Beauvoir:

> (...) le cas Dolto révèle une des sources de l'antiféminisme qui est une profonde aliénation, parce que si elle si identifie elle-même en tant que femme, elle réaliserait que ni elle donc ni aucune femme pourrait se faire avorter (par plaisir) avec le cœur ni d'un pied légers (Delphy in Vincent, 1985:06)

However, the alienation of Dolto's arguments is not only related to her condition as a woman; it is related to the ideology of *"Psychoanalysm"* (Castel, 1978) which consists in the direct effect of the abstraction of socio-political implications inside Psychoanalysis theory. With the statement of "unconscious desire" it prompted the mechanism of "dual relationship" to all the diverse situations in which psychoanalysts are professionally and ethically engaged, in configuring a specific apparatus of social control (Castel, 1978, p. 4). Hence, the dual relationship of mothers and babies has been exhaustedly theorized as the basis of human life, having contradictory effects on the subjects' development, the prevention of maternal over attachment and maternal abandon being frequently target by psychological interventions.

Aline, a psychologist who lived in France and worked in one of the *Maison Vertes* idealized by Françoise Dolto, reported that she was not prepared for the *"isolation of motherhood"*, confronting the specialized knowledge to her *real* experiences, asserting a tension between the desire of being alone – which means away from her daughter – and the suffering of being alone at home with the child. She recognizes the value of Dolto's *Maison Vertes* as places where mothers can have company while take care of children and where they can learn from each other. Despite that, the specialized knowledge did not prevent her of feeling guilty when she needed to be absent:

> "I had a psychoanalytical listening. I thought that that space was significant for those mothers, and that it was important for them, but I don't know... **Nobody is prepared. I think there is no preparation. It's not theoretical, it's not intellectual, everything you do, what you read what you study, having specialized knowledge, you will be informed... But, the fact is you come across the situation, in being a mother and being alone. I felt pretty helpless without my family around, at the same time I felt so lost! I think we keep looking for knowledge.** (...) And in Brazil, there is this good side, at least when you're middle class or upper class you can hire somebody to learn you doing everything, like the nurse or the nanny, which is a knowledge transferred by woman to woman, across generations. Even in Brazil, when you're not upper or middle class, and you live in a poorer class, [this knowledge] is transferred because people live in communities in the favela. You have the neighbour who lives close to your house, it is always done in a communitarian way. And here in France, there was this isolation. That's why Françoise Dolto had created that, the *Maison Verte*, because of isolation. We are *'tout seule'* with the baby at home, to make all the care duties, to be available, to stimulate the child, to play, to be emotionally available and everything. I got the burden of that when I became a mother. And despite I had study psychoanalysis, being psychologist, studying education theories, because I worked at a childcare centre and all, I realized motherhood in being a mother. There were days in which J arrived and I said: you take it, because she's all yours! Leave me five minutes alone! (...) **At the same time you have this guilt, right? Like: no, I have to go back! I thought it pretty tiring and isolation was quite heavy for** me, because we don't have any family here, so I was with G, and still take care of here, almost every week-day. Isolation was pretty heavy for me."

Some feminists have tried to renew Psychoanalysis from a political perspective, still giving the "desire" a fundamental role in emancipation and subjectification. For Butler, the subject is formed through pow-

er in a way that being subjected under the primary caregivers' presences produces subordination but also desire (Butler, 1997). Thus according to her effort of politicizing Psychoanalysis articulating it with Foucaultian theory, primary attachments are always ambivalent in their effects but should not be inconstant, which means that the primary experiences of power during early childhood are fundamental to the emerging of desire and subjectivity.

> The Foucaultian postulation of subjection as the simultaneous subordination and forming of the subject assumes a specific psychoanalytic valence when we consider that no subject emerges without a passionate attachment to those on whom he or she is fundamentally dependent (even if that passion is 'negative' in the psychoanalytic sense). Although the dependency of the child is not political subordination in any usual sense, the formation of primary passion in dependency renders the child vulnerable to subordination and exploitation, a topic that has become a preoccupation of recent political discourse. (...)Moreover, the desire to survive, 'to be', is a pervasively exploitable desire. The one who holds out the promise of continued existence plays to the desire to survive. 'I would rather exist in subordination than not exist' is one formulation of this predicament (where the risk of 'death' is also possible). (Butler, 1997, p. 7, her quotations, emphasis added)

By conceiving a "passionate attachment" to whom the child has a fundamental dependency – the one who "holds out the promise of continued existence" – Butler does not focus but tangencies a theory of time in care relationships. Her postulate of subjection assumes the caregivers' presence over time and her/his availability to participate in this kind of intense attachment – which we assume, involves bodily engagement. Beyond that, the author asserts the fundamental role of a "prior reference" to the "status of subject" for individuals, which requires a "third person perspective to itself" and to its "genesis" (1997, p. 11). Without clearly mentioning it, Butler is referring to maternal role in the formation of subjectivity, already theorized by Lacan, for whom the "dyadic pair" is a constant in the Symbolic.

Other heterodox psychoanalysts such as Winnicott already theorized the need of habitual presence of an individual caregiver in the first stages of children's emotional development from the observation of children in bourgeois families or in orphanages in the early 20th Century (Winnicott, 1990, 1993). The observation of subordination in dual relationships as central to the becoming of subject is not out of the context of a certain mode of being family, a certain mode of kingship, a mode that is not universal but dominant. Despite Butler accounts on the diversity of kinships in another text (Butler, 2003), she does not discuss the historicity and contingency of this specific psychoanalytical formation of subject. As a matter of fact, if not analysing the historical construction of the liberal individual of Psychoanalysis, then, trying to notch the diverse realities of mothers and infants into to this dyad of "passionate attachment", one constrains maternal bodies as *sine quo non* presences to the rising of "desire", and desire along with foreclosure remain as the fundament concepts of subjectivity (Vasterling, 2010). According to Vasterling (2010), those Butler's accounts do not give clear conclusions on the possibilities of re-

sistance. In my turn, I assert that the "ethic of desire", on which Butler's accounts seem based, does not offer a clear answer to mothers' resistance.

For instance, I could observe that, different from the majority of women I had interviewed, Helena did not have an expectation of presence with motherhood and did not have an authentic desire of having a second child, which produced guilty but not made motherhood her perceptions' forefront. She had already been a young mother during an *"unsuccessful marriage"* in Brazil, and told me that her decision of getting pregnant for the second time with her Portuguese husband in Portugal was in fact an *"acceptance"* of his desire. After accepting this desire, firstly, she had a spontaneous abortion, and then on giving up on this plan, taking back the contraceptives, she got pregnant for the third time. She liked the news but stayed quite *"stressed"* during pregnancy and even after the birth of her child because of *"fear"*, reporting: *"childbirth had no impact in my 'becoming a mother' again, what had impact was the loss of a baby... one characteristic of my personality is that I am a fearful person, I have always been, so I am afraid of living, I am afraid of my children die..."* (Helena). She explained that even if she had an involuntary abortion at the third week of pregnancy, she felt like she had lost "a baby", which intensified her fears of living a new pregnancy and childbirth – and which is related to the social demand for women to consent on their children subjective existence since conception. During our conversation, Helena still blamed herself for the stress during birth and confessed to me her non-desire despite of her choice:

> "**It was not that easy, mostly my fault. Because, I didn't tell you, but we talked about having a baby but I was too scared, I didn't want to have another child.** My first pregnancy was uneventful and such but I've always been too scared to get pregnant again... because of the fear of childbirth, I was afraid of getting pregnant, because there are so many changes. And as I thought I had found the person that I wanted to stay with for the rest of my life, I agreed to have another baby and then... I've been doing prenatal care, but besides having my own fear each month, there was the aggravation of having lost a baby. **So I had nine months of too much stress, everything was so stressful**." (Helena)

When we first met, Helena breastfed her six months child but also shared a large portion of the caring duties with her husband and mother in law, because during that time she was dedicated to a Master's course in Developmental Psychology, one she had started a year before getting pregnant. On the contrary of some of the participants, instead of centralizing her attention on biological motherhood, during her master's degree she decided studying the relationship between grandparents and adopted children. Further, she reported that her fears are less intense, and started to speak on other aspects of her life that can affect her individual wellbeing beyond of maternal-infant bonding, such as employment and financial stability in Portugal. Helena did not identify herself as a feminist or an activist of any social

movement, did not have weblog or a regular presence in maternalist Internet, and did not have desire or choice as fundamental aspects of her early transition to motherhood, still, she was able of caring for her child while configuring an emancipatory perspective to her situation in the country she chose to live:

> "And sometimes you get quite desperate, but... I have to move on, I have to keep overcoming the difficulties, because... that's it, sometimes I do not allow myself to be down, right? It's not possible to be down all the time or getting sad, I have to take care of my baby, and to study, because it is the only opportunity for me to stay in here, finishing my studies. Otherwise, if I couldn't, If I couldn't have a job here, I'll have to go back to Brazil, which I wouldn't like (...)I graduated from University, then straight after I got a graduate degree and a master's degree, and now I need, I always had this need, but now I have it even more, to work in my field. **Then I could stay here with my husband, with him working, and I can be doing anything, or just studying, but I need to have my job, having my own money ... and work in my field too** (...) And my Master's thesis is in child development. Right now I'm studying about adoption, my thesis will be on adoption and it has been quite interesting." (Helena)

The most recent Portuguese reports on "family policies" converge to this broader concerning presented in Helena's narrative. Karin Wall and colleagues (2013) have worked with the support of Ministry of Science, Technology and Post-Graduation (Ministério da Ciência, Tecnologia e Ensino Superior) to build the Families' Observatory (Observatório das Famílias). They have a clear sociological approach, articulating the analysis of those policies in the country to a gender perspective, having "masculinities" as important theme and also an acute concerning with parents' economic situation. It has the state as the main interlocutor, highlighting the consequences of the recent families' impoverishment, but also maintaining a website to communicate with scholars and citizens. The sole psychological rhetoric found on the report *"Principais desenvolvimentos das políticas de família em 2013"* by the Observatory was the concerning about the increased stress among children because of their parents' unemployment.

As I see, the most important problem with the ethic of desire is the failure in admitting "unconscious desire" also as a subjective production of capitalism not essential or inevitable for subjectification (Castel, 1978; Deleuze & Guatari, 1992). As a matter of fact, psychoanalytical perspective, even with a political concern, feeds the conception of attachment as an ethical constraint based on desire and choice, and as fundamental for human development. However, it brings the question on what kind of "human" those rhetoric convey, knowing that "liberal individual" and "therapeutic motherhood" are psychosocial processes of class and gender structuring. Those rhetoric can be quite persuasive in keeping mothers intensely engaged in domesticity even when they did not desired, chose and/or did not have the intense experiences of presence they expected with motherhood – and even if they are producing feminist agency.

In a conversation first published in the Italian magazine Micromega and translated into Portuguese in a Brazilian periodic, Adriana Cavarero and Judith Butler propose that we have to construct an ethic which includes vulnerability as fundamental of human condition, in two dimensions: the exposition *of* and *for* the others (Cavarero & Butler, 2007). Despite the choice of the word "condition" in substitution to "nature" – because of the Aristotelian definition of "human nature" – they both ask for an ethical effort to surpass the historical difficulty of societies in accepting relationality as fundamental of humanity. But Cavarero provokes Butler on the naturalization of psychoanalytical theory of development, especially on the correspondence of an individual parent to the child's needs and the aggressiveness of this one against its progenitors as necessary processes for individualization. Butler, on her turn, defends a contemporary approach of Psychoanalysis which would prevent naturalization, asking for a non-scientific status of the theory and agreeing to Cavarero on the avoidance of searching for a human nature. Nevertheless, she insists on the fundamental stages of dependency and aggressiveness in child development, emphasizing that it is part of a context, the context in which Psychoanalysis plays an ethical role. She says, for instance, that Psychoanalysis confronts parents with the asymmetry between them as adults and the infants. Cavarero insists, after all, on a critique quite useful for this discussion:

> Pergunto, pois, exatamente por confiar na sua radicalidade, se não será possível ler de maneira igualmente crítica a narrativa psicanalítica de um self cujo processo de formação, articulando-se através de estágios mais ou menos necessários de diferenciação, prevê o papel fundante (e, na minha opinião, mitologizado) da infância. (2007, p. 659)

Cavarero proceeds in criticising what she identifies as an "idealized autonomy" of adult individuals which would itself scape from the recognition of relationality as a fundamental aspect of human condition[45]. However, even avoiding a naturalistic tone, there is a tendency of structuralist and post-structuralist theories as Butlers' in naturalizing in a certain way the liberal individual who moves by desire. At this view, development would be determined by the voluntary action of adults in caring for children in a certain *necessary manner*. Despite her resistance against essentialist subjectivity the proposition of Butler in this interview previses a development in direction of a (quasi)integrated self, promoted by a (quasi)integrated caregiver, the relationality being a previous condition to it, not as a natural but an ethical process, which is indeed not open to the unpredictability of caregivers' bodily experiences. Yet, Cavarero pays more attention to the maternal setting and because of that she can raise a critique to the romanticising of the liberal individual subjection:

[45] Despite the avoidance of both authors in using nature as concept and paradigm, and my insistence in revise its implications I am persuaded that the discussion pursued in this chapter is easily clarified with the concept of "human condition" and with the critiques of Cavarero. "Condition" exposes nature to the paradox of relationality and impermanency.

> A infância – sobre a qual, nos meus escritos, várias vezes refleti com referência à cena materna – é assim, na minha perspectiva, simplesmente uma 'figura' hermenêutica, um 'lugar' para a fadiga do conceito e o trabalho da imaginação, e não um estágio fundante para a formação do self. (2007, p. 659, her quotations)

From this perspective, the dyad mother-infant would be free, not ethically constrained, of attachment as a fundamental relationship. Daniel Rousseau (2014) is one of the few practitioners in children psychiatry who gives some tools to the visibility of diverse parental situations. He wrote a book from an attentive analysis of orphan and adopted infants' development – situations in which biological mothers are not present or have a clear ambivalent relationship with motherhood. He realized the mismatches of his professional experiences and theoretical preconceptions, in criticizing the conception of biological family as "naturally good" for children and recognizing cerebral and emotional plasticity of human development. Céline Raphaël[46] introduces his book in saying that the author has "the courage of unbolt the myth of the importance of biological parents to remaindering us that the baby is before everything a human being, ready to embrace this world and act, at least if we do not turn it back" (Rousseau, 2014, p.102, free translation). At this point, one can imagine another boundary to "human" and "humanization", from the recognition of babies as active and reactive subjects whereas different from adults in their corporal autonomy. While working with institutionalized infants in France, Rousseau could observe that the insistence on the biological maternal bonding to an idealized child development produces constant ruptures in the relationship between infants and caregivers inside the institutions. Furthermore, he assumes that he was also "parasited" (*"parasité"*) by this ideal and admits that he used a normative habitual speech with children and caregivers, making an effort to forget the situations that could show him the opposite of his believes. After all, one of his patients stimulated his intuition and he started to better consider babies' efforts, even in very early stages, in connecting to other people beyond or despite the presence of their biological parents.

One participant who kept absent from home during a significant period was Cristina, a music therapist and musician, mother of a four year old son in Brazil. Cristina is a black and married woman from a poor family, who asserted a *"professional consciousness"* and the concerning with *"financial difficulties as a lifelong question"*. Despite and because of that, she invested on her Graduate studies while played on a *samba* group, and started to work on mental health facilities after her childbirth, being part of "middle class". The child was inscribed in a half-time childcare centre at the age of six months. And during the rest of the day, she and her husband shared equally the domestic and caring tasks, so the

[46] Celine is also a French author and physician, who published a book about the abuses she suffered from her biological father during childhood and adolescence. See: *La Démesure - Soumise à la violence d'un père; Max Millo, 2012.*

child was habituated to be cared by different caregivers. When he became two years old, Cristina had the opportunity to travel to Singapore with her music group. The way she faced temporality on her child's development at that moment favoured a capacity to dealing with the moral constraints related to her absence.

Cristina participated in virtual groups on the theme of "female entrepreneurship" in which she did not find the expected support and the professional consciousness she had in focus, on the contrary, according to her the most part of groups were quite focused on the ability of mothers of being present for their children while they work, having entrepreneurship a strategy to invest further in family life. Then, a year after the successful experience in Singapore, Cristina wrote on a website in which *"Mompreunership"* is one of the main topics, edited by another participant of the research, Raquel. She wrote about the "guilty" people hope you feel once you decide to be absent from your child for a while, and tried to encourage other women to share childrearing with their partners:

> "I knew it would be all too difficult: the concernment, missing him, the gossip and the guilt. Oh, the guilt! This accompanies each mother in many of the decisions of their lives and sometimes really gets in the way. But I had to go! I deserved it, I needed! Maybe there would not have other opportunity like this. (...) After talking so much with my husband, with my family, friends, and my therapist and even after receiving much criticism, I decided to not lose this opportunity and throw myself in the greatest adventure of my life. I travelled in 2012, October 17th. I kept contact with my relatives almost every day through Internet. And as the little one didn't have much vocabulary and patience for conversations, I used to sing with him. The songs were the same we sang before the trip and the ones he was learning from his father. **We were musically and emotionally together and it made distance decreasing a little bit. I knew my son was well taken care of. It is important to say that at two years old, B – as the kids at that age – had no awareness of time passing. He didn't know what was a week or even a month. It is also important to mention that my son was assisted by a network formed by family and friends who ensured his care. Even more important is to speak of his father's role in this story.** Fathers are just as responsible for the children as mothers, but sharing this responsibility is also a difficult thing for mums. I want to express all my gratitude to S – B's daddy – for the support and courage to take on this role with so much affection. We did it!" (Cristina)

Therefore, Cristina's experience shows how the conception of time and presence(s) for child development can be one more promising for women bodily emancipation, including professional career, when child development is not faced as a direct outcome of a certain passionate attachment favoured by dual relationship mother-infant. One can speak on emancipation at this because Cristina lived an authentic experience, which contributed to her existence not only as a woman but also as a mother with an authentic engagement to motherhood, which does not compromise her ability to endure her professional career and habitual existence with music. In his book, Rousseau launches an intuitive view on children development and parental presence, still dominated by a dual relationship, but also proposing that babies have a natural capacity of searching for connectivity and perceiving who are present for them in

which way. Thus, subjective development would be a process which does not occur from an undifferentiated form to an autonomous unity, but from a constancy of connectivity and disconnection, adaptable to different environments and relationships, with certain plasticity – which can be conciliated to the alter-naturalist perspective already discussed in this thesis.

By this perspective, instead of searching for a liberal pattern of subjectification based on "desire", one can imagine and recognize the multiplicity of subjective existence; which is open to the understanding of desire not always present in attachment, and attachment not always experienced as passionate in the direction of an intelligible integrity – to take Butler's definition of subject. With this sentence, I am focusing on temporality of attachment and in its experience as also a contingency not always embedded in unconsciousness. For psychoanalytical perspective, attachment cannot happens without unconscious desire, and this desire also contains aggressiveness; so it is a tautological equation according to which whether a caregiver is continuously present to the child, even if by an ambivalent position, then there is desire. However, as Rousseau has perceived in his work, sometimes, if the infant does not have an attached or a desiring parent to introduces it to language, it is not destined to become "abject", it does not remain in "trauma", it can reconnect to other kind of relationality. The moral constrain that predicts the trauma in this situation is, therefore, historically produced by the idealization of liberal individual from privileged classes.

Taking Cristina's experience as a black mother who made an important mobility from poverty to middle class, one can assert that her music comes from the authentic experience with reality – an experience she can share with other women in spaces mostly ruled by middle class' institutions of motherhood, such as the "child-centred" rhetoric, negotiating with therapeutic culture without subsuming in it. She resonates on her music:

> "De luta e de muita garra, faz a sua vida acontecer
>
> Faz bossa, faz choro, ciranda, cocada, na lida pra fazer
>
> É ela, eh de saia, é ela, eh trabalha
>
> Conta com seu axé, brilha onde estiver
>
> Tenta não se esquecer, arrumando o que fazer
>
> De dia, almoço, estudo, marido, filho e limpeza por fazer
>
> A noite, samba, discurso e mais trabalho não faltam, tem que ver
>
> É ela, eh de saia, é ela, eh trabalha
>
> Leva a vida assim, acreditando ser feliz, acreditando no que faz, crescendo mais e mais

Tem que sofrer, que é dela, mas não se entrega

Sentir, libertar, sorrir, chorar

É ela, eh de saia, é ela, eh trabalha" (Samba de saia, Rafael Furtado e Marlos Soares)

Part Three: Searching for humanization of childbirth

Delivery is one of the most mentioned events of the transition to motherhood among the participants of this research, and it is also a recurrent thematic of Brazilian weblogs, websites and virtual communities. Preparation, experience and narration of this event can be a catalyser of changings in women's identities, while they try to create sense to bodily changings of pregnancy. It is related to experiences of "self-actualization" based on the search of legitimated knowledge on their social class, bringing, in some cases, to a politicisation of motherhood (Johnson, 2014; Meyer, 2005). Therefore, following the research methodology, I chose to deeply analyse one of the most important "unities of sense" of the participants' experiences related to delivery: the searching for humanization. It does not mean only the engagement in the social movement for humanization of childbirth, but also the engagement in searching for an attentive, caring, "humanized" assistance as part of the desire of presence – which shows a continuum not a dichotomy among "chosen caesarean" and "chosen natural birth". The main difference between both outcomes is in the preponderance of scientific motherhood on one kind of choice and therapeutic motherhood on the other.

I found in the fieldwork that searching for natural childbirth in quite medicalized systems can be accompanied by the need of intelligibility discussed on the previous part of the thesis, with a strong scientific and therapeutic rhetoric, which pressures women to an intense dedication in preparing themselves to this "natural" event converging to a re-privatization of motherhood (Leite, 2014). The use of CMC converges to this privatization but is paradoxically fundamental in the construction of alternative spaces of social presence, confronting the traditional medicalization and policy making processes in Brazil to an increased participation of women in public agenda. This politicisation is a way of individual agency, but does not cope with universalization of reproductive rights as a political agenda, because it does not deal with the perinatal paradox where it exists, in resorting liberal rhetoric on humanization as a "personal good" and a "conquest" when women follow certain patterns of consumption. By another side, expecting for a planned caesarean in systems dominated by midwifery logic can produce interesting hesitations facing privatization and over-medicalization, whereas reinforcing national identity as a mark of difference. If both choices can confront gender hierarchy in perinatal system, they still reinforces gender imbalance among mothers and fathers, since the decisions about obstetric interventions and place of birth are justified by a child-centred rhetoric. This rhetoric is the core of perinatal paradox worldwide.

Thus, in this part of the thesis, I explore the relationship of the searching for humanization in the preparation and experience of childbirth and the perinatal paradox, explaining the conditions in each country which contributed to these women's experiences.

III.1 FACING THE PERINATAL PARADOX

In the first part of this chapter, I describe some aspects of the organization of perinatal system in Brazil, signalling some pivotal characteristics that contribute to understanding of women's experiences with perinatal health, including the experiences in other countries. As proposed by Richard Brown (1978), analysing organizational strategies by a phenomenological paradigm must contribute to understanding the "worlds [we are] ready to wear" (p. 375) as citizens who can raise a voice in public debate. As I have discussed in previous chapters, privileged Brazilian mothers have gaining space and influence in Public Health agendas related to reproductive rights, which is favoured by some organizational processes and also influences the redefinition of the system's "official paradigm". Thus, I analyse how those processes participate in the situated experiences of searching for "humanized childbirth", including power dynamics in the rhetoric of choice, which have prompted the expansion of scientific to therapeutic motherhood.

> (...) we could say that "making decisions" is not the most important exercise of organizational power. Instead, this power is most strategically deployed in the design and imposition of paradigmatic frameworks within which the very meaning of such actions as "making decisions" is defined (...)Yet at the same time that this "decision making" is going on, a subtle, diffuse, hierarchically low-level complex of negotiations is being enacted. What emerges from these subterranean activities is a redefinition of the official paradigm in the very process of its application (Brown, 1978, p. 376, his quotations)

Firstly I must define what the "perinatal paradox" is: an outcome of organizational trends in perinatal systems, which is one of the motivations of women's struggle for humanization in Brazil (Diniz, 2009) but also a global subject related to growing medicalization of birth. From the documentary research of this thesis and the debate in Public Health field, I define it as the contradiction of rights' systems related to birth, mostly determined by the misuse of medical technology. Such contradictions are installed among parturients and foetuses' rights, and among women's different classes, races, ethnicities and places of residence. As we are about to discuss, Brazil is one of the most exemplary case of perinatal paradox, having the world's highest rates of surgical births, with a great achievement in decreasing neonatal mortality, while maintaining high maternal mortality rates. This problem is related to a general culture of birth in the country – which is quite important for the situated experiences of the research's participants. Even in immigrating to Europe, the concerning and moral disposition of those women in

searching for prenatal assistance is constructed in this confrontation of Brazilian birth culture with the local perinatal system in which they are integrated as foreigner patients.

Moreover, the perinatal paradox is not only a Brazilian phenomenon; it was already debated in North-America (Rosemblatt, 1989; Rates & Early, 2004), Europe (Vangen et al, 2002; Speciale & Regidor, 2010; Juárez & Revuelta-Eugercios, 2015) and Polynesia (Mongelli et al, 2013). Usually, the studies compare infants' birth weight to parturients' social status, focusing on foreign born mothers and local born ones, pointing out a paradox according to which migrants and ethnic groups have better outcomes on prematurity and low birth weight. The same happens if comparing Brazilian regions: women living in most developed municipalities give birth more frequently to preterm and low weight babies (Silva et al, 2005). Those studies suggest that greater medical interventions in pregnancy and childbirth induce to prematurity (Diniz, 2009). However, some scholars argue that this is not true for specific foreign groups such as women from Sub-Saharan Africa in Sweden (Juárez & Revuelta-Eugercios, 2015) and Spain (Speciale & Regidor, 2010). Also, if one analyses the Brazilian case further, one finds out that most developed municipalities have much better outcomes in maternal morbidity and mortality rates (Ferraz & Bordignon, 2012). Therefore, perinatal paradox cannot be explained by a unique cause and a one-way direction. One should analyse social context and health systems to comprehending why some groups have better outcomes in maternal mortality while having preterm and at-risk new-borns most frequently, and the opposite.

In Brazil and United States, the core problem seems to be the prioritizing of at-risk new-borns' surviving over parturients' and "normal" foetuses' wellbeing, so as the individuals access to high technologies are prioritized over public health issues (Rosemblatt, 1989). This converges to perinatal systems organized around obstetric interventions for life-risk events, which occurred by the transition from Midwifery to Medicine as dominant profession on childbirth (Johnson, 2014). Moreover, it was intensified by the regionalization of perinatal care, an organizational strategy adopted in the 1990s worldwide. Regionalization is the adoption of regulations for differentiating complexity levels of health facilities, which should be strategically distributed among geographical regions, prioritizing the capacity of "in uterus transfer, which was considered the safest way to transfer a very preterm baby" (Zeitlin et al, 2004, p. 99). Conflicting to communitarian and cultural patterns of giving birth, this organizational strategy contributed to ensuring the best chance of survival for at-risk foetuses, promoting the evident decreasing of neonatal mortality; however, as the term "in-uterus transfer" suggests this perspective obscures parturients as living persons, because signifies parturients' bodies as devices for babies' lives rather than ways of women's living experiences. It occurred along with the increasing of surgical births and instrumental

deliveries; but not as an efficient way to reducing maternal mortality equally among different groups (Victoria et al, 2011), since it is dependent on other phenomenons such as birth cultures, universalization and privatization of health systems.

The majority of participants of this research did not track the usual pathway of perinatal assistance for middle class in Brazil, since only 8 of them had caesarean sections, 5 because of clear prophylactic reasons and 4 living in other countries than Brazil. Among the 11 ones living in Brazil 4 had their childbirth by out-of-pocket expenditure even if being clients of private health insurances, one was assisted by a public birth centre and the other 6 were assisted by private maternities covered by private health insurances. Nevertheless, during fieldwork, I observed a general concerning with the place of birth, the majority of participants searching for a best equipped maternity but also for more attentive doctors, midwives and doulas – which in some cases was conflicting *vis-à-vis* the standardized protocols for delivery assistance, long periods in the clinics' waiting rooms followed by quick consultations, longstanding and insufficiently assisted labours in big maternities, etc. For instance, for the women who had planned home births – all in Brazil – this choice was justified by the mistrusting towards hospitals and regular physicians of private health insurances, fearing to have *"premature delivery*" (Renata) or *"unnecessary caesarean"* (Luise) because, after seeing around 5 to 8 doctors from private health insurances during prenatal or having the first child in a hospital, those women thought physicians *"truculent"* (Luise) and *"impatient"* (Fátima). Being in another country converged or defied the concerning of conciliating attentive care to accessing technology, which also contributes to one identifies the relationship between "fear of vaginal birth" (Barbosa et al, 2013; Hirsh, 2015), "searching for humanization" and "choosing motherhood" as intertwined experiences of presence with childbirth.

As already mentioned, 11 of all participants reported some relationship to the movement for humanization of childbirth, 3 had planned homebirths and 20 had hospitalized vaginal births[47]. This aspect of doing a quite different pathway in perinatal systems in comparison of the majority of middle class pregnant and parturient women can be related to two possible explanations: the fact that the most part of participants are actually upper class despite of self-identifying as middle class (Estanque, 2003), and the use of CMC as part of social presence around pregnancy and preparation for childbirth. CMC is a tool quite used by those women to search alternatives to over-medicalization of private system and precarious assistance of SUS when living in Brazil, and used by women searching to comprehend European systems while trying to communicate to their Brazilian relatives after immigration. As already com-

[47] Considering the birth of all the children each mother had.

mented, CMC is a strategic tool to social movements around childbirth, as an alternative space of "participative democracy" in which domestic problems gain public status, especially the ones related to female issues (Casilli, 2010; Braga, 2005). Beyond that, the effort to be integrated in Swedish, French and Portuguese health systems, in which caesarean sections are less frequent, also influenced this outcome.

III.1.A THE COMPLEXITY OF BRAZILIAN PERINATAL PARADOX

In Brazil, despite of the three levels of regionalization stipulated by SUS, in practice, one can observe the expressive number of small clinics assisting childbirth without proper unities of intensive care for at-risk parturients and foetuses (Gomes, 2004; Magluta et al, 2009) – that is why it has five and not three or four complexity levels as preconized by global standards in perinatology[48]. Still, the country has a great demand for specialized assistance as the majority of its female population live in difficult social conditions, with an incomplete citizenship experiencing fertility and prenatal with few autonomy (Carvalho, 2004; Carvalho & Brito, 2005). Brazil has a high maternal mortality rate (72 per 100.000 live births, for 2006-2010 period)[49], with the most part of births occurring in public facilities (around 80%), where caesarean is common (around 40%) but less frequent than in private ones and frequently associated to sterilization (around 30% according to D'Orsi et al, 2014). Moreover, only 60% of all at-risk pregnancies ended with a caesarean section while 88% of all births in private institutions were surgical in 2011 (Leal, 2014). In this country, about 55% of women who died because of pregnancy or childbirth were racialized ("black", "brown" and "indigenous") in the period of 2000 to 2009 (Bordignon & Ferraz, 2012). Thus one observes the deviation of intensive care technologies, which would be crucial for more vulnerable women and new-borns. Therefore, in this country we can see the most evident problems of perinatal paradox, which feedbacks a general searching for more personalized and private assistance by middle and upper classes.

The executive summary of *"Nascer no Brasil"* recognizes that there is no consensus in scientific literature about the determinants of maternal deaths in the country, and that one cannot define a direct causal association between caesarean epidemics and maternal mortality (Leal, 2014). Even though, it asserts that the inquiry was conducted from the recognition of a great problem in the obstetric system: the astonish increasing and persistency of high caesareans' rate among Brazilian women, especially among users of private health insurances. Despite the great improvements on infant health in the last decades (PNUD Brasil, 2015b), the researchers wanted to:

> understand the reasons that lead pregnant women to submit to Caesarean sections, to verify any association between this type of birth and postnatal health consequences to mother and new-born, including premature birth and low birth weight, focusing particularly on late prematurity (34 to 36 weeks of pregnancy). (Leal et al, 2012)

[48] As one can observe in Table II, page 152

[49] See Table II to see sources and references.

In 2014, the inquiries' results were broadly publicized in Brazilian Medias, Academia and in political institutions through a short summary (Leal, 2014), an executive report (Leal, 2015), a website (ENSP, 2014), a special issue of one of the most important Brazilian journals of Public Health, *"Cadernos de Saúde Pública"* (CSP) (Leal & Gama, 2014), a Parliamentary Public Hearing (Brasil, 2014), a documentary film (Fioretti, 2014) and some interviews given by the coordinators of the project. It was also largely commented in weblogs and social Medias. Its political agenda is clear, claiming for the "humanization of childbirth" by the emphasis on "scientific evidence" and WHO's recommendations to revert the huge caesarean rate and its negative outcomes. The researchers were not able to determine causal relationship between over-medicalization and maternal mortality, but could suggest a systematic problem related to misuse of high technology and mistreatment in labour. They argue that "an important proportion of women and new-borns were exposed to unnecessary and avoidable risks" (Leal, 2015, p. 3, free translation). Therefore, the authors try to promote a paradigmatic changing in political agenda and in perinatal system, benefiting of privileged women participation in social Medias to strengthening their influence.

The inquiry also aimed to understand which women's real choices on the delivery mode are, and it concluded that, in the beginning of pregnancy, only 28% of them wanted to be submitted to a caesarean section. In the short summary, the authors emphasize the changing of preference among users of private health facilities, using a quite convincing visual rhetoric: an organogram with the percentages of primiparous and multiparous who preferred surgical births in the beginning and ending of pregnancy, in public institutions and in private ones separately (Leal, 2014). While SUS' users kept the same proportion of women who wanted caesarean (15% among primiparous and around 28% among multiparous), the others presented an expressive changing along pregnancy (from 36% to 67% and 58% to 75%). For all groups, the actual rate of caesareans was higher than the percentage of women who desired it. Thus, the authors suggest that there is a tendency of physicians and private maternity facilities, during pre-natal consultations, in emphasizing the convenience of the surgery in detriment of the benefits of vaginal birth.

At this point, *"Nascer no Brasil"* project tries to respond a recurrent justification by obstetricians and maternities to the vulgarization of caesarean, which would be the fact that women choose this mode of delivery because of the fear of labour pains. In a scientific paper, some of the researchers who participated in the project discuss how this preference occurs and how it is related to medical influence in women's decisions (Domingues et al, 2014). Despite of showing other aspects such as cultural values and payment source can be determinant in this process the authors conclude that women who keep

the decision for vaginal birth until the end of pregnancy contribute to lowering caesarean rates, signalling that "women without decision about type of delivery mode present a higher caesarean rate" (Domingues et al, 2014, p. 108, free translation):

> Independentemente da paridade e da fonte de pagamento, mulheres que mantiveram a decisão pelo parto vaginal no final da gestação foram as que apresentaram maior proporção desse tipo de parto, enquanto aquelas com decisão pela cesariana apresentaram o percentual mais elevado de parto cesáreo sem trabalho de parto. Mulheres sem decisão pelo tipo de parto apresentaram proporção elevada de cesarianas, sobretudo no setor privado. (Domingues et al, 2014, p. 108)

III.1.B THE PARADOX OF POLITICISATION OF BIRTH IN BRAZIL

The website and the interviews given by the coordinator of *"Nascer no Brasil"* also emphasize this rhetoric of "decision", "preference" and "choice" used by Domingues and collegues (2014) to explain caesarean epidemics, converging to the most important argument of the movement for humanization of childbirth, which is the individual agency of women in searching for evidence based information to resisting medical pressure and achieving the experience of humanized childbirth (Mendonça, 2015; Meyer, 2005). Moreover, in the executive report, the authors argue that "it is fundamental the involvement of health managers and professionals, researchers, civil society, and particularly women to changing the way of being born in the country" (Leal, 2015, p. 6, free translation, emphasis added). Thus they make various recommendations for each of these social actors in the aim of transforming perinatal assistance in Brazil, including the recommendation for women to improving the research for information about "good practices" in childbirth based on scientific evidences, participate in SUS' social control and of support groups in health facilities and social Medias, among others.

For Luise, a visual artist, white and married woman living in Brazil, pregnancy went without incident, but at the same time it was a difficult period due to childbirth-related *"anxiety"* – her story can illustrate many of the participants' experiences with this paradigmatic transition of Brazilian perinatal system, while they seek for "presence" with childbirth. During prenatal, she attended consultations with five obstetricians of her private health insurance. However, quite dissatisfied with their treatment because of long waiting lines and fast consultations, she started to research online about prenatal and found many testimonies of *"humanized childbirths"*, hospitalized vaginal birth and *"unnecessary caesareans"*. With those readings, she realized that she *"was in the line"* to unnecessary caesarean and became *"desperate"*. She said:

> "I started researching, I've always liked researching, looking for everything, like headache, I look at Google, anything, and about childbirth was not different, right? I'm pretty anxious so that littered my head. **And then when I started researching, I found right the way all the information regarding**

> **Humanized childbirth, and I began to read several stories of childbirth, caesarean section, and it gave me a tremendous panic because I was in line, right? Walking to one [caesarean]**. And I freaked out, and at 6 months pregnant I quit my job. Because it did not worth keep working in the Museum pedagogical sector, it was not Worthing, so I ended up quitting and turning myself to it. I went crazy searching everything I could about pregnancy, everything I found about birth, then T arrived from work and I discharged all that over him, for God sake! Then he said: man, you're crazy! This is Internet craziness! And I had to convince him that it was not craziness, it was reality, as we wouldn't be able to use the marvellous health insurance from his employ, and it was really a battle." (Luise)

Therefore, the first step to Luise but also to other participants of the research in facing over-medicalization in Brazil was the intense dedication to studying evidence based information online – which can be a ritualized experience for the intelligibility of the desire of presence with motherhood. For some of the participants, this "studying" contributed to the decision of leaving the job they were engaged with or diminishing workload and returning the maximum attention to childbirth-related subjects (as for Luise, Raquel, Simone, Luciana, and Carla). Along or after this step, they tried to *"convince"* their partners and relatives to supporting their search for a humanized childbirth, configuring a real emotional, financial and social *"battle"*.

When finding information online those women are pressured by this rhetoric of "decision of delivery mode" as a fundamental tool in the facing of technocratic system – at the same proportion as ethic of desire is important to revising ethic of justice. However, when they realize that most obstetricians from private health insurances would not respect their desire for vaginal birth, *"reality"* seems even more challenging, and "choice" can be an intense experience of self-actualization at the same time it can be damaging to the self (Johnson, 2014). Referring to Adrienne Rich's theory of childbirth as a pivotal event in the process of women's self-actualization and/or self-replacement, Candace Johnson (2014) identifies that the choice of midwifery and a more "natural" mode of delivery instead of medicalized obstetrics can represent different experiences in different contexts. She complements and criticizes an idealization of Rich's theory, confronting it to the results of her research with migrants and non-migrants in USA, Canada, Cuba and Honduras, showing how medicalization in certain contexts can mean resistance, and how fighting against medicalization can mean resisting but also revising gender identities based on conservative assumptions of nature, citizenship and gender differences. This idealization of natural childbirth in the affirming of an emancipatory social identity for women can actually be self-damaging if it pressures women to replacing their authentic experiences by a model which would be better independently of context – which means affirming a most "natural", universal, biologically determined experience as a goal for all women.

One of the most illustrative stories on this process of resisting, revising and replacing selfhood while preparing for childbirth is by Simone. Before leaving her job, opening an associative day-care at home, and starting to participate in a social movement for *"unschooling"*, she went through a *"battle"* for humanized childbirth. She reported:

> "and then this process was growing, I was already thinking about it: I want to be a full-time mother, and also want a natural birth, *normal* childbirth, and **the prenatal process was a very difficult process but at the same time pretty important for all that I'm living today. Because I had to face a lot, right? And there I constituted myself as a mother, I was empowering myself, you know?** (...) This process of reaffirming myself for the whole time to the doctor, of researching to really know if it was true what he said or if it was only to oppress me... that strengthened me." (Simone)

Simone also reported a *"unperturbed pregnancy"* but traversed by the *"pressure"* of her obstetrician to have a caesarean section at 38 weeks of pregnancy, justified by her age, 38 years old at the time. She made various researches on the Internet, reading other mothers' testimonies, and found a *"humanized doctor"* who accepted her health insurance in a nearby town. The encounter with this doctor was quite important, because she felt *"listened"* and *"accepted"* as she had not been by other obstetricians before. Even fearing a distance of 20 Km away of the private maternity hospital where she would be attended by him, she preferred this option rather than trying assistance in SUS's facilities in her village. She said:

> "because I was disposed to go to SUS, even though it was a hardship, but at least it would be a natural childbirth (...) then I said, Oh doctor but I'm afraid because is Niterói. Because then everybody starts saying: Oh you're crazy, you will change the doctor at the last minute, for one who works in Niterói (...) and then he said: Simone, the most that can happen is he born on the bridge, and if it happens you take it and put it in the breast, because a child who is born in a taxi, in elevator... first of all, that's novel, but if it happens, it's because the child is fine, it doesn't have any problem" (Simone)

Rather than going through *"hardship"* in SUS, Simone was ready to giving birth stuck in traffic if that was the condition to have a vaginal delivery – which was not considered by the obstetrician as a unsafe situation for the parturient, as he argued focused on the infants' wellbeing. With this moral disposition, she focused on certain conceptions of children's birth and development, in confirming her desire to be fully present for her child. Simone's readings on humanized childbirth and libertarian education reinforced her frustrations with her job in an NGO, approached her to her female kinship and reinforced the intense desire of presence with motherhood, converging to full-time mothering as a personal and political goal. According to her standards, *"unnecessary caesarean section"* and what she called *"outsourcing of childrearing"*[50] are *"oppressions of the system"* against which she intends *"to fight"*. She ended having the desired experience with labour and reported a good experience with it, emphasising *"free-*

[50] According to Simona, outsourcing childrearing is the sharing of it with childcare centres.

dom of movement" and her companion's presence as important elements – two procedures already recommended by WHO and Brazilian state (Brasil, 2001b) but subscribed by few private and public facilities in the country.

This pressure over women's individualized agency brought me to the question on which "humans" people are talking about when defending "humanization". Because, if detached of contextualized understanding of local cultures and inequalities of perinatal systems, one risks imposing certain patterns of resistance that actually puts certain groups in more vulnerable situations related to reproduction. As previously discussed, a dominant view of "human" is present in psychological speeches, which influenced recent organizational strategies for public and private spheres. Friedberg (1993) asserts how an important Western movement criticised the rationalist paradigm of formal organizations in the second half of 20th Century in promoting a psychologising view of "human person" to restructuring work organizations in the direction of satisfying "psychological needs" of individuals. However, this author identifies a problematic trend in the great success of this movement worldwide, because "in rationalizing in a general way, to not saying universal, about human person seen as abstract and isolated from context it must (...) recurring to *a priori* postulates about human behaviour" (Friedberg, 1993, p. 40, free translation) and "to postulate an ideal and unique model of psychological and moral health" (p. 41) – configuring an imperialist humanism.

Therefore, this idealized agency, mainly constituted by resistance against medicalization, can submit mothers in a more vulnerable situation under a quite conflicting experience. For instance, Luciana, in a situation as "single parent", autonomous health professional and athlete, the rhetoric of humanization quite coped with her expectations of presence in childbirth. However, after investing affectively, morally and financially in a humanized assistance for prenatal and delivery, Luciana did not have the outcome she expected and made important critiques on the *"elitism"* of this social movement.

Luciana had a difficult situation during and after pregnancy, since she did not have support from the child's father in this transition, and lost sponsorship because of the bodily changes related to it, therefore, living a *"very solitary gestation"*. Thus she wanted a humanized childbirth as a matter of health and as part of her "desire of presence", since delivery could be an intense event to the re-signifying of her bodily experiences at the time. She asked for the assistance of a private "humanized" obstetrician indicated by her yoga instructor and quite known among the activists for natural childbirth in her city, telling him her difficult situation and asking for an easier payment mode for his assistance. He agreed but afterwards he charged her the same amount as usual, contradicting their agreement.

During the most time of our first conversation, Luciana did not speak on her delivery experience; because of that I was quite convinced that she was one of the few interviewees who did not have childbirth as one of the most important mark of transition to motherhood. However, when I asked her specifically about it, it became clear how this subject was in fact a sensitive one, actually contributing to the conformation of subsequent habits she developed in the caring of her child. She told me that the conduction of her labour was not as expected, because the obstetrician divided his attention between two parturients in the maternity facility. As she did not have done prenatal in the same maternity as birth, but in the private office of the doctor, she did not have a professional reference in the institution beyond of him, then she kept alone for a long time during labour, only accompanied by a friend and the TV show's staff. One of the crucial moments happened when the doctor *"put her to sleep"*, and went performing a caesarean section in the other parturient; Luciana reported that he came back to her room complaining about that woman, saying *"if she did not want to push, I cannot do anything"*. After that, Luciana's contractions kept irregular and the foetus became distressed; for that, she had to undergo an emergency caesarean section. She is convinced that surgery was a wise decision at that moment, but affirming that it was the result of a series of "non-humanized" procedures applied by the doctor. In the interview, she indicated regret for not engaging a doula, but also emphasising how it was difficult to cope with the *"elitist costs"* of humanized childbirth, for which she paid 10.000 Reais (around 2.500 Euros). Luciana told me:

> "and then there was that thing with the return, and the scar... he said: you have to come back in a month, and I said: well, Chico, I'm really out of money, then he answered: Oh so you don't have to [come back]! Whoa! Man, you don't have to do it for free, I could pay in three times, I don't know (...), I'm a health professional too, I am a physical therapist, I've done this a lot ... why he, who really makes money as hell couldn't do like me? That is the question. (...) Later, I even sent a bunch of emails to the doctor talking about all that with him. **Then I went to some lectures with Michel Odent, and I got even more anger, you know, because the man says he is humanized and at the same time he does a lot of stuff that's not humane at all! For a price that's not humanized**... the price, huh? The price is *elitized* it isn't humanized! And there are people who quite believe in this and who want to go there, right? I was one of them." (Luciana)

Therefore, according to the contemporary politicisation of motherhood in Brazil, if women's emancipation is conquered through the right to choose not being mother, the mothers' emancipation would be conquered through the opportunity to choose better scientific and therapeutic resources for pregnancy, labour and childrearing, commonly through new and the revalidation of old consumption patterns (Pérez, 2011). For instance, Fillod (2014) reminds us that Michel Odent is articulated to the doulas' social movement in the searching for legitimating their professional activity facing the strong hierarchical power of obstetricians in perinatal assistance. The doulas are a new figure in perinatal systems inspired on

old times, when women gave births at homes coached by female relatives; but in some contexts, as in Brazil and Portugal, to have a doula during pregnancy and childbirth depends largely on financial and social resources not available for the most part of populations. Even so, the movement for the humanization of childbirth emphasizes this professional service as important choice based on scientific evidences to avoid over-medicalization of parturients' bodies. Still, the choices anchored on science and/or on the ethics of desire promise to reduce health risks and/or to produce ideal bonding between mothers and babies, but excluding from the causalities important aspects as social inequalities. From an *alter-naturalistic* critique, the viewing of human and nature without the complexity they actually imply obstructs a politicisation in the direction of an intersectional Feminism that comprises different women's situations.

Therefore, over-medicalization during prenatal and delivery strongly defy women's desire of primary experiences of presence, pressuring them to a passive and solitary situation during an event that could be lived with fluidity and familiar presences. When the desire of living maternal transition as an opportunity to improve own-body fluidity finds the rhetoric of humanization, facing over-medicalization can produce a quite contradictory injunction, as it seems an opportunity to improving selfhood through resistance, but a resistance mainly based on individual consumption. However, what could be an authentic performance ends up as self-replacement and conservative agency because of de-contextualization. This contradiction had already been intuited during my first steps of fieldwork, when I observed that the online maternalist activism in Brazil approached Feminism while excluding peripheral experiences such as the ones lived by SUS' users and stereotyping the experiences of insurances' users when they choose or "accept" planned caesareans.

> Nesse caso, onde está o lugar para o desejo? Onde está o espaço para se afirmar o desejo de cuidar? Antes, quando ela determinou para si mesma e para a sociedade que gostaria de parir seu bebê naturalmente. E foi interrompida em seu devir quando alguém, com alguma autoridade e credencial científicas ou políticas, disse-lhe que, então, deveria exercer integralmente e solitariamente esse desejo e esse cuidado. Essa mãe passa então a lutar, e coloca aquilo que seria uma dissonância construtiva – a vontade de fazer diferente do *mainstream* – como parte integrante de sua identidade. Ela coloca-se contra o "sistema" e contra as outras formas de parentalidade, para conseguir assumir um desejo que no fim das contas volta-se contra ela. § Se outra mulher possui uma existência corporal diferente daquela que deseja o rito do parto e vai buscar um acolhimento medicalizante para o nascimento, talvez ela esteja apenas repetindo uma identidade feminina fragilizada – ou, inversamente, "empoderada" pela inserção profissional, repetindo uma diferenciação de status social. Mas, talvez, esteja exercendo uma escolha divergente da identidade universalizante: ela quer ser mãe, mas não quer que essa identidade passe necessariamente por seu corpo, pela Biologia. (Pombo, 2013, p. 53)

In their turn, the participants who had planned caesarean sections speak of this outcome mostly as a failure, a lack of *"empowerment"*, as in Raquel's narrative, a white, married and heterosexual mother of

a two year-old child. At about 30 weeks pregnant, Raquel had bad news concerning her mother, who already had cancer and got even sicker, dying a few months after her grandchild's birth. Then, Raquel spent the rest of the pregnancy quite *"worried"*, *"insecure"* and *"emotionally weak",* fearing labour pain and timing. She had been preparing herself for vaginal delivery, doing physiotherapy to prepare the pelvis, creating a playlist of songs to listen to during labour, and discussing this decision with her obstetrician who agreed to assist her under the insurance coverage. However, she finally decided to get a planned caesarean. During the interview, she reported that at that time she was not *"empowered"* because she *"could not wait for her child",* affirming that she *"did not know how to keep being a mother"* in that *"uncomfortable situation"*.

In fact, Raquel's self-judgement resulted from her contact with an online maternalist group called *Mompreunership*, in which she met humanized childbirth activists. Like in France, *Mompreunership* in Brazil is a movement mostly formed by middle- and upper-class mothers for fomenting their autonomous occupations working with motherhood-related goods and services, after leaving their regular jobs – it presents a paradoxical trend of taking mothers out of isolation while isolating them from a larger labour market (Landour, 2015). Some women who have experienced humanized childbirth in Brazil invest in a career as a doula, participating in workshops promoted by "humanized" obstetricians, midwives, political and marketing consultants and using online social media as an important vehicle to publicise their new enterprise – such as Carla, a black and heterosexual mother who was employed as a Health Manager at SUS but started working in parallel as a doula after having her first child in a public facility with a liberal doula paid with out-of-pocket resources.

In the following quote, after reporting her delivery experience, Raquel confronts the rhetoric of *"female independence"* by an online group with a business-focused approach to the discourse of *Mompreunership* in which mothers' entrepreneurship is focused on the strategies for spending more time with children while working. This discourse addresses humanization of childbirth by the rhetoric of *"maternal empowerment"* as a process in which women choose to be *"protagonists"* of motherhood, which would occur by fighting against medicalization and experiencing the fluidity of *"maternal instinct".* Once again, sharing childcare is faced as a contradiction to this empowerment just as the acceptance of planned caesarean.

> "I'm very happy with this moment ... **I don't know if I'd call it Feminism, I'm happy with this moment in which the woman can speak for herself, you know? You can talk about making choices**, because I think a while ago a woman could not say: no, I want to do my labour because childbirth is mine. My god that did not exist! I think it's cool to take away the doctor's protagonism. **I studied physical therapy, I did various exercises to work the pelvis, I had an agreement with the doctor to**

> **have natural childbirth, I made a playlist of songs for labour, but I couldn't ... so, I wasn't empowered? I wasn't empowered! I thought myself incapable**, I could not stand that situation anymore, I didn't know how to keep pregnant in that situation of discomfort, apprehension, fear of pain, I didn't know how to keep being a mother... **so, to be empowered means to give woman reassurance? So, in these terms, I think we can talk about empowerment as a feminine, a maternal word** (...) This speech of independence by 'Empreendedorismo Rosa' is very complicated, because they get this female independence, asserting that she will leave the child with the nanny without a heavy conscience, but for me it's hard to see this speech as truthful you know? (...) **Because that's not something the mother says and you perceive in her that her instincts are being satisfied... we are mothers, we were biologically prepared to have this kind of instinct!** I think they come lighter as time passes, and something will change, but you can't deny that and act... for me, [if you do that] you end up becoming a survivor" (Raquel)

"I don't want to be just a survivor" is a usual slogan by activists for humanization of childbirth[51], not only referring to mothers who accept caesareans without prophylactic reasons but also the ones who do not *"satisfy their maternal instinct"* because they are not "attached" enough. This maternalist rhetoric of empowerment conceives the majority of Brazilians, who do not have humanized deliveries, as "survivors". Confronting the dominant discourse of technocratic obstetricians, according to whom it is the infants' and woman's surviving after delivery that matters, this slogan is expanded to other spheres of maternal experiences, opposing mothers who for different and complex reasons accept being submitted to medicalized childbirth to the ones who are *"empowered"* enough to fight against it. This means that it is not exactly vaginal birth that is the goal but the quality of birthing experiences.

According to Olivia Hirsch (2014; 2015), an anthropologist and activist of the humanization movement who conducted a comparative inquiry with poor and upper-class women searching for "natural childbirth" in Rio de Janeiro, the last ones seek humanized assistance from the perspective of giving birth as feminine agency, through controlling the body and the effort for re-signifying pain and parturition as positive experiences. This author opposes both classes, identifying that non-medicalized birth is not usually chosen by SUS users even when having prenatal appointments at one of the few normal birth centres. For them, natural birth is not the main reason to search for vacancy in certain facilities – instead, they search for less hierarchized relationships with health professionals, while expecting to have all the medical resources for rendering delivery less painful and longstanding. However, from a quite liberal perspective, Hirsh (2014) asserts that poor women accept natural birth "not exactly [as] a choice but [as] a 'bargaining chip'" (Hirsh, 2014, p. 329, free translation). Therefore, this dichotomist approach of confronting two kinds of maternal experiences – which would be the opposite of each other in terms of agency and empowerment – is not only present in women's narratives, but also in academic analysis and in the national inquiry *"Nascer no Brasil"*, as it compares women who "decide" to undergo

[51] See : « https://umavezmamifera.wordpress.com/2014/08/27/sobreviver-nao-e-o-bastante/ »

vaginal delivery and keep this decision until the end of pregnancy and the ones who do not have this kind of agency.

The Brazilian report also promoted an inquiry about the users' satisfaction and well-being with prenatal care, though it was concentrated in the risks of "post-partum depression" and on "maternal-infant bonding" as the core argument to defend the importance of mothers' well-being. It affirms: "When [depressive symptoms] occur during pregnancy and after childbirth, it produces serious consequences to mothers' and infant's health, particularly in the affective bonding and breastfeeding, with negative consequences lasting until adolescence" (Leal, 2014, p. 16, free translation). Therefore, in this part of the report, one can clearly observe the psychologising trend of the humanization rhetoric. It asserts that 26% of interviewed women had depressive symptoms, mentioning (but without revealing specific data) that they were more frequent among poor women who did not desire the pregnancy. Nevertheless, it did not present further social and economic aspects that can be related to this suffering and risk. Still, the rhetoric of "risk" associated to a child-centred approach appears along with the argument of "decision". Despite mentioning some of the difficult conditions in which SUS users get pregnant and give birth, and despite affirming that less than 50% of interviewed women desired their pregnancies, the report clearly privileges the arguments close to middle and upper classes' realities, in which "chosen motherhood" is the background and the "liberal individual" is the ideal interlocutor. Thus "human" here is the desiring psychological subject immersed in contemporary therapeutic culture.

For instance, as a contraposition, one could ask why the executive report did not analyse and emphasize other possible associations such as: undesiring pregnancy (55%), trying to generate a miscarriage (2,3%), desiring caesarean sections in order to be granted sterilization (8,4% of all women; 37% of SUS users who preferred surgery), actually having a caesarean section (52%), and getting depressed after childbirth (26%). Looking at those data from the historical concern with family planning and reproductive rights could really prompt to other conclusions and arguments for changing the perinatal system – perhaps a rhetoric that embraces the experiences of undesired children and deconstruct the (re)privatization of motherhood (Leite, 2014; Meyer, 2005). However, the emphasis in women's decision and engagement to the changing of obstetric system is under a similar ideology of the technocratic over-medicalization logic – as this one prioritizes individuals' access to technology over public health issues and justifies the perinatal paradox as an outcome of women's preferences for type of childbirth.

Furthermore, one can observe a contradiction between this recent perspective of Brazilian state on maternal health and the historical agenda of women's integral health represented by PAISM, as already

discussed in the first part of the thesis. Estela Aquino (2014), one of the authors of the special issue published in *"Cadernos de Saúde Pública"*, asserts humanization of childbirth as a feminist movement, recognizing, however, that the contemporary political context retrocedes with the emphasis on "maternal-infant health" approach instead of the women-centred perspective from PAISM (Aquino, 2014). Moreover, the trend of associating humanization of childbirth with Feminism is clearer in the institutional video *"Nascer no Brasil: parto, da violência obstétrica às boas práticas"* also produced from the national inquiry and distributed in DVD and online platforms (Fioretti, 2014). This video uses the rhetoric of "obstetric violence" and is fully filmed in SUS maternity hospitals. The tonality of denouncing violence is crucial to arguing the inadequacy of the technocratic logic of perinatal assistance in most of the country and can be easily related to demands for other reproductive rights such as adequate assistance for legal abortion. Nevertheless, it categorizes as "violence" some routine medical interventions, such as the use of synthetic oxytocin, lithotomy position and Kristeller manoeuvre, along with negligence, verbal and physical aggressions perpetrated by health professionals – which produces a necessary debate in public spheres about this ambiguous relation of medicalization and violence against women. But from women's experiences, the way this rhetoric is being spread can also converge to a culture of fear of vaginal birth and to de-medicalization where it is in fact insufficient, aspects already quite present in the country (Barbosa et al, 2003).

Another relevant critique related to medical interventions in *"Nascer no Brasil"* is the lack of specific data on instrumental deliveries, since it could also contribute to the understanding of medical decisions for caesarean sections (Cecatti, 2014). José Guilherme Cecatti (2014) contributed to the special issue of CSP criticising this lack of data and also the categorization of epidural anaesthesia as an "unnecessary medical intervention" and an index of over-medicalization. As already mentioned, re-signifying pain as an instinctive and necessary experience for "empowered" childbirth is part of the ideology of humanization, which probably influenced *"Nascer no Brasil"* to deal with epidural or other pharmacological analgesia in these terms. Furthermore, I would add that neither the reports or the online documentary mentioned the low rate of epidural analgesia (33,9%) as a possible index of obstetric violence – since the Ministry of Health recommends full availability of the procedure when it is demanded by the patients as a good practice in obstetrics (Brasil, 2001b). As we are about to analyse further, in European reports the access to pharmacological analgesia is considered as a woman's right and a factor for health equality (Zeitlin, 2013; OSS, 2013). Besides, if in Brazil, only 8% of births are accompanied by midwives and technocratic model is dominant, having 26% of vaginal births without any pharmacological analgesia could raise the question if these statistics represent parturients' choices or maternity hospital negli-

gence. Thus, having medicalized birth in hospitalized facilities without any kind of analgesia could be included in the rhetoric of obstetric violence, but it was not. Instead, the emphasis of this rhetoric puts obstetric interventions, in general, as invasive *per se* – which seems a relevant contradiction to the reality of a large part of Brazilian women, who do not have easy access to medicalization when they need it.

Regarding the SUS users who narrated their delivery experiences to the documentary filmmaker, one of the researchers of *"Nascer no Brasil"* says in the video: "they do not know that they are suffering violence (...) they lost this thing of reliving the natural, the instinctive (...) they are like warriors giving birth in here, I would never be able to receive all this kind of violence and still manage to give birth" (Fioretti, 2014, free translation). This condescending tone is nevertheless complemented by the voice of one of the interviewed parturients: "[the problem] is not SUS in itself; it is the question of health teams, of people. People judge Brazil, judge everything, but people themselves are the ones who do it to Brazil" (Fioretti, 2014, free translation). In listening to this SUS user, from an ethical responsivity, it seems quite important to highlight that, despite its innovative work, *"Nascer no Brasil"* reports did not approach one of the most critical problems of perinatal paradox in the country: the mixed and contradictory role of health professionals in the mixed and unequal Brazilian health system. In Brazil, private and public systems are articulated through the contradictory practicing of many physicians, who offer services to both types of population, poor and privileged classes, with different work contracts promoted by the 1990s' neoliberal reforms (Machado, 2008).

For instance, Luise reported that after participating in an independent support group for preparing for natural childbirth, she realized that it would be quite difficult to afford the work of "humanized" professionals. She found an obstetrician who was an acknowledged activist and practiced in a private clinic but was also in charge of the obstetric sector of a public maternity recently instituted as a pole for humanized assistance in SUS, the so-called "Maria Amélia Maternity". Then Luise considered giving birth in the public maternity, but her husband was adamantly against it. Afterwards, they decided saving the money that would be used in the baby's outfit to finance a private team composed by a doula, a midwife and this doctor – who was a "back-up" for an possible emergency – in a home birth. Planned home births are allowed throughout most of Brazil, but without standardized guidelines and social security insurance, then they are not recommended by obstetricians' representative councils, which usually represent a technocratic lobby. Thus home birth is a controversial choice mostly influenced by bad experiences with medicalization, but also by the practice of health professionals who attend at SUS facilities and do not have entrance in private maternity wards. Luise told me:

> "because it was money that we didn't have. I told T: we don't have any money! **Look at that, we don't have any money! Let's go to SUS! Let's go to SUS! Then he said: you're crazy! My baby is not going to be born in SUS. Not at all!** It was the worst thing, just because he didn't want to, but [the doctor] was a guy for whom we could not use our health insurance, and we didn't have the money to afford it. So, we had to save somehow, and SUS, was the hanger, right, between SUS and this huge amount of money. There was no middle ground, either we would go to SUS or we would spend money that we did not have at that time. As for him was 'SUS-no way', we stopped saving for the trousseau and all the money that was coming in we saved for childbirth." (Luise)

Maria Amélia Maternity is pivot of a great dispute between technocratic logic and the humanization movement in Rio de Janeiro. One has recently begun to observe this type of dispute clarifying the mixed and ambiguous role of health professionals who work with apparently contradictory logic in SUS and by private agreements. As Sara Mendonça (2014) has observed, Maria Amélia took a prominent place in this major context, being used by middle- and upper-classe activists to gain political space, as they can finally respond to the critique on the elitism of the movement:

> A existência de uma Maternidade pública atuando pelos preceitos da humanização apareceu como solução para duas questões difíceis dentro do movimento: a da elitização e altos custos de um parto humanizado e a da dificuldade de consegui-lo através dos convênios de saúde. Assim rebatendo diversas críticas de longo prazo as ativistas puderam finalmente exaltar "No SUS também tem". (Mendonça, 2014, p. 2019, her quotation)

Nevertheless, shortly after its inauguration, this public maternity was target by articles in the press with rumours and complaints regarding the abuse of health professionals against pregnant women and parturients (Mendonça, 2014). In her fieldwork, Camila Fernandes also heard stories of drug addicted and mentally ill women's babies gone missing, neonatal deaths and mistreatment of sterilization requests, which occurred in Maria Amélia (Pombo de Barros & Fernandes, 2016). In a paper focused on those kind of accusations, Mendonça (2014) discussed how women's complaints about "negligence" especially related to the longstanding labour and long waiting line to be attended by obstetric sector brought together SUS users and their relatives in 2013 around a collective movement which frontally criticised some of the humanization rhetoric. The militants of humanization responded to those criticisms in the same trend as Hirsh (2015), arguing that the problem is the lack of information among SUS users to confront bad practices and to choose de-medicalization.

Regarding Luise's case, she actually needed the obstetrician as "back up", because she had a placental retention after home birth. She experienced an intense conflict during this emergency: she could go to a private emergency service covered by her health insurance, to which her doctor did not have access, and in which she believed her baby would suffer *"bullying"* for being home-born, or could go to Maria Amélia, where her private doctor could assist her on a privileged basis, but where the paediatric sector was not really "humanized". Luise wanted to leave the new-born at home with the father and go

to the private facility, however, he was against it, as he was concerned about his son's breastfeeding in the first hours after birth. Therefore, they went together to the public maternity hospital, where she was quickly assisted to by obstetric service; but the child was also examined and diagnosed with a health problem which demanded hospitalization. Luise and her husband, supported by the midwife who attended the home birth, mistrusted the diagnosis and disliked the paediatric interventions such as giving the infant complementary feeding, and finally left the institution without the usual medical release. During the interview, Luise spoke about this situation:

> "The Obstetric sector in Maria Amelia Maternity was wonderful, wonderful staff, **but in Paediatrics they were very truculent, very truculent. They tried to feed him formula several times; I had to fight against it.** I had many problems with breastfeeding, so I had to keep calling people to help me because I couldn't position him to breastfeed properly, and the staff kept always trying to give him formula. They arrived in the room to measure his weight, a lot of things like that... And when the paediatrician said he was yellow, that he should be in there for a while, we panicked! They gave him bath, then they brought the cradle with lights, **and we started to cry (...) so, we said: look, you're wrong; then I look up T and told him: let's get out of here!** Then, we got D, arranged our stuff and we ran away." (Luise)

As illustrated by this story, one can realize that the privileged class who does not value SUS facilities most of the time, benefits from them with privileged access in specific situations, but have the option of leaving the *"system"* when they need or want to. This is also complemented by the fact that privileged classes compose most professionals who attend the most vulnerable populations, also feeding the deviation of human and technological resources from SUS to supplementary system, converging to privatization of health as one of the most important trend of perinatal paradox nowadays. Upper-class women like Luise, searching for respectful assistance in prenatal care, delivery and post-partum, when incorporating the humanization rhetoric do not have the background to comprehend SUS complexities, as they are not used to dealing with the system's historic contradictions. This engagement in "chosen motherhood" as a personal project with which they can search for intense experiences of presence and self-actualization can hardly be accompanied by an ethical responsivity towards most vulnerable women and families.

Therefore, as already discussed, "chosen motherhood", including choosing type of delivery, is a culture by which individualized medical care plays an important role in class differentiation. Candace Johnson (2014) also found this kind of dynamics in her research with Latin American immigrants and North American women in Canada and the USA. While the former ask for medicalized childbirth as a way of facing marginalization, the latter prefer midwifery as a way of resisting medicalization, which is incorporated in a process of differentiation that reinforces their privileged access to the healthcare system. She asserts:

> However, by resisting the medical regulation of a "natural" event, many Canadian-born women seem to have constructed identities that integrate the experience of pregnancy and childbirth into a social context that tends to separate them from other women, and in doing so have reinforced their privileged positions as persons in full control of their reproductive destinies. (Johnson, 2014, p. 32, 33, her quotations, emphasis added)

In Brazil, one can also view this process with a greater complexity: over-medicalization, including high rates of surgical birth, is an achieved claim by pregnant women from middle classes but not really as a political agenda, whereas natural birth, assisted by midwives, doulas, and "humanized" obstetricians, is usually demanded by upper- class women through a growing politicisation of motherhood. Outside this debate about less or more medical intervention in labour, there are poor women, who demand better access to family planning services, definitive contraception and non-violent births. They are motivated by fragmented but also collective movements, for whom, similar to Johnson's research participants, "there is no need to construct meaning or to integrate birthing experiences in their fragmented lives, as their own cultures (of origin) tend to embody these social goals" (Johnson, 2014, p. 33). For those women, it seems that the greater problem is lack of vacancies in hospitals, being abandoned by health professionals in the onset of vaginal births, and the lack of level III maternity hospitals for emergency care.

Along with this structural inequality, the apparent preference for surgery among Brazilian middle classes is related to a "culture of caesarean" fed by a general fear of vaginal birth (Barbosa et al, 2003), on which the precariousness of public services and the interest of private system operate. Abusive medical interventions contribute to this fear as well as the lack of adequate medical assistance for at-risk and/or peripheral parturients. One can assert that, for the majority, "choosing motherhood" includes choosing a "good" doctor and preventing life-risk situations related to birth, which leads to this "caesarean epidemic" and a general feeling of "surviving" childbirth. On another direction, to face this oppressive experience, without confronting structural inequalities, some women engage in maternalist movements such as the ones for natural childbirth, gaining attention in public spheres but not gathering this attention around historical demands on reproductive health such as adequate access to contraception and healthcare for abortion[52]. Both pathways – planned and non-prophylactic caesareans and planned natural birth – are not in fact opposed to each other, but can be related through contemporary injunctions of "chosen motherhood".

[52] It is important to notice that some acknowledged humanization activists are also clearly standing for legalization of abortion, although this relation are not done by the most prominent references of the movement. Besides, one can identify a conflict among humanization activists regarding abortion, an important part of them being clearly against it.

Besides, the research participants' approach to social movements based on scientific and psychologising ideologies of birth and parenting is not initially motivated by political activism but by this quest for living birth and motherhood as aesthetic experiences with a great intensity of primary presence. In this aim, and approaching humanization, privileged Brazilian women tend to keep the unpredictability of daily life out of the perceptive plan; they improve concentration in facing oppression over their own body fluidity, which is represented by obstetricians who work with a technocratic logic. Although it can be an agency over gender oppression, when meeting the moral rhetoric of decision of type of childbirth during prenatal care, these women find ethical norms for the ideal conditions to have this aesthetic experience, trapped by a "pedagogy of bodies" based on a "therapeutic culture"; still a culture that reinforces the privileged role of healthy behaviours as rational individualized choices (Moreau & Vinit, 2007). It produces a fundamental contradiction that reinforces class inequalities in the health system, while also weakening the potential of aesthetic experience, as suggested by Gumbrecht's analysis:

> É que as normas éticas fazem parte – e devem fazer – dos mundos cotidianos historicamente específicos, ao passo que já afirmamos que a experiência estética retira o seu fascínio (no sentido literal da expressão) do fato de oferecer momentos de intensidade que não podem fazer parte dos mundos cotidianos específicos. Portanto faz sentido dizer que a combinação da estética com a ética, ou seja, a projeção de normas éticas sobre os potenciais objetos da estética, levará inevitavelmente à erosão da intensidade potencial desses objetos. Dito de outro modo, adaptar a intensidade estética a requisitos éticos significa normalizá-la e até mesmo diluí-la. (Gumbrecht, 2010, p. 131)

Consequently, one should not conclude that ethical norms in childbirth assistance contradict the potentiality of primary experiences of presence with birth, on the contrary – ethical norms in this field should mainly target health workers such as obstetricians, building health organizations as ambiences that favour female body fluidity. Raquel intuited this conclusion, when wondering herself during interview: *"so, empowerment means giving women reassurance? Then I think it can be used as a feminine, as a maternal term"*. In her turn, Sofia had an experience of birth quite like that, in which "reassurance" from her private obstetrician and from the maternity staff was fundamental for an intense experience of presence with birth. Despite *"believing in humanized childbirth"*, Sofia recognized, during prenatal care, that *"fighting for it would be more an ideological obligation than actually a wish"*. Then, she searched for an obstetrician covered by her health insurance provider who agreed to wait for the spontaneous onset of labour and agreed to provide assistance from the staff of the maternity ward during labour, as well as some medical interventions such as an epidural. She reported:

> "**Finding an obstetrician who would do exactly what I wanted not how I believed it should be done was pretty good, because then I really started to enjoy my pregnancy without this obligation I imposed myself, an ideological obligation that I should have the birth in which I believed** (...) And it

> was quiterelaxed , because the obstetrician arrived with the anaesthetist who was also pretty nice; he was not chosen by me, the whole staff was from the hospital. I was pretty well assisted, and C also gave me a massage that helped me a lot. I could feel my contractions, so it was pretty easy to push, it ran very smoothly. It was fast, so at seven-thirty A was already being breastfed (...) **Ah it was amazing, it's something I miss the most, I miss my labour, I really enjoyed my labour, pretty much.**" (Sofia)

As Simone Diniz (2009) discusses, the Brazilian government has tried to promote WHO standards on perinatal care, issuing many laws to implement "humanized assistance" in SUS, struggling with practitioner representative bodies and women who keep asking for medicalized assistance for different reasons across classes. As the country does not face the contradictions of health privatization as a structural aspect, these governmental initiatives keep facing strong and diffuse resistances. From an organizational perspective, the humanization rhetoric , presented in the respective social movement and also in recent mechanisms of the Brazilian health system, seems to produce a paradigmatic transition in perinatal health, in the direction of most "situated analysis of behaviours" (Friedberg, 1993, p.39), however by this imperialist humanism. Friedberg (1993) proposes a perspective of "limited rationality", "less intentional" but also "pragmatic" view of human choice and action, in organizational studies, which can be useful in the contextualization of this paradigmatic transition in Brazil. Instead of fixing a model of an idealized organization to satisfy psychological and moral needs of certain humanization, one could observe the complexity of human beings in action, and prompting from there a politicisation of birth towards structural changes.

> Esta noção tem o mérito tanto de aceitar as multiplicidades das motivações que caracterizam as situações reais, como de restituir de algum modo aos indivíduos a sua autonomia face às suas próprias necessidades: voltam a ser activos, e por este facto, fundamentalmente imprevisíveis. (Friedberg, 1993, p. 42, 43)

III.2 EXPERIENCING BIRTH IN EUROPEAN SYSTEMS

The participants had diverse experiences with childbirth in the three European countries in focus. The similarity among those countries is the value assigned to vaginal birth, which is more or less medicalized depending on the role of midwives but also on the organizational logics of maternity facilities. Comparing the countries, the patients' paths through perinatal systems can be quite different. While in France they can be assisted in birth centres managed by midwives or in big institutions dominated by medicalization, in Sweden the pathway is quite similar for all participants, strongly marked by a midwifery-led logic. Portugal has a perinatal system somewhat close to the Brazilian type – as it presents a growing trend of privatization parallel to the growing rate of caesarean sections. Unlike the experiences of the majority of participants who lived in Brazil, one can say that the experiences lived by the partici-

pants who were in Europe reflect general trends of each country's perinatal care. Among those countries, politicisation of birth is less observed in the public agenda than it is in Brazil, however, they also present a more *naturalistic* childbirth rhetoric, sometimes related to the disputes between midwives and physicians, sometimes related to the right of having planned home births.

The following table shows the most important data of perinatal health, including medical procedures and system characteristics that expose medicalization, privatization and regionalization in Brazil, France, Portugal and Sweden:

TABLE II: PERINATAL DATA FROM BRAZIL, PORTUGAL, FRANCE AND SWEDEN

Perinatal health - data on medicalization. regionalization and privatization	Brazil	Portugal	France	Sweden
Maternal Mortality Rate (average 2006-2010)	72..6	12..2	9..1	3.1
Neonatal Mortality Rate 2010	11.2	1.6	2.3	1.6
Stillbirth Rate 2010	10.8	3.8	9.2	3.7
Births by caesarean % (2011 for Brazil / 2010 for Europe)	52.3	36.3	21	17
Caesarean without labour % (2011 Brazil / 2010 Europe)	34.1	NA	10.9	7.7
Episiotomy in vaginal births % (2011 Brazil / 2010 Europe)	53	72.9	26	6.6
Deliveries without obstetric interventions %	5	NA	NA	NA
Instrumental Vaginal Deliveries % (2010)	NA	14.5	12.1	9
Induced Deliveries % (2011 Brazil / 2010 Europe)	36.4	NA	22.7	13.1
Epidural Anaesthesia in vaginal births % (2011 Brazil / 2010 Europe)	33.9	NA	70	31.5
Use of non-Pharmacological Analgesia % (2011 Brazil / 2010 Europa)	26	NA	NA	3.1
Parturients who leaves the hospital in two days maximum %	NA	NA	4.8	73.8
Public expenditures in Health Systems % (2009-2013)	46.4	62.6	76.9	88.1
Hospitalized Births in Private Sector % (2011 Brazil / 2010 Europe)	20.1	12	28.2	NA
Hospitalized Births in Public Sector % (2011 Brazil / 2010 Europe)	79.9	88	71.9	NA
Caesarean Rate in Private Sector % (2011 Brazil / 2010 Europe)	88	67	24.5	NA

Levels of complexity (regionalization)	5	3	4	3

*Maternal mortality rate is per 100,000 live births; Neonatal Mortality and Stillbirth rates are per 1.000 live births.

**NA: no data was available.

***Sources: European Perinatal Health Report 2010 (Zeitlin et al, 2013); executive report "Inquérito Nascer no Brasil" (Leal, 2014); academic paper "Desigualdades sociais e satisfação das mulheres com o atendimento ao parto no Brasil: estudo nacional de base hospitalar" (D'Orsi et al, 2014); Enquete Nationale Perinatale (Blondel & Kermarrec, 2011); DREES' report "Les maternités en 2010: premiers résultats de l'enquête nationale périnatale" (Vilain, 2011); The Swedish Medical Birth Register 1973–2010 (OSS, 2012); Quality and Efficiency in Swedish Health Care - Regional Comparisions (SALAR, 2010); INE, PORDATA, DATASUS (Consulted online in various dates during 2014 and 2015); The World Bank Databank (Consulted online in various dates during 2015 and 2016).

When analysing the perinatal data of the four countries, one can observe that in Sweden, where regionalization occurred along with the expansion of midwifery and public funding for healthcare, the perinatal paradox is not so evident as in Brazil, Portugal, and (also present but less expressive) in France. In Sweden, most birth centres are nearby or inside level III maternity hospitals (most complex ones), favouring high vaginal births rates with few medical interventions but also better outcomes on stillbirths and neonatal mortality. In France, the universalization of perinatal care contributes to controlling the caesarean rates even in private institutions, but maintains high rates of hospitalization, instrumental deliveries and induced onset, commonly practiced in big institutions. In Portugal, during economic crises of late 2000s, under a strong pressure for rationalizing the public budget, governments concentrated the regionalization process in closing small maternity hospitals in peripheral regions and increasing the number of deliveries in level III maternity hospitals in the big cities (Matos, 2011). In those institutions, women have better access to emergencies whereas suffering more unnecessary medical interventions, such as routine episiotomy, which not considered beneficial by many scholars (Barros, 2013; Zeitlin et al, 2013). Therefore, one can assert that Sweden has controlled over-medicalization and privatization of perinatal health care while using a considerablyregionalized standard; France has a trend of over-medicalization but in control over some of its aspects such as surgical births, with regionalization but also discrete privatization; and Portugal has a regionalized system but threatened by evident over-medicalization and growing privatization of perinatal health.

According to regionalization, the "door" for public perinatal assistance in the four countries is generally integrated to the first level of health care, having general practitioners as important references. In Brazil and Portugal, this "door" can be played by obstetricians who are part of primary healthcare centres (including ESF in Brazilian case), but if in Portugal midwifery is present in over 50% of births, in Brazil this profession is quite limited to around 8% of deliveries (Victoria et al, 2011). In France and Sweden, prenatal care appointments can be accompanied by a physician, but always have midwives as co-

adjuvants or protagonists. Thus, in the last two countries, the ensuing steps inside maternity facilities are guided by the core role of those professionals, except when an at-risk pregnancy is diagnosed from the beginning – cases in which obstetricians play a central role and parturients have privileged access to level III maternity hospitals. As a general trend, perinatal private services work in a quite different logic, by which liberal obstetricians, private health insurances and clinics do not respect the principle of regionalization, whereas offering personalized assistance by doctors "chosen" by women. In those cases, the access for high technology is contradictory, having the majority of surgical births in level I or II maternity hospitals and motivated by economic reasons or for the doctor's personal convenience (HAS, 2012).

III.2.A GIVING BIRTH IN FRANCE: CHILDBIRTH AS A SOCIAL MATTER

The French documents analysed for this research emphasize the central role of midwives during prenatal consultations, labours and post-partum periods – they are present in about 80% of all vaginal births, and managed 55.8% of all childbirths in 2010, according to the European perinatal report (Zeitlin et al, 2013). Nonetheless it seems that the work of those professionals largely depends on the physicians' presence, since epidural analgesia, induced onset and instrumental labours have significantly increased in the last decade, but midwives' medical responsibilities have not. One can observe the increasing number of midwives engaged in maternity units including in private ones in the last years, but the number of medical specialists and childbirths in maternity wards with more than 3000 births per year rose equally (Zeitlin et al, 2013).

Besides, the hospitalization period ranges from 4 to 6 days in most cases, with no difference in the length between caesarean sections and vaginal births, because it is related to the effort of stimulating breastfeeding (Zeitlin et al, 2013). The role of supporting women to breastfeed belongs to midwives, but as the hospitalization rate suggests, it is conducted with a significantlymedicalized approach. In contraposition, one can observe that Sweden presents longer average breastfeeding time and higher rate of women who breastfeed in the early days compared to France, with only 2 days of hospitalization as dominant protocol. As some critics argue, although having great advances in reproductive rights the last 40 years, France still has a healthcare system that favours the physicians' moral conceptions on reproduction over women's autonomy (Winckler, 2013; Membrado, 2001). In this context, the concentration of births in big public institutions ruled by medicalized standards defies the possibility of childbirth being a personalized event, challenging the desire of some women in conciliating the access to high technology and attentive presences during labour. The participants of the research had different experiences in

French perinatal system, which can contribute to understanding this conciliation as an outcome of multiple and combined aspects.

In France, the autonomy of midwives is a matter of debate and dispute, since birth centres under the full responsibility of those professionals, like the *"Maisons de naissances",* are only allowed in some specific experimental programs attached to big maternity hospitals (CNSF, 2015). Beyond that, liberal midwives are not insured to attend planned home births. The difference that feeds this debate is not among caesareans and natural births, but mostly in the ways of managing labour pain without pharmacology and having fewer interventions during delivery and post-partum, to favour "physiologic" births[53] rather than vaginal ones (CNSF, 2015; Arnal, 2015). In this context, having access to a *"Maison de naissance"* contributed for Ana Lúcia, a research participant, to engage herself in an *"alternative"* parenting style, whereas also confronting Brazilian perinatal culture.

Ana Lúcia, a white mother, married to a Brazilian man, had childbirth in one of those facilities managed by midwives, and reported that the experience of prenatal care and delivery was determinant in her *"change of mentality"* regarding motherhood. She defends the movement for humanization of childbirth in Brazil as *"valid"* but emphasizes that *"what is needed is an entire change of the system with midwifery... the physicians must leave the pedestal"*. At this point, it is important to mention that in Portuguese language as in French, *"enfermeira obstétrica", "parteira"* and *"sage-femme"* are female words, do not having male correspondences, even if one can find few male practitioner[54]. In Ana Lúcia's narratives, this gendered way of talking about two different logics of birth assistance is quite clear, as in reporting physicians she used the male term *"médicos"*. Certainly, her analysis of the systems are embedded in the reality she experienced, however, one can also observe that in mentioning the ideal role of physicians she cites the *"technical part, when there is a problem [in childbirth]"* whereas midwives are *"prepared"* to do parturition. The preparation of midwives is not really conceived as *"technical"* as medical skills seems to be, since the value placed on their role is not dependent on scholarly background. Ana Lúcia explained:

> "For instance, when I lived in Brazil, with my friends and my family, I thought I was going to have a caesarean section, so I came here, the first thing that I found was that childbirth is through the vagina, right? Birth here is natural. **Then it broke me, because I had to adjust my mind to it, right? (...) I mean, for me it was like... it is like, you know Carol, it's like you had un identity, I think it**

[53] The definition of physiologic birth is also under dispute ; The College National de Sage-femmes with other representative institutions discussed this definition and defended the equivalence of physiologic birth to natural birth, which means « with few or no human intervention (...) respecting the rhythm and physiology of delivery » (CNSF, 2015, p. 9, free translation)

[54] In Portugal, but not in Brazil, the term « parteira » has been replaced by the male tense « Enfermeiro Obstetra » , as in Portuguese language the « neutral » adjectives and pronouns are usually in the male tense.

> **started to be deconstructed, somehow, by culture and by the way I had to adapt myself, like... really a mentality change** (...) I think everything is valid in that movement of obstetric violence, humanized childbirth, everything. But the problem, as I see it, would be a restructuring, a huge reform of the system, in a way that the doctor leaves the pedestal, right? That he would not be the main figure, and one could appreciate the nurses more, who are the midwives, the obstetric nurses (...) someone who has the right condition for doing the delivery, because that's it, it's a change... **redirecting roles, you know, letting the doctor be really occupied with the technical part if there is a problem, and the *sage-femme*, the nurse, with what she's prepared to do. I think the problem in Brazil is the lack of this other figure**. It's a quite important figure; we see here that it is a very respected profession in here." (Ana Lúcia)

Célia, married to a French-Portuguese man, mother of two children, one born in Brazil and another in France, did not have the same experience as Ana Lúcia with midwifery, however, the gendering aspect of perinatal care can be clearly observed in her narrative. She was assisted by a female obstetrician during prenatal care and by a male physician during labour in a maternity unity, preferring the presence of the latter rather than the former. Concerning the female obstetrician, she evaluated: *"she wasn't that attentive... she did not memorize my case"*. Besides, Célia did not like the idea of being assisted in childbirth by another obstetrician other than the one who already *"knew"* about her *"case"* during prenatal – which is usual in French system, as labour onset is commonly spontaneous. However, after being attended by a male obstetrician during delivery, one she had not met before, Célia reported feeling more confident: *"I don't know why... But I felt more confident when I saw it was a man attending my labour... Women, for me, look like a little more fragile. I was already kind of smelling a rat with her, then if it was her doing delivery, I would be left at the mercy..."* She liked the maternity care for childbirth, but afterwards Célia searched for a female gynaecologist because she did not feel comfortable with male physicians for this kind of assistance, and she finally found a *"good female doctor"* who was *"very kind, very attentive"*, emphasising her support for losing weight during the subsequent months after delivery.

Thus, according to Célia, female obstetricians seem to be more *"fragile"* and must be more *"attentive"* in giving parturients assurance. The culture of fear of vaginal birth seems dominant in the quest by some Brazilians for attentive assistance in perinatal health; however, this "attentiveness" can mean different things depending on the alternatives offered by the system, usually constructed under strong hegemonic representations of gender. For women who prioritize accessing medicalization, the male presence seems to reassure them more, regardless of the same criterion that is used to evaluate female practitioner, which is about affective presence, marked by temporal continuity of care. This hegemonic representation of gender differences is directly related to the binary culture *versus* nature and

reason *versus* moral affects, previously discussed, as technical capacity is associated to masculinity while moral affections is expected from female health workers.

Antonia, a white, heterosexual woman with a PhD in Engineering, married to a Brazilian man in France, also shared this concern with continuity of personalized care, but during prenatal care she deconstructed this expectation although still hoping to live intense experiences of presence with labour. She believed that switching between practitioners during prenatal was *"bizarre"*, but then she accepted that this was the way *"things work in hospitals here, by different shifts",* understanding that it was the condition to have a natural birth. She signalled that finally found out that *"there is no difference in terms of care",* the only difference is that *"you end up not creating a bond with them"*. Therefore, for Antonia, this gendered conception of "good assistance" on birth as dependent on *"bonding"* with a single professional, in which midwifery seem to play a core role, has changed during the process of prenatal, as she said:

> "Each month it was a different *sage-femme*. **So I discovered that there is no difference. The only difference is that you end up being assisted by different people, so you do not create a bond with them**. And none of the *sage-femmes* who I met during pregnancy was there during the birth. This was something I found pretty strange, but later, now, I got it... well, here it works like this, the hospital here is like this, it has different shifts, and I did wanted natural birth, and it's a lottery, if you find the person who assisted you during prenatal, it would be big luck." (Antonia)

The most important criteria for Antonia evaluating her experience with childbirth were basically two: the certainty of being *"well oriented"*, including the access to some courses about natural childbirth during prenatal care with all the information on medical proceedings that could be available in the maternity she was assisted, such as episiotomy and anaesthesia; and the physical ambiance in which she gave birth to her child, which was not like a *"surgical room as it usually is in Brazil"*. She also highlighted her husband's presence as important for this reassurance. For her, having a natural birth means being active in the process, by *"being there breathing, helping"*. Afterwards she signalled that she just cared about the sex of the infant only few moments later, emphasising that the important thing at that moment was the intensity of *"having the child"* on her arms, *"enjoying"* her family without the presence of the maternity staff:

> "Labour itself? It was long, it was moving... I don't know what else to say... it was moving. **And until we entered the delivery room it was long, but once we were there, I was sure that I was being well guided, everything they did they explained to me, and my husband was by my side ... so, that's a lot of emotion for a short time**, so I don't know if you understand what I'm talking about. And it was natural, then I stood there breathing, participating, and my husband was helping, and there was still one thing, because I didn't know the sex, I didn't want to know the sex, and in natural birth since the baby is born it's placed in the mother's breast, so the first contact is with the mother, and even the environment has no lights. It's not like in Brazil, as in the surgery rooms, it's not a

> surgical room, because as it was a normal birth, it actually happens at an intermediate room, where there are some instruments but it's not an operating room... **So, once I had that child in my arms, just with me, only then did it crossed my mind to see what it was, to see his sex, because while he was there I was enjoying him and welcoming him** (...) that's pretty nice, because after he was born, they left us three in that room... by ourselves, until we went to our room." (Antonia)

Thus, Antonia had an important experience of presence with childbirth, mostly propitiated by the maternity environment – not dependent on a personalized assistance but on a familiar ambience in which she trusted. For her, it was the continuity and coherence of the institution rather than the continuity of personal providers and the affective bonding with them which favoured this experience. Also, the core role of accessing information during prenatal care to the consolidation of this assurance was not related to a scientific rhetoric but to contextualized information about natural birth and the available resources that the institution could offer. She was not confronted with a dichotomy between medicalized and non-medicalized birth, but had the opportunity to choose and understand some of the usual medical proceedings that can be used for perinatal care.

Nevertheless, usually, in France, a general concern with "perfect babies", as discussed in the previous part of the thesis, seems to produce an intense race to level III maternity hospitals and to medical tests during the prenatal period, stimulated by liberal maternity physicians. For instance, Antonia was surprised with the liberal obstetrician's recommendation to her trying a vacancy in four different hospitals in the very beginning of pregnancy. As the first three did not have vacancy when she contacted them, Antonia *"panicked".* She also thought the first consultation with the hospital's obstetrician quite *"bizarre"*, because it was conducted by an authoritative and strict protocol focused on medical tests. She said:

> "When I went to my gynaecologist she recommended a few hospitals, and when we went to see the hospitals, trying to schedule an appointment, to see if it would be possible... **Among the four hospitals she recommended, the first three did not have vacancy! And I was at one and a half month due... so I panicked! So, this was the first stress because in Brazil the usual way is to having baby in the hospital where your physician works. You don't think too much...** and another strange thing happened when I went to my first appointment in the hospital, as I took all my medical tests, but the doctor who assisted me said that a test was missing and such, she was really stressed, and told me that it would be the last time I would see her since the next meetings should be with the *sage-femmes*." (Antonia)

This acute concern with prenatal medical exams among obstetricians can be related to one of the major problems found by the French reports about perinatal health: the high rate of stillbirths (9.2 – quite close to the Brazilian rate which is 10.6) and the persistency of avoidable maternal deaths. Despite the low rate of maternal mortality (9.1), a medical committee in charge of the investigation of its causes concluded that 50% of maternal deaths in the period of 2001 to 2006 were avoidable (Crepin & Breart,

2010). The rate of stillbirths is harder to evaluate because the country is one of the few in Europe which does not have a medical registration of the gestational age and the causes of foetus deaths for all pregnancies longer than 22 weeks, although it presents the highest rate in Europe since 2003 (Euro Peristat & Inserm, 2013). A hypothesis suggested by Zeitlin and colleagues (2013) is that almost 50% of stillbirths are due to medical abortions, probably motivated by a strong policy for active investigation of malformations (Euro Peristat & Inserm, 2013; Weber et al, 2008; Membrado, 2001). Most European countries differentiate the data of medical abortions and stillbirths; therefore, in 2013, the French program for medical information committed to unertake the same procedure.

The fear of not being granted access to high technology for attending an emergency was recurrent in many participants' narratives. In some cases this fear was followed by the discomfort with the *"lack of human side"* (Natalia) in hospitals even when they were assisted by midwives. Natalia, a brown woman and University professor, married to a French man, reported:

> "Delivery itself was great! The complicated thing was to stay in the maternity ward, which is that story... I had chosen it because it was a big maternity hospital, my parents are doctors, **then, as I wasn't in Brazil I wanted to have this security... that I could have all the resources in case of a problem. But in the end the problem was not the lack of resources but the lack of the human aspect of a medical relationship**, right? It is the story of... you enter the hospital, you go into the mass grave, is treated as whatever... considering that it's a quite important time to your life, it's your first child, you don't know what's going to happen, you're insecure." (Natalia)

Natalia added a criticism on the social inequality in French health system to her observation on the hospitalized assistance, as she asserted that the disrespect she felt during her stay in the institution was based on the fact that it was located in a *"popular neighbourhood"*. Observing the way a black woman was threatened by the maternity's staff, she realized that this "dehumanization" is related to strict medical protocols but also to power imbalances among practitioner and parturients, which produces a hierarchizing way of health workers communicate to women. She said:

> "And the maternity was in a popular neighbourhood, **and there were a lot of poorer women, and there they were even treated just like cattle, like what happened to me during my stay there. I had to lose my temper to find and see a professional.** Because you get there, nobody explains the procedure, they don't explain anything, you wait 48 hours, you're not consulted, people don't expect you to give your opinion about what's going to happen or not (...)At that moment there was another lady by my side, in the room with me, who was there to be consulted, she was abandoned there for two days the poor lady, no one would see her, nobody was saying anything to take care of her, a terrible thing... a black lady. And then when the midwife left the room she said: 'that's it: they treat us just like cattle'. Then you realize that the people's perception, even the least favoured one, is no different, she just doesn't have the same way of expressing, right? She just does not have the sufficient resources to be able to oppose a medical opinion... a system, a medical Protocol, to stand up for herself as a person." (Natalia)

The French report on perinatal health presents a clear concern with social inequality, because, beyond the usual epidemiological indicators and lifestyle determinants such as smoking habits and obesity, it includes income rates, women's employability before and after pregnancy, individual inclusion in the social security system, type of job and educational background, and the parents' socioeconomic status (Blondel & Kermarrek, 2011). The authors concluded that the occupational rate of pregnant women in the country is high, close to the rate of all French women at the age of 25 to 34 years. Also, the educational level of those mothers increased significantly since 2003, whereas the percentage of parturients who declared themselves stay-at-home mothers decreased 10% in the last 7 years – which is analysed as a positive outcome. The document dedicates many paragraphs in discussing these socio-demographic data, referring to other statistic researches with national representativeness. It shows how the perinatal system is open to dialoguing with social policy, presuming that mothers have to be present not only in private but also in public spheres. In this context, childbirth is evaluated as a medical event but within a broader concern on the social context of births, which seems an innovative way of confronting the system's problems; yet, it can be viewed with a certain discriminatory perspective.

As Natalia perceived in the maternity in which she had her delivery experience, midwives and physicians do not seem to consider poorer and immigrant patients as equipped with the same capacity to understand and communicate about the service and the labour process. One can observe certain misconduct towards those women, which was not on focus by the national report but was object of a specific guideline by the *"Commission nationale de la naissance et de la santé de l'enfant"* (CNNSE) in 2014, based on the results published by Blondel and Kermarrek (2011) and the Euro Peristat Project (Zeitlin et al, 2013). In the national report, Béatrice Blondel and Morgane Kermarrek (2011) asserted that women without any financial resources or with resources exclusively from welfare system live in a context that "represents an important risk factor to pregnancy outcomes" (p. 38, free translation). Among those women, 30% are immigrants and 16% are single – with no partner. They also attend much less prenatal consultations than the others and have more health problems that demand hospitalization. Facing this context, with the rhetoric of risk, the CNNSE's report argues that its objective is to persuade perinatal professionals about the different mechanisms they can use to assist pregnancy among women in precarious situation or in vulnerability, "aiming to prevent adverse effects in children" (CNNSE, 2014, p.4, free translation). Thus, in the effort of convincing perinatal workers to better assure adequate assistance to those women , the report appeals to the child-centred approach, not exactly to a rights-based approach – despite of also mentioning "parturients' common rights" and the goal of avoiding maternal morbidity and mortality (p. 4):

> Le présent guide a pour objet de faire connaître aux professionnels de la périnatalité les différents dispositifs afin de les aider à assurer un suivi de la grossesse, un accompagnement et une qualité de prise en charge de droit commun aux femmes enceintes en situation de précarité ou de vulnérabilité, de façon à prévenir les effets néfastes chez l'enfant. (CNNSE, 2014, p. 4, emphasis added)

Finally, the French reports cite over-medicalization in the perinatal system, but only related to the elevating rate of echography exams and medical consultations during pregnancy. The high rates of episiotomy, induced labours, pharmacological anaesthesia and caesareans (stable but 6% higher than WHO's recommendation) are not specified as part of this phenomenon. Even so, there is an evident and successful effort in diminishing episiotomy rates among primiparous women (Blondel & Kermarrec, 2011). The access to epidural anaesthesia during labour is evaluated as a general benefit to women, and the report on the maternity services remarks the inequality between units regarding the access to the technology of self-administration (Vilain, 2011). It seems interesting to note that the report analyses this data: while 58% of facilities announce that Patient Controlled Epidural Anaesthesia (PCEA) is available in their services, only 36% of women who had an epidural reported having it (Vilain, 2011). Thus in the reports, pain relief in childbirth is faced as a woman's right, having pharmacological relief as the main option and self-administration as an important option for favouring parturients' participation on the decision and use of this resource.

However, one of the participants of this research, Eliane, a black woman and English teacher, married to a French man, had quite a difficult experience with pregnancy and childbirth in a small city in the countryside. She discovered she was pregnant after 4 months of gestation, during a period in which she was taking pharmacological contraception and undergoing treatment for polycystic ovarian syndrome. She was first assisted by the liberal gynaecologist with whom she had the treatment and then was accompanied by midwives in a public maternity. In addition to facing *"late discovery of pregnancy"*, Eliane suffered a premature childbirth that was extremely painful and stressful, without access to epidural anaesthesia. She had attended some classes about natural childbirth in the maternity and wished to not ask for pharmacological analgesia during labour because in those courses she learned that natural childbirth would be free of medical interventions. However, at the moment of birth she was not feeling *"emotionally prepared"* and felt a *"very intense pain"* that *"disturbed the labour"* and caused her to be on the verge of *"fainting"*. Nevertheless, when Eliane asked for an epidural, the midwives who were present told her that the only anaesthetist in the institution was busy with another parturient. Thus, as one can observe, Eliane was not respected in her right of having access to epidural. Still, during our conversation, she did not complain about the maternity ward's assistance; instead, she felt guilty for not noticing she was pregnant early on and, because of that, being so nervous during labour. She reported:

> "**As she came earlier, I wasn't emotionally prepared, so I was very nervous and I didn't have my epidural. So, it was a pretty stressful labour, let's just say...** I felt so much pain, which was also connected to my emotional state, because I wasn't ready for that (...) because the anaesthetist was accompanying another mother who was having a complicated delivery, and they told me that he had to stay there with her in case there was a complication (...) **before I'd thought of having a natural birth, without anaesthesia, only the pain I felt was so intense that it messed up my childbirth, I nearly fainted, lost control of what was going on.** I remember that I just came back to me when the nurse held my arm and spoke my name and said 'Eliane, stop pushing otherwise you'll hurt your baby' (...) even if they talked about pain as a natural help for the baby to be born, in the preparation classes, even saying it was a natural part of the birth... first of all, my labour had already took too long, I was feeling pain for quite some time, and I'd reached my limits." (Eliane)

Therefore, one can associate Eliane's story to Merleau-Ponty's assertion about the bodily comprehension that surpasses reflectiveness, since learning to give birth is not something one can do exclusively by an intellectual effort, but it is an experience propitiated by the integral situation of the parturients' embodiment. Classes during the prenatal period are important, especially for informing women of their rights and of the resources available in the maternity where they intend to give birth; however, when those classes are only focused on pain self-management, through a liberal rhetoric of re-signifying pain as a way to being *"empowered", "natural", "prepared"* for childbirth, they contribute to blame women when they do not have the idealized labour. This way of preparing women to labour pain, quite frequent in France, reinforces the injunction for mothers to call attention to their own bodies as objects as if they could control their experiences merely with intellectual determination. When women assume the moral disposition for experiencing labour pain because of the information they learn in the prenatal period, this process does not correspond to the bodily intentionality discussed by feminist phenomenologists such as Young (2005) and Stoller (2009). Because the own-body concept "opposes the reflexive movement which releases the object from the subject and the subject from the object and (...) gives us that thought of the body or the body as an idea and not the experience of the body or the body in reality" (Merleau-Ponty, 1945, p. 250, free translation).

Only 2 of the participants in France underwent caesarean sections. One had an emergency surgery after labour (Isabely) and another had a planned surgery because the foetus was in breech position (Marcela). Isabely, a white woman with a PhD in Economics, married to a French man, reported that she loves midwives mostly because of their support in breastfeeding rather than in labour assistance. She suffered through 48 hours of painful labour before undergoing the caesarean, asserting that it was a bad experience because in France, *"caesareans are considered absurd, so nobody prepares you for it".* After that, *"breastfeeding became a matter of honour"* (Isabely).

In her turn, Marcela, a brown woman and English and Physical Education teacher, married to a French-English man, did not pursue the usual path in the French perinatal system. She avoided French physicians as much as she could because she found them *"impersonal and cold"* and only had access to midwives in the class of preparation for childbirth because she *"strongly associated vaginal birth to being a mother"*. She wanted to give birth in Brazil, surrounded by her compatriot friends and relatives, having a very difficult process of integration in the new country as a pregnant woman and mother. She reported the conflicting values of childbearing with the husband, signalling she was cared a great deal while he seemed *"disconnected"*. He also discouraged her to have public health assistance or enrolling the child in a public *crèche*. Thus, trying to conciliate her expectations with pregnancy and delivery whereas confronting the feeling of being "the other" as a Brazilian woman, Marcela wanted to have the same personalized assistance as the Brazilian private system in France, though desiring a vaginal birth. Finally, she had prenatal and delivery with the same obstetrician in a private clinic, where she felt *"well cared for"*.

The private clinics in France are mostly small and deprived of intensive care units, but their caesarean rates were significantly higher than the public maternity hospitals in 2007 according to the FHF's study (FHF, 2008). Inversely, this study has shown that, in the public sector, caesarean rates are higher in level II and III maternity hospitals, which are better prepared to attend at-risk births. The report also indicates that in the private sector the medical decision to conduct a caesarean usually does not rely on perinatal risk assessment, but on the financial benefit, since the hospitalization for the surgery is longer and more expensive, and also it can rely on the convenience to choose the date and the exact professional who will be present at birth. However the privatization of perinatal system has been well controlled in France, since the number of childbirths in the public maternity hospitals rose from 2003 to 2010, proportionally decreasing in private ones (Blodel & Kermarrek, 2011). Aline, a white and heterosexual psychologist working in a public facility, spent labour onset in a level I private clinic covered by a complementary health insurance provider, but was transferred to a large public maternity ward when she suffered complications during labour. There, she gave birth normally and was quite satisfied with the assistance.

In conclusion, the French contemporary context shows that the dispute among midwives and physicians in obstetrics seems to be related to labour pain management rather than surgical birth, which can be accompanied by a de-contextualization of women's embodiment and an unequal access to medical resources such as the epidural. Strict protocols and discriminations against immigrants and racialized women can also be present, even when the protagonists of perinatal care are midwives, who usually

work in less hierarchizing relationships with patients. On the other hand, the interest of French perinatal inquiries on the social and economic status of parents shows a broader conception of parenting and motherhood than the one presented by Brazilian researchers, including the public sphere as an important environment of mothers' experiences. The reinforcement of public sector and social security system, if accompanied by a rhetoric of perinatal health as women's rights, involving health workers in the guarantee of those rights, can be a major factor for controlling the privatization of motherhood. This approach can also favour parturients' experiences of presence with childbirth, guaranteed through institutional, not personal, references.

III.2.B NEGOTIATING DELIVERY IN PORTUGAL: BETWEEN RIGHTS AND INFORMALITY

In Portugal, the lack of detailed data on the medical proceedings during labour defies the comparison of over-medicalization *vis-à-vis* the other countries, despite the evidence of high caesarean and episiotomy rates. In this country there is not a recent national inquiry on perinatal health (Barros, 2013). However, there is an increasing concern on the vulgarization of those proceedings, as can be read in specific documents, such as the public consensus led by the National Association of Midwifes (APEO – Associação Portuguesa de Enfermeiros Obstetras), signed by the National Board of Nurses (OE – Ordem dos Enfermeiros) and supported by the General Social Security Department (DGSS – Direção-Geral da Segurança Social) in 2010. Also, in the same year, the Ministry of Health declared the government's commitment to decrease the caesarean rate from 34% to 20%, assuming a general concern with the cost and risks of surgical births (Barros, 2013). Therefore, in that country, the great improvements in maternal and neonatal mortality rates coexist with the increase of caesarean sections, high rates of instrumental deliveries and episiotomy, which are among the highest in Europe (Zeitlin et al, 2013).

The former Ministry of Health celebrated the fact that, in 2006, Portugal presented the best evolution on infant mortality rate in Europe, according to the OECD report (CNSMN, 2007). Since then, the country did not take a much more detailed evaluation of medical proceedings during pregnancies and labours, but published an important report conducted by the regulatory agency on the characterization of private maternity hospitals (ERS, 2008). The report affirms that these institutions offer assistance of satisfactory quality, but shows that the increasing caesarean rates in the country is mainly due to the private sector – since some of its facilities presented more than 80% of childbirths performed by caesarean sections in 2007. In fact, after the intense regionalization process of the perinatal system during the final 1990s and the subsequent shutdown of the smallest public maternity hospitals, Portugal witnesses the erection and expansion of the private sector in perinatal care.

According to the European Peristat report, nowadays, there are more births in high complexity hospitals in Portugal, created as references for at-risk pregnancies, than in moderate complexity hospitals – which has increased the expenditure of the system and has produced a growing over-medicalization of childbirth (Zeitlin et al, 2013). This structural change was accompanied by popular manifestations, with local communities and professional representatives such as the nurse and fire-fighter organizations (Matos, 2011; DGSS/APEO/OE, 2010), mostly in small cities where the referred maternity centresended up in another ward. According to INE database, from 2005 to 2008 the number of births that occurred during transportation and the number of children born without any assistance increased tenfold (INE, 2014; 2015), which was probably motivated by longer distances between residences and reference hospitals. During that period, in which regional maternity centers were closed, people called for closer and identitarian services to childbirth but were not really attended by the public sector (Matos, 2011).

In this context, privileged access to planned caesarean in the private sector with most personalized assistance becomes a convenient resource for middle and upper-class women in avoiding the risk of giving birth in traffic or having invasive experiences of labour in big hospitals. When pregnancy is accompanied by an intense fear of vaginal birth and labour pain, this outcome is even more expected. As already mentioned in the previous part of the thesis, Helena, a white, heterosexual mother, married to a Portuguese man, had a very stressful experience with pregnancy and childbirth, mostly because she suffered a miscarriage before but also due to *"fear of death"*. For her, the bodily changes related to pregnancy were frightening and were not integrated in an expectation of presence with childbirth. At the 40th week of gestation, Helena asked her private obstetrician, who also worked in a public maternity, to have a caesarean surgery, because her fear was increasingly intensifying. The obstetrician *"talked"* with the rest of the health team in the public maternity in which Helena intended to give birth, and the staff agreed with the decision. Everything went well and she became pretty satisfied with the assistance, but afterwards felt guilty for being so nervous about birth.

> "And then I started looking for a gynaecologist-obstetrician to accompany me, and I did prenatal care in the private system, **I was accompanied by a gynaecologist-obstetrician the way I wanted but I had the baby in the public system** (...)So, when I decided to choose my gynaecologist I researched and everything. And then I heard that she was head of Department at the hospital São João, the public hospital where I had the baby. So I chose her for that, because I talked to her and she was able to assist me there as well. She was the one who did my delivery. (...) **Then I had had nine months of so much stress, everything was quite stressful, so delivery, no wonder, wasn't different, everything was pretty complicated because I was complicated.** My doctor accepted, she talked to her colleagues that she would do my delivery through a caesarean, because I was reaching 40 weeks pregnant, and I was not having spontaneous labour onset, so I was even more stressed. Because I was afraid, as natural birth has this aspect... there, in Brazil, most births are

> caesarean, and here it is mostly natural birth. As I had already had a caesarean, I was so afraid of natural birth, and because I reached 40 weeks pregnant and no onset, she decided to do a caesarean (...) I was quite nervous at the time of getting anaesthesia, and all the staff was pretty tense, but at the end everything went fine. **My doctor was there with me trying to calm me down, but I think that, in general, the delivery was a little tense**." (Helena)

It is important to mention that Helena is a middle-class woman originally from a city in the Northeast of Brazil, where maternal mortality is significantly higher than Southeastern and Southern regions. There, she had already undergone a surgical birth with her first child, with private assistance, which intensified her distress regarding the possibility of having a vaginal birth in Portugal. Thus, she conciliated the first experience with pregnancy to the newest one, in appealing to a mixed assistance between public and private sectors, having the continuity of provider during prenatal care and childbirth as a fundamental reference. Therefore, considering Helena's situated experience, the opportunity of choosing caesarean with the support of health professionals instead of waiting for spontaneous onset of delivery at the 40th week of gestation was quite important. However, one could question if not having an institutional reference for prenatal care, but having a personalized attachment to the health system from the presence of her physician, did not hinder her reassurance regarding vaginal childbirth. Barros (2013) emphasises the need of Portuguese institutions to improve their mechanisms in reassuring women and diminishing fear of birth in the country – the main psychological aspect related to non-prophylactic caesareans. Even so, Helena reported that she was amazed with the quality of public assistance and the attentive presence of nurses during and after labour, which contributed to her positive experience with breastfeeding afterwards. She said:

> "Here the public system is much better than in Brazil. **The staff was really prepared, I felt very safe in the hospital. The nurses were also quite thoughtful, clarifying any doubt, always present.** It went very smoothly, even the physical structure of the hospital, everything very well structured... it was great (...) after childbirth, they gave me my baby and I've been told if I wanted to breastfeed. I said yes, so they put my baby to breastfeed. So I left the surgery room with my baby and went to the bedroom. So from the first moment she has been breastfed." (Helena)

Virginia also feared vaginal birth, but for a different reason – she was afraid of being subjected to forceps use, ventouse and birth induction, which are common proceedings for vaginal deliveries in the country. When sharing her feelings with a nurse of the public health centre, this professional told Virginia that those instruments were common and it was not a problem because *"complications always happen"*. Then, she advised her to attend a preparatory class for vaginal birth in a public maternity centre. While Virginia attended this class, she also searched for a private obstetrician with whom she could *"negotiate"* childbirth, however, when she reported her feelings about instrumental deliveries, the doctor said: *"you, Brazilians, do not want to feel pain. If you want to schedule a caesarean, I can recom-*

mend you one of my colleagues who does it, but if the baby is on the right position, we try vaginal delivery, we can induce it". Virginia did not like the approach of this doctor because she did want to have a normal birth, however, she did not think that induced deliveries are *"normal"*; she was afraid of the possible risks for her health and the baby's, saying:

> "**I think childbirth must be negotiated between the practitioners and the mother, because they will not take responsibility if something happens to the child**. If there is any sequel, it is the mother who has to deal with it. So I wanted to negotiate the type of delivery, but here it is not like that. (...) People spend three, four days in the hospital, waiting for an induced vaginal birth. I don't think it is normal (...) I am a nutritionist, so I have a sense of Anatomy, and I know that this type of delivery can cause urinary incontinence and can damage the baby's head, even if it's temporary, I didn't want to go through that kind of transition... I didn't want that kind of risk". (Virginia)

Then, Virginia continued getting prenatal care in the public health facility, quite anxious about the birth. At the end, she suffered a caesarean at the 4th week of gestation, in the public maternity, because the foetus was in breech position. She did not wait for spontaneous onset; it was a planned caesarean scheduled in the shift of a known doctor – because he was recommended by her husband's family. She asserted that the experience *"ran quite smoothly"* and was positively surprised by the good assistance in the public system, with the only exception of this *"vaginal birth obligation"*. Like for many Brazilian women, for Virginia, surgical birth was a better alternative to instrumental delivery in the lack of opportunity to have a normal birth without such interventions.

One can observe that for both Helena and Virginia the symbolism of risk in childbirth did not include the ones related to the caesarean surgery – which is also quite present in Brazilian birth culture. As asserted by Felismina Mendes (2002), the experience of risk depends upon culture and subjective boundaries. For this author, contemporary societies present a constant pressure to people being as sure as possible about the future, which contradicts transitional experiences, as this kind of experience has an implicit uncertainness.

> Perante todas estas categorias, pode dizer-se que em todos os aspectos da nossa vida diária, pelo que fazemos ou não fazemos, estamos sempre, de uma forma ou de outra, em risco. Porém, a forma como quotidianamente vivemos as nossas vidas, como nos distinguimos dos outros, como percebemos e experienciamos o nosso corpo, como gastamos o nosso dinheiro e como escolhemos viver e trabalhar, depende, não do facto de estarmos em risco, mas sim do facto de nos sentirmos em risco. Ou seja, é o nosso conhecimento sobre o risco que vai modelar os vários aspectos da nossa subjectividade e marcar decisivamente as concepções de risco que elaboramos e que irão guiar o nosso quotidiano. No fundo, o que está sempre em causa é o conhecimento do risco e sobre o risco, que é sistematicamente construído e reconstruído pelos peritos e que quotidianamente é construído e reconstruído por cada um de nós (Mendes, 2002, p. 57, 58)

Maria da Luz Barros (2013) also identified that the vulgarization of medical interventions in childbirth in Portugal ended up in associating a great complexity to vaginal delivery, including unpredictability and

lack of control, whereas the risks of caesarean are not diffused. Yet, it is interesting to note that the same rhetoric of risk that is used to convincing women to not have non-prophylactic caesarean reinforces this general pressure for predicting future. Besides, if the rhetoric of risk would not be sufficient to convince women to choose normal delivery, re-signifying pain as an experience of presence in a society of strong preponderance of a "culture of meaning" (Gumbrecht, 2009) is a common strategy of the movements for natural childbirth – as the movement for humanization. Mendes asserts that "our constant effort to control the future (...) forces us to ask for new ways of living with uncertainty" (2002, p. 55, free translation).

However, the experience of pain was not included in Virginia's narratives as a necessary condition to have childbirth nor as a way of "living with uncertainty" – even if she did not consider instrumental delivery "normal" she did not mention natural childbirth as a goal. Neither the normal labour pain nor any other painful and *"traumatizing"* proceedings were included in her expectations of transition with birth – which brought her to a confrontation with the perinatal workers in private and public facilities. In telling the experience with caesarean surgery, she reported that epidural did not prevent her from feeling the *"cut"*, which she immediately reported to the physicians in charge. They *"tested"* her sensitivity and proceeded to a general anaesthesia with her consent. From Virginia's perspective, being *"knocked out"* during her childbirth was better because she did not have the company of her husband inside the room and did not like the idea of listening to the practitioners' conversation during surgery. She preferred be "absent" during the birth of her child; which did not impede her to be present some moments later and starting to breastfeed while she was still in the maternity facility. Breastfeeding was initially painful, but she had the moral disposition to put up with the pain for *"achieving breastfeeding"*. Therefore, for Virginia, the caesarean was just a "necessary" procedure in avoiding the risk of *"trauma"* with vaginal delivery in Portugal, it was not a personalized event which could integrate birth in her life-meaning and did not create a contradiction to her experience of presence with motherhood in the subsequent events. She reported:

> "**When I did the epidural, when the doctor said he was going to start to cut, I felt it. I don't know if it's psychological, but I felt pain when they started cutting my belly, then I screamed and said, 'I'm feeling it!'** But then they told me 'no, but it's because you know we're cutting, you will feel the movements, but you won't feel pain'. But I said 'no, I'm in pain, yes I do!' And that's it, they waited some more time, did test with sprays, but I was still really feeling it. **And then the doctor chose to make a general anaesthesia. And for me it was very calm, I had no reason to complain, because I had already gone through other surgeries with local anaesthesia and I kept hearing doctors saying 'give me the scissors, scalpel'. So for me, it's better this way, to be off.** It was not his intention, but as they wouldn't let my husband in or watch the surgery, either... They let this happens only in natural childbirth. You cannot enter, there is no such thing as taking pictures and all that, as we have in Brazil, which is almost a Carnival, huh? (...)I really enjoyed breastfeeding, really it was the

> best thing, I found it fantastic! I really wanted to be able to breastfeed. From the beginning, as natural, in the first few weeks, I had the nipples cracked a little bit but did not bleed, but I was getting ready since pregnancy, right? I felt a little pain at first, but then it ran quite smoothly." (Virginia)

For Francine, childbirth was meaningful because it was devoid of pain. It was integrated in her experience with the transition to motherhood, bringing new habits for the subsequent months – as the habit of participating in a virtual community on the subject of normal delivery. Francine is a white mother, married to a Portuguese man, and discovered she was pregnant at 3 months of gestation during a treatment for ovarian polycystic syndrome, similarly to Eliane. She reported that she had *"always wanted to be a mother"*; however, at that period she was convinced that her health condition would be an impediment. For her, preparatory classes on childbirth were extremely important for diminishing her fears regarding the labour pains, because with this preparation she realized that getting an epidural was a right. And as a right, she stood for it, including in the conversations with Brazilians who live in Brazil and do not have easy access to the procedure in SUS. The possibility of giving birth normally with epidural anaesthesia was crucial for changing of her mind about performing a caesarean section in Brazil.

> "Then I discovered it [pregnancy], I started doing prenatal in a hurry, right? Taking vitamins, all these things, **preparing myself for delivery, which is pretty important because I was very scared about labour. I even considered going to Brazil to have a C-section, but then I discovered that here I could not feel pain during labour, and I could have like twenty children!** I do not regret having had a normal delivery, because it was the only choice, if it's inside it has to leave, right? And I'm not in Brazil to have a caesarean. I had an epidural... There is this controversy in BabyCenter because they say that in SUS they do not apply epidural. Only by Brazilian law it is a pregnant woman's right, but SUS does not want to apply it, just because they don't want to! Only they are paid for that. I had an epidural, at three centimetres dilated, and I spent all day without pain, preparing myself for birth, closed my eyes and it happened... all in a public hospital." (Francine)

The rhetoric of risk did not have much impact in Francine's experience, nor the continuity of provider during prenatal and childbirth. Having a positive experience with public facilities, however, was quite important. This was the hook for her transition among Brazilian and Portuguese perinatal cultures. In this context, a rights-based approach seems much more efficient in improving women's confidence and decision to vaginal birth than an appeal to evidence-based information. She reported:

> "Follow-up here is at the health centre. You get prenatal care there. Only, since my family doctor was kind of crazy, she sent me to the hospital saying that my pregnancy was at risk, but **when I got there, the doctor said that my pregnancy was not at all risky, that the other doctor was crazy, but he would assist me anyway because he liked my guts.** And then he supervised my whole pregnancy, he did not do my birth because he was on vacation, but it was not a problem because the team that assisted me was very competent, and there was no problem." (Francine)

As one can observe in these stories, Portuguese perinatal system has standardized protocols with a *universalistic* perspective, whereas also favouring informal rules and networks as important determinants. As the late regionalization process contradicted local communities' involvement in childbirth, in

closing small maternity wards and redirecting parturients for big maternity wards in near cities, it favoured a parallel privatization of the system. This privatization occurs not only by the procurement of private institutions by the public administration (Romoaldo, 2005), but also through informality. Similar to what happens in the Brazilian mixed system, Portuguese health professionals have been encouraged by this unpredicted process to play a contradictory role in perinatal assistance, especially when assisting Brazilian immigrants who fear vaginal childbirth. As discussed by Brown (1978), a rationalist paradigm of organizations is not capable of comprehending these "informal rules of irrelevance" (irrelevant in the managers' eyes) that indeed have the potential of gradually restructuring the organization. However, a phenomenological paradigm can illuminate the complexity in which organizations work. This way, some paradigmatic aspects of health systems can be transformed during the same process of implementing its rules without being noticed by policy managers – the problem here is universalization of perinatal health, as a right, to be gradually surpassed by privatization.

> In putting the official rules of relevance into practice, there emerges a set of unofficial, inarticulate "rules of irrelevance" by which information entering the official organizing frame is screened and manipulated. This can be stated simply by the dictum that input limits output, adding that those responsible for the output or production of decisions rarely have full control of the paradigm in use that restricts the formulation of their options. (Brown, 1978, p. 377, his quotations)

The Portuguese primary health care is centred in family health and standardised life cycles, with a great emphasis on community life (Reiz et al, 2011), but does not fully consider women's autonomy and need to choose their contraception, mode and place of delivery (Remoaldo, 2005). The country achieved enormous progress in child and maternal health, made important investments in the sector in the lasts 30 years, but has the great challenge of controlling medical expenditures without penalizing citizens. Therefore, it is surprising that Portugal has not accompanied the evolution of some important indicators on perinatal health and does not have perinatal reports with robust demographic data, since the country is also facing a recent economic crisis that can compromise the achievements from the last decades.

Paula Cristina Remoaldo (2005) asserted that the greatest challenge for the Portuguese health system in the late 21st Century is the "humanization" of care, which, according to her, needs to be faced not only as a "mentality changing" process but as an objective of the public policy itself. For "humanizing" the perinatal system, it would be crucial to change the strong hierarchy between obstetricians and women. However, she asserts that "an *economicist* spirit" has contributed to the shutting down of many maternity services, along with a restrictive employment policy of physicians, which inhibits these changes (Remoaldo, 2005, p. 556). From the stories here analysed, I understand that improvements

on women's rights-based approach along with the presence of midwives and public maternity hospitals in prenatal assistance may favour positive experiences with childbirth while strengthening the universalization paradigm. Midwives' representatives do not use the rhetoric of humanization in the same way as the movement for natural childbirth in Brazil, but they do assert the need for restructuring some systematic problems related to the growing rates of caesarean sections, referring to the WHO's recommendations and to the quality of women's experiences. The consensus *"Pelo direito ao parto normal"* signed by those representatives has an approach mostly centred on "professional groups directly involved with childbirth assistance, using a methodology that includes a citizens' perspective" (DGSS / APEO / OE, 2010, p. 13) – which indicates that this path to a rights-based approach is already in course even if defied by contextual aspects. In this country, there is not an opposition of roles between midwives and physicians despite a clear dispute in the political agenda around vaginal birth; then, women are not demanded to "fight" against the system by an intense dedication to the preparation of childbirth. Humanization here is mostly related to structural aspects of the system which reinforces a hierarchical relationship among health professionals and parturients.

III.2.C HAVING MIDWIFERY PHILOSOPHY AND RHETORIC OF DECISION IN SWEDEN

Regarding perinatal inquiries, Sweden is the country that provides the longest data series among the four, starting from 1973 for most variables. The context of production of this report is quite different from the context in the other countries, as it is not an occasional or problem-focused document, but a periodic one, produced with the cooperation of Swedish Official Statistics and Social Security. Still, the authors aimed to publish results demanded by health services and the general public in the country. The first variables presented in the inquiry's summary are related to the rising number of births, some lifestyle changes such as rising obesity, age of first pregnancy and decrease in tobacco use, and the presence of foreign-born pregnant women – which increased about 19 percentage points from 1973 to 2010. It also analyses regional disparities when they are relevant, such as the differences of analgesia methods.

The national report also details some variables on how onset, duration and finalization of births occur, suggesting that childbirth is conceived not only as a physiological event but a cultural and historical phenomenon, since it considers that factors other than scientific evidence influence the decisions regarding the entire delivery process. Based on this report but also on scientific papers referring to it, one can assert that the Swedish perinatal system emphasizes individualized assistance, access to information and the prevention of at-risk behaviours, through a universalistic perspective (Gottval et al,

2011; Lindgren et al, 2014) – but does not use the rhetoric of humanization nor the appeal to evidence-based information as the most important determinant for health decisions.

Rhetoric of decision is present and important in the logic of Swedish perinatology. Policies and services that favour the autonomy of patients is part of a larger strategy since the 1990s to improving subjective experience with health care (Hildingsson & Thomas, 2007). Even if women do not have much autonomy to choose the place of birth, they are invited to elaboratee delivery plans and to participate in decisions regarding medical proceedings during labour, such as mode of analgesia and use of instruments. The concern with subjective experience is analysed through statistical methods by some of the authors who participated in the national inquiry (Gottval & Waldenström, 2002). For instance, Krin Gottvall and Ulla Waldenström (2002) used the Birth Registry to evaluate if "traumatic birth experiences" impact subsequent reproduction decisions. Indeed, they found a positive correlation, but, paradoxically, do not point determinant variables other than the individualistic ones, such as personality, expectations and anxiety. Thus, this study did not contribute to the understanding of which medical proceedings and health outcomes in childbirth are related to traumatic experiences. Nevertheless, the Swedish report included detailed evaluations of physical sequels of vaginal births, such as sphincter ruptures related or not to instrumental deliveries. Thus, the system is attentive to the damages on pelvic floor functions, while maintaining low episiotomy rates – an important factor for the well-being of women after childbirth.

Another concern of Sweden is the regional disparity regarding the access to epidural anaesthesia – which, in the national report, is related to the fair distribution of physicians and to the possibility of women having their choices respected (OSS, 2012). Every type of non-pharmacological analgesia has been less used around the country, whereas the use of epidural anaesthesia had a small increase, and the inhalation of nitric oxide was present in 81.5% of all childbirths in 2010 (OSS, 2012). One can also identify that despite presenting one of the lowest caesarean rates in Europe, Sweden had increased it in 12 per cent since 1973, mainly because of the wide use of surgery for the birth of twins and foetus in breech position. Instrumental deliveries in general have been more practiced in the country during the past two decades; however there is a slight decrease of their rates since 2005 – which shows some effort of controlling over-medicalization. Even so, according to the national report, the induction of onset labours has also increased progressively about 0.3% per year since 1990 (OSS, 2012), which can suggest that the avoidance of one kind of obstetric intervention is related to the spread of others.

The European Peristat Project discusses some variables related to deliveries outside hospitals and labours without obstetric interventions in the context of "place of birth by volume of deliveries" (section R16), arguing that maternity ward size can be associated to the phenomenon of over-medicalization (Zeitlin et al, 2013). It informs that in Sweden, Portugal and France, planned home births represent less than 1% of childbirths, although the information about those events is not very consistent in each country. However, it points out that in Sweden more than 50% of births occurred in big units with more than 3000 births per year – contradicting the general assumption that big maternity wards *per se* induce high caesarean rates. At this view, it is important to note that in the Swedish system the main practitioner in charge of parturients' care are midwives and not physicians, mostly in public in-hospital birth centres, whereas birth centres far from hospitals are quite rare (Lindgren et al, 2014). Compared to other Nordic countries, Sweden is the least open to women's choice of place of delivery, however, it presents midwifery philosophy transversely to hospitalized care (Lindgren et al, 2014; Hildingsson & Thomas, 2007).

Therefore, in this country there is a strong public presence in the guidelines and outcomes of the institutions while midwives have a great responsibility and autonomy, which favours the articulation of standardized and individualized assistance – "there is continuity of midwifery philosophy throughout pregnancy, birth, and post-natal care, though not continuity of provider" (Lindgren et al, 2014, p. 127). This alternation of providers and the difficult access to high technology without prophylactic reasons – such as various ultrasounds during prenatal appointments, typically applied in Brazilian private services and in French ones – were marked experiences reported by the participants of the research who lived in Sweden. It was difficult for some of them to comprehend the usual pathway inside the system, as they were focused on searching this personalized attention, which in some cases comprises easier access to technology and continuity of relationship with health workers. For instance, Flávia, a white woman and Physical Education teacher, married to a Brazilian man, had immigrated to Sweden from Ireland, while she was one month pregnant. She reported a traumatic experience with childbirth in the new country, defining her delivery as *"sad and dangerous"* – she had spontaneous onset of labour and an emergency caesarean. She could not talk to me about it in details as it was still a very sensitive subject. However, she emphasised that her midwife's presence during prenatal and post-partum was *"fundamental"* to her adaptation to the Swedish system and to the recovery from this traumatic delivery.

Flávia nurtured an expectation of being early cared by a physician, and when she tried to initiate prenatal appointments in the public health centre she was surprised by its less-medicalized approach. In the first contact with the health centre, the couple received the recommendation of not telling anyone about

the pregnancy because there was still the *"risk of miscarrying"* and of returning to the service after three months of gestation, when prenatal could actually begin. Flávia followed the instructions, and it was only in the meeting with this specific midwife, then, that she first heard someone asking her *"how do you feel?"* and was finally able to feel confident about perinatal care in Sweden. She told me:

> "So I though it was quite shocking, right? I wanted to start right away. I wanted to talk to a doctor, though I knew I wasn't going to be assisted by a doctor. But I thought that I would have an appointment with a doctor at least for the first time and only after getting a *barnmorska*, which is how they call a midwife. **Well, then I went home and they had recommended us not to tell anyone about the pregnancy, to keep it to ourselves, and for me to stay calm, I couldn't keep stressing out because there was still the risk of losing it.** So I came home and waited another month, until I had my first appointment (...)When I had the first consultation I was assisted by a little old lady, a very experienced lady. And this little lady was my midwife for the nine months, staying with me... Aunt Eva. **She was fantastic.... And I was so emotional with everything that was going on that I looked at her, she said: how are you feeling, my daughter? Then I looked at her and started crying, sobbing. That's what I did; it was the first thing I did.** Look, I was already for so long... I couldn't tell anyone, I didn't tell my family, I was here alone, I didn't have friends, I kept myself inside the house, it was a lot of pressure, I had just moved here. And I got sick, I vomited every day, I hated the food, I hated the bread in here, then, when the first person asked me 'how are you feeling?' I just cried for like ten minutes, I couldn't stop crying. So she started reassuring me, explaining how the system works, she was an angel, you know? It was her who looked after me all this time." (Flávia)

Some time later, Flávia fell down the stairs inside the Swedish language school she was attending during that period. Because of this fall, she was assisted in an emergency room of a maternity facility, in which she finally had an ultrasound by a quite old device. The doctor in charge also performed some tests and recommended that she stop taking the medicine a Brazilian physician had prescribed for a chronic arm pain; according to the Swedish doctor, she did not have any physiological problem. With this situation, Flávia was very disappointed at the Brazilian physician, and started to trust the less-medicalized Swedish health system more. At the same time, she preferred to be alone inside the apartment for most of the time during prenatal period, so she would not have another risky situation like the fall from the stairs, which contributed to intensify her loneliness. In addition to accessing *"a lot of information"* in the neighbourhood's maternity service, Flávia read weblogs and Brazilian books about *"active childbirth"* during that period, and preferred not have much contact with her Brazilian relatives because she did not want to *"get them nervous"* and did not want their *"interferences"* on her decisions.

Along with this loneliness and the pressure to be integrated in the birth culture of her new country, Flávia was impacted by this rhetoric of risk at the first contact with the health system. However, in this context, risk was presented as relatively uncontrolled at the point that she would only be assisted by the health service after having this risky period expired. Unlike Brazilian middle classes and French birth

cultures, early medical interventions in pregnancy are not encouraged in Sweden; instead, the rhetoric of lifestyle and health decisions are quite present since the first contact with health care. Midwifery logic dominates from the actual beginning of prenatal assistance, and medicalization is faced as a complementary resource. Thus, the only risk management Flávia could engage in reinforced her loneliness, since she could not *"feel stressed"*, should not tell anyone about the pregnancy and avoided her family to be involved in her experiences and decisions. This kind of solitary experience during first stages of pregnancy were also identified by Carin Mohd and colleagues (2011) in a phenomenological research with Swedish women speakers, for whom the wish of keeping secret until bodily changes were perceived by others conflicts with their desires of experiencing those changes among other people's comprehension. Nevertheless, those women feel compensated afterwards by "a sense of community being a part of a larger context" (Mohd et al, 2011, p. 5604), which was not present in Flávia's experiences at that point, since she and the husband were recently arrived immigrants.

Despite all that, Flávia was quite satisfied with her midwife's assistance. As found by Hildingsson and Thomas (2007) in their research on women's satisfaction with perinatal care in Sweden, and as I found in other participants' narratives, midwifery is evaluated as positive when it is accompanied by the attention to "psychological and emotional needs" (Hildingsson & Thomas, 2007, p. 128) more than technical skills. This offering of an attentive care corresponded partially to Flávia's needs at that period, when she felt *"lost"* in the system. However, to cope with this less-medicalized approach, she kept herself distant from the Brazilian relatives and invested her time in reading online texts and books about natural childbirth – which can be related to the process of self-actualization but also to self-damaging. The fact that delivery did not happen as she expected contributed to her dedicating herself even more to childrearing the subsequent year but also for her to start writing on a weblog about motherhood and immigration, finding other presences in addition to the usual ones in this transitional period.

Olívia, a white woman, psychologist, also married to a Brazilian man, had a three year-old daughter and was pregnant at the time of our meetings. She actually liked this less medicalized approach in Sweden and her first childbirth in the country was a positive experience, to the point of making her think about a guided home birth for the second one. However, she did not report feeling lonely like Flávia, on the contrary – as her husband did not speak Swedish and did not have a social life in the country, even in work space, she assumed the role of making friends and improving the couple's social life. She also reported that she knew *"a lot of Brazilians in town"* and liked to be outside as most as possible. Regarding the Swedish health system, she asserted that *"many Brazilians do not like this tranquillity they have"*, having two immigrant friends who preferred to go back to Brazil to have prenatal care and child-

birth. But as she faced this tranquillity as a *"normal thing"*, she used her positive experiences to participate in virtual groups aiming to help her compatriots to surpass fear of labour. She said:

> "Among the Brazilians I know, two did not want to have children here, because of how relaxed they are here. It's not relaxed, it's a normal thing, you understand? There's no such thing as that... Like, I've been in the group ['Caesarean? No, thanks'] a long time now, before I came here, and I always tell the same story, here we have just two ultrasounds, there's no such thing as... you go there, you measure the stomach, get some tests, right? And that's fine. I am also very calm (...) **I'm willing, so to speak, right? I'm in the groups also to show a how things are different here, right? Because in Brazil I think things crossed the line**, I think it lost, it lost... I went there now and I was horrified with everything, from food to nurturing... horrified! (...) From health to having children... all trivialized, especially having children right? Because the gynaecologists there are all *caesarists*, you understand? (...) I was kind of freaked out by how things are going there, so sometimes if we show how things are here, you know, to calm down some people, I don't know." (Olívia)

Nevertheless, while the Swedish system's *"relaxed"* attitude was an opportunity to re-signify risk and fear of delivery, it also contributed to render experiences in prenatal and labour more difficult when Brazilian women engaged themselves in self-actualization process that demands isolation and a great investment in reading and learning how to have a "natural childbirth". Marina, a white woman, social worker, married to a Swedish man, did not have to suffer a "change in mentality" in order to understand and use Swedish perinatal care, and was not so lonely during prenatal period, as she could count on her husband's relatives. She already wanted to have a vaginal birth and did not fear it, since her mother and female relatives who lived in a small village in the South of Brazilian had positive experiences with it, and her mother-in-law also supported this choice. She was already a blogger before getting pregnant, and used it mostly to write about immigration to Sweden. However, she had contact with maternal blogs, with which she started to learn about humanized childbirth, parenting styles, and correlated themes, and started to articulate her own familiar experiences and local culture to the rhetoric of humanization of childbirth and attachment parenting.

During pregnancy, this confluence of ideologies did not conflict to what she found in the health system, since she was encouraged to decide and be prepared for a normal birth without epidural analgesia, pharmacological induction and episiotomy – medical proceedings condemned as "unnecessary interventions" by humanization of childbirth in Brazil. Despite not identifying herself as an activist for natural birth, Marina attended private preparatory classes. I could also identify during our conversations that she used some of the terms presented in those maternalist movements, reporting that *"now there are those groups in the Internet, (...) [where] the mothers stand for some things from my grandmothers' times, like 'hold your child in your arms rather than in the stroller' and those things"*. However, during labour, Marina and her husband experienced some dramatic situations, such as the lack of vacancy in

the maternity facility to where they first went, followed by a long labour in which Marina had fever, liquid retention, became very tired and finally had a 3rd degree sphincter rupture . Their child was born unconscious, needed intervention to start breathing and finally had to be transferred to a better equipped maternity to be examined by a specialist because he had spasms. Marina explained to me that her *"labour took too long"* and she though that her child almost died because of this delay. During labour, the midwife in charge offered Marina synthetic oxytocin to stimulate contractions, since she was too tired to perform the physical exercises to induce it naturally and the contractions were diminishing. But at first, Marina maintained her initial plan of having a natural birth – which for her did not include having *"artificial induction"*. The midwife also offered her epidural, but she refused, preferring only to inhale the nitric oxide gas and follow the learned exercises to analgesia. Labour lasted 15 hours and she suffered greatly, until she finally accepted synthetic oxytocin, and the child was born soon after.

During our conversation, three months after delivery, Marina told me about her childbirth as if she was in the middle of a process to re-signify it, still trying to understand what really happened and to which extend her child needed intervention because of her delivery choices. She had asked for psychological support in the first meeting with a paediatric nurse after birth; and since then, she had been getting therapeutic support by two professionals, a clinical psychologist and a *"therapist who helped women with post-partum depression or traumatic birth experiences for them to know how to relate to their children"*. Afterwards, she reported that the most important meeting was with the midwife who accompanied her childbirth, with whom she talked about the *"trauma of delivery"*. Marina told me that this person helped her understand that her child was never close to death despite his need of medical interventions, and by that she helped her: *"get a weight off my shoulders"*. Here is an excerpt of her story:

> "And then the midwives' shift changed, and the midwife who stayed with me until the end of childbirth was pretty good, pretty experienced, **I realized that she was quite experienced and really knew what she was doing, especially because it was so hard that part of my delivery, when the difficulties started**, because then the contractions are different because of the expulsive. And I had a lot of pain, of course, you're giving birth, but B couldn't go down, I was very swollen and it was like he was stuck in my vaginal canal, so it was very slow, and I had to keep doing a series of exercises during labour and it made me quite tired **(...)then I laid down a bit to rest, and she asked me if I wanted oxytocin because the contractions were getting weaker, and I told her no because I wanted to make all happening naturally** (...) I used that laughter gas, I didn't use any other type of anaesthetist, I had attended that class of prophylaxis, where I had learned some breathing exercises, so it helped a lot (...) and then when it was 8:00p.m., we decided, me and J, that I was going to get oxytocin for the labour to not stop (...) In Sweden you have the right to ask for episiotomy if you like, **but I told them that I didn't want this intervention, and the midwife helped me a lot with heat towels and doing massages in the perineum, while B got out, only as I was pretty swollen I had a 3rd degree perineum tear (...)I was quite shocked when they took him, and as the midwife didn't have time to explain what was happening I thought the kid was dying**, and then when he came back everybody was happy, and everybody was talking about how he looked happy, but **I was not**

> **happy because we couldn't understanding anything, and we were desperate, the both of us**." (Marina)

As one can observe, for Marina the quality of midwifery was evaluated as positive because the professional knew how to deal with the difficult situation of her delivery, and her expertise was valued as *"she knew what to do"*. Thus, this was one of the few stories in which expertise appeared as the main criteria of satisfaction with midwives' assistance, showing a different way of analysing perinatal care without being led by gender bias. This was probably favoured by the midwife's full autonomy during labour, when her assurance in managing the process without needing a medical expert (usually male) was clear. Also, Marina's midwives (from prenatal, labour and post-partum) were not especially "attentive"; in fact, two of them were absent in some important events: the first one was during the prenatal period, when the professional *"had forgotten"* to invite Marina and her husband to attend a preparatory class for childbirth, and the second one was just after delivery, when the practitioner in charge went out on vacation and took almost three months to discuss Marina's questions about the medical interventions her child received. Besides, one can identify in Marina's story that a contextualized approach to interventions in birth was provided by the midwife, since she tried to conciliate the parturients planning to the actual experience she was having with labour, offering synthetic oxytocin even when knowing that she stood for a natural birth. During Marina's labour, this ideal of natural birth as a process without obstetric intervention, fed by a dichotomist rhetoric – as the one that opposes synthetic and natural oxytocin and identifies epidural, induction and pharmacological analgesia as unnecessary interventions – was confronted by the complexity of bodily situations. From this kind of care, another way of comprehending "natural" can be raised, one close to the *alter-naturalist* perspective already discussed in this thesis.

Nevertheless, it is interesting to note that in Marina's case, the decision of accepting the synthetic oxytocin was not an individual one, but it was negotiated as a couple with the child as the central argument – which means it was not primarily based on her bodily fluidity and intuition at that moment. It was a decision for managing risk of stopping labour. Thus, her story does not offer a validation of her own body fluidity because, for her, "natural" did not integrate the actual experience she was having at the time of birth; her decisions did not seem to be taken as a development of such fluidity. At this point, one can observe the trend of *pathologizing* women's experiences with birth that do not correspond to the idealized natural delivery and the gendered relationship with partners in the decisions related to the risk of "unnatural events" – which is reminiscent of the debate about synthetic and endogenous oxytocin. The child-centred rhetoric in the context of therapeutic motherhood is a perverse pivot of a gen-

dered health politics, reinforcing other gender and class imbalances whereas confronting medical power.

In addition, along with this less-medicalized approach of risk, in Sweden, there is a growing apparatus of "health education" resources for parents emphasising how pregnancy, childbirth and breastfeeding are "natural" processes in which there is no need for systematic medical interventions (Hildingsson & Thomas, 2007). In doing so, the system has a strong protection against privatization and over-medicalization of perinatal health, whereas also favouring parents' participation on birth-related decisions. But this approach also presents some difficulties in comprehending why some immigrant women refuse to undergo usual obstetric interventions that can reduce their suffering (as in Marina's case), or even why some of the most vulnerable parturients refuse acute caesarean sections when they actually need it (which commonly occurs with Somali immigrants) (Essén et al, 2011). In fact, for some women, those procedures are associated to unnatural and life-risking situation, which confronts them with very difficult decisions. Éssen and colleagues (2011) discussed how Swedish health professionals are aware of the common fear of birth and obstetric interventions among some foreign-born groups, but they tend to comprehend this difference as a cultural determinant out of their capacity to act. The authors assert:

> One explanation may be that sociocultural causes of medical problems are not defined by the medical profession, but are handled on the basis that each individual handles them to the best of their ability and going partly on 'feel'. This also means that the stimulus for obstetricians to solve the problem is not the same as it would be if the underlying causes were more purely medical. (...) And so the professional leaves this problem to the foreign-born patient, since she does not 'understand' medical interventions that to us are good and well defined. It ceases to be a medical matter and is regarded instead as the patient's private affair. (Éssen et al, 2011, p. 77-78, their quotations)

Generally, one has this consensus on how a midwife should be a "good listener and treat the expectant parents as unique individuals and not merely as medical cases" (Hildingsson & Thomas, 2007, p. 128); however, obstetricians still have a quite impersonal approach, do not handling well women's demands for care when based on their fears and cultural backgrounds. In some cases, this kind of medical absence is based on ethnic misconceptions and discrimination, as lived by Viviane, a black woman and lawyer who works with Human Rights in Sweden, married to a Swedish man. Pregnant of twins, Viviane went to an emergency service feeling that she was about to faint, and heard from the doctor: *"in Brazilian favelas, women give birth at home! Pregnancy is not an illness!"* Thus, she had an ambivalent experience with the Swedish campaigns on pregnancy, childbirth and breastfeeding as "natural" processes. Despite being satisfied by the assistance she received for a natural delivery, she asserted that this less-medicalized approach *"trivializes"* women's knowledge about their own bodies, because they

do not consider their singularities. Unlike choosing caesarean and epidural, *"feeling everything"* in labour, for Viviane, was a way of being intensely present for the child, not only as a way of having her own-body fluidity, rather a way of assuring the child's health and well-being. However, three and a half years after her experience with natural delivery, Viviane raised strong critical points regarding the Swedish perinatal system, because, according to her, *"the propaganda in Sweden for natural birth and breastfeeding"* does not place women's health as a priority, *"the focus here is the baby"*. She reported:

> "What I see in here is a country which is pretty much for natural birth and breastfeeding, man, it's a propaganda for breastfeeding! (...) So, it ends up trivializing women, not only mothers, but women as knowledgeable of their own body. Thus as I see in here there is much of this trivializing. They come and say: **'no, but labour is not an illness! Pregnancy is not an illness!' I agree, it's not an illness, but each woman is different, each body is different, each one reacts in a certain way. So that's something that should also being said** (...) But I think that all this discourse of woman's health in this natural childbirth speech, she is completely left on the sidelines, the focus is on the baby." (Viviane)

Besides, after moving to Australia, and living there for a year with her family, she also realized that Swedish health services never helped her lose the excessive weight she had gained with pregnancy. She complained to me that she was worried about weighing 120 kilograms after childbirth, but when she tried to get access to medical tests to identify the reason for her weight gain and what she could do to lose it, the Swedish midwives and physicians she found at that time seemed more concerned with breastfeeding and never encouraged her to go on a diet or a more active lifestyle. It was in Australia where she finally was diagnosed with pre-clinical hypothyroidism and got support from health professionals to lose weight. At the time we met, Viviane was clearly thinner and frequently published pictures of her exercising on online social medias, showing how it was important for her to keep this habit. Also, she reported that Swedish health services are not *"preventive"*, arguing that they did not facilitate her access to a better contraceptive method such as hormonal IUD insertion.

As Ulla Waldenström (2004) discussed with a research on changing opinions of childbirth experiences in Sweden, negative experience can take much more time to be integrated in the mother's narratives, since just after the birth the feeling of relief and satisfaction with the child's presence is on focus. This author asserts that intensely painful labours and emergency caesareans are more related to this kind of changing from a positive to a negative opinion after one year. Thus, Viviane's critical position on natural childbirth, integrating it to a larger criticism of health care, at this point, can be related to this timing after the discrimination she felt and after her twins' vaginal delivery without epidural. About her labour

she said: *"My mother had given birth vaginally four times. So as I was a natureba[55], so let's go, I wanted to feel everything and more! – Oh the one who didn't know what she was saying!"* Regarding the movements for natural childbirth in Brazil and Australia, she also made an important critique to the contradictions of rhetoric of choice, focusing on the marketization of assistance:

> "Because now in Brazil there is this spectacle of natural childbirth and such (...) Because if you had a caesarean, you didn't choose it, you only made a real choice if you delivered naturally... I mean, it's a contradiction. I have a colleague who had a caesarean for the first child and later she had a water birth in Australia, and became a doula and now she wants everybody to have natural childbirth! But she doesn't do it for free, she charges you for that, so it is a market, right? You're not stimulating natural birth, as 'go there in the public system and have your natural birth', nope, you're saying 'you pay for me, then I go there and support you, then sure, you'll be the best mother ever, holy crap!' (...) I don't know, **I had a very painful labour! So, if you want natural birth, be aware that it's going to hurt a lot! But then it's your choice. It doesn't mean that if I had one I am going to impose it on other people as if it was a philosophy of life**." (Viviane)

"As if it was a philosophy of life": Viviane's quote is a perfect summary of the quest for humanized assistance among many of the participants of this research. In many of those cases, the decision regarding type of delivery became a demand for living a certain lifestyle, expressed as an intensely demanding presence for childbearing, consisted by bodily habits that do not privilege intuition and creativity, rather, in some contexts can be self-damaging. As Viviane felt pressured to integrate her habits and corporeity to a *"philosophy of life"* that could not be experienced as an authentic one, she hesitated on that and integrated her criticisms in a broader standpoint.

In conclusion, this paradigmatic transition in Brazil and among Brazilian privileged women, corresponding to the shift from a scientific to therapeutic culture of motherhood, has the potential of resisting over-medicalization in privileged contexts, but requires deeper concern with structural inequalities to really overcome the perinatal paradox. This concern will probably not come from upper-class women who are engaged in experiencing childbirth as an aesthetic and self-actualization event unless one can find space for hesitation, intuition and ethical responsivity in the meeting of diverse and peripheral experiences with birth and childbearing.

As one can observe with these stories in Swedish, French and Portuguese systems, Brazilian women share a similar "fear of birth" albeit through different corporal experiences with it, influenced not only by biological facts but by contextual, structural and relational ones which can be considered parts of their "natural experience" with the transition to motherhood. With these stories, it is possible to identify some aspects of social presence around birth that contribute to the experience of presence discussed in the

[55] "Natureba" is a Brazilian expression which means to be a person who adopts healthy habits related to the comsumption of certain products and services identified as more « natural » than the usual ones.

previous part of the thesis whereas also creating an ambiance for unpredictability of "human decisions". Those are mostly related to the articulation of institutional references with a rights-based approach in prenatal period and delivery, configuring spaces for more autonomous decisions not by a rationalist and liberal perspective of human action, rather by situational and intuitive connections of the own-body fluidity. Therefore, the politicisation of birth, as the politicisation of motherhood-related subjects, would be intersectional if seriously taking into account the diversity of women's embodiment and the ethical responsivity which arises from it.

Part Four: Hesitation and ethical responsivity in early childrearing

In this part of the thesis I analyse how the habitualities enacted in the early childrearing, especially the first year after birth, favour or not hesitation and ethical responsivity towards different women's experiences; in parallel I also analyse how the presences around mothers can be responsive to their authentic experiences of transition.

The paradigmatic changing of perinatal health in Brazil with the rhetoric of humanization of childbirth favours the confrontation of over-medicalization and the objectification of women's bodies; at the same time, it demands an individualized investment from women to fighting against the obstetric system, which can be understood as an intense presence towards the project of having children. Besides, the same kind of presence seems to be expected from the women who undergo medicalized childbirth, since both outcomes are part of a middle-class culture of choosing motherhood. Along with this process, the presence of male-partners and other relatives can contribute to hesitation and creative agency, but can also prompt to the injunctions of therapeutic motherhood if motivated by a child-focused rhetoric. Also, the presence of certified, institutionalized caregivers, such as child-minders and childcare centres, can contribute to women's trust in sharing childrearing, so that they can invest in their careers.

After accounting for the unities of sense, "desire of presence" and "searching for humanization", I identified, among some of the participants, mostly the ones who disclosed their intimate journals as part of the research, processes of hesitation and enactment of ethical responsivity related to the subjective injunctions of therapeutic motherhood: the injunction of "giving time" for children. Those processes reveal certain dynamics of temporality, already explored by Alia Al-Saji (2004; 2013a) in the field of racialization studies. Thus, in this part, I take the discussion leaded by this author with Deleuze's and Bergson's philosophies of time and from other philosophers who articulate temporality and care, such as Max Van Manen, Jacques Derrida and Sandra Laugier. I also articulate those accounts to the analysis of moral rhetoric of family policies, especially the ones related to parental leaves, employment rights for parents and early childcare. Thus I analyse how the perception of certain absences and presences performed by men, family relatives, virtual groups and social mechanisms favour "oppressive hesitation" and/or "creative hesitation" (Al-Saji, 2014) regarding the multiple and different ways of experiencing the transition of motherhood but also regarding more authentic self-experiences with childbearing.

I was able to realize that moral rhetoric' injunctions, related to the "good mother" stereotypes, are confronted with the actual experiences of the participants in establishing the *habitualities* of childrearing during the first transitions to motherhood. In some situations, I could observe the increase in ethical responsivity towards a broader politicisation of motherhood, in which structural problems can be better visualized, such as gender oppression, racialization and discrimination of non-heteronormative families.

IV.1 LEARNING TO GIVE TIME

During the transition from desire of primary presence with motherhood, to searching intelligibility in reading – and in some cases writing – on motherhood-related subjects, mothers were demanded by public spheres to "give" their time, which means assuring their presences more or less continuously to the project of having children – as if time would be a real "thing" to be given (Derrida, 1991). And this demand constrains women to a contradictory relationship with time, by a preponderance of the future anchored on the hegemonic representation of the "Universal Mother", in which temporality of childrearing is not taken into account (Pombo, 2013). This happens especially during the early period of childrearing because of the rhetoric on "human development" of therapeutic motherhood, which conceives the first three years as critical for psychological and neurological development (Bruer, 2011); but also because of the historical medicalization of motherhood, for which controlling and predicting mothers' behaviours since the very beginning would prevent risks for the health of children (Burman, 2008).

Thus, I could identify two types of demands for mothers' temporal dedication after childbirth: one related to the demanding absences, characterized by the absence of a consolidated field of family policy in Brazil and by the way children's fathers and other relatives are not really present in childcare routine but produce moral pressure for mothers' presences; and the other related to demanding presences, characterized by social policies and services that target mothers as the main and sometimes exclusive caregivers of children. Along with both types of demand, I could also observe the important presence of online groups that publicize parenting styles issued from ideologies such as Attachment Parenting, Motessori Parenting, Unschooling and Positive Parenting, which are also engaged to a recent phenomenon on the web, the "mommy wars". These groups were important presences for women who had very solitary experiences during the early period of childrearing because of immigration, unemployment and/or long maternal leaves; however, they can also be considered demanding absences, since they do not assume any responsibility for childcare albeit producing moral rhetoric on how mothers should feel and behave.

In the following table, one can visualize the general context of early childrearing in the four countries, including mothers' and parents' rights related to parental leaves and childcare. From that, one can observe how Brazilian welfare is fairly matrilineal, meaning it is dependent on mothers' presence, still having "family" as a private matter, and not taking much responsibility for social context of childbearing.

TABLE III: FAMILY POLICIES IN BRAZIL, PORTUGAL, FRANCE AND SWEDEN

Family Policies - Parental leaves and childcare	Brazil	Portugal	France	Sweden
Parental leave in days	0	330	366	480
Maternity leave subsequent to birth in days	120	42	70	60
Paternity leave subsequent to birth in days	5	10	11	60
Leave flexibility	No	Yes	Yes	Yes
Workload flexibility	No	No	Yes	Yes
Percentage of fathers who take parental leaves	NA	23%	4%	80%
Financial or temporal incentive for fathers' use of parental leave	NA	Yes	Yes	Yes
Maximum child's age for parental leave	NA	1	6	8
Percentage of children under three years old in childcare centres, preschools or certified child-minders	21%	35%	48%	50%
Minimum age for childcare centres	4 months	3 months	4 months	1 year

*NA: no data was available.

**Sources: "Política de educação infantil no Brasil: Relatório de avaliação" (Brasil, 2009); "Educação infantil no Brasil: primeira etapa da educação básica" (Nunes et al, 2011); "Histórico e evolução recente da concessão de salários-maternidade no Brasil" (Ansiliero & Rodrigues, 2007); "Maternity and Paternity at work: law and practice across the world" (Adatti et al, 2014); OECD Family Database (accessed various times during 2014, 2015 and 2016); "La petite enfance: l'accueil du jeune enfant en 2010" (ONPE, 2010); "Principais desenvolvimentos das políticas de família em 2013" (Wall et al, 2014); "Recomendação: a Educação dos 0 aos 3 anos" (Vasconselos, 2011); Family policy in Sweden 2008 (Duvander, 2008); "Sweden country note" (Duvander & Haas, 2013); "Modes de garde et d'accueil des jeunes enfants en 2013" (Villaume & Legendre, 2014)

Table III is not able to show the complexity of family policies. In fact, it is quite difficult to compare this kind of public policy because each country has specific categories and evaluation criteria (OECD, 2010; 2014). Regarding leaves, for instance, each of these countries has specific employment-related conditions, financial benefits, and alternatives to the basic time-use. Therefore, the category of "leave flexibility" means the possibility of sharing and using the time however the couple decides, according to the

demanded time for maternity and paternity leaves (which are not transferable). The category of "workload flexibility" referrers to parental leaves that can be used to diminishing workload without financial lost.

In Brazil the only alternative to the 120 days of maternity leave is 180 optional days, but only for employees of certain big companies that receive financial incentives to offer this benefit – but it always has to be used directly following birth. In France, one can have an extra two years parental leave and twice the maternity leave depending on the number of children. Portugal and Sweden also have complementary alternatives, less fragmented than France but still favouring certain diversification. In fact, in France, there are so many different combinations of financial benefits, time-use and childcare modes that the governmental reports assert that many people do not know exactly which options they have (ONPE, 2010). Nonetheless, one can observe that French fathers do not use the leave as expected – a new incentive for men to use it was created quite recently in 2015; however, a collateral effect was the reduction of total time women can profit from it exclusively. Only in Sweden one observes a great part of fathers using leaves beyond the required period of paternity leave, but still, in terms of total time of parental leave, they only participate on 22%, usually during school holidays and when children are older (Duvaner & Haas, 2013). In Portugal, the government incentivizes the sharing of parental leave between mothers and fathers giving thirty paid days as a plus for couples who share at least thirty days of the leave (Wall et al, 2013). As those initiatives are recent (since 2009) one has to wait some more years to evaluate if they are achieving the goal of contribute to gender equality in family life.

Among the participants of this research, 17 profited from paid maternity leave, 6 of them also had parental leave and 1 used it in reducing workload. The ones who did not have any paid leave did not have a job at the time of birth or worked as autonomous in informal labour force. Among the ones who lived in Brazil, 6 had maternity leave, and 2 of them left their jobs just after the benefit ending. Only 2, living in Sweden, reported that their partners also used parental leaves in the first year.

In terms of care, none of the countries have full capacity to offer certified and publicly funded childcare for infants under the age of one. Still, for most families in the four countries, mothers are in charge of the first year of childrearing without institutional aids beyond the leave and health facilities. Since in Brazil there is no such thing as publicly certified child-minders, and those professionals work under private domestic agreements, the percentage referred to childcare in this country, in this table, is restricted to day-care centres. Domestic work is quite common in the country and represents a great part

of childcare aid for middle- and upper-class women. However, it is a sexist, racialized and barely controlled market, with the lowest salaries in the country and 92.6% of female labour (DIEESE, 2013).

On the other hand, French child-minders are much more autonomous because they receive state support and abide by regulation; they select and receive the children in their own households the same as happens in the Portuguese "microcreches". Since in Sweden childcare centres do not account for children under the age of one, this percentage (50%) is due to around 80% of two and three year-old children attending preschools. In the Portuguese case, one also finds informal and certified domestic workers; however, their salaries are not so low and they have more autonomy and qualification when compared to Brazilian ones. Sweden and Portugal have more standardized childcare facilities than France, offering less flexibility in schedules and routines. As in France, Sweden also offers intermediary services in which mothers and child-minders can take children for short and flexible periods, however, in the first country the presence of mothers or fathers is not required and this service can be used by parents to invest their time in other activities. The French *halte-garderies* care for children under six years old in an occasional basis and are used by parents who are in full parental leaves or/and who want to make a gradual transition to schooling (Villaume & Legendre, 2014).

Thus, in general, since the countries do not offer institutionalized childcare options for all children during the first year, one can assert that this is still considered a private matter to be solved by individual caregivers, which means the mothers in most cases. This context in developed countries contributes to keeping the conciliation of work and family life as a female rather than a social issue in global agendas (Paihlé & Solaz). Usually, the reports on childcare for children under three years old do not present separate data for the first year, and reinforce that preschool is a matter of children's education more than parents' benefit. The globalized rhetoric of United Nations presents this trend in pressuring developing countries to abandon *assistentialist* focus for childcare policies and to improve an educational focus. As emphasised by the Brazilian report written with UNESCO's partnership:

> Os autores ressaltam que uma das consequências de integrar o atendimento da primeira infância ao setor educacional é a afirmação da educação infantil como um dever de Estado para com o direito das crianças a uma educação pública e de qualidade. Este processo efetiva o reconhecimento da criança como cidadã de direito e de fato, como sujeito sócio-histórico e cultural, cujo desenvolvimento se dá de forma integral nos aspectos físicos, emocionais e cognitivos. (Nunes et al, 2011, p. 8).

Therefore, in the field of family policy, the focus of UN organizations in the last decades was to lead this process of integrating early childcare to a child-focused perspective. This shift from Social Assistance to Education was quite present in the development of childcare policies in Sweden and other Nordic coun-

tries – currently mentioned as global models for family policy. In the 1970s, Sweden prioritized single parents for public childcare services and gradually universalized the system during the 1990s and 2000s by shifting it from the rhetoric of working parents' rights to the rhetoric of children's rights (Bergqvist & Nyberg, 2002). It was extremely important because it made it possible for unemployed and immigrant parents' children to also use the services. In this country, privatization was refrained since private institutions working in this field cannot be for-profit.

In Brazil, the shifting from Social Assistance to the Education sector is not exactly claimed by citizens or specific social movements; it is rather related to the influence of globalized rhetoric on children's rights. This is extremely important since it contributes to improve the quality of childcare in the country; however, it does not seem to be sufficient to achieve an integrated perspective with regards to gender issues, since local authorities continue to expect mothers to be responsible for their children's well-being. As a consequence, privately funded childcare centres and domestic work are used mainly as solutions by working mothers from middle classes. Therefore, mothers' needs regarding time-use and economic autonomy are not a priority in a local and global level and are confronted with the rising of children's rights as a sort of concurrence in political agendas of developing countries (Leite, 2014). At this point, if one cannot prove better educational benefits for infants enrolled in crèches than for infants who keep being cared by mothers, this kind of service is seen as a "necessary evil" for poorer families (Brasil, 2009), an idea that is quite present in many of the participants' narratives.

Among the 30 participants, only 7 used an institutionalized childcare centre during the first year, including publicly funded child-minders and all types of daycare centres; whereas 14 cared for their children by themselves, 5 employed private domestic workers who helped them with the child, 5 equally shared childcare with the children's fathers and 4 shared the care with the child's grandmother. Among the ones who used institutionalized childcare, almost all reported having mixed feelings with this decision, such as guilt despite recognizing the importance of keeping their professional activity.

Nevertheless, from the analysis of the participants' experiences, I suggest here that this first period of motherhood is very important for the establishment of women's and men's habitualities and ethical engagement in parenting activities. The way women experience social presence during this early transition to motherhood can define decisions and contingencies related to work and employment in subsequent years, determining their economic status for a longer time. For instance, in Sweden, most women do not have trouble going back to the labour force after taking 15 months of parental leave, however, as Duvander (2008) concluded, the Swedish labour force is really stratified by gender, and women are far

from the most well-remunerated and hierarchical positions. Moreover, if it is absence rather than responsive presence those women perceive after giving birth, the decision of being absent for a part of the day to invest in their own economic autonomy becomes quite difficult. Another problem of this context is that the injunction to be fully dedicated to childrearing activities can be self-damaging in the sense that it can produce feelings of *"identity loss"* as reported by many participants, contradicting their pursuing for body-fluidity and experiences of presence.

IV.1.A REPRODUCING INEQUALITY AND FRAGMENTATION OF FAMILY POLICIES IN BRAZIL

As already discussed, Brazilian family policies do not form a consolidated field; besides, they present a dual logic based on social class, which occurs in the health system. While the poorest families are entitled to cash-transfer and related benefits[56], middle classes are benefited by maternity and paternity leaves related to employment. However, both classes are traversed by a strong matrilineal logic, by which mothers have a core role as providers of family care rather than as beneficiaries. This reinforces a culture of fearing collective alternatives of early childcare, which also contributes to the great inequality among poor and privileged families. Similar to the fear of public health institutions, middle classes in Brazil usually have strong misconceptions regarding institutionalized childcare. In this subchapter I discuss the moral rhetoric found in the documentary research of "family and parental supports" in the four countries, whereas analysing the participants' experiences traversed by this cultural background of Brazilian inequality of family policies.

One interesting aspect of the Brazilian reports on family policies is the lack of interest in communicating with women and social movements, differently to the documents on perinatal health. The only research that was accompanied by an accessible summary, with Press release and strong visual rhetoric, was the one produced by SOS Corpo with international and national partners but without Brazilian state support (Marcondes et al, 2015; Data Popular/SOS Corpo, 2012). This context reveals the recent organization of Brazilian public agenda regarding women's rights. As I have discussed, in the last years, feminist rhetoric loses influence in public policy implementation, after an important period of improving women's political participation. Humanization of childbirth is one of the few influential movements in the public agenda that still use feminist rhetoric in the interlocution to Brazilian state, however, as already discussed, this movement brings a maternal-infant health rhetoric, contradicting the historical pathway of PAISM – the most important feminist achievement in the political agenda. If humanization

[56] PBF's families are not officially excluded from maternity and paternity leaves, however, the majority of them do not have formal jobs, keeping out of the Social Insurance system.

can deconstruct male power over childbirth, confronting the technocratic obstetric system, and can also motivate men to participate better of the project of having children, it does not cope very well with child-care and gender-neutral parental-leave demands. Once again, one can identify one of the outcomes of classist agency from middle- and upper-class women.

Some authors have argued that Brazilian social policy has expanded the conception of family in the last decade, mainly because of cash-transfer benefits, which started to include single-parent families in the early 2000s. However, in contrast, mothers are expected to fulfil a moral role of social inclusion of children, adolescents and elderlies[57]. As Meyer and colleagues (2012) observed in other research, the absence of men in the family care routines is naturalized by social workers and beneficiaries of social programmes. Formerly, it is implied that mothers are available to participate in the pedagogic activities proposed by those programmes – in terms of time and subjective disposition, since the complementary activities for PBF beneficiaries can have a strong "psychologizing approach" (Jannuzzi & Quiroga, 2014). This psychological emphasis is not really preconized by the policy design – in the MDS webpage dedicated to PAIF, for instance, it is written that the program does not have a "therapeutic character"(Jannuzzi & Quiroga, 2014). However, referring to Brown's (1978) and Friedberg's (1993) accounts on informal rules and low-level negotiations of organizational paradigms, this therapeutic trend in Brazilian family policies can be understood as a result of the burdens forced upon mothers by social and health workers. As recognized by the MDS report, there is a tendency to blame the subjects for family difficulties, especially mothers and adolescents, which in turn creates demand for psychological support: "another trend from the [social workers'] speeches is related to the blaming of subject, for his/her poverty, for the non-accomplishment of family roles, for not participating or accomplishing the contractual rules issued by social assistance rights" (Jannuzzi & Quiroga, 2014, p. 146, free translation).

Moreover, even though the report acknowledges the problem of blaming women for policy outcomes, this expectation is reinforced by the great amount of surveys focused on the accomplishment of PBF conditionality related to children's education and health: 11 of the 75 researches commented by the report are concerned to evaluate it, whereas only 2 clearly focused on the improvement of female beneficiaries' social status. Likewise, there was no study interested in issues related to masculinity and men's participation in the programs' activities or in family life. Economic status of programmes' benefi-

[57] The Brazilian state is under a strong dispute around sexual and gender rights, presenting contradictory rhetorics in the last few years. In this respect, while Meyer and other researchers recognized an expansion of family definition in public policies, conservative politicians and parties have managed to approve two bills that strongly contradict this trend: the Nascituro Statement (Estatuto do Nascituro) assures civil rights to foetuses and the recently approved but still not sanctioned project of Family Statement excludes homosexual couples and parents in the definition of family.

ciaries is only contemplated by 6 researches in the section "Productive inclusion"; this is commented by the publication's coordinator, Paulo Jannuzzi, who explains that this area of MDS' programs will be focalized further. However, these thematic absences related to gender issues can be understood as a consequence of the fragmentation of family policies in the country (Sorj & Gama, 2014).

As Sorj and Gama (2014) discussed, the dual system for Brazilian social insurance has private and individualized benefits funded by enterprises and out-of-pocket resources, mainly administered by the Ministry of Social Insurance, and a public sector for at-risk families, which consists mainly in financial benefits that are worth less than the minimum wage, supplemented by the services of the Ministry of Social Assistance. The benefits that respond to the productive inclusion of parents are generally conditioned to employment, which do not have a clear place in political agenda. This part of the system was built and consolidated in the 1940s and 1950s, when the Brazilian state asserted a strong *labourist* and liberal *developmentalist* rhetoric, and there were no important reforms in the subsequent decades. Therefore, the rights related to employment protections are still based on a male-breadwinner / female-homemaker model. As showed in Table III, there is no parental leave to be equally shared by women and men in Brazil.

In addition, many of the PBF female beneficiaries are informal domestic workers for middle- and upper-class families, who are generally excluded from maternity leave benefits, whereas assuming a great part of childrearing that fathers do not assume. Still, this inequality is not identified in the MDS report, as it does not account for the mixed welfare system in the country and the productive inclusion of those women in the informal labour force. In fact, one can assert that Brazilian social policies are based on an unrealistic family model, presupposing the presence of domestic workers in assuring the balance of the "ideal" middle class family. It is unrealistic because, despite all the injunctions against mothers' remunerated work, nowadays almost 45% of workers, including formal and informal markets, are women (IBGE, 2013). Also, women represent the majority in public organizations and complete more years of formal education than men (IBGE, 2013).

Regarding the articulation of social policies to childcare, in a recent research funded by the International Development Research Centre of Canada (IDRC) and coordinated by Maria Betania Avila and colleagues from SOS Corpo, the authors concluded that the ideological guidelines present in recent Brazilian policies of Child Education do not consider "the expansion of women's economic autonomy and equality in the labour market" (Marcondes et al, 2015, p. 6, free translation). The last initiative of the Federal Government through a programme called *"Brasil Carinhoso"* contributed to raising the number of PBF chil-

dren in crèches, albeit in a part-time basis, which does not contribute to better employment conditions for their mothers. As they analysed, for the lower middle class, public full-time childcare is crucial for women's careers (Avila et al, 2015); nevertheless, there is no difference among classes concerning claims for vacancy in those institutions. About 35% of women in all social classes reported that the main difficulties in obtaining remunerated work is finding childcare vacancy(Data Popular / SOS Corpo, 2012). Thus, for those authors, a child-centred rhetoric is not sufficient to promote gender-friendly childcare policies, which can be observed in the expansion of facilities with part-time services in a country without any gender-neutral parental leave and any related workload flexibility. I argue that it occurs mainly because of the persistence of this therapeutic culture that expands scientific motherhood to social policies.

Letícia, a journalist, lesbian and white woman, living in Brazil, had a six-month maternity leave. She reported that during childbirth and the following two months she suffered from high blood pressure because of her *"emotional state",* explaining that she had been quite worried because her pregnancy occurred during a break on the relationship with her female partner. Her partner had *"accepted"* her back and supported the decision of having the child; however, her parents *"did not accept that she would not marry the child's father"*. As for the father, he lived in another state and was absent. Thus Letícia lived a difficult context during the transition to motherhood; and having a good job with benefits such as health insurance and social security was quite important at that time, which reinforced her choice of not exiting the labour force after the leave ended. After birth, she expected to enrol the child at a private childcare centre; however, as she was over-come with domestic duties, exclusive breastfeeding and living *"that entire situation"* during maternity leave, she preferred to employ her maid – who until then worked in an informal basis – to be child-minder. Despite her marginal family context, Letícia's situation with early childrearing is quite common among privileged classes in Brazil. When privileged women have to deal with difficult very demanding chores during this period, and find responsivity in other subaltern women's presence, they prefer individualized agreements with them rather than running the "risk" of trusting in institutional childcare. Letícia reported:

> "Because I thought I wouldn't need a leave, but at the crunch time I needed it indeed. Because I had high blood pressure, I had health issues, I became dependent on people, had to call a nanny, **I had thought I would not call a nanny but had no choice... In sum, it's a story of discoveries along the way. Along the way I had to adjust myself to the situation** (...) I hired the nanny only after I had the baby and realized that I couldn't take care of it by myself, breastfeeding and doing all the other duties, in that situation (...) and my partner worked outside, and during the period she was working she could not take care of it, so everything regarding home was my responsibility! (...) **I thought of leaving the baby at a childcare centre, but then I realized that I don't know... in crèches they put ten babies for each caregiver, and a caregiver earns minimum wage** (...) But until then this nanny,

> she had been my cleaner, we had an informal relationship, so I asked her if she could afford being my nanny, and she said 'well, I have three children, I think it can work!' **And it... flowed through trust. And she took really good care of S, she's a terrific nanny, I recommend her to everybody. But, you know, it was by contingency, because I thought of having someone to help, as I wanted to remain in the workforce** (...) And I began by increasing her workload, increasing her salary, and she agreed." (Letícia)

Certainly, if the quality of public childcare is improved, women like Letícia would trust it more. Nevertheless, if privileged women keep employing poorer ones as domestic workers and do not use collective childcare it is harder to pressure public agendas to prioritize this issue. It generates a cycle by which both classes are affected; with worst effects for the poorest. After a year, the child-minder who worked for Letícia's family became pregnant and then could take maternity leave. During this period, Letícia and her partner discussed the possibility of one of them leaving the job and caring for the child; as she had the better salary, her partner did it. However, sometime later, Letícia lost her job. Finally, the couple dismissed the child-minder and Letícia decided not to look for another job, and tried to work in informal part-time basis while her daughter attended a part-time private preschool. This new situation pressured Letícia to rethink her decision of keeping the job after birth; even if, by now, she earns less than minimum wage, she thinks that her daughter needed her presence. During the interview she said:

> "It's happening like this because I do not have someone with whom to leave my daughter, **because full-time school is expensive, I have no means, and even though I do not feel comfortable leaving her there full-time at this age... I think she's too young so I don't know (...) so I need to spend more time with her (...) maybe I should have done this from the beginning** but I had no means because I was employed, I had that job, and I stayed there, negotiating with work (...) so, it really stressed me out (...) Also, this situation of having more 'free time', you end up just working less time, and your wage comes too slowly, so it's salary reduction, there's no way of calling the nanny again, it's a financial issue really." (Letícia)

While she recorded the diaries for this research, she realized how hard it was to keep working at home and caring alone for her child, evaluating this *"entire situation"* as *"unsustainable"*. In all of the seven recorded journals, she reported feeling very *"stressed out"*, *"very tired"*, and sometimes *"anguished"* by the difficulty of conciliating work at home and giving attention to her daughter. One can say that this experience of not having trusted in institutionalized childcare and having been fired after her maternity leave pushed Letícia to an "oppressive hesitation" (Al-Saji, 2014), by which she felt the injunction of being intensively present to her child whereas not regarding the child-minder with the same empathy. During the hesitations she reported in the diaries, Letícia oscillated among a moral injunction towards her daughter and a conscientiousness of her own limits as a mother. She and her wife seemed to have a great empathy for one another regarding their engagement in childcare, but Letícia had great difficulty in explaining to her the intense demands from the child that were impeding her remunerated work, as she *"did not know how to say 'no'"*. Explaining the conflictive situation with her wife, she said:

> "I was really stressed out, and I haven't sat down in front of the computer to work because I knew I wouldn't produce anything**. So, I was kind of anxious, afraid to not produce and not be able to deliver work on time nor to take care of her** (...) And there we go again through that process, S watching TV, P defending S, saying that she was ok with that, 'let it go, let's avoid conflict, do not fight', only I have my limit, you know? That's enough! That's enough! (...) **And I tried to explain to P that it's so stressful being demanded all day long, right, it's like that all day long**. The more you give her attention, the more you play, the more she requires it, you know? She wants more attention! So, establishing limits is an exercise, but sometimes I do not know how to do that. Because sometimes when I'm playing with her, suddenly, like in five minutes, **I get completely drained, tired, I don't have... I don't know how to say to my daughter 'ok, enough, it's over, because she wants to play**." (Letícia)

One can identify that the experience of vulnerability felt by Letícia and her wife was multi-factorial, conditioned by gender, sexuality and motherhood. As they formed a female couple, both felt responsible for giving the child individualized attention and suffered with the lack of qualified alternatives of collective childcare, and left remunerated work in different periods. This means that they both had contingent interruptions on their careers because of childbearing. But, as upper-class women, they reproduced the exploitation of domestic labour force to cope with this oppression. In this context, one can say that the lack of responsive institutional presences for children and the insistence of maternal-infant bonding as the core element for child development feed this structural problem of gender and class relations in Brazil.

The protection against discrimination based on reproductive issues in the workplace are part of the responsibility of the Ministry of Work and Employment in Brazil (MTE – Ministério do Trabalho e do Emprego). I tried to find a national report in the MTE's website on this issue, but there was no official document focused on the usufruct of parental leaves or work protections for mothers and fathers. Despite the existence of a specific category on "Fight against discrimination in workplace" in the webpage "Publications" dedicated to diffuse information on MTE's activities, there was no report on discriminations or employment programs focused on parenting. However, there was an important document prepared by the Special Secretariat of Policies for Women (SPM – Secretaria Especial de Políticas para Mulheres) on gender and poverty published in 2005 (Melo, 2005), which does not mention parental leaves or parental support as strategies to fight against discrimination. In fact, the word "mãe" (mother) only appears three times in the 47 pages of the report and "maternidade" (motherhood) is not even mentioned. However it recognizes the growing entrance of women in the labour force in the last fifty years, attributed to the decreasing fertility rate, the change in "female identity" influenced by Feminism and the great increase in women's formal education – signalling the parallel increase of informal work and unemployment. Despite this feminist perspective, this report did not approach family policies beyond cash-transfer as a feminist strategy to promote women's autonomy.

The lack of motherhood-related subjects in this feminist document is not an exception in Brazil. Unlike Sweden, where family issues have been faced as central for feminist agendas, in Brazil, there is a dispute on the issues to be prioritized by the movement's rare political spaces. Leite (2013) explains that there is a strategic fragmentation of women's movements, according to which the agenda of reproductive rights and freedom to choose not being a mother is disconnected from the maternalist agenda of humanization, even if both present feminist rhetoric. For the first one, the vulnerabilities produced by the injunction and *romantization* of motherhood is focused whereas the second one "deconstruct and (re)construct motherhood in a positive way" (Leite, 2013, p. 13) – none of them has clear claims for public childcare, protection for employment and equal parental leaves. This fragmentation is also related to the historical disputes inside institutional Feminism, based on dichotomist views such as gender *versus* sex and culture *versus* nature previously discussed, which does not favour *alternaturalist* and intersectional feminism.

Still, despite not mentioning "motherhood" or maternity leaves, in the concluding section of SPM's report, the author suggests an explanation to women's poverty related to family issues, alerting to the fact that 50% of the children who live with single parents are exclusively under their mothers' responsibility: "this is a sad reality and a burden for women, especially for the poor, who see their male partners moving among households as they change their clothes, without any responsibility to the children they conceived." (Melo, 2005, p. 43, free translation). Thus aiming to shed light on the vulnerability of those women, the report reinforces a moral distinction between mothers and fathers, recognizing this "injustice" but not suggesting any alternative explanation for men's absence in parenting and not recommending any political initiative to stimulate their participation in childcare. From this rhetoric, it seems that this male transiency is part of the reality those women and the state have to take for granted, searching for compensations that do not include demanding men's presence. As already asserted by Meyer and colleagues (2012) and Karen Giffin (2002), the flexibility in the definition of "family" in social policies articulated to a persistent focus on matrilineal and at-risk families produce an unexpected contradiction: the naturalization of men's absences and women's overburden in childrearing, with the state playing a supportive role in providing a minimum revenue.

I believe that there was not an important visibility of the great problem of domestic work and sexual division of labour, in all the reports produced by Brazilian governments the last decades dedicated to the fragmented family policies, because of a general assumption that this is not changeable by public policies. Formerly, unlike the movement for natural childbirth and in the social presence related to at-

risk families, the politicisation of motherhood among privileged classes do not contribute to the integration of a specific agenda for family policies in the country.

IV.1.B (NOT) SEARCHING FOR RESPONSIVE PRESENCES AND BECOMING ALONE

Like Letícia, other participants feared or avoided searching for complementary childcare or for sharing childrearing activities. Sometimes, this process was provoked by bad experiences with the fragmented social presence around motherhood in the early period, or the experience of social absence itself – which implies great responsibility towards the other-dependent and a loneliness that can be quite naturalized. As Jeremiah asserted, the ethical constraint sometimes identified as "maternal attachment" is not only culturally constructed but it is embodied and situated. In this sub-chapter, I analyse how moral rhetoric regarding family policies, even by feminist motivations, constrains women to this binomial attachment and to avoiding the transit of children and themselves through different spaces; which strongly defies their return to or permanence in the workforce after motherhood. In this process they can find feminist and maternalist groups and discourses that can be important to the overcoming of loneliness, but sometimes reinforcing it.

As already discussed, the research participants who approached feminist groups in the transition to motherhood raised the liberal aspect of chosen motherhood as a *"hook"*, from which they could not find arguments to improve their economic autonomy as mothers. For instance, Renata, a single parent who identified herself as a lesbian after childbirth, explained to me that after participating in different feminist virtual groups, in which she did not find the opportunity to share her bodily experiences with this transition, she decided to create her own online group *"to share daily experiences... to share traumas with other mothers"* which brought to her *"much more lucidity"*. Throughout this process, she participated from virtual groups for the humanization of childbirth and launched a *crowdfunding* campaign to pay for the assistance of "humanized" health professionals for a home birth. This experience contributed to change her positioning *vis à vis* her professional career, since she worked with social medias in the Internet, and then she realized that she did not need *"enterprises"* for joining women in the web. She reported that this first experience with motherhood brought her to a *"new ethical consciousness"* regarding the work she used to do before:

> "My stance changed, the way of looking at the tools. The tools are still the same, what has changed is the way of using them, definitely, the way of seeing other possibilities... by the way, I think that's what I'm going to use in my professional life, and that's what I have been looking for (...) **the fact of achieving my goal by asking for a contribution, in a short period, crowdfunding for all this money, and moving women... two things that I could trust: women are powerful, and yes, I**

> **can articulate myself in the Internet, I don't need an enterprise to pay for me, because I'm able to do... that thing about ethics**, you know, so, it completely changed, I see so many bullshit, right? In the Internet (...) I attended a course one year before I got pregnant, which was about contemporary communication, and now I am like this, kind of observing the opportunities... trying to trace a pathway, one that it's still vague, but in which I believe." (Renata)

Renata reported having read and participated in parenting groups online, from which she *"learns"* about children development to not *"traumatize"* her child as her mother traumatized her. But she did not like to participate in a particular feminist group related to motherhood, one of the few in the Brazilian Internet, where we had met. About this group, she criticises *transfeminist* rhetoric that exclude lesbians and single mothers like her. This rhetoric is related to the post-structuralist perspective that has been largely diffused in online activism in Brazil, favoured by the focus on agency through language (Vasterling, 1999) contrasting with a "queer materialism" that is interested in "experiences of domination" (Girard & Dorlin, 2007). Responding to a questioning by Irene Costera Meijer and Baukje Prins (1998) regarding the place of materiality in her theory, Judith Butler asserted her work as a "political fiction", thus emphasising the importance of language, but in trying to relate this political framework to "questions of survival as well" (Meijer & Prins, 1998, p. 277):

> My work has always been undertaken with the aim to expand and enhance a field of possibilities for bodily life. My earlier emphasis on denaturalization was not so much an opposition to nature as it was an opposition to the invocation of nature as a way of setting necessary limits on gendered life. To conceive of bodies differently seems to me part of the conceptual and philosophical struggle that feminism involves, and it can relate to questions of survival as well. (Butler in Meijer & Prins, 1998, p. 277)

However, it seems that these questions related to material survival, quite important to Latin-American and other ex-colonial geographies, are not Butler's main concern; then, if used as isolated or as main reference, her theory is not very promising to the understanding of experiences of domination lived by women under economic vulnerability because of reproduction and does not have much to answer regarding resistance in this kind of situation (Vasterling, 2010). However, since she makes quite a lot of effort to contextualize her proposals, it is intriguing why Brazilian Cyberfeminism promoted by post-structuralist rhetoric resists the inclusion of mothers' experiences in trying to "survive" in its political agenda. It seems that those resistances are related to Saba Mahmood's (2001) discussion on "docility" as the dimension of agency that comprises "those acts that (...) aim toward continuity, stasis, and stability" (2001, p. 212).

I do not only perceive this "aim of continuity" in agencies by mothers like Renata; instead, I understand that feminist groups in Brazil who prioritize deconstructing nature as a discursive limit to bodily life act in a complacent way towards the subordination of the most vulnerable women in the structure of do-

mestic work. This is certainly conditioned by the social class of the majority of those activists and by the fragmented way Feminism approaches the political agenda in Brazil. In concentrating in the claims by *transfeminist* activists, Brazilian Cyberactivism strongly defies the visibility of historical claims regarding the survival of mothers in a political system that criminalizes them for trying to have abortions, voluntary permanent sterilizations and for being absent to their children – therefore, a system in which "compulsory motherhood" is a material reality, experienced as a huge limit for different embodiments. When I asked Renata about her *"trouble"* with that specific group, she introduced the discussion on biological differences, which for her experience were quite important, however not easily recognized by those activists. She told me:

> "The trouble is that I am a single mother, right? I have no money, and I had no access to a pregnancy that did not affect me biologically because it affected me biologically. And the speech in which Biology does not count freaks me out! Biology fully counts, you know? I was physically sick, and I could not make a sense of this... I was trying to understand all this" (Renata)

Later, in 2015, she further radicalized the criticisms regarding *transfeminism*, enlarging it to all queer activism, in which she recognized this process of rendering the material reality of being a lesbian mother invisible – a paradoxical situation, since lesbian embodiment is one of the most focused by Butler and other queer feminists. It reveals the lack of an intersectional perspective in Brazilian Cyberfeminism, which would not be improved by adding different political identities but by the comprehension of the articulation of different sources of experiences of domination. Renata wrote in her weblog:

> "The agenda of this post is to fight against the appropriation of lesbian condition by whoever has a penis. As I said in my last post, *lesbianity* is a type of sexuality which has nothing to do with gender identity. Lesbianity is the sexuality of AFAB[58] gay people, those who were designated women at birth. It's independent of gender identity. Therefore, the relationship between a *trans* man and a material woman is a lesbian one. There is no risk of pregnancy in homosexual relations. A lesbian can never get another lesbian pregnant. The relationship of a self-proclaimed *trans* person and a material woman is heterosexual. We're talking about sexuality. Sexual relations can have consequences, and one of them is pregnancy. **If a self-proclaimed person can make a material woman pregnant, so the sexual relationship between them is straight. Whoever feels morning sickness, whoever feels bodily changes, whoever feels social pressure for compulsory motherhood, can never run away from this material reality which is pregnancy**. But the other part, the conceptual woman, that one who proclaims herself a woman but has a penis and testicles, this one has the privilege of being able to escape, and never appearing anymore, leaving the pregnant woman alone, even if not really abandoning her." (Renata)

Renata did not receive any support from her child's father that would be enough to maintain her; and since she was unemployed during pregnancy, she did not profit from a maternity leave when caring for the child during the first year, so she did not earn an individual income and was living in her own moth-

[58] AFAB means "Assigned female at birth".

er's home. During our conversation, she said that she could not pay for private childcare and could not trust public ones, because she had heard *"barbarities"* about them. Moreover, she was planning to share a house with other lesbian mothers who she thought would be *"really engaged, careful and involved"* in her child's education. She said:

> **Until then I don't know where to leave him [the child], I don't know who to trust.** And that is what I search for the future, you know? I want to make this plan for the near future; that is what I want when living with lesbian mothers. I want to leave my child with other persons and also take care of their children, for them to be able to study and do what they need to**. I need involved people, careful and really engaged and involved, you know?** Because it is not possible to... I don't know... I don't have money for a crèche, and **I don't trust public childcare**, I don't know, I heard so many barbarities..." (Renata)

Thus, coping with the rhetoric of preventing risks for children's healthy development, issued from maternalist groups, and female empowerment, issued from humanization, Renata could not feel comfortable enrolling her child at an institutionalized childcare centre. Trying to keep her head above water, after this *"diving"* into motherhood-related themes and not having responsive presences among feminist activists, she expected to count on the empathy of other lesbian mothers – with whom she hoped to find similar bodily experiences. Therefore, Renata had found, in the humanization of childbirth, a way of connecting her bodily experience with reproduction to a *"female empowerment"* strongly anchored on biological difference.

Like Renata, Sofia, also a single parent in Brazil, needed a full-time childcare service to be able to rejoin the workforce. But as she also had heard *"barbarities"* about public crèches from her mother – who is a retired preschool teacher – and could not afford private ones, she became paralysed in this issue. When I asked her what would constitute these *"barbarities"* she reported: *"the dirt, the food... the way caregivers smoke in front of children during recess... it seems that everything is very brutal"*. Later, in one of her diaries, she recognized that this image could be based on *"misconceptions"*, saying that nowadays she really wishes *"to have the courage"* of leaving her child at a public facility in a full-time basis. Sofia wanted to do an internship in a public preschool and supposed some positive aspects of public institutions of education, based on what she was learning in the Pedagogy course in university. According to her, one of the most positive aspects is the broader participation of families in the routine and decisions of crèches' organization. Being able to better participate in the institutional care of her child would improve her belief in this kind of facility.

Sofia's experience with the current preschool in which her daughter is enrolled part-time is positive, but, she reported feeling *"odd"* among the other parents, since they behave more like *"clients"* than as

active parts of the organization. The fact that she perceives herself as a different mother because of her unemployment status and the absence of her daughter's father intensifies this strangeness regarding the other families from the private school. In one of our conversations she said: *"I think that since I know they have regular jobs, with regular workloads, I feel even odder, like I do not belong to this world, their world"*. Despite this ambivalent feeling regarding childcare, Sofia's main goal was to *"be economically independent"* to leave her parents' house and not need the financial contribution of her daughter's father. Nevertheless, after feeling discriminated by the Editorial market, in which she used to work, and after the intense experience of presence she had in the first transitions of motherhood, she decided to change her career and keep working in an informal and part-time basis, which impeded the fulfilment of her goal.

Regarding the discrimination by Editorial Market, she narrated two job interviews that discouraged her from wanting to remain a journalist and editorial analyst. In those events, the company interviewers questioned the child's age and type of childcare, insinuating that the child was *"too young"* for Sofia to go back to work. She told me:

> "I think that, **at first, it was not me who rejected the editorial market, in fact it rejected me!** (...) I went to a few interviews, showed my CV and all that, always mentioned that I had a child... it happened in the first year, right, when she was eight months old and did not attend daycare yet, and I went looking for a job. **And twice I clearly felt the uncertainty regarding the fact I had a child and it was not in daycare yet, since I left her with my mother at home, so this was clearly the end of the interview, you know?** It happened twice... in one of those interviews, even the female interviewer said 'don't you think it's too soon for you to work? She's pretty young, your daughter' like giving me a hint, you know? Gently criticising me... So, I went back to doing *freelance* because I had stopped doing it, because you earn too little for it, as a proof-reader, the person who prepares the text for edition, so in these jobs you earn a pretty low income, like 600 Reais, you know? I had only few hours to work in daylight, even when my mother was taking care of A, she was a little baby, right? And I had to breastfeed... **So I started to reduce my expectations of going back to the workforce... and getting money as well, I started to enter in this cloudy period, which made me think that I could never go back**, and as I had already begun pregnancy leaving an employment, leaving a job, in which I was a journalist, and at the time I didn't want to work in this field anymore..." (Sofia)

In parallel to the troublesome experience of searching for a job, Sofia had also felt discriminated by a private *"alternative preschool"* in her city – one that she had idealised before. In trying to schedule a first reunion with the school's director – a Brazilian renowned "alternative" educator – she heard from the school's secretary that *"the presence of the child's father is very important for the school"*. Therefore, if he could not attend the reunion the secretary would *"see if the director could make an exception"* to schedule it without him. Sofia had told her that her daughter's father *"was not present"*, so she would be the one who would choose and pay for the school. Nevertheless, the meeting was not confirmed because of the father's absence, which made Sofia feel clearly discriminated as a *"single moth-*

er" for the first time. This opened her perception to other families' situations in which the heterosexual-marriage model is deconstructed. She said:

> "I didn't tell her, but right after I kept thinking... What if I had been raped? What if I was a lesbian? Like the three lesbian couples who are friends of mine, and there is no father, unless you consider the sperm donor as a father! We have all these different realities that are not considered by this progressive school. Even the simplest cases, like the case of separated mothers; they don't know how to deal with it! (...) **It was a lot of trouble, I mean... I had already gone through those two job interviews, which had led me to an intuition on how having children and being a single woman are issues for people to be like 'oh I get it', but I didn't see it as a problem, you know? I mean, I hadn't realized at that time**." (Sofia)

If Sofia could have a generating hesitation when living this last discriminatory situation, Ana Lúcia, who also approached Feminism after becoming a mother through maternalist groups, could not be as responsive as Sofia towards a divorced family. Her response to this different arrangement was to feel sad and sorry for the children, something close to the alternative preschool's approach. Still, it is comprehensible why Ana Lúcia experienced this transition to motherhood with a sexist perspective, even when identifying with feminist rhetoric, because during her preparation for childbirth, she found a source of intelligibility in *"alternative parenting"* for the project of undergoing natural delivery and bodily fluidity. In identifying herself with Dumonteil-Kermer's texts, Ana Lúcia reported having changed her *"identity"* and *"mentality"* after motherhood, and during our conversations, she mentioned a *"letter to a feminist"* from this author's magazine. She recognized the feminist criticisms to the approach of Positive Parenting while reinforcing motherhood as a political role via the voluntary donation of time:

> "She wrote a letter to a feminist, it's an article, I thought it quite interesting, it's nice because she says that it's a responsibility and she does not stop being a feminist because of that, because she assumes her political role, because she's educating the citizen of tomorrow. **I support Feminism, but I am a mother, I'm raising the citizen of tomorrow... I want a valuable citizen, and that's why I donate my time for him, because it is a phase in which he needs it**." (Ana Lúcia)

In addition, it is quite important to mention that Ana Lúcia herself experienced a sexist division of labour in her marriage and professional status in France. During the her diary recordings, she reported feeling very tired, wishing to have more time to be on her own, and expected her husband to *"collaborate better"* in being more present for their daughter after the year's end; however, she finally claimed to understand that it would be hard for him to improve his presence because of the demands from his professional career.

Their daughter, nowadays enrolled at public preschool, only started to attend day care centres in an occasional basis at the age of two and a half. Ana Lúcia did not have maternity or parental leave because of her status in the country, where she had never worked before; so she did not have an individ-

ual income. As she did not have an easy access to the formal the labour force and her husband *"never complained"* about her contributing to the family budget, she had been *"unworried"* about the pause in her career, thinking in giving up Law to becoming a *"Montessori assistante maternelle".* Ana Lúcia used feminist rhetoric to defend midwifery and maternal empowerment, however, with a quite sexist perspective that reflects her own family arrangement. During one of her diaries, she told me about a family in which parents were divorcing and reported feeling *"quite sorry for these girls"*, because they were going to live with the father, who is *"a very present person, who does everything for them"*, since *"the mother does not care"*. Then she received the girls at home to play with her daughter and reported me later:

> "**Yesterday was a different day, because I felt kind of sad about the girls**, because I know their situation with the father and mother... Then, I feel like... as I do like children, you know, I feel a lot of pleasure when they come here and feel well.... **That they can see a woman who bakes a cake for them and takes them to promenade, because I know that their mother doesn't do that**" (Ana Lúcia)

As Ana Lúcia had this binary perspective on family life, it was quite bizarre for her to know about a different family which could not correspond to this ideal. As gender differences were naturalized in her perception, she felt a *"sad"* hesitation regarding this other family. This kind of naturalization is a process by which habitual perceptions foregone certain aspects of bodily distinctions and erase the relationality in which the body is engaged (Al-Saji, 2014). Although those children's father is *"very active and present"*, she could not recognize his presence as sufficient, since he is not a *"woman"*. On another hand, she engaged herself in performing an activity she directly corresponds to female maternal motility, to ensure those children but also to respond to her own sad hesitation: in *"baking a cake"* and deriving *"pleasure"* from being with children.

This kind of repetition of gendered gestures that correspond to intelligible modes of being-in-the-world constitutes the habitualities that Ana Lúcia developed during a long-term situation in which she was her child's main caregiver, responsible for domestic duties, without any significant social presence around them. Without other responsive presences that could de-construct sexism, and having childbirth and early childrearing as events for which she needed this naturalized perception on female motility, Ana Lúcia could not have a creative hesitation. That is why, for her perspective, while the other mother's absence was quite sad, her husband's absence was easily understandable. As one can note, although reporting being feminist, Ana Lúcia could not be ethically responsive to this other woman, since her way of identifying to Feminism was quite child-centred and naturalized sexual differences.

However, as Ana Lúcia's experience is also marginal in France, she connected to Positive Parenting as an alternative way of being parent in the country, using Brazilian identity as a justification for her choic-

es of breastfeeding on-demand and of being dedicated full-time to childrearing when confronted by French culture. It seems that being confronted with otherness and being "the other" may encourage women to crystalize the mark of difference and agglutinate some aspects in one "alternative" Brazilian identity. Ana Lúcia told me:

> "French mothers don't want to be so attached, they assume their choice for bottle feeding, because they cannot be dependent on the baby. But, in here, they really criticise who does it differently. **I say right away that I'm Brazilian and because of that I do it this way, to avoiding getting harrassed. You have to be pretty alternative, pretty confident, to give an explanation (...) But what I have seen in here is a growing movement for alternative mothering** by mothers who want to breastfeed more, wearing slings, who are against the French parents' violence." (Ana Lúcia)

Regarding this process of *othering* French mothers, I observed different kinds of hesitations propitiated by the broader environment in which the participants experienced the first transitions of motherhood, such as childcare arrangements and professional situations. Like Ana Lúcia, Célia referred to her Brazilian nationality as an explanation for protecting herself from French people's judgments on her parenting style, because she felt she was being *"too protective"* compared to those women. In Célia's case, this process of antagonizing French mothers and *nounous* led her to a fear of institutionalized childcare, reinforced by her husband's story on his own bad experiences with *"l'école maternelle"* in his childhood, since he was raised by his Portuguese parents who *"had to work a lot"* in France. Therefore, she avoided thinking of leaving her child at an institutionalized childcare centre, and only sought vacancy in crèche in an occasional basis when the child was almost two years old and she was feeling quite tired of the care routine.

Furthermore, in different situations, I could identify moments of authentic hesitation which could motivate those women to find a way of sharing childrearing and having better time for rest and self-caring. However, since they could not find a social presence that assured the quality of a good and affordable care, in accordance to the ethical *attunement* they had developed, they could not open the perception to intuitions. Furthermore, if they were not supported by their partners in this search, and instead they were pressured by them for accomplishing a moral disposition of being continuously present despite fatigue, these women could barely legitimate their intuitions and were trapped by guilt. As Al-Saji (2004) examined, intuition is more than a cognitive effort, it is intensely affective and occurs even when one does not expect it: "Intuition represents a double effort with respect to recognition: it is not only the temporary suspension of habitual action (automatic recognition), but also a pulling back from the actualization (condensation and selection) of memories into representational images (attentive recognition)"

(Al-Saji, 2004, p. 225). Therefore, intuition has a great potential for improvisation and creation of new responses to adversities, when it can be expressed and "auscultated".

For instance, Luise's husband was quite engaged in the project of having children through the rhetoric of humanization and Attachment Parenting, as he was intensely dedicated to reading and writing about this project; and through that, he reinforced the demands of therapeutic motherhood to Luise. In obscuring her authentic intuitions just after their son's home birth, and in refraining from fully participating in the collective childcare she created with other parents a year later, he contributed to her loneliness and sense of overburden. When describing the subsequent events of childbirth, during a serious case of *"baby blues"*, Luise told me about her need to be distant from the child for an entire night – which became possible after the child's second hospitalization demanded by a paediatrician. Unlike her husband's concern with breastfeeding, this temporary absence did not impede it to happen; instead, this *"distance"* was fundamental for her to pursue the goal to breastfeed, as she told me:

> "As he was hospitalized, we could not stay with him, he was in the ICU, then we came back home. So I don't know exactly if I managed to distance myself from the problem, you know? To leave that fog of a problem... **I could sleep for an entire night, and he was away, I knew that he was being well taken care of, I slept very well, so I don't know if it was that or if it was the fact that I saw that things could be much worse. But I think that was very important, walking away from the problem was quite important.** And soon, in the next day, I came back there, and I've tried to breastfeed him, and I went to the milk bank, and I succeeded breastfeeding without having as much trouble as I was having before." (Luise)

Regarding the collective childcare Luise created with other mothers, she reported that her husband justified his absence towards care activitieswith the Attachment Parenting rhetoric , in saying that *"it is not good for the child to have this caregivers' alternation"*. The last time I talked to Luise, after her participation in the research, she complained about his position, asserting that she would try again to convince him to better participate in the project, since the crèche was creating a greater demand for her instead of liberating more time for rest, study and work. According to the last news I had, this collective childcare did not prosper. It is important to mention that Luise did not have much contact with the child's grandparents and did not like her mother-in-law to be close because she had *"a complicated relationship with her son"*, which produced more *"demand"* over Luise instead of some relief.

As for Célia, she planned her pregnancy two years in advance, because she knew that *"it is not so easy to have children in France, it is very expensive"*, mentioning the lack of vacancy in public crèches. Therefore she researched about the parental leave she could have in the country, and worked as a cleaner for two years before getting pregnant, so she could be entitled to a benefit of 700 Euros during her second child's first three years. As she did not speak French fluently and did not have the oppor-

tunity to work on her field of expertise, she found that it was better to stay with her son at home, not pursuing a job, and receive this payment, which she considered her individual income to help the husband paying for their *"lifestyle"*. She said:

> **"But everything was planned, because I told him: 'I really want to have another baby'**. And my husband will be 50 years old next month and I am thirty-five, and he always said like... he doesn't have children, he had two relationships before but he never had children, so he said that he was quite old and our child would call him grandpa... and I told him: 'no, stop that!' **So it was laborious, it was a psychological labour to convince him, but I said: 'no, first of all I need to have all my documents, firstly I need to have a job', because I knew about my rights regarding the second child**. Because for the first child one gives you six months leave, but for the second one you can have three years leave and even earn 700 Euros for taking care of your child at home until he is three years old, right? So, after I got my documents, I got a regular job, and you have to fulfil a minimum period working, you pay your taxes to have this right three years later. And that's how I got it, two years of registered work, then we started to try but it was pretty quick, I got pregnant soon after (...) as in France it is not so easy to have children without help... so as I already knew that I said: no, to have a child in here I need to wait a little to earn the right, because if I did not have the minimum time of regular work I could not receive the help they give you here, which is pretty good, isn't it? Because leaving the child with a *nounou* is quite expensive in here." (Célia)

During our conversations, Célia told me that she was quite tired of being alone with her baby at home, and tried to search for a place in a public *halte-garderie*, which was difficult because she did not have a paid work and was therefore not considered a member of the priority group for this service. Despite that, she continued to wait, and finally had a place to keep her child three times per week in a part-time basis when he was two years old. She was thinking aboutusing those intervals to study and preparing herself to develop a new profession in France.

The French welfare system has been particularly built on the idea of common age straits and life cycles, in which one identifies specific relevant events, such as schooling, marriage, entry into the labour force, reproduction and ageing (Nicole-Drancourt, 2007). The pension system is strongly anchored on this ideal structure, in which men are expected to be dedicated almost entirely to employment and women are expected to allocate their time between flexible work and motherhood. Thus women's employability is, in the long term, dependent on this chronological conception of life-time; despite their increasing dedication to educational and vocational training, it is difficult to achieve further space in the labour market competitiveness, especially for immigrants. This kind of affirmative policy based on sexual difference has failed to promote greater integration of men in family life, while it also failed to integrate young people in the qualified work force. Therefore, young people are mostly staying dependent on their nuclear family structure, while women are gradually more involved in public and economic affairs. However, it increases inequality among women from different social classes or backgrounds, as immigrants

have most difficulties to integrate the labour market, having higher fertility rates. Such critique appears in Nicole-Drancourt's (2007) analysis:

> Les critiques féministes qui se sont développées dans le sillage des travaux sur les régimes d'État providence ont montré combien des « conventions de genre » inégalitaires sous-tendaient, en France, la logique d'organisation familiale traditionnelle, familièrement nommée le « modèle de Monsieur Gagne-pain ». Ce modèle, qui encadre et distribue droits, protections et obligations pour les hommes et pour les femmes, est issu de la logique des premiers régimes spéciaux de sécurité sociale qui accordaient aux femmes des « droits spécifiques » fondés sur leur « différence ». Cette logique, qualifiée de « protectrice », conçoit la capacité féminine à enfanter comme un devoir maternel qu'elle élève au rang de devoir national. (Nicole-Drancourt, p. 185, her quotations)

During her diaries, Célia complained about the expectations of her husband for her to accomplish all the domestic duties beyond childrearing. However, one can observe that her experience was marked by a consciousness of her economic and social situation as a Brazilian mother in France, which prevented her from being completely dependent on her husband, despite not having enough time to invest in her professional career. One can assert that French family policies contribute to women being less vulnerable when they do not have easy employability, but it is still insufficient because of the lack of childcare vacancy. The French report on women's decision to apply for a full parental leave asserts that those mothers have a higher possibility of getting back to the labour force after ending the leave than mothers who stop working without any aid (Crenner, 2011). However, it also recognizes that those women have less professional qualifications than the ones who do not use parental leaves and go back to work soon after their maternity leave. Therefore, their situation is worse than the French working mothers' but better than the ones who do not enjoy any institutional aid.

Regarding Swedish family policies, I observed that despite an important set of parental-related benefits and strong gender equality rhetoric, the first year of childrearing can barely be shared between the couple, including with grandparents. For the participants of this research, this constituted a social presence that legitimates the experience of loneliness and fatigue as unavoidable and "natural" parts of becoming mother – a very similar type of experience to what Martiskainen de Koenigswarter (2006) found in a research with Finish mothers in extended parental leaves. For instance, Marina reported that her Swedish husband's relatives behave *"as they should not be involved in affairs between mother and child"* during the first months after birth and she did not find them sufficiently present during that period.

Vanessa, a mother of a six month-old child who was enjoying a full-time maternity leave in Sweden, did not have a good experience with pregnancy, because she felt various mobility difficulties, was constantly *"tired, sleepy, with hip pains"* and wanted to have a caesarean surgery instead of vaginal birth because of the pain and discomfort of labour but, since in the Swedish system, *"there is a huge campaign*

against caesarean", she decided to *"experience pregnancy without thinking a lot about birth"*. After a fast labour and a very satisfying assistance with vaginal childbirth in the public system, Vanessa felt quite emotional and received the help of midwives in the maternity facility to engage in breastfeeding, with which she ended feeling *"irritated because of all the different tips they gave"*. Being at home, finally, she could *"relax"*, but then, she started feeling like her *"identity didn't exist anymore"* because of all the changes in domestic ambience and routine, including the fact that now they *"only listen to childish music at home"* and that her daughter is who *"decides"* what they are going to do during the day.

Vanessa reported that when her daughter sleeps during the day she is able to enjoy reading – an activity she really misses – but ends up *"reading about motherhood on the Internet"*. In recognizing this habit, she was startled for a while and could not find an explanation. Finally, she explained to me that once she connects to interests other than motherhood she becomes less patient with her daughter and more frustrated because of the constant expectation of being interrupted – this is reminiscent of Tillie Olsen's quote on mothers' absences as literary authors:

> More than in any other human relationship, overwhelmingly more, motherhood means being instantly interruptable, responsive, responsible. Children need one *now* (and remember, in our society, the family must often try to be the center for love and health the outside world is not). The very fact that these are real needs, that one feels them as one's own (love, not duty); that there is no one else responsible for these needs, give them primacy. It is distraction, not meditation, that becomes habitual; interruption, not continuity, spasmodic, not constant toil." (1995, e-book edition, p. 942, her italics)

Vanessa's constant expectation to be interrupted was accompanied by a limitation of space, because at the first month after birth she was asked by a midwife to reduce breastfeeding intervals, since the infant was not *"gaining proper weight"*. This produced a routine that was extremely limited by domesticity since she had much difficulty to breastfeed outside. The *"relief"* of this daily constrained routine was on the presence of another responsive caregiver – her husband, who arrived from work at the end of the day. Vanessa explained:

> "**This is one of my frustrations with motherhood, because you cannot plan things**, it's her who decides... when she's hungry and such... (...) **because I hate initiating something and being interrupted, and in the last months I have realized that I don't even want to start anything because I don't want to be interrupted**, then I don't start at all. So there are a lot of pending things that I wanted to have done, that I could be doing every day, including taking care of myself, then I tell myself 'oh no, soon she's going to wake up and I'll have to stop anyway, so I'm not even going to start it, in a while my husband will arrive to keep her or during the weekends, then I'll do it' but then I just don't do anything, and it has been like that for the last six months (...) I am not used to leaving the house really, because during a month I had to feed her each hour because she wasn't gaining proper weight, and it was pretty laborious to get out with her, so during the first three months I just kept at home, I hardly left (...) **at night I'm much more relaxed, when it becomes four and a half I start to be anxious, wishing him back from work, and he usually arrives at five, five and a quarter,**

> **then I keep looking at the clock, waiting for his coming, because I know that when he arrives (long sigh) then I can relax** (...) I began to compensate my frustration in another way (...) unfortunately I found the wrong way of compensating my frustrations." (Vanessa)

In fact, I could observe through the documentary research that Swedish reports on family policies privilege evaluating gender bias in the use of parental leave rather than introducing a discussion on early (0 to 12 months) childcare facilities. In this country the only option to complement parental childcare at this period is private child-minders such as "au-pairs". The reports has sown that despite the variety of possibilities for using financial and employment benefits related to parenting, most Swedish families use the 15 months of parental leave continuously (Duvander, 2008), with the mothers as main caregivers, which is related to the high rate of breastfeeding (Well & Sarkadi, 2012). Fathers are entitled to this right since the 1970s, but use less than 25% of the total time used by all parents (Duvander, 2008; Duvander & Haas, 2013), and when they do, usually they do not engage in usual childrearing practices such as visiting Children Health Centres (Wells & Sarkadi, 2012). One of the reasons for men's absence from Health Centres, found by Wells and Sarkadi, is the centralization of mothers as the main focus of professional recommendations and interventions towards infant health. This is probably due to mothers' co-presence at home most part of the time when fathers are using parental leaves – which was the case in Vanessa's family.

Vanessa told me that her husband was anxious to take six months *"vacation"* in reference to the leave. This way of talking about the leave made her quite concerned and irritated because it seemed that he did not have a realistic idea of how difficult her work was caring for their child all day long. Actually, Swedish family policies assume that women are able to take full time of childrearing during the first year, as part of the *"campaigns for the 'natural'"* (Viviane); they do not inquire on the parent's emotional availability of doing so, especially mothers. If there is sign of postpartum depression or traumatic events in early motherhood, women can get psychological help, still with the goal of helping them to be present for their children – the kind of support described by Marina after a traumatic childbirth for her to *"learn how to be connected to the child"*.

The strong gender perspective in Sweden, since the 1970s to improve equal parental leave is represented in the goal of giving women and men the same opportunity to have "free personal development" (Nyberg, 2004, p. 1), whereas childcare policies are focused on children's rights to Education. Thus, the policies undertake that sharing childrearing with nurseries during the first year is neither beneficial for parents nor children, assuming that during this period the binomial relationship (mainly mother-infant) is naturally satisfying for both. Before getting pregnant, Vanessa was enrolled at a University to

prepare herself as a language teacher and also gave Spanish private classes, but after listening to her reports about the fatigue and frustration of her *"new routine"*, I asked her if she had thought in complementary childcare service for going back to her professional activities, and she said that:

> "Here, in Sweden, there is no option of sharing childcare during the first year because for Swedish people **this attachment to the babies is almost a religion**, they say 'poor little thing' if you say that you're going to leave the child with grandmother or another person". (Vanessa)

Vanessa told me that *"eating*" is how she compensates this frustration with time-consuming of motherhood, because it is something pleasurable she can do while she continues to be present for her daughter. In parallel, she had ambivalent feelings regarding her work life, feeling *"forced"* to assume most of the responsibility for childcare as a real *"work"* activity and feeling bad when the child's father woke up in the middle of the night to take care of the baby, saying:

> "He is a journalist, then he has to be with a rested mind to work. **My fatigue is not mental, it is physical. I feel that taking care of our daughter is an obligation**. So if he is awake in the middle of the night, I think it is not fair. This is my work now... I'm not doing anything... I don't have to study, I'm not working outside, I am in maternity leave for this". (Vanessa)

At this point, one can assert that it is quite relevant that Sweden concedes parental leave as an individual right, not restricted by the beneficiaries' sex. However, since one has flexibility of time-use and sharing of the leave – as it can be used by one or both parents in a part or full-time scheme and until the child turns eight – it should be interesting to provide childcare services for the first year as an effective support for parents, also in the aim to stimulate men to increase the use of the leave in this period. As asserted by Elvin-Nowak and Thomsson, "Mothers who live in Sweden have to construct their motherhood within the context of a gender-equality discourse, but in an everyday reality that is not gender equal" (2001, p. 410). Even while recognizing the important social rights that favour high fertility rates along with high female employment rate, Elvin-Nowak and Thomsson's concern is still suited Swedish reality regarding the sharing of childrearing and domestic duties.

Portugal is the European country which presents the highest employment rate of women of childbearing age and represents an important evolution in gender equality the last decades (Vasconselos, 2011; Wall & Amâncio, 2007). However, men's general attitude regarding childrearing and domestic duties did not accompany this economic situation, nor did the expansion of childcare policies, which is probably related to low fertility rates (Wall & Amâncio, 2007). Karin Wall and colleagues reported that the last governments have continuously reduced family financial supports, menacing important rights that have already been granted in this field. The authors identified the rise of poverty among Portuguese families and the impact of this problem in children's well-being (Wall et al, 2014).

Furthermore, in a report for the National Board of Education *(Conselho Nacional de Educação)*, Vasconselos recognized an improvement of 13% in the number of crèche vacancies in the last decade, albeit asserting that in light of female workers' needs it was not sufficient. In her turn, the author emphasises the need for quality improvement of childcare services, including professional qualification of caregivers and a clearer position from the Ministry of Education regarding its role. In the last twenty years, Portugal went through the same transition as Brazil, shifting childcare policies from Social Assistance to the Education sector, but still maintained a strong workers' rights rhetoric, with interesting strategies of articulation among the Ministry of Work and Social Security *(Ministério do Trabalho e da Segurança Social)* and the Ministry of Education. However, the analysts assert that those political strategies can produce better outcomes if receiving adequate public investment – which has been jeopardised by the context of economic crisis.

Furthermore, while Wall and colleagues (2014) present a strong focalization in welfare and economic status among Portuguese families, Vasconsellos (2011) tries to argue for the investment in early childhood as a strategy to reduce the risk of poverty and related social problems. Bringing the globalized rhetoric by UNICEF in the infant's neurologic and emotional development but also affirming childhood as an "interdisciplinary field", referring to sociologists and philosophers, Vasconsellos emphasised that the low quality of Portuguese nurseries is admitted by different scholars.

All participants who had children in Portugal planned to use childcare services after the first year, since they were not employed and thought that at this age *"the baby would be too young"*. But only one actually did before participating in this research. Lidiane suffered a bad experience with the first crèche in which she enrolled her son at the age of thirteen months. She was strongly willing to use this service for retaking a University course in Psychology and to *"redeem"* her *"identity*", which she felt she lost with motherhood transition. Nevertheless, the child's adaptation at the daycare centre was quite difficult, since he *"cried a lot and got a rash all over his body"* in the first weeks. She insisted in using this crèche, even *"feeling guilty for being relieved to leave him there"*, because she believed that her *"negative feelings with motherhood could be improved through distance"*. But not long after this, Lidiane's mother came to visit her in Portugal and interfered in the situation, asserting that her grandson *"was badly suffering in this nursery"*, and offering to pay for another more expensive one – which Lidiane and her husband accepted. According to her, the child really got better attending that second crèche, and she could finally feel well in reorganizing her routine without feeling guilty.

However, just after this change, her husband lost his job, and since Lidiane did not work and could not find a job to provide for the family while he searched for another employment, they had to move from Portugal. He had received an offer in Brazil, but this proposal did not materialize when they arrived in the country. During the entire year the family stayed there, searching for employment and living in the grandparents' households, Lidiane stopped her Graduation and the child was enrolled in a part-time "alternative preschool" chosen and paid by the grandmother – which contradicted Lidiane's wish because she *"did not agree with the school's philosophy"*. Finally, her husband got a job in France and they moved there. When we first met, Lidiane was starting to learn French, while the child was in a part-time public *école maternelle*. She had to postpone her plans of studying Psychology and kept struggling with the feeling of *"not liking to be a mother"* and *"not loving"* her son as she was expected to do.

Therefore, as one can observe, the interferences and breaks on Lidiane's childcare strategies in the early period of motherhood hampered her expectations of overpass the *"very difficult experience"* she had with the transition to motherhood. As already commented in a previous part of this thesis, despite of not having a clear diagnosis of Post-partum Depression, during our conversations, Lidiane wondered if this pathology could explain her negative feelings towards motherhood. It is not my goal to pursue a deeper discussion on Post-partum Depression (PPD) in this text; still, it is important to note that other feminist scholars have analysed how this pathology can be used to expose the suffering of different women with the idealization of motherhood and the related loneliness in trying to be a "good mother" without relevant social services. As Williams has discussed in analysing North American cases of maternal violence, the same ideal that is used to condemn women suffering from PPD is the foundation of their terrible negative feelings.

> In fact, these ideals themselves contribute to maternal depression; in a recent qualitative study of women who killed their children, the murdering mothers cited this very cultural idealization of motherhood, and their resulting feelings of failure that they could not live up to the ideal, as a contributing factor of their crisis (Williams, 2014, p. 115)

IV.1.C TRYING TO BE A GOOD MOTHER THROUGH THE IDEAL TIME BALANCE

The ambivalent relation of middle and upper-class mothers with childcare is associated to an ideal pattern of motherhood in which there is not much space for institutional and male presence directly towards children. This model is constructed under the dichotomist moral rhetoric of "good" and "bad", by which non-normative mothers are pressured to somehow compensate their "failures" in dedicating themselves even more to the project of chosen motherhood. Although the participants did not mention "good" or "bad" as specific categories, these ones appeared in their narratives through specific enunci-

ations such as *"being a conscientious mother"*, *"active mother"* and *"attached mother"* – the latter being a "new" reversing of old disciplining of mothers' relationship to their children, as a resistance against modern control of bodily engagement of women towards children. In this context, the dichotomies that hierarchize mothers' identities are in fact reinforced or deconstructed by disputes around the ideal time imbalance among work and family. However, this "time-use" is enunciated as a personal choice, sometimes as a "privilege", rather than a contingency related to social presences for "good parenting" (Zimmerman et al, 2008) – as Toni Schindler Zimmerman and colleagues identified in discourses in the press:

> Important issues such as poverty, lack of affordable, high quality childcare, unequal pay for women, third-shift work by mothers, and low levels of participation in child rearing by fathers are regularly neglected in the contemporary discussion on mothering. The public dialogue also fails to recognize families where there are two mothers involved in the children's lives, such as lesbian families and binuclear families that consist of both a mom and a step-mom. (...) These messages have contributed to the illusion that working mothers are selfish and deny affection to their children. On the other side of the spectrum, the media depicts stay-at-home mothers as dependent women. (Zimmerman et al, 2008, p. 205)

The "mummy wars" diffused online in different webs, as British, North American and Brazilian Internet is constituted with this kind of hierarchizing of "good/more" and "bad/less" mothers according to the fake antagonism of "stay-at-home mothers" *versus* "working mothers", which occults the *real* issues of social rights for parenting under a rhetoric of mothers' choice (Zimmerman, 2008). Despite being present in contemporary Internet, this ideological war is not new. It is related to the historical construction of maternalist movements that fed political agendas and consumption markets around families in the 20th Century. As Casilli (2010) has pointed out, the political engagements through CMC are not separated from the broader political context – they have the potential of approximating further different standpoints whereas also intensifying their *massification* under hegemonic narratives and social representations (Santos, 2000; Jovchelovicht, 2008). The following lines from a weblog text written by Marina, seven months after her participation in the research when her son was one year old, exemplifies how this ideological war is presented in the maternal web. In discussing her experience in Sweden, commenting on the importance of having close friends who are also mothers with children of the same age, she hesitates when she recognizes some differences among them. Reporting to the common "mummy wars", she responds to an imaginary reader that she is not trying to show "who is better" whereas clearly standing a defence against the use of pacifier:

> "The issue about the child's age, here it is important not for B to have a buddy – at this point is difficult to know if those children will sympathize with each other – but because we as mothers can talk about more or less the same things. More or less... right? **Because I've been told that I chose**

> **mothering the hard way: cloth diapers, breastfeeding on demand, attachment parenting, sling, co-sleeping and... the most terrible thing of all: I didn't give B a pacifier**. Particularly, a pacifier is an accessory used to shut the kid up and to ruin his teeth. Fortunately, when B was a new-born he slept so much that I never felt like (or needed to) give him a pacifier. **So, before anyone accuses me of calling someone who gives pacifier "less of a mother", I just say that I'm not stating that. I know much better mothers than me who give pacifiers to their children**." (Marina)

The idealization of maternal identity was important to early women's movement to claim for formal education and political rights, based on the valorisation of mothering activities as a nationalist and scientific informed role (Knibiehler, 2000; Freire, 2005). By that, it favoured the politicisation of domestic matters but also prompted a paradox to subsequent women's rights in intensifying inequalities among women (Ladd-Taylor, 2014). As discussed by many feminist scholars, this historical politicisation of Maternalism has resorted to psychological and sanitarian discourses that do not favour the inclusion of different realities and experiences of being a mother in the large scope of women's rights (Meyer, 2005; Fay-Robles, 2013; Ladd-Taylor, 2003; 2014). One can say that the "good mother" identity does not include maternal experiences by which motherhood is a contingency, not exactly a desire, or in which desire is not fulfilled by choosing motherhood or by time-consuming intense mothering. Even if this model has been deconstructed by different contingencies and social movements, nowadays, therapeutic and chosen motherhood update fake antagonisms based on those categories.

As a historical outcome from old Maternalism, the category of "bad mother" encompasses women who do not correspond to the ideal female citizen, which means that it also depends on the national states' rhetoric about nationality and citizenship. In the contemporary paradox of globalization and Human Rights (Brito, 2013), globalization is mistrusted and blamed for various social problems in developed countries, whereas it appears in the political agenda as an opportunity for poor and developing nations (Pombo de Barros, 2009). It means that in Europe, immigrant mothers from ex-colonized countries barely have access to this ideal identity of "good mother"; the same happens to lesbian, adoptive, poor, and other categories that, in each country, confront the nationalist projects still represented in contemporary states. On the other side, in ex-colonies, the hierarchizing of mother identities not only reproduces the historical colonization but also corresponds to the local class relations. Among the participants of this research, the referring to internationally recognized activists and authors, such as Michel Odent, and globalized norms enunciated by UN organizations, such as "exclusive breastfeeding", revealed how this mothering "socially constructed on a mass scale" (Zimmerman et al, 2008) is lived by middle-class Brazilians as an injunction to fulfill a pattern of citizenship, whereas conflicting to the realities of many women in the country. As reported by Natalia when she wondered about the time she spent in materni-

ty leave in France, during one of her diaries: *"if you stay with the child at home for long time, you can be trapped by the ideologies of motherhood"*.

As Ladd-Taylor observed in North American context, I could observe how in Brazil, Portugal and France one can view a hierarchical separation among mothers who have social benefits to conform to maternity models and the ones who would not need these benefits because of their accomplishment of chosen motherhood by a meritocratic logic. As for Sweden, one observes a powerful discourse on children's and women's "natural" needs in parallel to a pressure for women to achieve economic autonomy to accomplish gender equality ideals, albeit with a strong valorisation of state provisions for all families (Elvin-Nowak & Thomsson).

Regarding maternity leaves in Brazil, I could find one report from 2007, produced by MPS' researchers, in which they analysed the history and evolution of this benefit. The survey showed that the rate of maternity leaves used by mothers remained almost stable in the last decades, with few variations related to the changing of some contractual rules. Unlike MDS reports, this one does not account for racial inequalities, but analyses differences among rural and urban beneficiaries. The report does not have interest in communicating with beneficiaries or a broader audience than the Ministry and public policy managers, which can explain why it recommends the Ministry to focus more on the "stimulation for opportunistic behaviours" by the recipients (Ansiliero & Rodrigues, 2007, p. 9, free translation). After presenting a misleading comparison among different countries – for instance, including parental leave time in Sweden as if it were exclusively maternity leave – the authors suggest that Brazil is in accordance to international recommendations on the "protection of motherhood". It also argues that low fertility is the main reason for other countries improving maternity leaves, which would not be the case in Brazil.

Nevertheless, as Carvalho and Brito asserted (2005), fertility was historically used by political ideologies in Brazil to standing communist, neoliberalism and/or autocratic projects in the public agenda. This disrupted the development of effective public actions regarding family planning. The imaginary of the "greatness" of Brazilian geography and the myth of social policies as incentives for "opportunism" regarding fertility are still present in political agenda as a problematic heritage[59]. According to these authors, Brazilian state took too long to recognize the declining of fertility as a sign of great social inequalities, and is taking too long to recognize it as an opportunity to improve welfare (Carvalho & Brito, 2005).

[59] One of the most common criticisms about PBF refers to the belief that the benefit would encourage poor women to have more children in the aim of being entitled to a higher amount of money, which proved not be confirmed by the most recent MDS assessments.

This kind of exploitation of sexual and reproductive rights by Brazilian state shows how women's citizenship is historically disregarded, especially African-Brazilian's.

> O declínio da fecundidade no Brasil foi vertiginoso: a taxa de fecundidade total de 5,8 filhos nascidos vivos por mulher, em 1970, caiu para 2,3 em 2000. Contudo, nem todas as mulheres têm tido um acesso democrático aos meios contraceptivos e a todo o progresso técnico ligado à saúde reprodutiva. (...)Hoje, os direitos sociais impõem- se sobre as teorias que justificavam as velhas contendas. (...)Não se trata de uma interferência impositiva ou constrangedora, como ocorreu e ocorre em outros países, mas de criar condições, através do poder público, para que todas as mulheres possam cuidar de sua saúde sexual e reprodutiva e regular a sua fecundidade, segundo seus desejos e necessidades, podendo, assim, caminhar para para o exercício de sua cidadania plena (Carvalho & Brito, 2005, p. 365)[60]

While, in Brazil, being a poor mother enrolled in state's social programmes is one of the "bad-mother" stereotypes who needs state protection and control, in France, this occurs mainly with immigrants who, because of the difficulty of having qualified employment, are not a priority for vacancy at childcare centres, using further parental leaves. In identifying the "identitarian dynamics" of mothers benefited by parental leaves, in a monograph financed by the *"Caisse d'Allocation Familiale"*, Stéphanie Gosset (2004) categorized those women into two types: *"mères possessives"* and *"mères conciliatrices"*, clearly conferring to the second ones a more "adapted identity". Even considering that professional status, qualification and having childcare options in accordance to their expectations play important roles on the decisions of those mothers in using full or reduced parental leaves, Gosset (2004) attributed these outcomes to personality aspects and cultural beliefs. In her analysis, one can realize a naturalizing perception on the difference between mothers who take full parental leave and stop working and the others who use the benefit to reduce workload – the latter being part of the "good mother" stereotype. The author tangencies the idea of this difference as unchangeable by public policies, converging to the process of naturalizing discriminatory perceptions. In discussing the dissatisfaction of *"mères possessives"* with childcare options, she asserted:

> Mais aux yeux des « insatisfaites », aucun dispositif d'accueil ne trouve grâce. Leurs présomptions entraînent inévitablement le choix du taux plein. On retrouve parmi ces femmes, celles qui se seraient complètement arrêtées de travailler y compris si l'APE n'avait pas existé (...)La crainte de laisser ses enfants est expliquée par le fort attachement dont ils font l'objet (Gosset, 2005, p. 64, her quotations)

On the other hand, DREES reports clearly focus on the direct association between workload and childcare mode, further analysing how much chronological time parents assume for childrearing activities and how it is related to their professional status (DREES, 2014; Villaume & Legendre, 2014). In those

[60] In 2015, Brazil registered a fertility rate of 1.72, according to IBGE's website : http://brasilemsintese.ibge.gov.br/populacao/taxas-de-fecundidade-total.html

reports, the French government seems to attribute to employers an important role on time imbalance inside families, which is a growing trend in the country following what Pailhé and Solaz (2009) have defended as a major problem in the debate on the conciliation of family and work-life. However, it is firmly anchored on a chronological logic in which the temporality of mothers' moral disposition, even if they pass much time physically away from their children, is not considered (Bessin, 2015). In addition, the ONPE report shows a broader concern with regional disparities and childcare modes, focused mainly on the quality and duration of those modes. They account in detail how much time children are cared for outside homes, recognizing a growing demand for full-time services but also a raising concern regarding the long-stay of children out of their homes (ONPE, 2010). In France, the tendency of investing further in certified child-minders instead of providing more places in childcare centres is favoured by this idealization of a home-based care. Still, the ONPES report shows that parents who preferred crèches were able to attend less than the ones who made other choices in the recent years.

Karin Wall (2007) has concluded that Portuguese men's and women's aptitudes facing gender imbalance and parenting are quite contradictory. Although, among Portuguese people, the agreement on the importance of women's work for gender equality is significantly high, there is also "a very negative aptitude facing mothers who worked in a full-time basis when their children are too young. According to these patterns, one values 'maternity' and women's part-time workloads in the aim to support children" (Wall, 2007, p. 218, free translation). For Vasconsellos (2011), the Portuguese government should encourage the flexibility of nursery shifts, not only to cope with unusual workloads but also to complement part-time parental leaves. Furthermore, she referred to worker union recommendations for a "politics of time" that includes territorialisation as an important issue, considering the time parents spend in routes between crèches, workplace and homes.

Therefore, Sweden, France and Portugal have made important improvements in their family policies in the last decades, incorporating "time imbalance" issues; still, the temporality of early childrearing is not fully accounted for, since they maintain insufficient places at full-time collective childcare for children under three years old – despite the recognition of parents' demands for this kind of service. In this context, in which the rhetoric of risk expands through therapeutic culture, from spatial to temporal disciplining of bodies (Moreau & Vinit, 2007), being a "good mother" means to be able to dedicate most part of chronological day-time to children or affording an individual caregiver for reproducing the maternal-infant boding. At the same time, it means to not be dependent on the state's provisions and enjoying minimum economic security.

From this rhetoric, one identifies an idealized measure of giving time to children mainly related to a full presence during the first year and a part-time presence in the subsequent ones, without charging the state or demanding men's presence in domestic duties; however, expecting their participation in family decisions. Thus, many of the participants asserted that being stay-at-home mothers during the first year was a *"privilege"* (as for Luise, Raquel, Simone, Ana Lúcia, Virginia, Olivia, Flávia, Rebeca) even if this kind of situation was not usually an outcome of individual planned choice, but a *"family decision"*. Even when those women reported having planned the break in their careers, this planning did not include clear perspectives to their return to the labour force; in some cases, they were surprised by the difficulty of letting the child in a full-time childcare and backing to work – as in Flávia's experience. For her, the best part of living the transition to motherhood in Sweden was the first year, in which she had full-time parental leave; however, the most difficult situation was related to professional career, since *"Sweden does not give you much information on the career field. On the field of motherhood it is great, but not in the career field. It was so hard that I kept hiding myself in the immigration profile"* (Flávia).

When Flávia finally got a full-time job offer as a teacher in a bilingual school, when her daughter was four years old, she was compelled to give it up because her husband had received an offer for an important professional promotion in Norway. During her diaries, we could discuss this situation, and I perceived how intense this dilemma was for her, since her husband put the decision regarding this new transfer in "her hands". This subject was so sensitive that she felt her arms getting numb while we talked, explaining: *"it is the second time this week that I feel this pain... it is certainly related to the impact of the news of moving out"*. She told me:

> "Of course I will not say no, Carol. He is very funny, you know, he approaches me, saying 'this is a great opportunity for my career, but I cannot decide. You decide if we are going or not'. Of course I am going to say yes... **again, I'm putting him first, after my daughter, and me last**..." (Flávia).

As one can observe, the risk of being unemployed and/or unmarried (since they depend on the husbands' income) is not at the centre of those women's perceptions, nor in the political agenda of family policy, because of a strong centralization in children's development. The argument about the *"privilege"* of staying long time at home with children also defies the approach of this contingency to feminist agendas; I understand that this rhetoric is related to the desire of presence with motherhood, and the experience of intense motherhood as a "scientific truth", as already discussed. However, regarding their professional life, they do not have much incentive and support, being also blamed when keeping longer out of the labour force.

By the perspective of the "good mother" idealization, "past" – including mothers' habitual perceptions and historic situation – is not valued. Failure is seen as an individual outcome, at must an identitarian problem that does not account for the variability of habitualities the mothers can express, including a lonely situation with a strong moral engagement in the first period of childrearing. As observed by Mendes (2002), risk-societies promote a preponderance of future trying to disconnect from the past:

> O risco refere-se a perigos calculados em função de possibilidades futuras. Só tem uso corrente numa sociedade orientada para o futuro e que vê esse mesmo futuro como um território a ser conquistado ou colonizado. Neste sentido, o risco implica a existência de uma sociedade que tenta activamente desligar-se do passado e conquistar o futuro. (p. 54)

In conclusion, it seems ironic how in "giving support" for parents to "give" time ("*accompagnement"* in the French report by Hamel et al, 2012), some mechanisms rescind the potential "donation" of parenting in itself – if we agree with Derrida (1991), who discusses how the meaning of donation has a paradox that helps us analyse the "enigma" of the primary dimension of presence. For this author, the intention of giving something to another is always in a circle of retribution and temporality, being part of the economic logic from which the meaning of "donate" intends to escape. The only situation in which one can see "donation" is defined by "forgetfulness" – when donor and receiver forget of the "gift", because it is part of a "fortuity" – as the objects amalgamated to the perception's background. One can relate Derrida's intuition about donation of time to Sandra Laugier's definition of care: "care would be defined from this specific attention to the not-visible importance of things and moments" (2011, p. 363, free translation).

Moreover, Laugier asserts that by the ethics of care Feminism can find a "voice" to express this invisible dimension of experiences while Derrida conjectures that the visibility of "donation" sacrifices the intensity of the experience itself. His consideration converges to what Gumbrecht (2010) asserts on the creation of ethical norms (or "moral laws", to referring Deleuze[61]) to aesthetic objects, affirming that this institutionalization of aesthetic experience empties it of its potential intensity. However, as he also considers, in contemporary societies in which the "culture of meaning" preponderates over the "culture of presence", there is always a tension in experiences of presence related to the almost impossibility of not attributing sense. Thus he concludes that having or not this primary experience of presence is a matter of intensity level rather than a radical difference among presence and absence. At this point, one can see the pertinence of Laugier's suggestion of an ethical approach that is radically pragmatic –

[61] The differences of definition for "ethical" and "moral" is not assumed by Gumbrecht, therefore, I understand that this assertion about ethical norms for aesthetic experiences is better defined as "moral laws" from a Deleuzian perspective, since for this other author ethics has a quite generating potential that overcomes the institutionalization of general rules for human experiences.

which cannot be capable of fully understanding the invisible experience of presence but can confront reality to the recurrent institutionalization of moral affections that empties the experience of donation. Besides, if Derrida marks "donation" as an "almost transcendental illusion", he also asserts that this is what impulses the circle of experience and meaning:

> Nous y sommes impliqués de toute façon, en particulier à cause de ce qui communique, dans cette dialectique, avec le problème du temps d'un côté, celui de la loi morale et de la raison pratique de l'autre. Mais cet effort pour penser le fond sans fond de cette quasi-« illusion transcendantale » ne devrait pas être non plus, s'il s'agit de penser, une sorte d'abdication adorante et fidèle, un simple mouvement de foi devant ce qui déborde l'expérience, la connaissance, la science, l'économie — et même la philosophie. Il s'agit au contraire, désir au-delà du désir, de répondre fidèlement mais aussi rigoureusement que possible à l'injonction ou à l'ordonnance du don (« donne ») comme à l'injonction ou à l'ordonnance du sens (présence, science, connaissance) : sache encore ce que donner veut dire, sache donner, sache ce que tu veux et veux dire quand tu donnes, sache ce que tu as l'intention de donner, sache comment le don s'annule, engage-toi, même si l'engagement est destruction du don par le don, donne, toi, à l'économie sa chance. Car enfin le débordement du cercle par le don, s'il y en a, ne va pas à une simple extériorité ineffable, transcendante et sans rapport. C'est elle qui met le cercle en marche, c'est elle qui donne son mouvement à l'économie (...) Même si le don n'était jamais qu'un simulacre, il faut encore rendre compte de la possibilité de ce simulacre et du désir qui pousse à ce simulacre. Et il faut aussi rendre compte du désir de rendre compte. (Derrida, 1991, p. 47)

This means that the moral rhetoric used to persuade women to donate their time for children cannot favour authentic mothers' bodily engagement in childrearing; instead, they can favour alienation and self-damaging experiences. When these middle and upper-class mothers search for intelligibility in their experiences with therapeutic and scientific motherhood, they find liberal rhetoric on "choice" and ethics of desire as a common ground – both in feminist and maternalist movements. Assuming "chosen motherhood" as a hedonistic injunction (Martiskainen, 2011), they find psychological rhetoric and universalized norms of parenting, in which they can become trapped by the disputes on "good" *versus* "bad" mothers. For this kind of appeal, the maternal desire and bodily engagement in a time-consuming circle are seen as core elements to performing the maternal role well, however, both cannot be predicted as a scientific truth, but constitute an ethical constraint that lastly oppresses divergent experiences. That is one of the reasons why many of the participants of this research started their transition with a desire of intense experiences of presence and finally found themselves in a strong frustrating moral engagement to mothering, converging to a centralization of their presences *as mothers* in domestic and public spheres instead of having broader relationships with multiple forms of responsive presence.

IV.2 HAVING RESPONSIVE PRESENCES FOR GENERATING HESITATIONS

As I have mentioned, the transition of motherhood along with immigration and other radical life-course changes can put women in difficult hesitations, reinforcing a process of *othering* and isolation *vis à vis* the idealization of "good motherhood". However, I also identified processes of generating hesitations, from which women sustain perceptual openness and creative intuition for developing authentic solutions in their daily routines. Those processes are favoured by certain aspects of social presences which will be discussed in this chapter.

As Milton Santos (2000) has discussed, the "globalization fable" has been spread in "third world" countries as a way of "shortening distances", "condensing time and spaces" (Santos, 2000, p. 19); as if this approximation with global rhetoric issued from the developed world could emancipate us as "global citizens" without having to face the most important problems of our societies, such as poverty and racial and economic inequality. However, if one can observe the perverse dimension of this globalization through consumption – which Santos calls "monetization of life" – he also suggests the possibility of thinking in a more "human" globalization, which is enacted from the same phenomenon but by the experiences of peripheral subjects. He asserts:

> (...) podemos, em primeiro lugar, reconhecer um certo número de fatos novos indicativos da emergência de uma nova história. O primeiro desses fenômenos é a enorme mistura de povos, raças, culturas, gostos, em todos os continentes. A isso se acrescente, graças aos progressos da informação, a "mistura" de filosofias, em detrimento do racionalismo europeu. Um outro dado de nossa era, indicativo da possibilidade de mudanças, é a produção de uma população aglomerada em áreas cada vez menores, o que permite um dinamismo ainda maior daquela mistura entre pessoas e filosofias. (...) A universalidade deixa de ser apenas uma elaboração abstrata na mente dos filósofos para resultar na experiência ordinária de cada homem. (Santos, 2000, p. 21, his quotations)

As already discussed, some of the participants of this research did not act only motivated by the patterns of "good motherhood" or did not even recognize their existence. Indeed, many of them raised strong criticisms regarding the pressure for being intensely dedicated to mothering and having the obligation to feel happy because of it. Those critiques appeared especially when the participants had to face intense conflicts among their experiences and the dominant rhetoric of motherhood, as immigrants, single mothers, black or/and unemployed. However, they also appeared when they had the opportunity of discovering a different rhetoric in the Internet, or among friends and relatives. For instance, Sofia did not accept the *"ideological obligation"* she felt with the humanization of childbirth and maternalist discourses on the Internet. Despite having left the formal labour force and fearing institutional childcare, she hesitated in a creative way regarding discrimination against non-normative family arrangements, such as homosexual and monoparental families. Her approach to Feminism online had been related to sexual freedom and self-acceptance, through the writings of an overweight woman who

described her sexual relations with 100 men while also discussing the aesthetical and social patterns of female identity. These readings contributed to Sofia's hesitation and intuition facing discrimination as a *"single mother"*, asserting: *"I'm not less of a woman because I have a daughter without being married!"*

Isabely, a white woman and PhD Economist, married to a French man, had a different hesitation with the encounter of differences between French and Brazilian parental cultures. She had completed her PhD in France, participating further in the academic labour force before becoming a mother and having French friends in addition to her husband – which suggests that she was relatively integrated to the new territory. Her work contract ended when she was pregnant, so she took an unemployment leave and planned to go back to the labour force just after her daughter completed six months – even though she recognized that *"French public universities can be very discriminating against foreign researchers"*. Throughout this period of maternity leave, she cared for the child during the day shifts without help, whereas her husband was in charge of all the childrearing duties in the evenings. She felt responsible for the most part of domestic duties, because she stayed longer at home while he worked outside, however, she did not feel the same regarding childrearing. Her husband *"liked"* to be with the daughter when he arrived from work and on weekends, assuming the tasks of giving her baths, bottle-feeding her and putting her to sleep every night – which he did in a *"French way"*, according to Isabely, because he left the baby alone in the cradle until she slept. Firstly, Isabely did not feel assured with this *"ritual"*, because during the first three months she was used to helping the baby sleep in her arms. But then she accepted that if it was up to him to fulfill this task, she should trust and see the *"advantage"* of that. Finally, Isabely reported being *"quite happy with the routine"* they established:

> "So he takes her upstairs, put her in the sleeping bag with a little *doudou*, like a French little girl... because if it was in Brazil, it would not be like that, right? So she sleeps with the *doudou* in the little sleeping bag, and she has a musical mobile, you know? So he gives her a kiss, plays the music, leaves the room and she sleeps (...) **Look, I think our routine is prettylaid-back , because we could establish a pretty cool routine, because I was really afraid of not being capable of my daughter sleep.** So I really like this routine we could establish, and now during the day it's getting calmer because she's also taking more of these naps, **which gives me more time to breath, as I told you, right? Time to take a shower, breathe, gett dressed, take care of myself and of the house** (...) Once he gives her the bottle, she still gets some time with us, because, as he is gone all day, he likes to keep her up for a while at night. Then she sleeps, and after she sleeps she doesn't wake up. **So it's super quiet, because we can have dinner together, quietly, we talk... because every day she sleeps at the same time... we even have around three or four hours to stay together at night.** (...) But during the first three months, it was not like that, uh! C only felt asleep in my arms, breastfeeding, and I said P: 'look at that, she will never sleep on her own!' He said: 'Stay calm, one day she will', and some people said 'oh mine sleeps alone in the baby room since day one!' and I said 'oh, you see, not with me'. **Only that she didn't keep sleeping with me for longer because my husband didn't allow it, ok? But it was good that he didn't let it happen, it was a good thing.** Because, like, we al-

> ways talk through everything, but always try to reach a solution, and when he said 'no, I think now it's time to try', we tried and it worked." (Isabely)

The responsive presence of Isabely's husband and her acceptance of his way of caring for the child was very important for her not to reinforce an opposite Brazilian identity facing French parental culture, also favouring her confidence in French public services for childcare despite the discriminatory experience she had as a researcher in the University. Besides, she kept herself open to the positive aspect of what she perceived as typical characteristic of French mothers, even if it made her feel *"ashamed"* and *"angry"*. As Al-Saji (2014) asserts, "generating hesitation" is an experience from which the break on habitualities does not reinforce opposing and paralyzing affects, rather it favours "sustained coexistence with others" (p. 142). Nevertheless, one can also question if this openness in Isabely's perception, accompanied by *"shame",* would not be a trigger for racialized sentiments, since she could assume a subaltern identity as a Brazilian "imperfect" mother. Still, since she could feel assured by the responsive presence of her husband and French friends on motherhood-related issues, she could honestly confront the *"perfection"* perceived on those women and coexist with differences without submitting to a power relation. Moreover, it is important to mention that this is not a definitive and closed process, since generating hesitation coexists with unpredictability and unfamiliarity (Al-Saji, 2014). Laughing about this experience, Isabely told me that she questioned a French woman if she was never *"desperate"* about childrearing and domestic duties for which her interlocutor responded *"yes, of course!"* contributing to the sustained coexistence mentioned above.

> "**But the French women... it almost makes me angry! Because they manage things quite well, Carolina, like, you can be ashamed of showing a French woman that you're desperate.** Because I don't know what these women do that they can handle housework, work and children, and everything stays impeccable! I don't know if in the end they are stressed out with their husbands, if they're cold, unhappy, I don't know, but the fact is: they handle it, they handle it... I came clean to a French woman once, asking her: 'girl, don't you get desperate sometimes?' And she said 'yes, of course I do' (...) I told her 'Holy Mary, for God's sake! Tell me or I think I'll go crazy!' **So, this image of perfection from those women who handle it... sometimes, I feel embarrassed towards my husband, of not managing! Because he's French and must think 'French woman can manage'**." (Isabely)

IV.2.A SHARING CHILDCARE THROUGH ASSOCIATIVE PARTICIPATION

Among the participants, 6 participated in associative crèches; 1 in Sweden, 2 in France and 3 in Brazil. I perceived that this opportunity contributed to the development of generating hesitations regarding ideological model of "good mother" and the injunctions of chosen motherhood, since they could perform a gradual transition from maternity leave to shared childcare. However, as we are about to dis-

cuss, in Brazil, as those associations are not common among privileged women and do not have any institutional reference, they have been encompassed by the dominant politicisation of motherhood.

Furthermore, after enrolling her child at an associative childcare at the age of eight months, Isabely reported feeling *"very satisfied with the crèche"*, affirming that *"these French associative institutions work very well. At first I thought I would be sad in letting my daughter in the crèche, but I realized that I am very happy indeed and so is she"*. Subsequently, Isabely found two jobs in her field of expertise in private undergraduate universities. Natalia, a mother also working at French Academy, reported a good experience with the *"crèche parentale"* in which she and her husband was engaged during two years. After a conflict with another family in the association because of *"motherhood ideologies"*, she was elected as vice-president and was able to build an important solidary web with other parents. That family, close to the former vice-president, was adamant to reject non-organic food, demanding to throw away the remaining supplies. However, in thinking about Brazilian children who are too poor to eat a regular meals, Natalia fought against this claim, criticising the *"excess"* of privileged class centralization on their children's wellbeing. She told me:

> "For me, suggesting to throw away a package of pasta because it's not organic is completely absurd! It's been bought, the pasta is there, and it's not poisoned! Your child won't get sick from eating non-organic pasta once, right? **There is so much exaggeration of this: I want the best for my child, and the best for my child can mean trampling over the someone else's child**, do you get it? It can be something like a double bias... but, at the same time the crèche knows how to deal with the issue." (Natalia)

Natalia did not have a job during pregnancy, having just completed her PhD; therefore, after maternity leave, she started to work part-time at home, which she found quite hard. She waited for an available-crèche since her child's fourth month and was accepted in the eleventh month after childbirth, which made it possible for her to conciliate childrearing to a new temporary job in her field of expertise at that time. Some months later, she participated in a public hearing to be a University professor, was approved, and starting to work in a full-time workload with a stable contract, while also contributing to the crèche's administration. Regarding her choice and experience with the enrolment of her child at the institution in a full-time basis, she reported two motivations related to the potential of those facilities in favouring perceptive openness and creative hesitation: *"to decentralize our own way of seeing things"* and *"to have a network"* that could fulfill the role of an enlarged family. She said:

> "It's not just the idea that childcare is for socializing, only among children, my idea was that he would be confronted with other adults and other world views, and that's important to him too. And for me it is also important be in touch with other kids, and see other families... **kind of decentralizing our own way of viewing things, right? For really broadening the view... And the great advantage of the *crèche parentale* was precisely this network.** (...) Because there is this story of children being

> cared by mother and father... and in fact it's not like this... the family nucleus is much more restricted nowadays, but things haven't been like this for long, right? The overburden for mother and father happens because families are quite isolated, because you don't have your own mother and father by your side, you don't have a brother, uncle, cousin, by your side, so you have to handle everything. And you have childcare centres for that, even if we don't need... even if we do not ask for help a lot, just in knowing that there is this possibility is a great advantage." (Natalia)

Also, for Flávia, the opportunity to engage in an associative childcare centre in Sweden prevented her from keeping her child at home full-time after 15 months parental leave. She had had a bad experience with a regular public centre when her daughter was two years old; therefore, she found this parental cooperative, supported by the state and by the parents. In the first institution, her daughter did not fare well, was constantly ill, which caused Flávia to question the quality of care and the capacity of caregivers, as she thought that *"there is a lack of care in public crèches because the employees are immigrants with no other alternative to work and are poorly paid"*. In the parental cooperative, she found better qualified and remunerated caregivers, and she could participate in the organization and daily routine. She worked once a week in a part-time basis playing with the children and her husband helped clean the childcare house in the weekends, except when he was working abroad. Therefore, for a woman who had suffered a difficult experience with delivery and felt quite lonely during the first years of motherhood engaging in maternalist websites and having trouble betaking remunerated work, submitting to a gradual institutionalization of childcare was really important.

Furthermore, during my field work, I had the opportunity to visit two of those facilities in Paris, talked to the pedagogic director of one of them, and shared my own impressions about this model in a Brazilian website specialized in Education. It had an important diffusion through the web, which brought me in contact with some of the few parental initiatives in Brazil that are similar to the first *"crèches parentales"* from the 1960s in France, when they were still considered "savages" (CERISES, 2014). During that period, I interviewed one woman who matched the criteria of my fieldwork method and had created a small cooperative with four other mothers. After taking six months maternity leave, Raquel, a journalist who held an important hierarchical position in the major newspaper of her city, decided to leave the labour market and develop a small business in order to be more present to her child in the first years. Through a partnership with her husband, she launched a thematic web portal with motherhood-related subjects and, as she could not find an affordable childcare centre that coped to her expectations of "good care", she created this cooperative with mothers founded in maternal online networks. One of those mothers had lived in Denmark and was familiar with the Danish model of parental cooperatives and proposed the creation of a similar one in her house. Therefore, Raquel was quite engaged in this project while trying to invest time and money in her new enterprise.

In trying to conciliate both projects, Raquel transited among different online thematic groups, comparing rhetoric of women's entrepreneurship to child-centred rhetoric, including "Mompreunership". However, she found it hard to conciliate *"motherhood ideologies"* to her own routine and professional goals, since her enterprise demanded intense dedication as did her daughter and parental cooperative. During her participation in the research, she invited me to participate in a Facebook group she created, in which Brazilian families searched for partners to create collective childcare. After a while, we both discussed how the parents' rhetoric in this group were becoming more child-centred; various declared to search for collective childcare as a way to promote the activism towards *Unschooling*, blaming institutional childcare for children's emotional problems. At that point, Raquel was feeling quite distressed by this trend in the group, asserting in a private conversation: *"I did not create a collective crèche because I'm afraid or against crèches. I did it out of necessity"*. And seeing mothers blame each other and discussing Unschooling and Attachment Parenting ideologies, presented in this and other online groups, she developed a campaign on her web portal approaching mothers who had different modes of mothering, entitled "All mothers are mothers: for the end of mommy wars".

Regarding Raquel's experience with the first two years of motherhood, I could identify a change of habits and perceptions. From the desire of presence with an intense attachment to maternal-infant bonding, related to a difficult experience with birth and to her own mother's death, to the raising of a critical positioning towards maternalist ideologies that confronted her professional and financial needs. As her husband was also a business partner, he actually demanded financial results of their company from her, although also he also contributed to her engagement in domestic and childrearing activities, since he did not participate equally in these duties. At a certain point, the couple searched for a therapist with which Raquel expected to improve their communication regarding these issues. According to her, he was relatively present in the child's daily routine but had to improve it gradually, since Raquel started to work part-time in another company because of financial needs, simultaneously managing her own business. Then, the couple decided to enrol their daughter at a regular private childcare centre that was closer to their home than the associative crèche and with which they developed a business partnership; Raquel reported to be quite satisfied with this decision.

Therefore, I observed during my fieldwork that primary experience with presence in pregnancy and childbirth do not always lead to an impulse for understanding this experience by reading, writing or intensifying temporal engagement in childrearing. When during the first periods of motherhood other important subjects of life-course, such as professional career and material survival, take the perception's forefront, and the woman perceives other responsive presences towards the child, authentic ex-

periences with motherhood are favoured. In this context, the ethical constraint discussed by Jeremiah (2006) is constituted by a less limited motility, in which other presences are included.

I observed that this is better favoured by the improvement of social rights to employment, childcare, and public health, which also contribute to improve fathers' presences as caregivers than by pedagogical apparatus of "parental education". Male presence in the very first stages of infants' lives, with embodied and responsive engagement in childrearing, can significantly contribute to free women of the temporal injunction of motherhood, freeing them to donate their time as a more authentic experience. This is important for the early establishment of more emancipated habits, which in this context means less restricted by gender norms. Therefore, I found that having social presence constituted by responsive caregivers since the beginning of the child's life is quite important for the development of the mother's *habitualities* in the direction of childcare socialization. In its turn, socialization rather than privatization of motherhood can produce broader politicisation; and associative childcare strategies, if supported by institutional rules and democratic logics, can favour socialization, the engagement of men in childrearing and this broader politicisation.

IV.2.A HAVING THE PARADOXICAL PRESENCE OF GRANDMOTHERS

If it is quite difficult to find institutional alternatives for sharing childcare duties in the first months of motherhood, one kind of presence was very important to most participants during that period: the grandmothers'. While many of the participants complained about the absence of these figures, for different reasons, 16 actually had their physical company, 4 of them sharing the most part of childrearing activities with those women. Moreover, contact with other planes of past, discussed by Al-Saji (2014), can occur along with the meeting of other persons from different generations and different experiences, with whom the early mothers feel reassured. During the first months of motherhood, those presences can be quite interesting to help the new parent develop the basis of habitualities that will constitute a new horizon in which the child has a place. However, these presences can be respectful to the mothers' experiences and open to novelty, or they can also be invasive and oppressive, which can contribute to intensifying isolation and restricting bodily motility. For most the participants, the grandmothers' presence favoured their possibilities of maintaining a professional life and goals, whereas also confronted their *"autonomy"* regarding childcare-related issues (as reported by Sofia, Fatima, Helena, Lidiane, Luciana). Besides, in some situations, their presence could also disturb fathers' participation in domestic duties. In fact, an enduring family arrangement involving grandmothers in childcare seemed as a

quite naturalized strategy among Brazilians, better incorporated in the model of ideal time imbalance than the use of institutional childcare.

When I asked Célia about her transition to motherhood in France, related to her second pregnancy, she told me about the planning and prenatal period and then narrated the first months after childbirth in which her own mother's presence was important for her *"to know what to do"*. Although she already had the experience of a first child, Célia explained that she was *"raised with these mothers' and grandmothers' little things",* referring to caring habits she learned from the older women of her kinship. During our conversations, she mentioned many advices her mother gives her on the phone or Skype, such as: *"not being nervous otherwise the milk [for breastfeeding] can dry"*, *"letting the child fall and learn from it"*, *"to not be excessively protective towards the child"*, etc. Advice that gave her confidence while it certainly contains gendered norms according to which experienced women know better regarding children than any other caregiver.

In another story, Aline mentioned that, in France, she felt quite isolated as a mother because she did not have the *"community around motherhood"* normally found in Brazil, recognizing that in privileged classes this *"community"* is also formed by the employment of other women as child-minders. The lack of this communitarian network is related to the search for other sources of knowledge, such as weblogs and books, in many of the participants' narratives. In fact, what these "communities" propitiate is the sharing of legitimated childcare and self-caring habits, which diminishes the concentration of responsibility in mother's choices and has the potential of relieving guilt, but also contradicts a broader socialization of childcare. Aline finally employed a Brazilian student that worked in France as a private *nounou* and kept working in a part-time basis.

The invisibility of domestic workers as women and mothers – when it is the case – in the landscape of privileged Brazilians' perception constraints the entitlement of those workers to social rights already conquered by the majority of the labour force in the country. In Brazil, this workforce had the least improvements in work conditions the last decades, after a recent economic and democratic expansion – which is a clear heritage of slavery (DIEESE, 2013), a past which is constantly present in the *racializing* and sexist perceptions. In 2011, according to a national inquiry in Brazil, domestic work was the worst paid occupational category, with an average salary of 509 Reais (around 150 euros), 39% less than the

average of all occupations; 61% of them were black and 92% were women (DIEESE, 2013)[62]. When not being directly occupied with childcare, many of the Brazilian mothers employ and exploit other poorer women as child-minders under precarious agreements, while staying under unjust matrimonial arrangements – in reference to the concept of "unjust families" by Susan Okin (2005). In those cases, privileged women stay in charge of the surveillance and maintenance of this contradictory relationship between children and private child-minders, but still economically dependent of their companions.

Some rituals well known in the country, such as keeping video cameras at home, taking the nannies to the beach and aquatic parks but forbidding them to enter the swimming pools or even to using bathing suits, forbidding them to use cell phones while in charge of children, beyond other disciplinary practices, are constantly reiterating the hierarchy between mothers and their employees, fathers and mothers. This hierarchy is a performance of biological maternal presence as morally un-replaceable, since the domestic workers are not expected to have authentic relationships with the children. Indeed, when paying attention to temporality and moral affections of this kind of relationship, one can see how privileged women delegate partially their "biological role" to the subaltern bodies, as if those bodies could be used as objects that emanate "free love" – such as European women did to wet nurses in the past. These habitualities are also learned from the presence of this "community" mentioned by Aline, constituted by experienced mothers such as grandmothers, who can barely have responsive hesitations towards those subaltern women.

Luna's situation is illustrative of this common habituality among Brazilian women. Luna is a heterosexual and married mother of two children in Brazil, and has in her own mother's presence a fundamental strategy to construct early childrearing habitualities while keeping her job as a full-time music producer for a great orchestra in the country. She decided to buy an apartment nearby her mother's and shared with her the salary of a domestic worker (also a grandmother) in an informal-basis. Regarding the children's father, Luna reported that *"he is very present, but he works too far from home, arriving pretty late on the evening"*. As she gradually returned to the workplace in a part-time basis, after a 4 month maternity leave, she reported: *"The fact that he works so far it is a lost for both of us, as I am feeling overburdened now, and he is losing children's presence, because of the distance he kept from them"*. Therefore, this kind of configuration that privileges the proximity of grandmothers' households can partially explain the perpetuation of sexist division of labour reinforced by Brazilian early mothers; since

[62] Only in 2016, domestic workers received the same rights as the other occupational categories in Brazil already have. Nevertheless, in practice, most of those women still work in the informal sector and are not entitled to the protections promoted by the recent legislation.

they can profit from the habitual knowledge and caring presence of more experienced mothers, who usually are relatives or subaltern women, in an ambience strongly marked by the absence of men or the government.

A similar culture to the Brazilian one regarding grandmothers' presence has developed in Portugal's history, where welfare is quite dependent on women's caring and domestic work (Portugal, 2008). As Silvia Portugal discussed, this country presents one of the highest rates of mothers' employment while maintaining social policies by a quite family-dependent perspective, which suggests that a "female web of solidarity" is activated by the "needs of caring and raising children" while it also reinforces profound inequality (2008, p. 33). In Portugal, there is a benefit for grandparents who are the main caregivers of children when parents work full-time and do not profit of full parental leaves (DGSS, 2013). Among the participants who lived there, 3 resided in the same place as the children's grandmothers, counting on them as important presences for parental-support, even if in some cases it generated conflicting situations. This configuration favoured them to keep working or studying whereas the children remained at home most of the time, as in Helena's case, who reported not *"having much affinity with her mother-in-law"* whereas recognizing that her help was really important for her to keep studying to complete her master's degree. She planned to enrol the child in a philanthropic childcare centre when she was one year old; before that she thought it was *"too soon"*.

Rebeca, a white woman, married to a Brazilian man expatriated to Morocco by a French company, did not have the presence of any grandparents. But she reported the importance of neighbourhood solidarity in Morocco. She had prenatal assistance in both countries, gave birth in France, but lived in Morocco for about a year. She quite liked the assistance of French perinatal system, however, she emphasised the importance of the Moroccan community in caring for her child. Besides, that country was where she took first steps to open her own business as a chef de cuisine, because she felt *"quite confident with people's support"*. Before pregnancy, she had just completed a graduate degree in this field of expertise in France and received an important business partnership offer. In moving to Morocco and getting pregnant she did not give up her professional goal, planning to open her restaurant, but then her husband was called back to France. At the time we talked, Rebeca was experiencing institutionalized childcare for the first time, as her son was two and a half years old, and oscillated between the desire to work in her field of expertise and to plan getting pregnant again. The last news I heard from her was that she was pregnant and the first-born son was beginning preschool in France, where she did not have this community support despite the proximity of some Brazilian families.

From the stories of those women with intergenerational female care, one can observe that the Brazilian culture of fearing institutional care is related to a strong reference in familiar female presence, and in the employment of domestic workers as a replacement and complementary alternative to this network. It is related to the fact that those women resort from *intersubjective* past certain bodily *puissance* anchored on habitualities enacted from gender, class and other structural aspects, but mostly from the perception of male and state absence. Considering Célia's and Aline's experiences with and without female familiar presences, one can realize that responsiveness can enact from the meeting of these plans of past and an affective *attunement*, discussed by Al-Saji (2004). Furthermore, the expectation they have regarding those presences is related to the corporal proximity commonly found among Brazilian women in the transition of motherhood. This corporal proximity, however, does not bring privileged mothers to responsive hesitations regarding other women in subaltern positions; for that, they should not amalgamate their bodies to a "descriptive role" as "a character" (Al-Saji, 2004) in the "story of humanization".

> (...) where language plays a suggestive rather than a descriptive role, and where communication occurs in terms of affective attunement to the "tone" or style of another rather than in terms of discursive content. Such attunement is not merely a vague inspiration, nor does it aim at identity or coincidence with the other. It is an encounter that will take place in proximity – auscultation being impossible at a distance or from a point of view detached from lives and events. Intuition is therefore a difficult effort of coexistence that does not reduce the other to a character in my history, to an echo of my voice. (Al-Saji, 2004, p. 229, her quotations)

Therefore, this attunement is propitiated by the possibility of living the "positive aspect of risk" (Mendes, 2002) embraced by a "safe" ambience in which one can find responsive presences. According to Mendes referring to Antony Giddens, risk can also have a positive acceptation, related to "excitement and adventure (...) the source of creative energy of richness in a modern economy" (Mendes, 2002, p. 55). For instance, in having an intense experience with childbirth, Michele, an economist living in Sweden, pregnant and mother of an eighteen month-old child, did not subsume under the "good mother" identity transmitted by her female kinship or maternalist readings, rather, she accepted that an important part of motherhood is unpredictable; something she is open to discover on a daily basis, asserting: *"Being a mother is a huge journey"*: Even if Michele went to Brazil just after childbirth to stay surrounded by her parents and relatives, she did not incorporate a sexist division of labour. Future related to children's development, in here, is not as preponderant as in other participants' narratives, whereas the planning of professional career is on focus.

Michele discovered her first pregnancy in Sweden some days after a job interview, and then she got the job, worked until childbirth and profited from a maternity leave without being stocked by her new do-

mestic routine. She had her mother at home during the first month and went to Brazil with her child and Swedish husband for three months to enjoy her family's presence, including her father's, who *"got very emotional and cried when saw his grandchild for the first time"*. Despite Michele's acknowledgement of the importance of *"studying to be prepared for childbirth"* she admitted not having prepared herself the same way for childcare. Indeed, for her, the establishment of a new routine that involved breastfeeding and childcare *"naturally"* involved others' presences and also her absence to endure professional activities. Even experiencing *"ecstasy"* during childbirth, she did not need to *"chase after information"* to know how to take care of her child, because she could coexist with uncertainty and face motherhood as a *"huge journey"*. Now that she is pregnant again, she asserts that she will probably give nursing bottle earlier because *"breastfeeding makes motherhood very laborious"* – which shows that primary experience of presence with motherhood did not take her to a hedonistic injunction with breastfeeding. In reflecting on the alternatives, she did not become guilty, and can be open for intuition at the time it comes. Here are some lines of her story:

> "**Because we need somebody to help us! At least that was my reference, we need somebody who can help us** (...) J breastfed every two hours... I breastfed and changed nappies with intervals of two hours, so you sleep pretty badly, it's a hard period. But I remember that, when I came from the hospital, **after birth, I was in ecstasy, in a joy, plenitude, because of something that turned out to be an amazing reason for living.** Then I came home and I started to cry, like I had passed through 36 hours of labour, when J was born I did not sleep as much because I wanted to be with him, everything was sore down below, full of blood and stitches, and I didn't sleep well since I was breastfeeding all the time... then I got home and started to cry (...) but I told my husband: I have never felt so happy in my entire life! (...) **That's amazing because we're exhausted but happy (...) Something that I also felt about getting pregnant is the fact that I discovered that the world of giving birth was huge, so I read and studied everything I could, but I really didn't care too much about 'after' childbirth, what really happens** (...) like sleeping rhythm, breastfeeding, nutrition, I've never cared too much about those things! (...) In its turn, to be a mother is a huge journey, so I'm learning that it's not about theory, I'm learning much in practice and when it's possible I read something (...) I got pregnant in a quite difficult period in here, between me and my husband, because I had doubts about going back to Brazil, since getting a job in here is not easy. I stayed a year studying Swedish, looking for a job everywhere here (...) then I told myself: oh no, I'm going back to Brazil because here it's not working (...) but then I got pregnant and it was like a sign (...) since I've got pregnant everything started to work. Because I started to work in my field of expertise (...) I feel that I'm developing my work quite well and they are very satisfied with me." (Michele)

Furthermore, it is important to mention that there is no personal characteristic that explains this openness by Michele; indeed, from what I see, her story reveals the confluence of different elements which favoured this outcome. At first, it is important to notice her wish to develop a career in her field of expertise in the new country, since she was used to work in Brazil in a satisfying job. Besides, the achievement of a qualified job in parallel to the knowing of pregnancy in Sweden contributed to her associating motherhood to a *"good sign"* regarding an integral life experience, which means that be-

coming a mother did not seem to disturb her plans to develop a career. The fact that she did not have much access to readings on motherhood ideologies and parenting styles also contributed to her "lightness" towards childcare choices and routine. Her husband also took parental leave, and shared equally the custody of another child from his first marriage, which suggests that Michele was used to male presence as capable of caring for children. Thus, the help she received from her mother and other relatives did not contradict this broader social presence she was already experiencing. Instead, having them close for this initial period was important for her not be *"exhausted"* and admit that she *"needed help"*, reinforcing her decision in enrolling the child in a public childcare centre in a full-time basis since the ending of parental leave.

Therefore, I observed that many participants reported being *"exhausted"* during the first year of parenting, searching for solutions that were coherent to the responsiveness generally found in the female gender, because of the knowledge and caring by experienced mothers. As the presence of grandmothers can be engaged in sexist rhetoric of family organization, those women could naturalize men's absense, but could also profit from those presences to invest in their careers without feeling guilty. Generally, their perceptions of a responsive aptitude were limited to it, excluding the potential of demanding for the presence ofchildren's fathers, since they are not much represented in the plans of past that contributed to their habitualities. In addition, a culture of fearing collective and institutional childcare prevented them from employing this resource as a social good; many of them reinforced the perception of institutions as a "necessary evil", as the last alternative when they can no longer stand to be the only caregiver and cannot have familiar presences, and reproducing the domestic work structure. On another side, I could observe that the confluence of other elements, such as more responsive and engaged presence by the children's fathers, positive experiences with career, and an open coexistence with risk can contribute to grandmothers' presence to be faced as necessary but transitory help to the generating of creative hesitations.

IV.2.B BEING RACIALIZED AND DECONSTRUCTING THE "GOOD MOTHER" IDEAL

Likewise, I could observe in my fieldwork that non-white mothers were more concerned in finding institutionalized childcare in order to keep working, which can be related to their perception of racial inequality in Brazil and in the European countries articulated to better access to social services than poor Afro-descendants have. While among the 20 white women only 2 used institutionalized childcare during the first year (both in France), among the 10 Afro-Brazilians 4 used childcare centres in this early period (in Brazil and France) and 1 had certified child-minder (in France). Among the other 5, 1 created a col-

lective childcare and 4 assumed the main responsibility for childrearing with the grandparents' help or through extended parental leave. It suggests that the menace of being discriminated by the labour market (by race or other aspects such as motherhood) and being excluded from the middle-class "safeguard zone" (Estanque, 2003) can also contribute to creative hesitations for the development of strategies to share childrearing and being open to different parenting styles, if one can have social presence that favours intuition – a process experienced by Sofia when she felt discriminated as a single parent. At the same time, it reveals an oppressive situation related to racialization, it also shows resistance as an important dimension of the agency those women perform in the transitions of motherhood.

When discussing with Eliane, a black woman living in France, about sharing childrearing and continuing to work, she asserted that, despite feeling guilty for not being *"so attached"* to her daughter to prevent her *"nightmares and many fears she felt that time"*, profiting from the job offer she received was very important to her. During pregnancy, Eliane had been dismissed by the school in which she worked in a temporary basis; then she was quite sure she had suffered discrimination because of becoming a mother. Later, another opportunity appeared when her daughter was six months old, and she was determined to cease this opportunity even though she was still breastfeeding. It is important to mention that the "guilt" Eliane reported was related to her readings on Attachment Parenting theory that helped her *"relax"* regarding disciplining her children but also provoked this feeling of being insufficiently attached.

Cristina, a black mother in Brazil, had just completed her undergraduate studies as a Music therapist when she got pregnant and worked in an autonomous regime; for her, it was fundamental to enrol her child in a crèche to develop her new career at that period. The infant was cared in a part-time basis by a private institution and by the father in the evenings, and later experienced six months of his mother's physical absence while she worked in Singapore, as already commented in a previous part of this thesis. Like Eliane, Cristina stated that the experience of being black contributed to this *"professional consciousness"* (Cristina). Both women had approached North American maternalist rhetoric from middle class groups, such as Attachment Parenting and Mompreunership. This rhetoric led to guilt but was not able to paralyze them under a hedonistic injunction towards chosen motherhood – as also occurred with Viviane, who perceived the contradictions of this rhetoric *vis à vis* her experiences in Sweden. Viviane was quite aware of the racial discrimination she suffered in Sweden and despite having been out of the labour market for a few years after childbirth – also produced by the family's moving to Australia because of her husband's career – she pursued a Master's degree in the field of Human Rights; even

working in a city far away from her household, 4 hours' drive away. Later, she gave up this job, because it was not what she expected, but kept searching for another opportunity.

Carla, a black woman, an activist for humanized childbirth in Brazil, took classes to become a doula and planned to do a transition from her career as Public Health Manager in few years. She created the first independent group for supporting natural childbirth in a peripheral neighbourhood of Rio de Janeiro, and desired to be completely dedicated to this activity, reporting that *"this Conscientious Motherhood is like learning to read! You start reading things and can't do anything else! So I was absorbing... absorbing... and when I had the opportunity to take the classes of perinatal education I found it interesting"*. She changed her workplace and suffered a salary decrease in order to have more *"flexibility"* to be a doula and be close to her son whereas kept working – despite that she kept a greater salary than her husband. Even though, she enrolled her child in a full-time private crèche near her mother's residence, otherwise she could not conciliate all these activities, since her husband was not sufficiently present in sharing domestic duties. During her diaries, this weak participation of the child's father in the domestic routine was one of the most important complaints. She planned to discuss this issue with him, but until the end of her participation in this research, she had not been able to do it.

Carla viewed herself as a representation for the comprehension of humanization of childbirth as a right not a privilege, asserting that *"it is not only for women who have money to pay for a private midwife";* still, she also asserted that *"this can be possible for everyone who is willing to fight, because it is not a simple fight".* ,She was thus extremely engaged in this therapeutic and liberal rhetoric of humanization, albeit with a quite cautionary attitude regarding her finances and the professional transition she intended to face; she remained *"unworried "* in leaving her child in a full-time institution.

As already discussed, in the Brazilian context, maternalist movements are closely related to the privileged status of white middle- and upper-class women, who do not perceive the "menace" of being discriminated by class and racial inequalities and are not used to public services that could prevent discrimination. In fact, I could observe certain alienation among some of the white participants of the research concerning the structural gender inequality in the labour force. Thus, Carla's experience is quite marginal, since she reproduced some of the maternalist rhetoric although she maintained a clear professional consciousness; this suggests that other contingencies can limit this *"absorption", "diving"* under hedonistic injunction. Despite the plans of *"leaving the job and fully dedicating to be doula"* Carla kept conciliating both professional activities until the last time we communicated. In the following quote, she comments the access to humanization as a woman's right but ends her discourse with a rather

liberal rhetoric, reinforcing the injunction of *"fighting against the system"* through individualized search for information. In her turn, she did not *"sacrifice"* her own economic status to engage in this fight; besides she remarked a rights-based view:

> "**I think of quitting my job, in the future I think of making a transition, and organizing myself to live just by that, so that can be my new career** (...) here in my workplace I have some flexibility to go combining these activities as doula (...) So I want to start assisting one or two births per year, with the intent of really leaving what I have today and completely dedicating myself to that in 2015, but I need to organize myself financially at first, for it can be a reality (...) Now that my son attends a preschool in full-time basis near my mother's house, I'm pretty satisfied with this choice (...) **I think I can demystify this story of humanized childbirth as only for the woman who can pay for a liberal midwife at home. I think it's a right for all women**, SUS users, private insurance users, so I think it's a desire that should be respected among women. So, I think that being a black woman, resident of the Baixada[63], public servant and SUS user is useful to show that it's for all women. You can be from any race and ethnicity, with low income, low level of education, the only thing you need is information, it's not about money, it's about knowing that it's a right (...) I think it's possible for everybody since they are conscious of the fight they must undertake, because it's not a simple fight indeed. **I don't think it's only an economic battle, I think it's a woman's issue, of her knowing as a woman what pregnancy represents, what childbirth can represent, the amount of transformation that it can represent**." (Carla)

The last effort made by the Brazilian government in detailing racial inequality in different official reports can also be an important influence for these women's self-awareness regarding discrimination and economic status, even if those documents do not embrace the conditions of middle-class black women. For instance, the SPM report signals the importance of characterizing women's economic situation inside families, asserting that Brazilian poverty has "a black female face" (Melo, 2005, p. 43, free translation), and emphasizing the strong association between race, gender and poverty. This study presents a moral rhetoric quite present during the implementation of the PBF, which consists in the recognition of women as the most responsible citizens for family care and black women as the most vulnerable members in the poorest families, justifying the focalization of them as PBF beneficiaries. It also contributed to the rising of studies on the impact of social policies in the life of black Brazilians and other minorities, as in the MDS report (Jannuzzi & Quiroga, 2014).

Moreover, according to UNESCO's report on Brazilian childcare policy, the number of places in childcare centres for children under three years old has significantly risen from 1995 to 2005. However, the difference in access between black/brown and white children has risen as well, which means that the expansion of such services benefited more white children than racialized ones (Nunes, 2011) – despite the Brazilian Census having reported that more than 50% of the population declared being non-white, about 5% more than in the last Census. On the other hand, for children from four to five years old, at-

[63] Baixada is a region in the city of Rio de Janeiro which comprises poor and lower middle-class neighbourhoods.

tendance in preschools increased further among black and brown children than white ones. The same tendencies occurred between the children of poor and wealthier parents. It seems associated to the PBF effects, since PBF's receipts have to prove that their children are enrolled at schools in order to be entitled to the benefit. However, if they do not have priority in childcare centres, those children may suffer late schooling and are probably situated at a disadvantage comparing educational accomplishments.

Regarding middle- and upper-classe women who have better access to the labour force, their *"professional consciousness"* related to perceptions on discrimination contributed to they keep longer remunerated jobs and/or to betake financial benefits such as parental leaves to construct a full citizenship, from which they were historically excluded. It seems that in doing so they confront the ideal of "good mother" created mainly from the experience of white middle-class mothers living at heteronormative families. In doing so, they can suffer *"guilt"* and other oppressive feelings regarding their way of reorganizing time after childbirth, but they can also contribute to "deconstruct whiteness" (Dorlin, 2005), in deconstructing the sexist idea of "choosing" to leave the labour force and fully dedicating themselves to childrearing as a *"privilege"*. In fact, from the goal of accomplishing a dominant representation of "good mother", one can perceive as a privilege the pathway of becoming further dependent on male partners. However, since the comprehension of whiteness as naturalization of white women's experiences as ideal models, I understand that this common pathway is not exactly a privilege but the outcome of a strong alienation of those women regarding their own social condition. In discussing the mainstream Feminism that incorporates this supposed white superiority, Elsa Dorlin (2005) asserts:

> Si l'article d'Adrienne Rich marque un tournant dans la pensée féministe, il est symptomatique de la difficulté à penser un sujet du féminisme véritablement dénaturalisé et décentré. L'expérience des femmes afro-américaines reste perçue comme une expérience « différente » de la domination patriarcale, articulant divers rapports de pouvoir, exactement de la même façon que la féminité a longtemps été perçue comme une variation, une différenciation à partir de la norme que représentait la masculinité. Adrienne Rich, comme nombre de féministes, ne comprend cependant pas que la dénaturalisation des catégories de « sexe » et de « race » suppose également de déconstruire ce que les anglophones appellent *whiteness*, la *blanchitude*. L'expérience de la domination de genre des femmes « blanches » de la classe moyenne exemplifie tout autant le croisement de la domination de genre, de classe et du racisme. (p. 89, her quotations and italics)

Therefore, when it comes to "race" and "ethnicity", racialized Brazilian women might suffer of a preponderance of past – "no longer lived at a distance, as past, but [is] experienced as a fixed and overdetermining dimension of the present" (Al-Saji, 2014, p. 5) – however, in the transition to motherhood, in middle class context, they resort to embodied perception of discrimination as a strategy to prevent future vulnerability. Alia Al-Saji (2013) describes *racializing* perception as a process of closure regarding

difference, which I could perceive in the engagement of some white participants of my fieldwork in maternalist and feminist movements, since they prompted essentialist ideals of giving birth and becoming a mother that exclude the reality of black women – as the paradoxical process discussed by Candace Johnson (2015) regarding preferences of mode of delivery. But, in their turn, middle-class racialized women were not paralyzed in the face of discrimination; instead, even in the cases in which they approached white middle class ideologies of mothering, they did not incorporate the normative habitualities that constitute being dependent on a male partner and taking care of children in a private basis. Despite a general misconception towards black women – who, according to Eliane's *"would have the tendency of becoming dependent on male partners after marriage"* – the black and brown women I interviewed had a most active and autonomous laborious life than the majority of the white ones who participated in the research. When we had the opportunity to discuss these issues in a feedback meeting, and I commented to Eliane how I realized this different trend among the participants, she was positively impressed and said *"you see it was a misconception I had myself regarding black women!"*

On her turn, Simone actually left her job after maternity leave to be an "intensive mother" for the first years after a "humanized childbirth", resorting from the past an idealization of female maternal motility – a past constituted by memories of her own mother and aunts. As already discussed in another part of the thesis, the meeting of those plans in Simone's perception did not include the visibility of the gender inequality her female kinship had suffered. During the interview, speaking of some of the commentaries she had heard from feminist activists, she told me:

> "**They told me that it is a privilege to be able to leave my job and dedicate myself to my son... but I don't think it is a privilege**, it was a choice... albeit having the possibility of doing a choice is already a privilege... I could keep earning the same salary I had before, but I don't because I choose to be a full-time mother". (Simone)

In hesitating during this conversation, she expressed a process of incorporating whereas also confronting mainstream feminist rhetoric of the "good mother" ideal. Even leaving the formal labour market, Simone did keep working, having an individual income and keeping a professional network: in parallel to her main activity of taking care of children in the collective childcare she created, she produced handicrafts and sold them with a friend's partnership, and participated in academic groups to study Feminism and Childhood Education – her field of expertise. Simone reported that despite her desire of being completely dedicated to her son's education, she *"could not stop working"* and she did not know why. In trying to explain that, she asserted: *"those are all activities I love to do, and I am like that, I cannot stop working.... I think that it'sbecause motherhood is easy to me, it is not a burden"*. Now, I would complement in asserting that this habit of continuing to work with activities one loves even during the

first months and years of motherhood is also embedded in an embodied perception of inequality – bodies can know that re-entering the labour force, still dominated by masculinity, can be quite hard after a long period of dedication to domestic issues, especially if one had suffered from racial discrimination.

Moreover, I could also identify this *"professional consciousness"* among some women who lived the process of being "the other" in European contexts, especially among the ones who had identified some kind of discrimination because of their non-European identity whereas also having responsive presences in early childrearing – as from their husbands, friends, relatives and/or institutional childcare. While 8 of the participants declared *"I did not need to work"* (all white and married) justifying this by the financial support of their partners, Helena (white and married to a Portuguese man) reported that even if she could be economically dependent on her husband, she *"needed"* to work for having her own financial resources and to develop her career as a post-graduated psychologist, even acknowledging that, as a Brazilian, it can be harder to find a qualified job in Portugal.

One year after her participation in the research, Marina, who lived in Sweden, contacted me to suggest an online text written by a black mother and blogger in Brazil, in which the author harshly criticises the "uses and abuses of attachment parenting" and related ideologies (Gonçalves, 2015, free translation). In that occasion, Marina told me that I would be interested to know that she felt *"extremely guilty"* of going back to work when her child was six months old, because she was afraid of *"damaging him emotionally for life (...) especially in Sweden, where parental leave is big time"*. Living a process of self-actualization with childbirth, Marina identified herself with attachment parenting virtual groups – as illustrated in her weblog text previously commented – then she became extremely disturbed by their therapeutic rhetoric, by which she should be the main responsible for her child's emotional health, anticipating at the present the possible damages he could have in the future. As she was confronted by a similar oppressive process she had suffered after a traumatic birth, and as it contradicted her wish to get back to work, Marina hesitated regarding the engagement to this maternalist rhetoric and became open to another perspective, "attuned" to the different voice such as Gonçalves'. In the online text, Guaraciara Gonçalves (2015) identifies the correspondence between attachment parenting and humanization of childbirth as a "liberal and meritocratic view", showing the perverse dynamics of normatizing mothers under the discourse of "expertises":

> Depois do nascimento da minha filha, também passei a encarar a medicalização do desenvolvimento dela como algo desnecessário. (...) Só que eu vejo uma contradição dentro do ativismo, uma vez que o discurso da humanização do parto e o da criação com apego, muitas vezes são faces da mesma moeda, muitas vezes partem das mesmas pessoas e lugares e se confundem. Eu acho contraditório demais, mas entendo a confusão já que a criação com a pego,

no seu princípio primeiro defende o parto natural. A visão ideológica de ambos os ativismos também é parecida. É liberal e meritocrática, pautada no "a mulher tem que correr atrás". § Pois bem, enquanto para o parto humanizado a mulher é senhora do próprio corpo, protagonista que sabe parir, na criação com apego ela já não tem mais a mesma capacidade para amar seu filho e precisa usar as muletas chamadas de...oito princípios (regras). Deixa de ser a protagonista e passa novamente a depender dos especialistas que vão dizer qual é a melhor forma de desenvolver o amor entre ela e seu filho. § Novamente os cientistas e os médicos são convocados. Novamente ela perde o controle da situação. Novamente ela volta para a condição de mulher imposta pela sociedade. Se torna mãezinha, mas dessa vez de forma sofisticada, embasada em pesquisas neurocientíficas. Surge até um novo termo, a MATERNAGEM. Essa abordagem dificulta a percepção de algumas armadilhas, como no caso da mulher que está sem condições financeiras e sem condições de estudar e que para aderir ao "movimento" e se tornar uma boa mãe, deixa de pensar no próprio futuro ao "decidir" que não vai mais trabalhar. (2015, p. 4, her uppercases and quotations)

Final considerations: improving social presence for promoting care ethics

Summarizing, the main objective of this thesis was characterizing and analysing social presence in the transition(s) of Brazilian women from privileged classes to motherhood, in Brazil, France, Portugal and Sweden, in recent years. As a final goal, I intended to contribute to de-construct the hegemonic model of "good motherhood" in Brazil, which is established from the experiences of middle-class white Brazilian women. As methodological framework, I conducted a fieldwork focused in analysing those women's experiences in different national contexts, comprehending moral and bodily dimensions since "presence" is understood here as a phenomenological concept. This focus on experiences of presence brought me closer to the project of a feminist epistemology proposed by some scholars fairly mentioned in this thesis (Vasterling, 2003; Dorlin, 2005; Paperman, 2013; Al-Saji, 2013; Stoller, 2009; Simms & Stawarska, 2013).

Besides, the study has considered different indexes of women's situated experiences, such as: social class, national status and immigration, racial identity, sexuality, family arrangements and gender. And, being an intersectional study, it ended up contributing to de-construct "whiteness", in its classist, racist, colonialist and sexist aspects (Dorlin, 2005) in the global field of Public Health. Moreover, from my fieldwork, I could also observe processes of paralyzing or generating hesitations in the first periods after childbirth, which are related to one of the goals of this project in understanding how privileged Brazilian mothers reproduce normative perceptions and deconstruct them in facing *real* and dissonant experiences with motherhood. I could analyse how, in these processes, mothers were target by moral rhetorics and in their turn used or confronted them, also enacting new ethical engagements. In this final chapter, I introduce a summary of the main research conclusions, raising a discussion on this ethical engagement that can be related to the contemporary debate on the ethics of care (Paperman & Laugier, 2011).

THE MAIN CONCLUSIONS

After four years of intense study and about two years of field research, this project found the following main conclusions: 1) social presence in the transition(s) of motherhood produces a general injunction for mothers' presence towards children as irreplaceable, because of an idealization of biological mater-

nal-infant bonding as crucial for human development – which I could identify in different ways in the four countries here analysed; 2) this injunction of a maternal irreplaceable presence could be identified in the capture of women's desire for bodily emancipation with pregnancy by a child-centred rhetoric in perinatal care and family policies; 3) at the same time, some aspects of social presence in each country favour, in paradoxical ways, the transit of infants under other's attention beyond their biological mothers', mainly among ones who are responsive to children and can partially reproduce the idealized dual boding, such as the presence of grandmothers, domestic workers and, in certain cases, biological fathers; 4) Brazilian mothers' perceptions of responsivity are strongly influenced by a sexist and classist division of labour, since gender norms exclude men from care work and legitimize their absences from the domestic sphere, also reinforcing male-dominant Rationalism regarding health care and family decisions; 5) likewise, female caregivers in subaltern positions are often perceived as better caregivers than institutionalized childcare, because of this idealization of maternal bonding but also related to the classist and racist mechanism of invisibility of those women from the cultural models of "good mothers", which varies from one country to another but is commonly related to the injunction for mothers to "give" time for children whereas also being relatively independent from welfare systems; 6) the exclusion of single, poor and racialized women from these models feeds the sexist division of labour and defies the development of better institutional alternatives for childcare, which has been faced as social injustice and the state's problem in each country but from different perspectives; the three European countries have older history and larger experience of responding to feminist claims about this inequality among mothers than the Brazilian state; 7) the mothers' perceptions of presences can be open to different ways of being mother and sharing childrearing, confronting gender and classist norms, if women have the opportunity of experiencing generating hesitations; 8) those kind of hesitations are favoured by: men's responsive presences towards children, positive experiences with collective childcare, experiences of being *otherized* or racialized as a Brazilian, single or black mother whereas also having responsive presences around, and having different types of aesthetic experiences with motherhood which favour the co-existence with difference and the positive aspect of risk; 9) finally, this research has found that, for propitiating responsivity among women and authentic experiences with pregnancy, birth and childrearing, countries should invest further in responsive collective and male presences rather than in mothers' individual emancipation through rational choice, especially for changing the paradigm in perinatal health and to enhance women's capability of professional development after the transition to motherhood.

Regarding this last conclusion, one can observe that, historically, Brazilian women have accessed a "regulated citizenship" (Carvalho, 2002) mainly based on few social rights conditioned by normative behaviours for promoting public health and preventing social problems. The same maternalist tendency has been observed in the social presence towards motherhood in developed countries; however, France, Portugal and Sweden present, in different ways, better devices driven by woman's rights and influenced in different levels by feminist approaches, which favours the expansion of civil and political rights for women in Europe.

When having children in those countries, Brazilian women are not only compelled by maternalist and feminist rhetorics, but also by Brazilian cultural aspects, such as: the culture of chosen motherhood, which is also found in European feminist rhetoric, that represents a mechanism of class differentiation among Brazilians, the culture of fear of childbirth as a risky event for mothers and foetus and the fear of childcare institutions – all three aspects are quite influenced by gender norms such as the child's centrality in family and domestic sphere and the dominance of patriarchal Rationalism in health care. Therefore, the feminist movements from North to South transitions that are focused on a liberal agenda based on choice do not have the same potentiality than the ones driven by the focus on improving women's rights to welfare, including the rights for employment, full access to perinatal care, better contraceptive methods and assisted abortion. The focus on individual emancipation through choice is important to join privileged women for political participation, but it implies a paradoxical barrier for the universalization of women's reproductive and social rights.

Moreover, the social representation of good motherhood among Brazilian privileged mothers and the social presence built for and by them are constructed through a moral rhetoric that constrains women to assume maternity as rational choice and simultaneously as a fulfilment of unconscious desires, which are strongly related to gender norms. Those rhetorics also constrain women who did not plan their pregnancies to intensely engage themselves in seeking intelligibility in the first transitions of motherhood in psychologizing discourses, which puts them under even more difficult situations. Thus, among some of the participants of this research, one could observe a gradual process of becoming more vulnerable since motherhood, because of unemployment or decrease in income, which could be worse when they were immigrants or single parents. At this point, I could also identify that previous experiences of marginalization, such as the ones related to racism, prevented some of those women to be trapped in economic vulnerability, probably because of intuition and creative hesitations, which could be propitiated by their situation as middle or upper-class women.

Finally, this research found that the desire of presence with motherhood is profoundly linked to an idealization of biological affiliation, in which women invest great expectations of bodily fluidity and emancipation. However, this desire is confronted with reality itself, by which the complexity of nature and nurture propitiates opportunity to hesitate and construct more authentic relationships with motherhood. For instance, as one could observe in the stories of searching for humanization of childbirth, Brazilian women share a similar "fear of birth" whereas having different corporal experiences with it, influenced not only by biological facts but by contextual, structural and relational ones, which can be considered parts of their "natural experiences" with the transition. From these stories, it is possible to identify some aspects of social presence that contribute to the expected experience of presence whereas also to safe ambiances for co-existing with unpredictability. Moreover, according to the epistemological perspective of the *alternaturalist* approach, this revealed a complex and dynamic relationship among Biology and Culture of motherhood in determining not only the situations of women's aesthetical experiences with childbirth and childbearing itself, but also their moral disposition to care.

CONSIDERATIONS ABOUT CARE ETHICS IN THE TRANSITION(S) OF MOTHERHOOD

After the findings of this research, one can assert that the care ethics discussed by feminist scholars such as Carol Gilligan (1989) is strongly related to the "ethical impulse" and "ethical constraint" Van Manen (2000) and Jeremiah (2006) respectively observe in parental relationships. From that, care ethics is not a feminine ethics *per se*, and it is not essentialist, as other feminists argue, since it reveals the process of producing an ethical framework from daily and practical reasoning which is under gender determinations but not limited by biological differences. In fact, in observing this ethical constraint of parental relationships in mothers' bodily engagement to childbearing, one can better understand Gilligan's assertion:

> Dans cet univers genré du patriarcat, le care est bien une éthique féminine, qui reflète la dichotomie du genre et la hiérarchie du patriarcat. Prendre soin des autres, c'est ce que font les femmes bonnes et les personnes qui prennent soin des autres (font du care) font un travail de femmes. Elles sont dévouées aux autres, sensibles à leurs besoins, attentives à leurs voix... Et s'effacent (*selfless*) (...) Mais le care et le caring ne sont pas des questions de femmes ! Ce sont des préoccupations humaines. Il faut avancer vers la prise en compte des vraies questions, à savoir : comment les questions de justice et de droits croisent les questions de care et de responsabilité. (2009, p. 77, her italics)

With this research, I could scrutinise this process of enactment of care ethics in patriarchal culture. In these parental relationships, care ethics is constructed from an "unmediated encounter" between the one who cares and the one who needs to be cared for (Van Manen, 2000); however, it also brings the intertwining of past and future plans (Al-Saji, 2005). The mother's presence towards infants, when re-

lated to intense experiences of presence and/or self-actualization, occurs under a tension: responsivity is perceived in corporeal "in time" relationship to the infant as part of the "world of objects" on which they can act, and this possibility of action is not an intellectual representation but a practical one. As asserted by Al-Saji in discussing Bergson's theory of time: "the discernment and selection of material images in light of the possible actions of my body on them (...)are made into representations or 'pictures' (...)however, practical and material, not intellectual or mental" (Al-Saji, 2004, p. 219, her quotations). This practical reasoning of representation is also at the core definition of social representations by Serge Moscovici, as asserted by Denise Jodelet:

> The transition through the image, which ensures the concrete character of the representation, guarantees the applicability of knowledge that is developed by the practical aspects of the processes of objectification and anchoring. This transition is also the means to ensure the permanence of representations in the collective memory, their accumulation in layers referring to times more or less ancient and their relation to the symbolic and imaginary. The image comes also in support of an approach which is "aestheticising" and creative of representations. It reveals its character of "poiesis". (2011, p. 39.10, her quotations)

According to this view, corporal presence and temporality configures habitual perceptions of infants' needs and contribute to this "accumulation of layers" regarding hegemonic representation of motherhood. Therefore, co-presence has a much more important role in the enactment of care ethics than the rationalist project of incentivize parents to learn from moral rhetorics focused on risk and biological determinants.Devices such as paternity leaves and equal parental leaves, responsive childcare centres, communitarian support etc. can play a significant role on the establishment of this ethics as not limited to feminine work; this means that social presence in its phenomenological definition promotes much more care ethics than rhetorical texts, especially if the reader is living this early period after childbirth. At the same time, aesthetical experiences seem to have this potentiality of conciliating Rationalism, or "culture of meaning" (Gumbrecht, 2010), to ethical co-existence. With the aim of contributing to men's and women's opportunity to live parental relationships as authentic experiences, which can also contribute to bodily emancipation, one should focus on improving responsivity of social presence rather than on changing parents' "mentality", because, this "mentality" is in fact produced and deconstructed in action.

When paying attention to the experiences of women with the transitions related to motherhood, such as the experiences of planning and conceiving, getting pregnant, preparing for childbirth, having medical care, breastfeeding, etc.– one can realises how oppressive it is to expect biological mothers to accomplish certain patterns of autonomy and empathy on the behalf of children's self-foundation. In assuming a necessary process of dedication and mutual correspondence between young children and individual-

ized parents, subjective development remains dependent on a universal and essentialist representation of motherhood in which there is no room for ambivalence and change – as already discussed in this thesis, it produces marginalization and invisibility of real and non-normative experiences. Therefore, even if the "ethics of desire" critically revises the domination of the "ethics of justice", opening it to a critique of the "rational individual" model, still, according to dominant rhetorics of Public Health, mothers remain in a constrained position: representing a moral disposition of caring, recalling the ethical constraint of human condition but, at the same time, being charged as mainly and singularly responsible for the emotional development of each individual. If it is interesting to propose an ethical role of Psychoanalysis and other fields of knowledge related to motherhood – scientific or not – it is most in constructing an ethical approach from "the attention to the particular" as Laugier (2011) suggests, an attention to social presence for real embodied experiences.

Despite the intensification of "present" in primary experiences of presence, the subsequent events – such as the need to *"study"*, *"research"* and *"see a human being in formation",* as told by Renata and expressed by other participants – are always intertwined to past. One can relate it to the concept of "past-presence" by Derrida (1991), which is a "whole" constructed of habitualities and the encounter of different planes of others' pasts (Al-Saji, 2013). Not only the practical knowledge of childrearing transferred by other caregivers play an important role but the intencity of actual experiences of presence during pregnancy and birth contribute to those habitualities. That is why some of the participants of this research, when having intense experiences during the prenatal period and childbirth, isolated themselves from their relatives such as children's grandmothers and searched for this practical knowledge in the Internet and parenting groups in which they had found identification and hoped for prolonguing and understanding the experience.

Thus, one can assert that the desire of presence is an intuitive feeling that would produce a more authentic experience with life as an opportunity to produce novelty though also reinforcing the feeling of a shared world – a world that is "*already there*" (Al-Saji, 2013a, p. 8, her italics). However, as we could see with this research, during the search to comprehend this desire and to deal with the conflictive rhetorics of chosen motherhood, authentic experiences can be replaced by a self-damaging process (Candace, 2014). When this "shared world" is built on the hegemonic representation of motherhood as a universal and ontological category conceived as fundamental for the child's humanization, it actualizes the "fear" of the future, which means fear of health and psychological risks repeatedly used by Public Health rhetorics towards mothers. In this process, mothers' agency can be captured by the pressure of the contemporary politicisation of motherhood:

> Thus, the self is dissolved into a collective identity, which might or might not truly reflect the unique and complex multiplicity of identities that belong to each individual. In the case of motherhood, shifting cultural norms concerning what constitutes the good mother, or what choices one ought to make in preparing for childbirth, including identities that resist historical and patriarchal norms and expectations, are potentially damaging. § Also damaging is the replacement of the maternal self with the infant as the individual of real importance. (Johnson, 2014, p. 94)

Therefore, this process of searching for "emancipation" – a recurrent word in my fieldwork – from this ambiguous experience of feminine embodiment discussed by Young (2005) – occurs in a re-presentation of past with a subjective openness but also a closure that is very hard to surpass (Al-Saji, 2013a). This closure is delimitated by presences, in each country and within specific family arrangements, that favour or not the visualization of "present", "past" and "future" in mothers' experiences. While the "past" is a landscape, as static "natural" aspects of being a mother, the future appears as a horizon in which the individual child's development is in focus. In this sense, this engagement in "chosen motherhood" as a personal and political project can hardly be accompanied by an ethical responsivity towards more vulnerable women and families. But as an incomplete process, full of hesitations, the transition(s) of motherhood can also present opportunities to re-invent it. One must be aware of the incongruences, mismatches, and hesitations that find a way to appear in intersubjectivity and can propitiate intuitions for care ethics not only in parental relationships but among mothers themselves.

Instead of fixing a model of an idealized organization to satisfy psychological and moral needs of certain humanization, one could observe the complexity of human beings in action, and prompting from there a politicisation in the direction of structural changes, such as in gender, racial and class norms, for improving social presence for mothers and families in general. Then, it seems interesting to face human development through performativity, which implies the recognition of human condition as a complex and relational one (Gilligan, 2003); at the same time, one should not ignore the bodily constraint of performativity, especially in dealing with childrearing – a subject exhaustedly theorized by male voices in the position of experts, observers, and exploiters of care work.

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Annex

PARTICIPANTS' QUOTES IN PORTUGUESE LANGUAGE

By order of appearance:

"Mas a conversa que eu puxei sobre ter filho era na época de namoro ainda. Na verdade era uma vontade que estava um pouco distorcida na minha saúde emocional. Porque comecei a ver que eu projetava muito a maternidade nos relacionamentos sexo-afetivos, que isso na verdade era uma maneira de eu negar querer ser mãe, porque é uma bandeira inicialmente muito feminista de não querer me confessar pra esse meu lado feminino, e aos poucos eu fui arrumando isso na minha cabeça e coincidiu com esse meu relacionamento (...) Até hoje eu tento estudar e entender, mas as vezes eu consigo mais sentir do que entender, né? Não sei se é uma análise muito pretensiosa minha, mas é que tem muito estímulo erótico, de modo geral, principalmente em cima da imagem do feminino, da mulher, e eu acho que a maternidade é o fechamento do ciclo. Em tese, o sexo existe pra gerar vida e acho que isso acabou me ajudando a fazer essa bagunça emocional, tanto estímulo erótico, de todas as relações sexuais que tive, nenhuma delas, em muitas delas, não foi gerada vida, eu não engravidei, acho que isso também dá um excesso de domestificação, como o eu li no 'Mulheres que correm com os lobos', ela fala muito disso, que a feminilidade começou a ficar muito doméstica e tem um lado selvagem que eu acho que é o que tem a ver com esse meu desejo da maternidade, e agora também com essa minha segunda gestação." (Fátima)

"Se eu ficar no campo do crítico literário, sobre a literatura, eu não vou conseguir chegar muito lá (...) eu não vou entender muito do que eu acho que estou procurando no final: quem é a minha filha, como é que eu lido com ela, que tipo de ser humano ela é, etc. E comecei a achar essas criaturas muito interessantes mesmo, desde que eu fiquei grávida que eu comecei a achar criança uma criatura muito interessante. Sei lá, cientificamente muito interessante mesmo. Não acho gravidez fofo, não é essa coisa da mãezinha, do bonitinho, eu achava muito animalesco, muito interessante tanto a mãe quanto o filho." (Sofia)

"Como é que foi a entrada na maternidade? Essa pergunta é larga... não sei... eu acho que foi meio no processo das coisas acontecendo aos pouquinhos. Eu estava na tese há um tempo já, naquela fase que você ainda não sabe se já é gente grande ou se não é, quando é que você vai começar a sua vida de verdade... se vai poder ter outros planos além da tese... e aí eu tinha uma amiga que estava tentando ter bebê já há um tempão e não estava conseguindo... e aí meio que funcionou a história no sentido que eu falei: bom, minha vida está presa na tese mas não dá pra ficar nessa história... é, vamos começar a tentar porque pode ser que demore muito tempo e eu não posso suspender todos os meus projetos por conta disso, entendeu? (...) isso foi em 2010, eu tinha 31 anos... é aquela fase que você não sabe... eu tinha feito uma consulta na ginecologista, ela tinha me dado um puxão de orelha: pra não ter filho é fácil, mas pra ter filho nem sempre é fácil, tem que começar a prestar atenção se você quiser, a idade também influencia... chegou uma hora em que eu sabia que eu queria ter filho, isso pra mim era uma certeza... e chegou uma hora que eu disse: bom... eu prefiro correr o risco de engravidar agora, mesmo se o momento não é ideal, se ainda estou na tese, eu não estou trabalhando... do que correr o risco de não poder ter porque eu esperei demais." (Natalia)

"Minha filha foi super, master, mega planejada e desejada (...) quando eu decidi parar de tomar o remédio, eu falei com o meu marido, a gente entrou num acordo, e aí a gente falou, é isso, é agora que a gente vai ter bebê. E eu fiquei completamente bitolada na intenção de engravidar pra poder engravidar logo, e eu parei de tomar o remédio em dezembro e engravidei em abril, o que

pra mim foi super longo, mas as pessoas falam que foi rápido, mas a minha vontade de engravidar era tão grande que o tempo pra mim foi enorme." (Marcela)

"E aí eu me organizei pra isso. Porque eu sempre quis ser uma mãe presente, e eu sou pedagoga, então eu estudei muito Educação, trabalhei numa ONG durante oito anos com projetos de Educação, então eu sempre fui muito decepcionada com a escola, sem acreditar nesse sistema, e aí uma coisa que eu sabia é que pelo menos até os dois anos eu queria ficar plenamente com meu filho. (...) Então essa relação com a minha mãe me fortaleceu muito, falando de como meu pai era próximo, me fazendo lembrar da minha infância, de cuidado assim, da rede que era a família, que hoje em dia a gente não tem mais né, que eram as tias, que todo mundo se ajudava, e que não tinha essa coisa de botar na escola tão nova, porque as mães não trabalhavam fora, né, porque as minhas tias todas foram donas de casa e só começaram a trabalhar depois que os filhos cresceram, então a lembrança dos primos juntos, dessa primeira infância mais ligada ao quintal né, isso tudo foi me constituindo, foi me relembrando quem eu era, e foi me fortalecendo, e quando o V nasceu estava tudo muito sólido, sabe?" (Simone)

"O espaço escolar me possibilitou muitas descobertas, muitos encontros e experiências, mas não me acolheu nas minhas crises e no meu autoconhecimento. Logo nos primeiros dias de aula, quando descia o morro e atravessava o bairro para ir para a escola, já fiz inúmeras descobertas. (...) Percebi que o mundo ia além da minha família. (...) Nesse lugar, também descobri que eu era negra e pobre. (...)Depois fui para a universidade, onde aprendi sobre currículos, didática e história da educação. (...) Comecei a transitar na Zona Sul [regiã rica da idade do Rio de Janeiro], a trabalhar por lá e me descobri vivendo o racismo e o machismo a cada dia. Mas, apesar de todas essas descobertas, só me afirmei negra, mulher e educadora muito tempo depois da escola. Porque a escola, com sua estrutura rígida e compartimentação dos saberes, não me preparou para nenhuma dessas transições. (...) Durante esse trabalho e busca por formas alternativas de educação, procurei um curso técnico de dança, pois queria valorizar o corpo que a escola desconsiderou durante toda a minha vida. (...) Construímos uma escola propiciando um espaço no qual todos participamos como educadores e educandos, onde podemos fazer virar realidade uma visão de mundo segundo a qual é possível misturar criativamente educação e cuidado. Trata-se de sincronizar tempos vitais e de aprendizagem, por meio da construção de um espaço de criação, brincadeira, vivencia e pesquisa." (Simone)

"Eu me sinto culpada em relação a não ter conseguido manter esse apego depois dos seis meses... Pra mim, é como se eu tivesse desistido... (...) Porque assim, Z não dormiu de imediato. Eu deixei ela chorar no berço muitas e muitas noites. Então, é essa a minha culpa... Será? Eu me questiono muito. Porque Z tinha muitos pesadelos. Então eu me questiono se eu não devia ter tido esse apego depois dos seis meses... Se eu não devia ter segurado a minha onda um pouco mais... De ter estado mais disponível pra Z (...) Quando ela começou a aparecer com muitos medos, pesadelos com desenhos, eu falei: caramba, eu desisti muito cedo. Eu devia ter continuado, eu devia ter ficado, sei lá, um ano sem dormir, como uma amiga minha ficou (...) Sem trabalhar, e amamentando, amamentando... mesmo sabendo que eu tinha chegado ao meu limite, depois eu cheguei a me questioner: poxa? (...) Porque quando eu encontrei essa teoria da criação com apego, que dizia que pirraça faz parte, que pirraça é assim mesmo, que você não precisa ficar louco, aí eu comecei a mudar minha relação com Z (...) Porque como eu estava te falando, eu sou muito rígida. Por isso que eu não quero mais ter outro filho, porque eu não quero passar por essa fase de educação de novo, entendeu? Porque eu acho, eu sei que isso é um saco... A gente imagina como a gente quer que sejam os nossos filhos, entendeu? Eu quero meus filhos bem educados, eu não quero passar vergonha em restaurantes, em supermercados... Eu me lembro muito disso, que eu não queria passar vergonha de jeito nenhum com crianças esperneando em supermercado, entendeu? Então eu tenho muito essa rigidez em relação a essas coisas... Sabe esse negócio de ficar dizendo: não, isso não pode, você não pode fazer isso, fazer aquilo, senta direito, segura o garfinho... Sabe? Isso eu não quero mais. Isso me cansou muito." (Eliane)

“E aí a gravidez veio e foi um baque. É, eu não estava preparada, não era planejado, eu queria ter filho, a gente falava em ter filho, mas não era o momento certo (...) e aí eu fiquei super confusa, pensei em abortar, então a decisão, foi uma decisão mesmo, mas compulsória, sofri bastante, mas o que pesou mais pra mim no fim das contas foi que, eu sempre... me enxerguei educando, sabe? Eu sempre planejei isso pra mim. Talvez, muito provavelmente, pela condição a qual a gente é condicionada, mas também pela possibilidade de ver uma consciência humana se desenvolvendo. Então eu falei: não, vou assumir esse bebê, e eu achava que ia ter apoio né? Mas eu estava com depressão, e aí eu vi que eu não estava tendo apoio. (...) Porque a minha mãe começou a ligar... no começo da gravidez foi muito estranho porque a partir do momento que eu oficializei, ela dominou a situação. E aí ela tinha mais controle sobre mim mesma, no corpo, sobre as minhas experiências... todas as pessoas estavam dando pitaco que eu devia ter filho ou não, e foi nesse momento que eu estava tendo depressão” (Renata)

“Porque eu tive uma gravidez de risco (...) eu fiz o tratamento, descobri que estava grávida, mas eu pensei na minha cabeça que eu ia levar a gravidez até o fim e que quando eu estivesse no final da gravidez, eu ia ter ele e já estava terminando aquele período de provas, né? (...) Só que quando eu estava fazendo a prova, foi no dia do meu aniversário, eu adorava o dia do meu aniversário, nada de mal poderia acontecer comigo (...) e quando eu fui no banheiro eu estava completamente suja de sangue, cheia de sangue por tudo! Eu não sei como é que não passou do vestido (...) Aí eu achei que já tinha perdido (...) a gente saiu pro hospital, a médica muito grossa, não deixou ele nem entrar, não deixou ele nem falar comigo, ela me fez sentir culpada porque a gente tinha tido relações... porque quando a gente está fazendo tratamento, tem muitas mulheres que tem um mito assim: ah não pode ter relações sexuais não sei o que... nada impede sabe? Geralmente nesses grupos elas evitam ter porque elas demoram tanto assim pra ter aquela oportunidade né, que na verdade elas não conseguem ter naturalmente que elas até se privam as vezes até de sexo pela gravidez toda, né? Tem mulheres que fazem isso. (...) E aí a médica me fez sentir muito culpada, e ela fez uma cara tipo que não ia adiantar, ela disse: ah pode fazer o repouso que você quiser! Ele estava vivo ainda, só que estava com o saco (aminiótico) completamente descolado, um pedacinho de nada assim colado. E ela disse: pode até fazer repouso mas eu acredito que não vai dar certo (...) Aí eu fiquei de repouso, na verdade parou toda minha vida, e eu era muito ativa. (...) Eu sei que eu fiquei três meses completamente de repouso, só levantava pra fazer xixi, pra me lavar, e voltava pra cama né, o tempo inteiro deitada.” (Lidiane)

“Na verdade quando ele nasceu eu senti que perdi minha identidade. Eu não me sentia mãe mas também não me sentia menina, sei lá, jovem, mulher, e eu estava num vácuo assim porque eu não me achava em papel nenhum (...) Porque o blog no início foi uma forma de eu colocar meus sentimentos assim. No início por causa da infertilidade e depois por essa questão do F ter nascido e de eu não ter sentido aquela identificação, em nenhum momento eu senti aquela identificação, aquela coisa que as pessoas dizem: ah que amor, aquela coisa que surge não sei da onde, sabe? Eu nunca senti isso. E eu acho que isso foi uma das coisas que me deixou mais depressiva e me afundei mais porque eu me sentia culpada porque as pessoas... tudo assim a gente vê, sabe, nas redes sociais, que as pessoas ficam mais a flor da pele ainda, das pessoas quererem mostrar aquela felicidade, querendo mostrar que estão completas, né, e tu ter um filho ainda pra uma mulher é visto hoje como meu deus, tu alcançou o nirvana né? E eu não sentia nada daquilo e eu não podia falar com ninguém.” (Lidiane)

“E quando eu voltei de novo eu fiz umas sessões, com o mesmo terapeuta que eu tive toda minha vida, do meu período dos quinze anos até eu ir pra Portugal. E ele me falava muito assim, ele tem uma abordagem humanística, ele sempre tentou me tirar a culpa quando eu falava: mas eu não sinto isso! Eu ficava me castigando, e ele falava: mas porque que tu tem que sentir? Ele sempre me dizia assim, mas também era homem, né? Eu não sei qual seria a abordagem de uma mulher. Mas ele sempre me dizia assim que ser mãe é apenas um dos papéis que nós temos, né? Tu é filha, é sobrinha, é afilhada, é madrinha... enfim... e tu é mãe! Claro que ser mãe tu tem uma responsabilidade maior, óbvio, né? Porque tu é responsável pela criação, tu e o pai no caso. Mas

não é uma coisa assim tão sobrenatural. E foi ele quem me ajudou muito nessa parte de ter sinceridade comigo mesma também. Porque ele adotou dois meninos, e ele dizia que um dos meninos tinha um trauma tão grande do abandono que ele gritava e chorava às vezes uma hora sem parar (...) e ele admitia que ele mesmo às vezes tinha pensamentos... que ele tinha vontade de matar! Mas é claro que ele não iria fazer isso. Uma coisa é a gente sentir outra coisa é a gente fazer. Sentir a gente pode sentir, também não quer dizer que a gente seja um monstro porque a gente sente uma coisa que não é ou que admite uma coisa que não é cabível na nossa sociedade." (Lidiane)

"Então, eu fiquei sabendo que estava grávida de surpresa, né... eu não participava do mundo da maternidade. Eu já tinha um desejo ao longe de ser mãe... e na verdade eu estava desconfiando, fiz o teste, chorei que nem uma desesperada, só que assim, em nenhum momento eu tive dúvidas se eu teria ou não, eu sabia que eu teria. Enfim, a minha entrada na maternidade foi uma entrada meio 'punk' assim... cara o que vai ser de mim agora? Mas eu acho que eu não tinha também muita noção da dificuldade que era. No primeiro ano, assim, eu mergulhei no mundo da maternidade... eu fiquei ali, tentando não entrar, mas eu acho que quando a ficha caiu, eu relaxei e falei: não, agora eu quero saber tudo sobre isso. E eu acho que até o blog é um reflexo disso, porque eu gostei, né?... porque eu acho que ele foi me gerando frutos, assim, em virtude de tudo que eu pesquisei, do que eu começava a ler, do que eu vivenciei e tal." (Luciana)

"Cheguei com 4 ou 5 cm de dilatação (não lembro bem) e logo nos acomodamos na suíte. Ao chegar na suíte a primeira emoção – foi a suíte onde fiz minha última consulta na quarta feira – dois dias antes e ela possuía um quadro de uma Preta Velha que me emocionou profundamente. Achei um bom sinal já que minha mãe sempre me contou que durante meu nascimento ela recebeu amparo e conforto de uma preta velha durante seu TP, logo, como não existem acasos... Outra coisa que notei é que o relógio que fica em frente à cama tinha sumido, o que achei ótimo porque isso me ajudaria a desligar do tempo e mergulhar de cabeça no meu parto. Liguei o MP3, conectei as caixinhas de som e a black music voltou a tocar me fazendo dançar entre as contrações." (Carla)

"Eu estava falando há um tempinho atrás com a minha irmã, porque ela ligou, queria falar aqui comigo, mas a B ficava o tempo todo em cima de mim, e eu disse pra ela: olha, não vai dar pra gente falar direito agora. Aí ela disse: poxa, mas a B não te dá paz, né? Poxa! Pensa bem, se coloca no lugar dela! Ela é uma criança de três anos, ela não tem ninguém aqui! O pai está viajando, ela está sozinha, só tem a mãe, não tem vó, não tem tios, tá nevando pra caramba... ela não vai grudar em mim?! É claro que ela vai! Não é ela que é um grude, é a situação que eu estou dando pra ela, entendeu?" (Flávia)

"Eu acho que é bom você correr atrás de informação e ver, ler, ler blog, ler lista de discussão, agora tem esses grupos de Facebook... Eu acho que é muito bom por um lado, mas por outro lado dá uma tensão que no segundo filho não tem. Você vai muito mais intuitivamente. É claro que essa experiência é a melhor coisa, né? É o melhor mestre, a experiência é o melhor mestre." (Luna)

"Gosto muito de ir no Babycenter tirar dúvidas, ver as dicas, apoiar o parto normal, porque eu vi que é uma boa experiência, né? Eu vi que eu não precisava cair numa cesárea. (...) Como não tinha minha mãe pra perguntar, tinha que procurar em algum lugar, né? (...) Eu não falo com muita gente não. Eu só leio os tópicos, e criei um tópico sobre parto normal sem dor, onde eu contei a minha experiência. E teve pessoas que me perguntaram como é que eu tive acesso à peridural, como é que eu tive um parto sem dor, se era um direito, aí eu tive que pesquisar, né, e descobri qual era a lei do ministério da saúde, resolução não sei que lá das quantas, pra eu poder falar né o que era... Só isso... Eu vou lendo, e se eu vejo que alguém tem alguma dúvida sobre alguma coisa que eu passei, que eu posso ajudar, eu respondo... É o tempo que eu tenho, né, o meu tempo pra ler é rápido, é quando ela dorme, ela tira um cochilinho." (Francine)

"Foi só um gancho né? Pra eu encarar a verdade... O meu corpo, estava nítido pra mim, que era uma verdade que estava transpassando o meu corpo, não era uma lembrança imagética sabe? Era uma lembrança física. Era uma lembrança funcional que eu não conseguia compreender com palavras, eu não conseguia me compreender, por que eu queria ficar só deitada num quarto escuro sem contato com ninguém, estava fora do meu alcance. Até que eu parei pra ver, peraí, o que está acontecendo? Isso não é normal. Isso não é normal. E aí eu fui né buscar ajuda... meu, preciso entender a psicologia da gravidez. Foi a palavra-chave assim, foi a palavra-chave, e aí eu comecei a estudar, e aí eu encontrei que uma gravidez pode causar revivências, né? (...) E aí eu entendi e falei: bom, preciso me curar, como é que eu vou fazer pra me curar? E aí eu fiquei no parto né? E aí estava lá: o parto pode ser empoderador, realmente foi muito empoderador, realmente (...) uma experiência de posse, de domínio (...) antes de eu engravidar, apareceu um dia na minha timeline "parto orgásmico", eu falei, nossa, que legal, parto na banheira, que demais, a moça super tranquila, a cara ótima, nunca vi isso. E assim mas não, não é pra mim, né? É pra gente que tem grana e tal. Aí com o tempo aquilo foi vindo mais pra minha timeline por causa do feminismo, às vezes tinha uma coisa ou outra, que alguém tinha compartilhado e aí eu comecei a querer um parto humanizado, que pra mim era o parto natural não era parto humanizado, que eu achava bonito, não tinha nada de científico, só que quando eu engravidei e comecei a lidar com tudo que eu estava lidando sozinha eu falei: caramba eu vou ter que lutar por isso. E aí eu comecei a estudar sobre parto, cesária, e psicologia (...) mas antes eu era totalmente leiga" (Renata).

"Eu quero que o desmame seja... se não natural, né? Se eu não conseguir... se não for possível, né? Por qualquer motivo que seja... mas que seja um desmame respeitoso e não abrupto. (...) O desmame natural é ele parar de mamar, parar de querer mais, ele ter o processo dele. Sem o mínimo de interferência minha, porque ele não chupa chupeta, ele não usa mamadeira (...) Mas eu também não quero esperar até sete anos de idade como a minha prima, sabe? Eu vou saber quando eu cheguei no meu limite, então, por isso que eu falo não abrupto." (Renata)

"Tudo aquilo que eu imaginava é... foi uma desconstrução, foi uma desconstrução. Eu achava que, sei lá, eu achava que as coisas poderiam ser práticas, você tem um bebê, você ganha um bebê, você contrata uma babá, você coloca o bebê na babá e você vai dar mamadeira, enfim, só que aí eu cheguei aqui, virei, é, mãe, e dentro daquilo que eu entendi que seria melhor era totalmente ao contrário né? Quer dizer, B dormiu junto, amamentei, carreguei no colo, e tem sim os livros que até hoje eu... eu continuo nesse caminho, sabe? Então na questão da maternidade tem uma autora que eu gosto muito que se chama Catherine Dumonteil-Kremer, que é hoje uma referência do que é uma educação diferente, outra mentalidade, os livros dela me ajudam bastante. E... enfim, o livro dela se chama assim: "Élever son enfant autrement", educar seu filho de outra maneira, é um manual assim sabe? Manual? Não é um manual? Eu não sei como se fala isso no Brasil, mas fala né, das etapas de desenvolvimento e tal, mas ela sempre vai pra aquele lado assim: écharpe, amamentação, parentalité positive, non violence, e ainda hoje participo (...) foi o que eu falei para ela, para a Catherine, na reunião, eu por ser brasileira, pelo choque de cultura, pelo caminho que eu escolhi, ela foi a francesa que pensa diferente, e que pelos livros dela me ajudou muito, assim, entendeu? E ela é francesa, ela pensa diferente mesmo. (...) Porque as francesas, de maneira geral, elas são... a menina que estava no quarto comigo ela teve o bebê e ela logo deu a mamadeira entendeu? Então essa é a mentalidade da maioria delas aqui" (Ana Lúcia)

"E aí foi muito legal engravidar, por um lado, porque eu estava num registro de morte, de perda, de tristeza, de recuperação, e de repente eu estava de um dia para o outro num registro de vida, de futuro, então foi muito legal. Mas, assim, jamais eu teria tomado essa decisão, fiquei desempregada, fiquei doente, não tinha onde morar, ah vou engravidar! Nunca teria tomado essa atitude. Então foi ótimo ter engravidado sem precisar pensar sobre isso, porque senão eu não teria tido e não estaria aqui hoje onde eu estou, né? Muito legal engravidar. Então não foi nada planejado mesmo, e a partir do momento em que eu imaginava que estava grávida, quando eu fui

fazer o teste de sangue, eu já sabia que eu queria muito ficar grávida, mas não era uma consciência interior ao fato, eu não imaginava que eu quisesse tanto assim ficar grávida".(Sofia)

"Essa é a minha experiência e pronto, meio que como se eu tivesse caído na minha vida para começar a viver ela, parar de olhar ela de cima e... foi nessa época também que eu comecei a ficar muito puta com a Laura Gutman que eu tinha lido pra caramba como todo mundo, né, e aí eu comecei a ler os textos dela e falei, 'meu mas essa mulher está viajando, sei lá, meu, nada a ver' (...)Então eu comecei a achar, não a Laura Gutman em si, mas o exército da Laura Gutman às vezes, essa repercussão imediata desse discurso, que eu comecei a achar excludente de realidades como a minha e de outras mães que eu poderia conhecer no posto de saúde também (...) Então eu não achava assim tão bonitinho a gravidez e ter bebê, e não achava principalmente que era uma decisão sabe? Não era uma opção. No meu caso, eu fui jogada dentro dessa situação. Então eu achava... eu comecei a me irritar com todo esse discurso, ler o discurso de naturalizar demais a mãe!" (Sofia)

"Porque eu cheguei a pegar o livro da Laura Gutman pra ler, algumas coisas assim pra ler, e eu percebi que a maternidade abriu várias comportas, assim, é impressionante como a gente começa a lembrar de coisas da nossa infância, não sei, eu acho que uma coisa que achei muito bacana, não só pra entender o parto, depois de tudo o que aconteceu, mas pra me entender como mãe, que mãe eu quero ser pra ele, e essas coisas né?" (Luise)

"Eu tinha uma escuta, eu achava que aquele espaço era significativo para aquela mãe, que era importante, mas eu não... ninguém está preparado, eu acho que não há uma preparação... não é teórica, não é intelectual, tudo que você faça, que você leia, que você estude, que você tenha conhecimento da area, que você seja informada... é o fato de você se deparar com a situação, de ser a mãe e estar só. Eu me senti bem desemparada por não ter a família, ao mesmo tempo eu me senti assim bem perdida, eu acho que a gente fica procurando saberes (...) e no Brasil tem um lado, pelo menos quando tu é classe média ou classe média alta, que você contrata alguém pra te ensinar a fazer tudo, que é a enfermeira ou que é a babá, e que é um saber passado de mulher pra mulher, de geração pra geração. Mesmo no Brasil quando tu não é classe alta ou classe média, tu vive numa classe mais desfavorecida, se passa, poque as pessoas vivem numa comunidade na favela. Tem a vizinha que mora perto da sua casa, tu tem... é sempre feito, tipo, em comunidade. E aqui na França, houve um isolamento, foi por isso que a Françoise Dolto criou isso, a *Maison Verte*, por conta desse isolamento, a gente está *'tout seule'* com o bebê em casa, pra fazer todos os cuidados, pra estar disponível, pra estar estimulando, pra estar brincando, pra estar disponível emocionalmente e tudo. Eu entendi o peso disso quando eu fui mãe, apesar de eu ter estudado psicanálise, de eu ser psicóloga, ter estudado teorias educacionais, porque eu trabalhei em creche e tudo. Eu descobri a maternidade sendo mãe... tinha dias que o J chegava e eu dizia assim: toma é toda tua! Me deixa cinco minutos sozinha! (...) e ao mesmo tempo tem a culpa, né? Tipo: não, tenho que voltar! Eu achei cansativo e o isolamento foi pesado pra mim, porque a gente não tem família nenhuma aqui, então eu fiquei com a G, eu ainda cuido dela hoje, quase todos os dias da semana. O isolamento pra mim foi bem pesado." (Aline)

"Não foi tão tranquilo não, mais por minha culpa. Porque, eu não te falei, mas a gente conversou pra ter bebê mas eu tinha muito medo, não queria mais ter outro filho. A minha primeira gravidez foi tranquila e tal mas eu sempre tive muito medo de engravidar de novo... por medo do parto, medo de estar grávida, porque são muitas alterações. E como eu achei que eu tinha encontrado a pessoa que eu queria ficar para o resto da minha vida eu concordei em ter outro bebê... e aí, é... eu fui fazer o pré-natal mas além de em todos os meses ter o meu medo próprio ainda tinha o agravante de eu ter perdido um bebê. Então foram nove meses de muito estresse, tudo era muito estresse" (Helena)

"E às vezes você se pega desesperada assim, mas... eu tenho que ir em frente, tenho que ir driblando as dificuldades, porque... pronto, às vezes eu não me permito ir à baixo né? Não tem

como eu estar triste toda hora ou ficar mal, eu tenho que cuidar da minha bebê e tenho que estudar, porque é a minha única possibilidade aqui, é terminar meus estudos. Se eu não conseguir, e se eu não conseguir um emprego aqui eu vou ter que voltar para o Brasil. (...) É uma coisa que me preocupa, não conseguir um emprego aqui, e me preocupa muito mais também é voltar pro Brasil, eu não gostaria (...)Eu emendei a graduação com a pós-graduação e com o mestrado, e agora eu tenho a necessidade, sempre tive, mas agora eu tenho mais necessidade de trabalhar. Então eu poderia ficar aqui com meu esposo, com ele trabalhando, e eu fazendo nada, ou só estudando, mas é uma necessidade minha de ter meu trabalho, de ter meu dinheiro... e trabalhar na minha área também (...) E meu mestrado é em desenvolvimento da criança. Nesse momento eu estou estudando sobre adoção, minha tese vai ser sobre adoção e tem sido bastante interessante." (Helena)

"Eu sabia que seria tudo muito difícil: a preocupação, a saudade, as más línguas e a culpa... Ai, a culpa! Essa que acompanha cada mãe em muitas das decisões de suas vidas e que, às vezes, atrapalha tanto. Mas eu tinha que ir! Eu merecia, eu precisava! Talvez não houvesse outra oportunidade como esta. (...)Depois de conversar muito com meu marido, com a família, com amigos, com minha terapeuta e mesmo depois de receber muitas críticas, decidi não perder esta oportunidade e me lançar na maior aventura da minha vida. Viajei em 17 de outubro de 2012. Mantive contato quase que diariamente com os meus pela internet. E, como o vocabulário e a paciência do pequeno eram curtos para conversarmos, eu cantava com ele. As canções eram as que já cantávamos antes da viagem e as que ele foi aprendendo com o pai. Estávamos musicalmente e emocionalmente juntos e isso diminuía um pouco a nossa distância. Eu sabia que meu filho estava bem cuidado. Importante dizer que com 2 aninhos recém completos, o B – como as crianças dessa idade – não tinha consciência da passagem do tempo. Não sabia o que era uma semana ou mesmo um mês. Importante também falar que meu filho estava assistido por uma rede de familiares e amigos atentos, que asseguravam seus cuidados. Mais importante ainda é falar do papel do pai nessa história. Eles são tão responsáveis pelos filhos quanto às mães, mas viver essa responsabilidade igualmente compartilhada é uma coisa ainda difícil para as mamães contemporâneas.Toda gratidão ao S – o papai do B – pelo apoio e pela coragem de assumir este papel com tanto carinho. Conseguimos!" (Cristina)

"eu comecei a pesquisar, sempre gostei de pesquisar, procuro tudo, dor de cabeça, procuro no Google, qualquer coisa, e pro parto não foi diferente, né? Eu sou muito ansiosa então isso povoava muito a minha cabeça. E aí quando eu comecei a pesquisar, achei de cara todas as informações do parto humanizado, e comecei a ler vários relatos de parto, cesárea, e aquilo me dava um pânico tremendo porque eu estava na fila, né? Caminhando pra uma. E eu me desesperei, e com 6 meses de gravidez eu larguei o trabalho que eu estava. Porque não estava valendo a pena, trabalhar no educativo do museu, não estava valendo a pena, aí eu acabei largando e acabei voltando tudo pra isso. Enlouqueci procurando tudo sobre gravidez, tudo que eu encontrava sobre parto, aí o T chegava do trabalho e eu despejava tudo em cima dele, pelo amor de deus! E aí ele, cara você está maluca! Isso é maluquice de internet, isso é maluquice! Então eu tive que convencer ele de que não era uma maluquice, era uma realidade, que a gente não ia poder usar o nosso incrível plano de saúde do trabalho dele, foi uma batalha" (Luise)

"e aí esse processo foi se construindo, eu já estava pensando nisso: eu quero ser mãe em tempo integral, e também quero um parto natural, parto normal, e aí o processo do pré-natal foi um processo muito difícil mas ao mesmo tempo muito importante pra tudo que eu estou vivendo hoje. Porque eu tive que enfrentar muita coisa, né? E aí eu fui me constituindo como mãe, eu fui me empoderando, sabe? (...)Esse processo de ficar o tempo todo me reafirmando para o médico, de ter que ficar pesquisando pra saber realmente se era verdade o que ele estava falando ou se era pra me oprimir mesmo, e aí isso me fortaleceu" (Simone)

"porque eu estava disposta a ir pro SUS, mesmo sabendo que era perrengue, mas pelo menos ia ser parto normal (...) aí eu disse, ai doutor mas eu tenho medo porque é Niterói. Porque aí todo

mundo começa, ah você é maluca, vai trocar de médico em cima da hora, que trabalha em Niterói (...) e aí ele falou: Simone, o máximo que pode acontecer é ele nascer na ponte, e aí você pega ele e bota no peito, porque criança que nasce em taxi, que nasce em elevador, primeiro que isso é coisa de novela, mas se acontecer, é porque está bem, porque se a criança nasce rápido é porque ela não tem problema nenhum" (Simone)

"e aí teve essa coisa do retorno, e ainda com a cicatriz ele falou: tem que voltar daqui a um mês, eu falei: po Chico, eu to muito ruim de grana, aí ele: ah então não precisa vir! Uou! Po, não precisa fazer de graça, podia parcelar em três vezes, sei la (...) po, eu sou profissional de saúde, eu sou fisioterapeuta, já fiz muito isso... por que ele que ganha dinheiro pra caramba com isso não podia fazer? Essa é a pergunta. (...) depois eu até mandei uma porrada de e-mail para o médico falando tudo isso pra ele. Depois eu fui numas palestras do Odent e fiquei com a maior raiva, po, o cara diz que é humanizado e faz uma porrada de coisa que não é humanizada porra! Por um preço que... também não é humanizado o preço, né? O preço é elitizado, não é humanizado! E tem pessoas que acreditam muito nisso e querem ir lá fazer, né? Eu fui uma delas." (Luciana)

"Eu fico muito feliz com esse momento de... não sei se eu chamaria de Feminismo, eu fico feliz com esse momento em que a mulher pode falar de si mesma, sabe? Pode falar de fazer escolhas, porque eu acho que há um tempo atrás a mulher não poderia falar: não, eu quero fazer o meu parto porque o parto é meu, meu deus isso não existia! Eu acho bacana tirar o protagonismo do médico. Eu fiz fisioterapia, eu fiz vários exercícios para trabalhar a pelvis, o combinado com o médico era parto normal, eu fiz um playlist de músicas para o parto normal, mas eu não consegui... então, assim, eu não estava empoderada? Eu não estava empoderada! Eu me achava incapaz, eu não estava mais aguentando aquela situação, eu não sabia mais como continuar grávida naquela situação de incômodo, de ansiedade, de preocupação, de medo de dor, eu não sabia como continuar sendo mãe. Então se empoderar é dar à mulher a segurança? Então aí eu acho que pode ser usado como um termo feminino, como um termo materno (...)Esse discurso da independência do 'Empreendedorismo Rosa' é muito complicado, porque eles pregam essa independência da mulher, que ela vai deixar o filho na babá sem peso na consciência, mas pra mim é difícil entender esse discurso como verdadeiro, sabe? (...) Porque não é uma coisa que a mãe fale e que você perceba nela que aquilo está satisfazendo os instintos dela... a gente é mãe, a gente foi biologicamente preparada para ter esse tipo de instinto! Eu acho que eles vão diminuindo com o passar do tempo, e vai mudando alguma coisa, mas você não pode negar isso e agir... isso pra mim acaba virando sobrevivente" (Raquel)

"porque era uma grana que a gente não tinha mesmo. Eu falava pro T: a gente não tem dinheiro! Olha isso, a gente não tem dinheiro! Vamos pro SUS vamos pro SUS! Aí ele disse: tá maluca! Filho meu não nasce no SUS de jeito nenhum! Mas não nasce mesmo! Foi a pior coisa, assim, porque ele não queria, assim era um cara que eu não podia usar o plano de saúde, e a gente não tinha grana, a gente ia ter que economizar de alguma forma, e o SUS, era o cabide, né, entre o SUS e esse dinheiro imenso. Não tinha meio termo, ou a gente ia pro SUS ou a gente ia gastar uma grana que não tinha. Como pra ele era: o SUS nem pensar, a gente parou o enxoval aonde estava, assim e todo dinheiro que foi entrando, que a gente foi juntando numa poupancinha foi para o parto." (Luise)

"a obstetrícia da Maria Amélia foi maravilhosa, pessoal maravilhoso, mas na pediatria eram muito, muito truculentos, muito truculentos. Tentaram dar complemento pra ele várias vezes, tive que brigar pra não darem complemento pra ele, tive muitos problemas de amamentação, então tive que ficar chamando as pessoas para me ajudar porque eu não conseguia colocar ele no peito, e o pessoal sempre tentando dar complemento pra ele, chegaram no quarto pra medir o peso dele, uma série de coisas assim. E quando a pediatra falou que ele estava amarelo, que ele tinha que ficar lá um tempo, nossa, a gente ficou em pânico, deram o banho aí trouxeram o bercinho de luz, a gente começou a chorar (...) aí a gente falou, olha, vocês estão errados, aí eu olhei pro T e falei: vamos embora daqui! Aí a gente pegou o D, arrumou nossas coisas, e a gente fugiu." (Luise)

"encontrar um obstetra que fizesse exatamente como eu queria fazer e não como eu achava que deveria fazer foi muito bom porque aí realmente eu comecei a curtir mais a minha gravidez sem essa obrigação que eu mesma me impunha, ideológica assim, que eu deveria ter o parto de acordo com aquilo que eu acreditava. (...)E foi tranquilo porque aí a obstetra chegou, com o anestesista que também era muito legal, não era, não foi um escolhido por mim, a equipe toda era do hospital. Eu fui muito bem atendida, o C também fez umas massagens que me ajudaram bastante, e eu conseguia sentir minhas contrações então foi fácil empurrar, assim foi muito tranquilo. Foi muito rápido, aí sete e meia a A já estava no meu peito mamando. (...)ah foi demais, é do que eu tenho saudade assim, eu tenho saudade do meu parto, eu gostei muito do meu parto, muito mesmo" (Sofia)

"Eu morando no Brasil, com minhas colegas de trabalho e minha família, eu achei que fosse fazer cesárea por exemplo, então eu cheguei aqui, a primeira coisa é que o parto é pelas vias baixas né? O parto é normal. Então isso me quebrou no meio porque eu tive que adaptar a minha cabeça a isso, né? (...) Quer dizer, pra mim foi como uma... é como se, sabe Carol, é como se você tivesse uma identidade, eu acho que ela começou a ser desconstruída, de alguma forma pela cultura e pela forma como eu teria que me adaptar, é... mudança de mentalidade mesmo (...) Eu acho que tudo é válido, aquele movimento da violência obstétrica, parto humanizado, tudo. Mas o problema, como eu vejo, seria uma reestruturação, reformulação enorme no sistema de modo que o médico, ele saia desse pedestal né? Que ele deixe de ser a figura principal e que tenha mais valor às enfermeiras, né, que seriam as *sage-femmes*, as enfermeiras obstétricas. (...) uma pessoa que tenha a condição de fazer o parto, porque é isso, é uma mudança... é redirecionar os papéis, sabe, e deixar o médico realmente com a parte técnica, se tiver algum problema, e a sage-femme, a enfermeira com aquilo que ela é preparada pra fazer. Eu acho que o problema do Brasil é que não aparece essa outra figura. E é uma figura extremamente importante, a gente vê que é uma profissão hiper respeitada aqui." (Ana Lúcia)

"E aí cada mês era uma *sage-femme* diferente. E aí eu descobri que não tem diferença nenhuma na parte de acompanhamento, na parte de cuidado, não tem diferença nenhuma. A única diferença é que você acaba sendo atendida por pessoas diferentes, então você acaba não criando vínculo com elas. E nenhuma dessas que eu vi durante a gravidez estava lá comigo no parto. Isso foi uma coisa que eu achei muito estranha, mas depois, agora, eu entendi... bom, aqui funciona assim, o hospital aqui é assim, tem turnos diferentes, eu queria parto normal mesmo, e é uma loteria você encontrar a pessoa que te consultou ia ser uma sorte grande" (Antonia)

"O parto em si? Foi longo, foi emocionante... eu não sei mais o que falar... foi emocionante. E até a gente ir pra sala de parto foi longo, mas uma vez que a gente estava lá, eu tinha certeza que eu estava sendo bem orientada, tudo que elas estavam fazendo elas estavam me explicando, e meu marido estava do lado... então, é muita emoção pra pouco tempo, assim, eu não sei se você está entendendo o que eu estou falando. E ainda foi natural, então eu estava ali respirando, ajudando, e meu marido estava ajudando, e tinha ainda uma coisa, porque eu não sabia o sexo dele, eu não queria saber o sexo, e no parto natural assim que nasce eles colocam no peito da mãe, então o primeiro contato é com a mãe, e até o ambiente não tem muitas luzes, não é como no Brasil nas salas de cirurgia, não é uma sala de cirurgia, porque como foi um parto normal é numa sala intermediária na verdade, tem alguns instrumentos mas não é uma sala de cirurgia... e aí uma vez que eu estava com aquela criança nos meus braços, junto comigo, só depois é que me passou na cabeça de ver o que era, qual era o sexo dele, porque enquanto ele estava ali eu estava curtindo ele, e dando boas vindas pra ele... (...) é legal isso, porque depois que ele nasceu, eles deixaram nós três naquela sala, é... sozinhos, até a gente passar para o quarto" (Antonia)

"Quando eu passei com a minha ginecologista, ela me recomendou alguns hospitais, e quando a gente foi conhecer o hospital, e tentar marca hora, ver se era possível... dos quatro que ela me deu, os três primeiros não tinham vaga! E eu estava com um mês e meio, quase dois meses de gravidez... e aí eu entrei em pânico! Então esse foi o primeiro estresse porque no Brasil o caminho

normal é você ir no hospital que o teu médico trabalha. Você não pensa muito... e a outra coisa estranha foi que quando eu comecei a ir no hospital, eu levei todos os meus exames, e já na primeira consulta, a médica obstetra que me atendeu disse que estava faltando um exame, e disse: onde já se viu chegar faltando o exame isso e aquilo, ela ficou meio estressada, e ela falou que era a última vez que eu ia vê-la, porque as próximas vezes iam ser com as *sage-femmes*." (Antonia)

"O parto em si foi ótimo! O complicado foi a estadia na maternidade, que tem aquela história de... eu escolhi a maternidade porque era um hospital grande, os meus pais são médicos, então, como estava fora do Brasil eu queria ter essa segurança de... que tivesse todos os recursos para o caso de ter algum problema, e aí no fim das contas não foi a falta de rescursos que teve problema, foi a falta de... a falta do aspecto humano da relação, né? É a história de... entra no hospital, você entra na vala comum, é tratada como um qualquer... e sendo que aquele momento é importante pra sua vida, é o seu primeiro filho, você não sabe o que vai acontecer, você está insegura." (Natalia)

"E no hospital que eu estava, ele fica num bairro popular, e tinha muita mulher mais pobre, e aí eles tratam igual a gado mesmo. Até acontecer o que aconteceu durante minha estadia lá, eu tive que rodar a baiana, pra poder encontrar, pra poder ver um profissional. Porque você chega lá, não te explicam o procedimento, não te explicam nada, você espera 48 horas, não é consultado, as pessoas não esperam que você dê a sua opinião sobre o que vai acontecer ou não vai acontecer (...) Nessa hora tinha uma outra senhora do meu lado, no quarto comigo, que tinha ido pra fazer uma consulta, estava lá dois dias jogada a coitada, ninguém ia ver ela, ninguém falava nada pra tratar ela, uma merda, e aí... uma senhora negra. E aí quando a parteira saiu do quarto ela falou: é isso mesmo, eles tratam a gente igual a gado. Aí você se toca que a percepção das pessoas, mesmo as menos favorecidas, não é diferente, ela só não tem a mesma maneira de exprimir, né? Ela só não tem os recursos suficientes pra poder se opor a uma opinião de médico, né? A um sistema, a um protocolo médico, a se impor como pessoa." (Natalia)

"Como ela veio antes, eu não estava emocionalmente preparada, então eu fiquei muito nervosa e acabou que eu não tive a minha epidural. Então, foi um parto bem tenso, vamos dizer... eu senti muitas dores, que estavam ligadas também ao meu emocional porque eu não estava preparada para aquilo (...) porque o anestesista estava acompanhando uma outra mãe que estava tendo um parto um pouco complicado, e elas me disseram que ele tinha que ficar lá com ela caso houvesse uma complicação (...) antes eu pensava em ter um parto natural, sem anestesia, só que a dor que eu senti era tão intensa que me atrapalhou durante o parto, que eu quase desmaiei, perdi o controle do que estava acontecendo. Eu me lembro que eu só voltei à mim quando a enfermeira segurou no meu braço e falou meu nome e disse 'Eliane, para de empurrar senão você vai machucar o seu bebê' (...) mesmo eles falando nos cursos de exercícios para aliviar a dor, mesmo eles falando que a dor é pra ajudar o bebê nascer, que isso é uma parte natural da coisa... primeiro que o meu parto já tinha demorado bastante, eu já estava há bastante tempo sentindo dor, e eu cheguei ao meu limite" (Eliane)

"E aí eu fui procurar um ginecologista obstetra pra me acompanhar, e eu fiz o pré-natal na rede particular, fui acompanhada por uma ginecologista obstetra a meu gosto mas tive o bebê na rede pública. (...)Então, quando eu resolvi escolher essa minha ginecologista eu pesquisei e tudo. E aí eu fiquei sabendo que ela era a chefe de departamento do hospital São João, o hospital público em que eu tive o bebê. Então eu escolhi ela por isso, porque eu conversei com ela e tinha a possibilidade de ela me atender lá também. Foi ela que fez o meu parto. (...) Então foram nove meses de muito estresse, tudo era muito estresse, então o parto, assim, não foi diferente, tudo foi muito complicado porque eu compliquei. A minha médica aceitou, falou com os outros médicos que ela faria o meu parto por uma cesariana, porque eu estava chegando em 40 semanas, porque aí eu não estava entrando em trabalho de parto, e aí eu estava muito mais estressada. Porque estava com medo, porque parto normal tem esse diferencial, lá no Brasil a maior parte dos partos são cesarianas e aqui é mais parto normal. Como eu já tinha tido uma cesariana eu estava com

medo de ter parto normal, e aí por eu ter chegado as 40 semanas e nada, ela decidiu fazer uma cesariana... (...) eu fiquei muito nervosa na hora de tomar a anestesia, e aí a equipe toda ficou muito tensa, mas no final deu tudo certo. Minha médica estava lá comigo tentando me tranquilizar, mas eu acho que em geral o parto, é, foi um pouco tenso." (Helena)

"Aqui a rede pública é muito melhor do que no Brasil. A equipe estava muito preparada, eu me senti muito segura no hospital. As enfermeiras muito atenciosas, esclarecendo toda e qualquer dúvida, sempre presentes. Foi super tranquilo, até a estrutura física do hospital, tudo muito bem estruturado... foi ótimo (...)depois do parto, me deram minha bebê e já me disseram se eu queria amamentar. Eu disse que sim, aí colocaram minha bebê pra mamar. Então eu já saí da sala de cirurgia com a minha bebê junto e fui pro quarto. Então desde o primeiro momento ela já mamou." (Helena)

"Quando eu fiz a epidural, que o médico disse que ia começar a cortar, eu senti. Eu não sei se foi psicológico, mas eu senti dor quando começaram a cortar, aí eu gritei e disse 'eu to sentindo!' Mas aí eles me disseram 'não, mas é porque você sabe que estão lhe cortando, você vai sentir os movimentos, mas não vai sentir dor'. Mas eu disse 'não, eu estou sentindo dor sim !' E pronto, esperaram mais um pouco, fizeram teste com sprays, mas eu continuava sentindo realmente. E aí o médico optou por fazer uma anestesia geral. E pra mim foi muito tranquilo, não tive razão de queixa, porque eu já tinha passado por outras cirurgias com anestesia local e ficava ouvindo os médicos falando 'me dá a tesoura, me dá o bisturi'. Então pra mim, foi melhor assim, apagar. Não era essa intenção, mas é que eles também não deixaram meu marido acompanhar, assistir a cirurgia. Eles só deixam acompanhar se for parto normal. Não entra, não tem história de foto, não tem nada disso como no Brasil, que é quase um carnaval, né? (...) Eu gostei muito de amamentar, realmente foi a melhor coisa, eu achei uma coisa fantástica. Eu queria muito conseguir amamentar. Desde o início eu tive facilidade... Nas primeiras semanas, é natural também, o peito rachou um pouco mas não chegou a sangrar, mas eu estava me preparando desde a gravidez, né? Senti um pouco de dor só no início, mas depois foi muito tranquilo." (Virginia)

"E aí descobri, e fui fazer o pré-natal correndo né, tomar vitamina, essas coisas, me preparar pro parto, o que é muito importante porque eu estava morrendo de medo do parto. Eu até cogitei a ideia de ir pro Brasil fazer a cesárea, mas depois que eu descobri que aqui no parto normal eu podia não sentir dor, eu podia ter uns vinte filhos! E não me arrependo de ter sido parto normal, porque era a única escolha, entrou tem que sair né? E eu não estou no Brasil pra fazer cesárea. Levei a epidural... porque está uma polêmica no Baby Center porque dizem que no SUS eles não aplicam a epidural. Só que pela lei brasileira é direito da gestante, só que o SUS não quer aplicar porque não quer! Só que eles são pagos pra isso. E levei a epidural, com três centímetros de dilatação, e passei o dia todo sem sentir dor, me preparando pra hora do parto, fechei o olho e foi... tudo no hospital público." (Francine)

"O acompanhamento aqui é no centro de saúde. Você faz o pré-natal lá. Só que como minha médica de família era meio doida, me mandou pro hospital falando que minha gravidez era de risco, mas quando eu cheguei lá, o medico falou que minha gravidez não era nada de risco, que a médica era doida mesmo, mas que ele ia me acompanhar mesmo assim porque foi com a minha cara. E aí ele acompanhou a minha gestação toda, não fez o meu parto porque ele estava de férias, mas não teve problema nenhum porque a equipe que me atendeu foi muito competente, e não tive problema nenhum." (Francine)

"Ai eu achei meio impactante né? Eu queria já ver né, assim. Eu queria conversar com um médico, embora eu já soubesse que não seria tratada por um médico. Mas num primeiro momento eu achei que, na primeira vez eu ia ter atendimento com um médico e depois ia ficar com uma *barnmorska*, que é como eles chamam obstetriz. Bom, daí eu voltei pra casa e recomendaram a gente não contar isso pra niguém, da gravidez, guardar isso pra gente, eu ficar muito calma, eu não podia ficar me estressando porque existia muito o risco de perder. Aí eu voltei

pra casa e esperei mais um mês, até que eu tive minha primeira consulta. (...) Quando eu fui fazer a primeira consulta eu fui atendida por uma senhorinha, uma senhorinha experiente. E essa senhorinha foi a minha obstetriz durante os 9 meses, ela que ficou comigo, que é a tia Eva. Ela foi fantástica... E eu estava tão emotiva ainda com tudo aquilo que estava acontecendo que eu olhei pra ela, ela disse: como você está se sentindo, minha filha? Ai eu olhei pra ela e comecei a chorar desesperadamente. Foi isso que eu fiz, foi a primeira coisa que eu fiz. Olha, eu já estava há tanto tempo... eu não podia contar pra ninguém, eu não contei pra minha família, eu estava aqui sozinha, eu não tinha uma amiga, eu só ficava dentro de casa, foi muita pressão assim, eu tinha acabado de mudar. Eu passava mal, eu vomitava, eu detestava a comida, eu detestava o pão daqui, daí eu cheguei, quando a primeira pessoa que perguntou assim pra mim: como é que voce está se sentindo? Eu chorei, eu acho que eu chorei assim uns 10 minutos, eu não parava de chorar. Aí ela começou a me acalmar, a me explicar como é que funcionava o sistema, ela foi um anjo assim, né? Foi ela que me segurou no colo durante todo esse tempo, assim." (Flávia)

"Das brasileiras, eu conheço duas pessoas que não quiseram ter filho aqui, por causa dessa tranquilidade deles aqui. Não é que é tranquilidade, é uma coisa normal, entendeu? Não tem isso de... que nem, eu estou lá no grupo faz muito tempo, antes de eu vir pra cá, eu sempre conto a mesma história, aqui só faz dois ultrassons, não tem isso de... você vai lá mede a barriga, faz exame, né? E tudo bem. É que eu sou muito sossegada também. (...) Eu estou disposta assim a falar, né? Que nem assim, eu estou nos grupos pra mostrar um pouco como as coisas aqui são diferentes, né? Porque no Brasil eu acho que as coisas estão demais, eu acho que perdeu, perdeu... eu fui pra lá agora e fiquei horrorisada com tudo, desde alimentação, criação... eu fiquei horrorisada! (...) Desde saúde também pra ter filho... banalizou tudo, principalmente ter filho né? Porque os ginecologistas lá estão todos cesaristas, entendeu? (...) Eu fiquei assim meio assustada com o jeito que está lá, então às vezes a gente mostrando como as coisas são aqui né, pra acalmar um pouco as pessoas lá, não sei..." (Olívia)

"e aí trocou o turno das parteiras, e chegou a parteira que ficou comigo até o final do parto, que era muito boa, muito experiente, eu consegui perceber que ela era uma pessoa muito experiente e tinha conhecimento do que estava fazendo, principalmente porque foi muito difícil essa parte do meu parto, foi daí que começou as dificuldades, porque aí que a contração fica diferente, porque é o expulsivo. E eu tinha muita dor, claro normal, você está parindo, mas o B não conseguia descer, eu estava muito inchada e era como se ele estivesse preso no meu canal vaginal, então foi muito lento, e eu tive que ficar fazendo uma série de exercícios durante o trabalho de parto e isso foi muito cansativo (...)aí eu deitei pra descansar um pouco, e ela me perguntou se eu não queria ocitocina porque as contrações estavam ficando muito fracas, e aí eu falei pra ela que não porque eu queria deixar o negócio acontecer naturalmente (...) eu usei aquele gas do riso, eu não usei nenhum outro tipo de analgésico, mas eu fiz aquele curso de profilaxia, eu fiz alguns exercícios de respiração, então ajudou bastante (...) e aí quando foi 8 horas da noite, a gente decidiu, eu e o J, que eu ia pegar a ocitocina para o trabalho de parto não parar (...) você tem na Suécia a liberdade de pedir pra fazer episiotomia se você quer, mas eu falei que eu não queria que fizessem intervenção, e a parteira me ajudou bastante com toalhas quentes, e me ajudou a fazer massagem no períneo, quando o B estava saindo e tudo mais, só que por causa de eu estar muito inchada eu tive uma laceração bem grande, uma laceração de grau três (...) eu fiquei muito chocada quando eles levaram ele, e como a parteira não teve tempo de me explicar o que estava acontecendo eu achei que o moleque estava morrendo, e aí quando ele voltou estava todo mundo contente, e todo mundo falando olha como ele está todo contente, mas eu não estava contente porque a gente não estava entendendo nada, e a gente estava desesperado, os dois" (Marina)

"O que eu vejo aqui é que é um país muito pro parto natural e pra amamentação, nossa é um comercial para a amamentação! (...) Então acaba virando uma banalização da mulher, não só da mãe, mas da mulher como conhecedora do próprio corpo. Então eu vejo que aqui tem muito essa banalização, aí vira e diz: não, mas parto não é doença! Mas gravidez não é doença! Eu concordo, não é doença, mas cada mulher é diferente, cada corpo é diferente, cada um reage de uma

forma. Então é isso que tem ser dito também (...) Mas eu acho que essa coisa da saúde da mulher nessa coisa de parto natural, parto normal, ela é colocada totalmente em segunda mão, o bebê é o foco." (Viviane)

"Porque agora no Brasil tem esse espetáculo do parto natural e o diabo a quatro (...) porque se você fez cesárea é porque você não escolheu, você só escolheu se você fez o parto normal... quer dizer, é uma contradição. Eu tenho uma conhecida que teve cesariana nos primeiros filhos e depois teve parto na água na Austrália, e aí ela virou doula e ela quer que todo mundo faça parto natural agora! Mas ela não faz de graça, ela é doula, ela não trabalha de graça, ela cobra pra isso, então é um mercado né? Você não está estimulando o parto natural, ah tenha o parto lá no sistema de saúde, não, você paga pra mim, que aí eu vou lá te dou o suporte, e aí claro, você vai ser a melhor mãe do mundo, nossa senhora! (...) Eu não sei, eu tive um parto em que eu senti dor pra cacete! Então, quer ter um parto natural, tenha consciência que vai doer pra caramba! Mas aí é uma opção sua. Não é porque eu tive que eu vou impor isso para as pessoas, como se fosse uma filosofia de vida" (Viviane)

"Porque eu achei que eu não fosse precisar de uma licença, mas aí na hora do vamos ver, precisei. Porque eu fiquei com pressão alta, tive problema de saúde, eu fiquei dependente de algumas pessoas, tive que chamar uma babá, e eu achei que não ia chamar mas não teve jeito... enfim, é uma história de descobertas no meio do caminho. No meio do caminho eu tive que me ajustar à situação. (...)A babá que eu contratei foi quando eu tive o neném já porque eu não dava conta de ficar sozinha com ela, amamentando e fazendo todas as outras coisas, naquela situação (...) e minha companheira trabalhava, e no período que ela trabalhava ela não podia dar atenção, então tudo que dizia respeito da casa era eu! (...) Eu pensei em colocar em creche, mas depois eu vi que em creche, sei lá, os bebês ficam cada dez bebês pra um cuidador, e o cuidador ainda recebe um salário mínimo (...) Mas até então essa babá, ela era minha darista, tinha uma relação informal, então eu perguntei pra ela se daria pra ser babá, e ela disse 'ah eu tenho três filhos, eu acho que dá!' E foi... foi na confiança mesmo. E ela cuidou super bem da S, é uma ótima babá, recomendo pra todo mundo. Mas assim, foi na contingência também, porque eu pensava em colocar uma pessoa pra eu continuar no mercado de trabalho (...) eu fui aumentando as horas de trabalho dela, fui aumentando o salário, e ela aceitou." (Letícia)

"Está sendo desse jeito porque eu não tenho com quem deixar minha filha, porque o horário integral é caríssimo, não tem condições, e nem eu me sinto a vontade de colocar ela no horário integral nessa idade que ela está... eu acho ela muito novinha assim, não sei (...) então eu estou precisando ficar mais com ela (...) talvez eu devia ter feito isso desde o princípio, mas eu não tive condições, porque eu já era empregada, já tinha aquele trabalho mesmo, e eu ficava no trabalho negociando (...) então assim, me deu uma tensão muito grande isso. (...) E também com esse negócio de você ter o horário mais livre, aí você acaba trabalhando menos, e o seu ganho é muito devagar, então é uma redução de salário, não tem como chamar a babá, é uma questão financeira mesmo." (Letícia)

"Eu estava muito estressada, e eu nem sentei no computador pra trabalhar porque eu sabia que eu não ia render... Então, assim, fiquei meio angustiada, com medo de não render e não conseguir entregar o trabalho no prazo e não conseguir cuidar dela igualmente (...)E aí de novo, aquele processo, a S foi pra frente da televisão, a P defendeu a S, disse que deixava, deixa, 'não entra em conflito, não entra em conflito', só que assim eu tenho meu limite, entendeu, não dá. Não dá, não dá. (...) E eu tento explicar pra P que, assim, é muito desgastante você ser requisitada o dia inteiro, né, o dia inteiro é assim. Quanto mais você dá atenção, quanto mais você brinca, mais ela exige, mais quer atenção ! Então é um exercício de você impor um limite, mas às vezes eu não sei impor esse limite. Porque eu to brincando e tudo e de repente me dá cinco minutos que eu to esgotada, cansada, eu não tenho, eu não sei como dizer pra minha filha 'oh, não dá, acabou' porque ela quer brincar."(Letícia)

"Mudou o posicionamento, a maneira de olhar as ferramentas. As ferramentas continuam as mesmas, o que mudou foi a forma de usar. Com certeza a maneira de enxergar outras possibilidades... inclusive eu tenho pra mim que isso é o que eu vou usar na minha vida profissional ainda, e é isso que eu tenho buscado. (...) O fato de eu ter conseguido fazer a vaquinha, em tão pouco tempo, ter conseguido esse dinheiro, e movimentar mulheres... duas coisas assim que eu pude confiar: mulheres são poderosas, e eu consigo sim me articular na internet, eu não preciso de uma empresa pra me bancar, porque eu sou capaz de fazer... aquela coisa da ética né, então, mudou totalmente, né, eu vejo tanta baboseira, né, na internet. (...) Eu fiz um curso antes, um ano antes de engravidar, que tinha a ver com comunicação contemporânea, e aí agora eu to assim, meio que observando as oportunidades... tentando traçar um caminho que ainda está meio vago mas em que acredito" (Renata)

"A pauta deste post é a luta contra a apropriação da condição de lésbica por quem tem pênis. Como disse no meu último post, a lesbianidade é uma sexualidade, nada tem a ver com identidade de gênero. Lesbianidade é a sexualidade homossexual de pessoas afab, aquelas designadas mulheres ao nascimento. Independe de identidade de gênero. A relação entre um homem trans e uma mulher material é lésbica, portanto. Não existe risco de gravidez em relações homossexuais. Uma lésbica nunca poderá engravidar outra lésbica. A relação entre uma pessoa que se autoproclama trans e uma mulher material é um relacionamento hétero. Estamos falando de sexualidade. Relações sexuais possuem consequências e uma delas é a gravidez. Se uma pessoa que se autoproclama mulher trans pode engravidar uma mulher material, então a relação sexual entre essas duas pessoas é uma relação hétera. Quem sentiria as náuseas, quem sentiria seu corpo se transformando, quem sentiria a pressão social da maternidade compulsória, nunca poderia fugir dessa nova realidade material que é a gravidez. Mas a outra parte, a mulher conceitual, aquela que se autoproclama mulher mas que possui pênis e testículos, essa tem o privilégio de poder fugir, nunca mais aparecer, largar a mulher grávida sozinha, mesmo que nunca venha a abandonar de fato a gestante." (Renata)

"Eu acho que de início não fui eu que rejeitei o mercado editorial, ele que não me quis mais! (...) Fui à algumas entrevistas, mostrei meu currículo e tal, e sempre dizia que eu tinha filho... isso no primeiro ano, né, quando ela tinha 8 meses, eu saí atrás de trabalho. E por duas vezes, assim, eu senti muito claramente o receio porque eu tinha um filho de 8 meses que ainda não ia pra creche, ela ficaria com a minha mãe, então, isso era claramente o fim da entrevista, entendeu? Duas vezes aconteceu isso... numa delas até a entrevistadora que era mulher falou 'você não acha que é muito cedo pra trabalhar? Ela é muito nova a sua filha', tipo me dando um toque, sabe? Me criticando gentilmente. Então não procurei muito emprego, fiquei com ela, sem, sem trabalho mesmo. E aí eu voltei a fazer uns *freelas* porque eu tinha parado de fazer, porque ganha-se muitíssimo mal, trabalho de revisor, preparador de texto, então ganha-se muito mal, você pode ganhar 600 reais, sabe? Então eu tinha muito poucas horas para trabalhar por dia, mesmo a minha mãe ficando com a A, ela era bebê né? E eu tinha que amamentar... enfim. Aí então eu fui diminuindo minhas expectativas de voltar para o mercado de trabalho... e também de ter dinheiro, fui entrando aos poucos numa coisa meio nebulosa, que eu achava que nunca mais eu ia voltar, e como eu já tinha anteriormente começado a gravidez saindo de um emprego, saindo de um trabalho, que eu era jornalista e na época eu não queria trabalhar mais na área" (Sofia)

"Eu não disse pra ela, mas depois eu fiquei pensando... e se eu tivesse sido estuprada e pai existe só que, e aí? Se eu fosse lésbica? Como, tenho três casais de amigas lésbicas que tem filhos e aí não existe o pai, a não ser que você considere que o pai é um doador de esperma! Tem todas essas realidades familiares que essa escola progressista simplesmente desconsidera. O mais simples, que eu acho, é o caso de mães separadas, eles não sabem lidar nem com isso! (...)Foi um transtorno, é... eu já tinha passado por aquelas duas entrevistas de emprego que tinham se tornado pra mim como uma intuição de que ter filhos e ser uma mulher sozinha era uma questão para as pessoas ficarem 'hum, entendi' mas eu não enxergava que isso era um problema entendeu? Quer dizer, eu não tinha percebido naquela época."

"Ela escreveu uma carta pra uma feminista, é um artigo, eu achei bem interessante, é legal porque ela diz que é uma responsabilidade e ela não deixa de ser feminista por isso, porque ela assume seu papel político, porque ela está educando o cidadão do amanhã. Eu apóio o feminismo mas eu sou mãe, eu estou criando o cidadão do amanhã... e eu quero um cidadão de valor, e é por isso que eu dôo o meu tempo pra ele, porque é uma fase que ele precisa." (Ana Lúcia)

"As mães francesas não querem se apegar muito, elas assumem a escolha pela mamadeira, porque não podem ficar dependentes do bebê. Mas, aqui eles criticam muito quem faz diferente. Eu digo logo que sou brasileira e por isso faço assim, pra não ter muita chateação. Você tem que ser muito alternativo, muito seguro, para dar uma explicação (...) Mas o que eu vejo aqui é o crescimento de um grande movimento de maternagem alternativa, de mães que querem amamentar mais, carregar na *encharpe*, contra a violência dos franceses com os filhos" (Ana Lúcia)

"Porque como ele estava internado, a gente não pôde ficar com ele, ele ficou na UTI, aí a gente voltou pra casa, então, eu não sei exatamente se eu consegui me afastar do problema, sabe? Sair daquela névoa de problema... eu tive uma noite de sono, inteira, e ele estava longe, eu sabia que ele estava sendo bem cuidado, eu dormi super bem, então não sei se foi isso ou se foi o fato de eu ter visto que as coisas podiam ser muito piores. Mas eu acho que isso foi muito importante, ter me afastado do problema foi muito importante. E já no dia seguinte eu voltei pra lá, e já tentei dar o peito, e fui no banco de leite, e consegui voltar a amamentar sem ter tantos problemas como eu estava tendo." (Luise)

"Mas foi tudo programado, porque eu disse pra ele: 'eu quero muito ter um outro bebê'. E meu marido vai fazer no mês que vem cinquenta anos e eu tenho trinta e cinco, ele sempre falava assim... ele não tem filho, teve dois relacionamentos mas sem filhos, e ele falava que ele era muito velho e que o nosso filho ia chamar ele de avô... E eu falava: não, pára com isso. Então foi um trabalho psicologicamente pra convencer ele, mas eu falava: não, primeiro eu preciso ter meus documentos, primeiro eu preciso ter um trabalho. Porque eu sabia os meus direitos referentes ao segundo filho. Porque o primeiro filho dá-se o direito de seis meses de congé mas o segundo eu poderia ter três anos de congé parental e ainda receberia 700 euros pra estar cuidando do meu filho em casa até os três anos, né. Então depois que eu consegui meus documentos, consegui um trabalho registrado, e tem um mínimo, um tempo de trabalho, você paga os impostos né pra estar tendo o direito depois de três anos, né. E aí foi assim que eu consegui, dois anos de trabalho registrado direitinho, aí que a gente foi tentando mas foi super rápido, já já engravidei. (...)Do jeito que a situação aqui na França não é tão fácil pra ter filho, sem ajuda... Então eu já sabia, eu falava: não, pra eu ter um filho eu preciso esperar um pouco pra eu ter o direito, porque se eu não tivesse o tempo de trabalho eu não poderia receber ajuda que eles dão, que é muito boa, né? Porque, pra colocar numa nounou pra guardar é muito caro, aqui..." (Célia)

"Essa é uma das minhas frustrações com a maternidade, porque não tem como você planejar as coisas, é ela quem decide... quando ela tá com fome e tal, essas coisas... (...) porque eu detesto começar a fazer alguma coisa e ser interrompida, e nos últimos meses eu percebo que eu nem quero começar a fazer nada porque eu não quero nem ser interrompida, então nem começo. Então tem várias coisas pendentes assim que eu queria ter feito, que eu poderia estar fazendo todos os dias, inclusive cuidar de mim mesma, e aí eu falo ah não daqui a pouco ela vai acordar e eu vou ter que parar no meio, então não vou nem fazer, quando meu marido chegar e ficar com ela, ou no fim de semana, eu faço, mas aí eu acabo não fazendo, e nos últimos seis meses tem sido assim (...) eu não costumo sair muito de casa, porque tinha um mês que eu tive que dar de mamar pra ela hora sim hora não porque ela não estava ganhando muito peso, e era muito trabalhoso assim sair pra passear com ela, então os três primeiros meses assim eu só ficava em casa, saía muito pouco (...) a noite eu fico bem mais relaxada, quando vai dando assim umas quatro e meia eu já vou ficando ansiosa, querendo que ele chegue logo do trabalho, ele chega cinco, cinco e quinze, aí eu já vou olhando no relógio, esperando a chegada dele, porque eu sei

que quando ele chegar... (longo suspiro) aí eu posso relaxar (...) eu fui pra outra forma de compesar a minha frustração (...) infelizmente eu achei o caminho errado de compesar as minhas frustrações" (Vanessa)

"A questão da idade da criança aqui é importante não porque o B vai ter um amiguinho – a essa altura do campeonato é difícil saber se o santo dessas crianças vai bater – mas porque nós como mães podemos conversar sobre mais ou menos as mesmas coisas. Mais ou menos né, porque já me disseram que eu escolhi maternar no modo hard: fralda de pano, amamentação em livre demanda, criação com apego, sling, cama compartilhada e... a coisa mais terrível de todas: não dei chupeta para o B. Particularmente, chupeta é um acessório que serve para calar a boca da criança e estragar os dentes. Felizmente, quando B era recém nascido dormia tanto que eu nunca tive vontade (ou necessidade) de dar chupeta. Então, antes que alguém me acuse de intitular como "menos mãe" quem dá chupeta eu só digo que não estou afirmando isso. Conheço mães muito melhores do que eu que dão chupeta para os filhos." (Marina)

"aí ele leva ela lá pra cima, bota ela naquele saco de dormir, com um *doudouzinho*, como uma francezinha... porque se fosse no brasil não seria assim, né ? Então, ela dorme com o *doudou* no saquinho, e ela tem um *mobile* musical, sabe ? Então ele dá um beijinho nela, coloca musiquinha pra ela, sai do quarto e aí ela dorme. (...) Olha, eu acho que a rotina da gente é muito tranquila, porque a gente conseguiu estabelecer uma rotina muito legal, porque eu tinha muito medo de não conseguir fazer minha filha adormecer. Então eu gosto muito disso que a gente conseguiu estabelecer, e agora durante o dia também está ficando mais tranquilo proque ela também está tirando mais essas sonecas, que me dá tempo de respirar, como eu te disse né, de tomar um banho, de respirar, de me arrumar, cuidar de mim e da casa... (...)Depois que ele dá mamadeira pra ela, ela ainda fica um tempo com a gente, porque como ele fica o dia todo fora, ele gosta de ficar com ela um pouquinho a noite. Então ela dorme, e depois que ela dorme ela não acorda mais, então é super tranquilo, porque a gente pode jantar junto, tranquilamente, a gente conversa... porque todo dia ela dorme no mesmo horário... até que a gente tem umas três quatro horinhas pra ficar junto de noite. (...) Mas nos três primeiros meses não era assim não, hein, C só dormia no colo, só dormia mamando, e eu dizia para P 'olha isso, ela nunca vai dormir sozinha!' Ele dizia 'vai, não se inquiete que um dia ela vai', e tinha gente que dizia 'ah o meu dorme sozinho no quarto desde o primeiro dia!' e eu dizia 'ah comigo não dá, viu?' E ela só não ficou mais tempo dormindo comigo porque meu marido não deixou viu? Mas foi bom ele não ter deixado, foi bom. Porque tipo assim a gente discute, mas a gente sempre tenta chegar numa solução. E quando ele falou 'não, eu acho que agora é hora de tentar', a gente tentou e deu certo"

"Agora, as francesas... chega dar raiva! porque elas administram as coisas muito bem, Carolina. Tipo assim, dá vergonha você mostrar que está desesperada pra uma francesa. Porque eu não sei o que essas mulheres fazem que elas dão conta da casa, do trabalho e dos filhos, e fica tudo impecável! Eu não sei se no final das contas elas são estressadas com os maridos, se elas são frias, se elas são infelizes, eu não sei, mas que elas dão conta, elas dão conta. Eu consegui assim fazer um desabafo com uma francesa, que eu disse pra ela 'menina, tu não fica desesperada assim não ?' Ela disse 'fico, claro que fico !' (...) Eu falei 'ave maria, pelo amor de deus, me diga isso porque senão eu vou achar que eu to ficando louca!' Então, assim, essa imagem de perfeição das mulheres que dão conta... às vezes eu sinto vergonha do meu marido, de eu não dar conta! Porque ele é francês e deve pensar 'as francesas dão conta'" (Isabely)

"Propor de jogar fora um macarrão porque não é orgânico, pra mim, é o cúmulo do absurdo! Tá comprado, o macarrão taí, não está envenenado, seu filho não vai ficar doente porque vai comer uma vez um macarrão que não é organico, entendeu? Tem uma exarcerbação desse negócio de: eu quero o melhor pro meu filho, e o melhor pro meu filho pode significar passar por cima do filho dos outros, entendeu? Pode ser uma coisa meio a duplo viés... mas assim, ao mesmo tempo a creche sabe como lidar com a história" (Natalia)

"Não é só a ideia que a creche é pra socializar, só entre crianças, a minha ideia era de que ele vai se confrontar com outros adultos e outras maneiras de ver o mundo, e que isso é importante pra ele também, e que pra mim é importante ter contato com outras crianças, e ver outras famílias... meio que pra descentralizar da sua maneira de ver, né? Que é pra poder... abrir a visão mesmo. E a grande vantagem da *creche parentale* foi justamente essa rede. (...)Porque tem a história de que criança é criada por pai e mãe... e não é assim... o núcleo familiar hoje em dia é mais restrito mas não faz muito tempo que é assim, né? A sobrecarga pra mãe e pro pai acaba sendo maior porque as famílias estão isoladas, porque você não tem pai e mãe do lado, você não tem irmão, você não tem tio, não tem primo do lado, então você tem que dar conta de tudo. E aí, a creche, pra isso, mesmo que a gente não precise... mesmo que a gente não peça muito, só de saber que existe a possibilidade de, já é uma vantagem muito grande." (Natalia)

"Porque a gente precisa de alguém pra ajudar! Pelo menos a minha referência foi essa, que a gente precisa de alguém pra ajudar (...) J mamava de duas em duas horas... de duas em duas horas eu estava dando mamá e trocando fralda, então você dorme pouquíssimo e é uma fase difícil. Mas eu lembro que depois que cheguei do hospital, depois do parto, que era um êxtase, uma alegria, de uma plenitude, de uma coisa que virou uma razão de viver incrível, eu cheguei em casa e eu comecei a chorar, e tipo assim eu tinha passado por 36 horas de trabalho de parto, quando o J nasceu eu também não dormi porque eu queria ficar com ele, lá embaixo estava tudo inflamado, cheio de sangue e ponto, e não dormi bem porque eu estava amamentando o tempo todo... então eu cheguei em casa e comecei a chorar (...) mas eu disse para meu marido: eu nunca me senti tão feliz na minha vida! (...) É incrível porque a gente está exausta mas feliz (...)Uma coisa que senti também é que quando eu fiquei grávida, como eu descobri que o mundo do 'parir' era gigantesco eu li e estudei tudo que eu podia sobre isso, mas eu nem me importei com o depois que a criança nasce, o que acontece (...) de ritmo de sono, de amamentação, de alimentação, eu nunca me importei com isso! (...) Agora, ser mãe é uma viagem assim gigantesca, e aí eu to aprendendo que não tem muita teoria, eu to aprendendo mais na prática e quando dá eu leio alguma coisa (...) Eu fiquei grávida numa época que estava bem dfícil aqui, entre eu e meu marido, porque eu estava na dúvida se ia voltar para o Brazil, porque arrumar emprego aqui não é fácil. Eu fiquei um ano aqui estudando sueco, procurando emprego em tudo quanto é lugar (...) então eu falei ah vou voltar para o Brasil porque aqui não está dando certo (...) mas aí eu fiquei grávida e foi como um sinal (...) desde que eu engravidei tudo começou a dar certo. Porque eu comecei a trabalhar na minha área (...) eu sinto que to desenvolvendo bem o meu trabalho e eles estão muito satisfeitos comigo" (Michele)

"Eu penso em largar o meu trabalho sim, mais lá pra frente eu penso em fazer uma transição, eu penso de ir me organizando pra viver só disso mesmo, assim, trabalhar somente com isso, pra isso passar a ser minha nova carreira (...)aqui no meu trabalho eu tenho uma certa flexibilidade pra eu ir conciliando esses trabalhos de doula (...) então eu quero começar atendendo um ou dois partos por ano pra chegar em 2015 e eu consiga realmente abrir mão do que eu tenho hoje pra me dedicar pra isso integralmente, mas eu preciso me organizar financeiramente primeiro pra isso se tornar realidade (...) hoje o meu filho fica numa creche-escola em horário integral perto da casa da minha mãe, eu estou tranquila com essa esolha (...)Eu acho que eu posso desmistificar essa história de que parto humanizado é pra mulher que pode pagar a parteira dentro de casa. Eu acho que é um direito de todas as mulheres, sejam elas usuárias do SUS, usuárias de plano de saúde, então eu acho que é um desejo a ser respeitado entre as mulheres. Então, eu acho que ser mulher negra, moradora da Baixada, funcionária pública, usuária do SUS serve pra mostrar que é pra todas. Você pode ser de qualquer raça e etnia, de baixa renda, com baixa escolarização, que a única coisa que você precisa é ter informação, não é ter dinheiro, é saber que isso é um direito (..) eu acho que é possível pra todas desde que elas tenham noção da luta que elas tem que enfrentar, porque não é uma luta simples não. Não acho que seja uma luta econômica só não, eu acho que é uma questão da mulher, de ela se entender como mulher, do que uma gravidez

representa, do que o nascimento de um filho pode representar, o tanto de transformação que isso pode representar, então eu acho que é pra todas sim." (Carla)

"Eu não sei até hoje onde deixar ele, eu não sei em quem confiar. É isso que eu tenho procurado, no sentido pro futuro, né? Eu quero planejar isso pro futuro próximo, é isso que eu quero fazer morando com mães. Eu quero deixar meu filho com outras pessoas e ficar também com os filhos delas, assim para elas poderem estudar, fazer o que precisam. Eu preciso de pessoas envolvidas, carinhosas, e realmente envolvidas e engajadas né? Porque não dá pra, pra... sei lá, creche eu não tenho dinheiro, e creche pública eu não sinto confiança, não sei, escuto tanta coisa, barbaridades" (Renata)