# Citizenship, sisterhood and scientific evidence: Strategies for 'humanising' childbirth policy and practice in São Paulo

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**Signed declaration**

I, Lucy Cara Irvine, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

# Abstract

I conducted an ethnography of the humanised birth movement in São Paulo, Brazil between 2015 and 2018. In this thesis I examine the strategies used by the movement to address the two-fold problem in maternal healthcare in Brazil: excessive clinical interventions in childbirth (particularly caesarean sections), and "obstetric violence": the disrespectful and/or abusive treatment of women during childbirth. Movement activists work towards a shared goal of promoting a woman-centred, normalised model of care through changes to policy and clinical practice.

I took an ethnographic approach to "studying through" policies across sites and over time in order to examine how they are formed, implemented and contested. Interviews and focus groups with movement members (including mothers, doulas, midwives, obstetricians, politicians and programme leads), and observations in health facilities, participatory policy spaces, online, and in "everyday" social settings, led me to identify a range of strategies used by the movement to achieve their goals. These include: the strategic use of scientific evidence to support claims about the benefits of humanised birth; driving up demand for private humanised birth services; and the advocacy role of doulas, who "multiply" the movement's messages.

My findings contribute to debates around the medicalisation and humanisation of childbirth, questioning their dichotomisation, and instead provide evidence that what "matters" is how women perceive care. I also found that there is potential in the humanised birth movement as a space for political action and successful health policymaking based around a shared feminine experience of *sororidade* (sisterhood), which encourages women to work collaboratively in a male-dominated socio-political context. Lessons might be drawn that have wider relevance in settings where policymakers are trying to reduce iatrogenic harm from unnecessary interventions in childbirth, and for supporters of normal birth working to reduce barriers to accessing midwifery-led, woman-centred care.

# Impact statement

The fact that Brazil is currently in the midst of a pandemic, as well as a political and economic crisis, make the findings of this thesis particularly timely and relevant. Many of my research participants are currently struggling to provide adequate maternal healthcare because of the huge strain on the health system due to the coronavirus outbreak. Brazil has had a high number of maternal deaths linked to Covid-19. The issues covered in this thesis – obstetric violence and excessive c-sections – are potential contributing factors to morbidity and mortality. Drawing international attention to these now might mean the concerns of the movement are taken more seriously in future.

This work adds to the already vast body of evidence regarding the risks of overusing clinical interventions in childbirth. Global best practice recommendations recognise that birth is a normal physiological event for the vast majority of women. But in Brazil, many women still struggle to find appropriate care, and some suffer obstetric violence. This is not an isolated problem: c-section rates are rising globally. This thesis outlines innovative approaches taken to address this trend in Brazil, which might have wider applicability.

This thesis also provides evidence of the value of taking an ethnographic approach to studying two "political" fields: citizenship and policymaking. It strengthens the call for anthropologists to investigate citizenship as a central point of inquiry. Studying citizenship as situated in specific contexts demonstrates the huge divergence of viewpoints on what has traditionally been viewed as a static legal status. Studying policies ethnographically confirms that they are inherently anthropological phenomena, and productive of new ideas and relationships. They also provide "windows" onto wider societal shifts, and are therefore a highly useful lens through which anthropologists can examine our world.

I am committed to disseminating my findings widely. I have presented preliminary findings at several conferences in the UK and in meetings in Brazil over the past three years, and have a forthcoming chapter in an edited volume on the anthropology of global maternal health policy. I plan to follow up on the further research questions I identify in the conclusion, particularly studying the impact of the Bolsonaro administration's regressive policies and the impacts of coronavirus.

I hope to provide a novel perspective on the humanised birth movement for who are actually part of it. By taking an anthropological approach to studying policy and providing an outsider's view of the movement, I aim to feedback useful insights into my fieldsite, fully aware that the work of the movement is ongoing. As part of this commitment I am producing a summary of findings in Portuguese to send to participants.

For citizens and "non-experts", who are not policy professionals but who are nonetheless interested in shaping policy – this research demonstrates policies can be shaped at all stages of the design and implementation process by the everyday actions of a hugely diverse range of people. Local campaigning, multiplying ideas, sharing knowledge – all of these small acts can lead to change.

# List of figures and images

**Figures:**



**Images:**

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# Acknowledgements

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# Introduction

I was told about the c-section “epidemic” as soon as I arrived in São Paulo for the first time in October 2015. Exploring my new neighbourhood after flying in from London, I visited one of the numerous nail salons where local women gather to socialise at all times of the day, in an attempt to get my bearings. I sat in the tiny tiled front room of the salon on *Rua Heitor Penteado*, a busy polluted road dividing the middle-class neighbourhoods of *Vila Madalena* and *Sumaré*, and explained to the woman who was painting my nails bright orange that I was in Brazil to conduct research on maternal health policy. “Ahhh yes! The situation here with birth is *uma locura* (crazy). *Temos uma epidemia de cesárea* (We have a caesarean epidemic)!”

*Image 1: Graffiti art on the walls of Vila Madalena, São Paulo – characteristic of the neighbourhood.*

The definition of an epidemic is the rapid spread of disease (usually an infectious one) among a large number of people in a given population. The term was being used to describe c-section overuse in mainstream media sources (Associated Press 2015, Ferey and Pelegri 2018) and by established national and international maternal and public health experts

(Barros et al. 2018, Lancet Series 2018). At this point I was already aware that Brazil had one of the world's highest rates of c-section births. Rather optimistically, I thought that if the overuse of c-sections was now being widely recognized as a *disease*, and there was public acknowledgement regarding the risks of c-section misuse, then I had arrived in São Paulo at a critical moment of change. Over the next three years of ethnographic fieldwork, and over multiple visits to São Paulo and surrounding Brazilian states, I was to discover that despite this recognition, addressing the problem was extremely challenging and change was slow – though undeniably positive.

I also learnt that this particular problem in maternal healthcare in Brazil is two-fold. The overuse of c-section is one important and widely acknowledged issue, which primarily affects women using private sector obstetric services. Another significant concern that has not received as much attention in the media or in academic journals is the substandard care provided to women in some public and private hospitals. In some cases, this amounts to disrespectful treatment or even abuse – and is referred to as "obstetric violence" by those who campaign to address this problem. Unfortunately, many women across Brazil are exposed to obstetric violence during pregnancy and labour. There are frequent reports of staff ignoring women, name-calling, denying women freedom to move around and food during labour, and even junior doctors "practicing" invasive and unnecessary procedures multiple times on the same patient (Diniz et al. 2015, Niy and Delage 2015, Diniz et al. 2018). Women who are already marginalised due to poverty, racism, and other intersecting inequalities are most at risk. These women are least able to pay for their preferred healthcare provider are left with little choice as to where they deliver. In many ways, this two-fold problem reflects wider societal issues in São Paulo: the inequality of access to healthcare across social classes and neighbourhoods, entrenched patterns of gendered violence and racial discrimination, and the steady creep of consumerism into health service provision. These structural health inequalities are visible across Brazil as a whole, with poor women in the most rural areas unable to access basic antenatal care (Caldwell 2017), while wealthy women in urban centres can access higher quality services (Diniz and Chacham 2004).

The two-fold problem is the primary concern of various individual activists, civil society groups, NGOs and private sector initiatives which make up a fragmented social movement widely known as the *movimento pelo parto humanizado,* or the humanised birth movement (also referred to in this thesis as simply 'the movement'). These diverse actors have a

unifying goal: to "humanise"[1] maternal healthcare in Brazil. The movement's primary aims are to reduce unnecessary clinical interventions and to promote the normalisation of birth and vaginal delivery for low-risk births, and thus change the model of care during childbirth from one that is excessively medical to one that is "woman-centred"[2] and midwifery-led where possible. The humanised birth movement is my primary research focus. I followed its activities between 2015 and 2018, conducting research at multiple sites in São Paulo and beyond, including hospitals, antenatal groups, protest marches, council meetings and conferences, and interviewed many of the movement's members. I observed as they communicated and collaborated with government officials, lawmakers, hospital administrators and women service users in order to shape public and institutional policies, clinical practice, and wider public opinion. I witnessed the results of these efforts: improved choice for women in terms of where, how, and with whom they gave birth; and a growing number of women who felt their births had centred around them and their needs.

By the time of my fieldwork the movement had become relatively well known in Brazil, and was starting to see measurable progress in reducing unnecessary interventions, with rates of c-section and episiotomy falling in São Paulo's public and private hospitals (Irvine 2021)[3]. Obstetric violence was being widely discussed on social media and in the press, and was even recognised in official government policy. Women from different areas of the country and different social classes increasingly sought out information about "alternative" delivery options on social media – measured by the growing number and membership of humanised birth groups online and the proliferation of doula training courses. Public awareness grew as national and international celebrities advocated for midwifery-led care and humanised birth, detailing their own positive experiences.

98% of births in Brazil take place in hospital and maternal healthcare in general is highly medicalised (Leal et al. 2012). "Aggressive management" and excessive intervention are common in both public and private hospitals (Diniz et al. 2018). Women regularly undergo a

[1] In Brazil this model of care is known as "humanised", but it is also referred to here and in other settings around the world as "natural" or "normal" birth. I discuss these definitions in detail later in this chapter.

[2] There is no one accepted definition of woman-centred care, but the idea is used as a framework in a range of policy documents related to midwifery, and tends to refer to a model of care that responds to women's unique needs, where she is closely involved in planning her care, is provided with adequate information, and where her autonomy is respected (Morgan 2015).

[3] For example, as a result of the *Parto Adequado* policy programme there was an 85% increase in vaginal delivery rate from 12.3% to 22.8% between 2011 and 2017 in participating private hospitals (Leal et al. 2019). Public hospitals participating in *Parto Seguro* had reduced their episiotomy rates to an average of 25% (CEJAM 2014) from a national average that had hovered around 95% a decade before (Diniz and Chacham 2004).

high number of clinical procedures throughout pregnancy and labour, even if they are considered low-risk and want a normal birth. In the public system (the *Sistema Único de Saúde* or SUS), women are more likely to deliver vaginally but may be treated disrespectfully and deliver in a low-resource setting with limited pain relief. It can be difficult for women to secure a bed and sometimes they will have to go to several public hospitals before they are admitted (Diniz and Chacham 2006). Even though they have the right to have a companion with them during labour, sometimes they are refused due to cramped conditions on the obstetric ward. Hospitals are generally under-resourced and clinical staff are overstretched. Women do not always receive one-to-one care and may only be attended to when they are in the final stages of labour. This is not the case in all public hospitals, and there are a significant number that have implemented normal birth protocols and redesigned facilities and management to improve care (including the policy case studies explored in depth in this thesis). However, these tend to be in large urban centres, proximal to research centres and universities that are leading humanised birth research and policy pilot studies.

In private hospitals, women can expect better facilities but are more likely to undergo unnecessary clinical interventions. The estimated rate of c-section in the private sector is between 80-90%, and has been for decades (Secretaria Municipal da Saúde 2015). The increase of elective c-section (which is often carried out before 40 weeks gestation, the typical full-term duration) means that more babies in Brazil are being born prematurely with low birth weight, which increases the risk of illness later in life (Barros et al. 2018). A study across eight Latin American countries, including Brazil, identified an association between rising caesarean section rates and increases in maternal mortality and morbidity (VIllar et al. 2006). This could at least partly explain why the maternal mortality ratio in Brazil is relatively high at 60 deaths per 100,000 live births, compared to country health systems with the lowest ratios of 3 deaths per 100,000 live births (World Factbook 2019). Preference for c-section is greater among Brazilian women who are of higher economic status, white ethnicity and who have higher levels of education and access to antenatal care (Leal et al. 2012). Several studies found that the majority of women prefer normal birth at the beginning of their pregnancies, but opt for c-section by the time of delivery – suggesting that it is exposure to clinicians which alters their preferences (Hopkins 2000, Dias et al. 2008). Women who do opt for a c-section indicate that they see it as being a mode of birth of superior quality due to the medical technologies being used, and express concerns about the safety and pain of normal birth (Béhague 2002). Women who pursue humanised birth do so precisely because they want a more natural and less technological birth, and they are concerned about the risks of c-section.

While there had been a great deal of positive progress, over the course of my fieldwork important questions arose about the extent to which the humanised movement represented those most at risk of obstetric violence (Black women from low-income households with lower than average educational attainment). While humanised birth movement activists are deeply concerned about obstetric violence and conscious of intersecting inequalities, the vast majority of them are wealthy, white and educated. At the sites and events I observed, there were a small number of Black women activists, but none who were also from low-income neighbourhoods. This is not to say that Black and poor women are not politically active – as Perry (2016) points out in her work on Black women's activism in the northern Brazilian state of Salvador, many of these women are very influential in their communities – but they are not widely recognised as being leaders of social movements. Here I consider how far humanised birth activism can address deep seated structural inequalities and its potential for long term change.

In this thesis I also contribute to the expansive debate on the medicalisation of birth by studying women's experiences and perceptions of medicalisation and humanisation in São Paulo. Using an ethnographic method has been essential in my examinations of how the supposedly binary models of humanised and medicalised birth are lived through and experienced by women and their caregivers. While it might be useful for "normal"/"natural" birth activists around the world to focus on ending the excessive use of clinical interventions, another hugely important (and sometimes overlooked) issue is *how* women are cared for. From my own experiences and data, it would appear that the way women are treated determines whether or not they feel their birth was humanised, rather than what procedures they undergo. The Brazilian humanised birth movement's prioritising of ending "obstetric violence" and highlighting the differences between the current state of practice, and the woman-centred model of respectful care, means that there are important lessons to learn from studying their efforts.

Before undertaking a PhD, I had been working in global health for several years, and was fascinated by how policies are formed, implemented and experienced. I was particularly interested in the human interactions around policymaking – the social relationships and power dynamics – as well as the lived experience of policy programmes for those on the "receiving end" of interventions. One particular global health policy challenge I had encountered in my work was the drive to involve citizens and patients in decision-making about their health. Brazil was described in academic and policy literature as having achieved this kind of participation with relative success (Cornwall 2008, Coelho 2013). Its *Conselhos de Saúde* (Health Councils) and *Conferencias de Saúde* (Health Conferences) have been

studied in depth by both Brazilian (Dagnino 2005, Coelho 2013) and international (Cornwall et al. 2008) researchers. I set out to understand more about how these participatory processes worked, and if they had changed significantly since Cornwall and colleagues collected their data a decade or so earlier. On an early scoping visit to Brazil, I contacted the *Conselho de Saúde* in Recife, the capital of the state of the northeastern state of Pernambuco, and spoke with local NGO staff and doctors at a primary healthcare unit. These preliminary informal interviews gave me a sense of whether the councils were as effective and viewed as positively as the academic coverage had made them out. To my surprise, the health workers and NGO staff, as well as the family that hosted me, were overwhelmingly negative about the efficacy of the councils and conferences. They did not believe the councils represented their interests, and so sought to change health policy and practice using other methods.

And so began my exploration into what these other strategies were. By broadening my understanding of what "counted" as policymaking I could better comprehend the complex ways in which people seek to influence and implement health policy programmes and change clinical practice. It meant that a multi-sited ethnography, following the humanised birth movement's various strategies, would be a much more accurate picture of reality than if I had focussed only on the Health Councils and Conferences. The methodology of "studying through" policy, as developed by Wright and Reinhold, was perfectly suited to conducting this kind of research as it enables the researcher to 'follow a process of contestation as it tracks back and forth across different sites in a policy field and over time' (2011: 88).

My longstanding concern with improving women's sexual and reproductive health drew me towards childbirth as a case study to examine in detail. Brazil is internationally infamous for its excessive use of c-section, and in researching this I quickly became aware of the humanised birth movement: the ideal "fieldsite" in which to conduct an ethnography of policy. Given my own interdisciplinary background and my views on the responsibilities of researchers, I wanted this to be an applied anthropology, one that would tell readers something useful, one that might even produce lessons or at least ideas for future policymaking. I was strongly influenced by other authors who have conducted ethnographies of policymaking processes and policy communities (Shore and Wright 1997, and authors in the edited volume by Shore et al. 2011), especially Storeng and Béhague's (2014) study of global maternal health actors. Also useful were ethnographies of clinical spaces, where anthropologists are situated in order to provide new perspectives on processes and culture, especially obstetric units and midwifery-led wards and birth centres in the UK and Brazil (Bonadio 1988, McCourt el al. 2014, Nunes et al. 2016). My writing and personal views on

childbirth have been shaped by feminist anthropologists who have written extensively about the dangers of overmedicalising childbirth, the benefits and joys of woman-centred, midwifery-led care, and the powerful relationships between (mostly) women around the time of pregnancy and birth (Jordan 1992, Martin 2001, and an extensive list of articles and books by Robbie Davis-Floyd).

# 1. Research aims and objectives

**Aim 1**:
To conduct an ethnography of the humanised birth movement in São Paulo in order to understand how its members work to "humanise" childbirth policy and clinical practice.

Objectives:

- To use the methodology of "studying through" to identify all of the strategies used by the movement, capturing the complexity of policy change.
- To examine specific strategies in depth and understand how movement members used different approaches dependant on audience and context.
- To look at participatory policymaking structures in the public health system to see how effective they were in shaping childbirth policies.
- To use an anthropological approach to evidence-based medicine and evidence-based policymaking to analyse explore how people strategically use scientific evidence in shaping childbirth policies.
- To examine how movement members working in the private sector use market mechanisms as a strategy to shape institutional-level policies.

**Aim 2:** To explore what an anthropological approach to citizenship reveals about wider societal shifts, including how people engage with health policy and participate in society.

Objectives:

- To consider how specific historical and political contexts shape people's views of citizenship and the extent to which they engage with policymaking processes.
- To consider how groups of people might form new collectivities based around shared experiences, including the experience of childbirth.

**Aim 3:** To reflect on what an ethnographic approach to policymaking can reveal about decision-making processes and people's perspectives of them, in order to identify lessons that could make policies more acceptable to those involved.

Three additional research questions emerged when I broadened my analytical gaze to a wider understanding of what policymaking could involve. It became quickly apparent that the humanised birth movement's aims were in alignment with the best available scientific evidence on obstetric intervention and normalising birth – and that its members frequently and purposefully made this clear. Despite this, some health professionals ignored this or claimed the irrelevance of this evidence in the Brazilian context. I went on to examine the meanings of evidence, and the strategic ways it is used to change policy in detail in my interviews. Secondly, I noticed that a large subsection of the movement focussed their attention on "selling" humanised birth as an attractive product in the private sector to stimulate demand among wealthy women in São Paulo. Several of them clearly indicated this was in response to what they saw as the failings of participatory policymaking and the SUS *Conselhos*. This led to further questions about what the commodification of humanised birth meant for how women perceived this model of care, and whether it exacerbated existing inequalities of access to care. The third question that emerged was about the emotional relationships that form around childbirth itself, and how these influence the political activities of those involved in the movement and women receiving care from humanised health professionals. The shared female experience of childbirth gave rise to something my participants named *sororidade* (sisterhood). This was particularly poignant in a patriarchal society like São Paulo, where women often have less decision-making power than men, including in medical settings where male doctors are authority figures. *Sororidade* was important for many women involved in the movement, and held potential as a new form of sociality through which political action might be organised.

## 2. The movement to humanise birth in Brazil

The issues in maternal health outlined above have been the concern of activists, academics, civil servants, policymakers, health professionals, and women seeking care for many decades, often working in collaboration. Since the early 1990s, public health experts and progressive health professionals have worked with the federal and local governments to develop various public policies and laws to reduce unnecessary interventions, with varying degrees of success. Actors in this movement have been involved in various activities to

improve care during pregnancy and childbirth. These include raising awareness, information and education campaigns, lobbying politicians and lawmakers, conducting research, creating humanised birth centres and hospital obstetric wards, and being involved in the development and implementation of public policy programmes.

Because the movement is constituted by actors from a broad range of professional backgrounds, as well as women seeking or who have had a humanised birth, there are different factions or subgroups that use different strategies to bring about changes to health policy and practice. I observed movement activists using different tactics depending on the site and audience, and what exactly they were trying to achieve. The same individuals would, for example, use terms associated with evidence-based medicine and clinical research when conversing with health professionals and policymakers, appeal to women's rights in legal settings, and use emotive language to depict humanised birth as a desirable and beautiful experience when speaking to the wider public, journalists and women seeking care. Some subgroups would refer to the poor state of care as a public health problem (the "c-section epidemic"). These actors tended to be public health academics working at universities. Those in government saw it as a policy problem that could best be tackled through passing laws and public policies that incentivised normal delivery and regulating the private sector.

Almost all movement activists defined the maltreatment of women during pregnancy, labour and the postnatal period as "obstetric violence," and as a violation of women's rights (Diniz et al. 2018). The term emerged a little over a decade ago as a legal construct in several Latin American countries to address the mistreatment of women around childbirth (Williams et al. 2018). Obstetric violence can include: refusal to admit women to the hospital; denying companionship, food, water or free movement during childbirth; procedures performed without consent or which cause physical or psychological harm; denying the use of anaesthesia; c-section without a valid medical indication and/or without consent of the woman; and impeding breastfeeding in the first hour of life (Ministério Público do Estado de São Paulo 2014). In Brazil, both the disrespectful treatment of women in the public sector *and* the excessive use of clinical interventions in public and private hospitals are considered obstetric violence. They are two distinct types of violence, each requiring different strategies to address them.

*Parto humanisado* (humanised birth) usually refers to childbirth free from unnecessary clinical interventions, where the woman is well informed about her choices, and where her needs and wishes are respected by the health professionals attending her. For many

activists, the ideal humanised birth is a delivery at home or at a birth centre, led by humanised health professionals (obstetrician, obstetric nurse or midwife, and often a doula). It could also be a hospital birth with interventions, even ending in a c-section delivery if these procedures are genuinely necessary, and the woman gives informed consent and is able to make decisions regarding her own care. Some humanised birth activists feel strongly that interventions are only needed in extreme cases, but most accept the need for clinical procedures in obstetric emergencies or when the mother or baby has an underlying health condition. The terms *parto normal* (normal birth) and *parto natural* (natural birth) are also frequently used. In Brazil, *parto normal* usually refers to a vaginal delivery that may involve a manual extraction with forceps or an episiotomy. In this case, a woman might say "I had a *parto normal*, but not *humanisado*". The term "normal birth" is also used widely throughout English language literature and policy documentation in this field. While the concept of "normality" is not universal, it is widely taken to reflect a consensus among global maternal health experts that maternal healthcare should be "normalised" where possible, based on the understanding that birth is a normal physiological process that can be accomplished without intervention for most women (WHO 2018). *Parto natural* usually refers to a vaginal delivery without intervention. Each of these terms conveys a subtly different meaning: that this way of giving birth is natural as opposed to highly medicalised birth that is unnatural; normal and thus the standard, opposed to abnormal; and humanised, where women are treated humanely and not objectified as they might be in the medicalised model. The idea of natural birth has long been used in feminist literature on childbirth (Davis-Floyd 1994) to counter the medicalised/technocratic model, and by some midwives who appeal to the 'authority of nature' as the basis for their work' (Macdonald 2006: 236). These authors also tend to place natural birth in opposition to medicalised birth.

One problem with this positioning is that it leaves little room for the experiences of women and caregivers who want as natural birth as possible, but genuinely need or want some form of intervention. As I discuss in Chapter 6, in some cases this can leave these women feeling ashamed or as if they have failed. More recently, natural birth advocates are moving away from this strict dichotomy. In her research with midwives in Canada, Macdonald found that 'the construction, negotiation, and experience of natural birth in midwifery in Canada both reflects and promotes a fundamental shift away from essentialized understandings of the natural female body and childbirth' and allows for the use of biomedical technology and hospital births (Macdonald 2006: 236). This concept of a more open and practical view of natural birth was clearly present in Brazil. While there were 'extreme' members of the movement who rejected the need for any interventions (there was a well-known midwife in Rio who had never performed an episiotomy in the many decades she had practiced), a

considerable number in the mainstream were more open to negotiating what *parto normal* involved in practice. This is why many activists preferred the term “humanised”, explaining that even a c-section can be humanised if the woman is cared for appropriately.

The Brazilian humanised birth movement has been influenced by the international natural birth movement, and has similarities with other national level movements, such as those documented in Mexico (Vega 2006), the USA (Davis-Floyd 2004) and Canada (MacDonald 2006). These movements tend to have similar overarching goals, but their activities and strategies may vary depending on factors such as: health system structure (whether high quality services are publicly available free at the point of use); whether there is a strong midwifery profession or traditional birth attendant coverage; and whether there is gender equality in the country or region, particularly the extent to which women are considered to have decision-making power with regard to their health. As with other countries, the Brazilian humanised birth movement has been supported by feminist movements, and strengthened by the vast and growing body of scientific evidence that supports their claims. What is specific to the Brazilian movement is the fact that it emerged from an era of dictatorship, that Brazil continues to be a patriarchal society in many senses, including in healthcare decision-making, and that the quality of healthcare is highly unequal depending on people’s ability to pay. The midwifery profession has remained relatively weak in Brazil, but in northern and Amazonian regions, traditional birth attendants continue to play an important role (Rattner et al. 2009). On a more positive note, Brazil has a functioning public health system that (at least in theory) provides a minimum level of basic care for its citizens. The country also has a long history of social movements and health activism. Finally, Brazilians are generally quick to take up new technologies – including smart phones and internet access, facilitating access to information and social media networks that enable almost anyone to participate in the movement.

# 3. A global epidemic

The humanised birth movement is situated in and deeply influenced by global trends in maternal healthcare, and these warrant consideration throughout this thesis. The goals of the movement are closely aligned with the global maternal health community’s priorities in normalising birth and implementing women-centred models of care. Brazilian public policy programmes and other movement activities draw heavily on international best practice guidelines, overarching policy goals, and globally produced scientific evidence to advance their cause.

The overuse of caesarean sections is a global concern. The World Health Organization (WHO) recommends that the optimal rate of c-section delivery is 10-15% (WHO 1985). There is considerable variation in c-section rates between different countries, as shown in the map below, as well between rural and urban areas. The majority of central and West African countries and some South Asian countries underuse c-sections, usually due to insufficient staffing and infrastructure, resulting in avoidable maternal and infant death and illness. In many high and middle-income countries rates of c-section births have reached frequencies above what is expected based on obstetric indications, a trend that has become a concern for maternal health experts (Boerma et al. 2018).

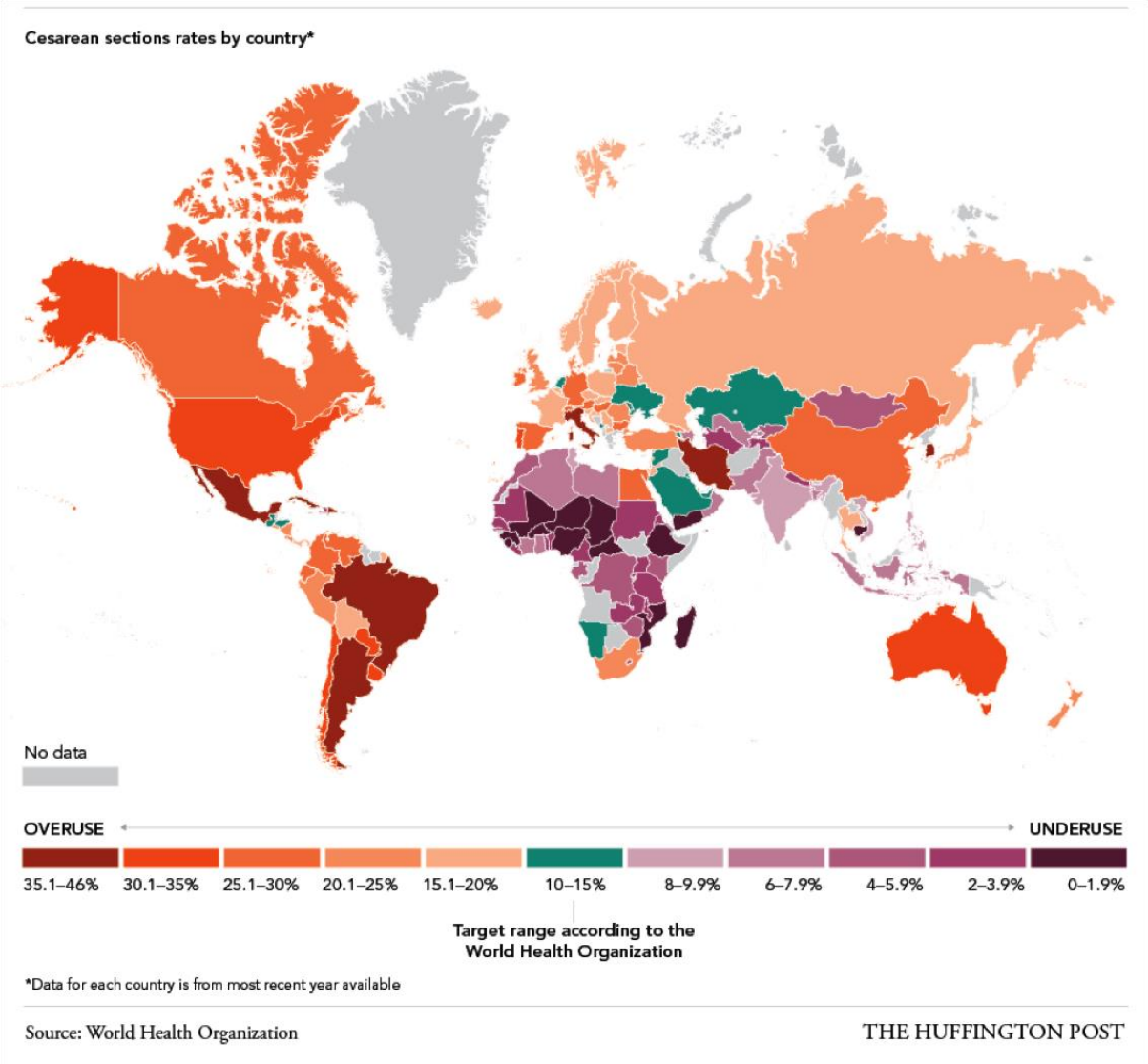


*Figure 1: Rates of c-section by country from WHO data (Source: Scheller/ The Huffington Post 2014)*

C-sections are invasive operations that should only be carried out if clinically indicated as necessary to save the life and health of the woman and/or the baby, with the consent of the woman. The procedure involves the surgical delivery of the baby, usually via an incision in the lower abdomen, peritoneum and uterus, which is sutured afterwards. C-sections should be used in cases of obstructed labour, if there are problems with the placenta or umbilical cord, or if the baby becomes dangerously unwell (NICE 2019). Previously c-sections were advised for twin pregnancies and breech deliveries but in many settings, these are now managed as vaginal deliveries.

Women and their babies can be harmed or even die as a result of c-section deliveries, which carry the risk of complications from surgery including haemorrhage and infection. C-sections are 'associated with an increased risk of uterine rupture, abnormal placentation, ectopic pregnancy, stillbirth, and preterm birth' (Sandall et al. 2018). Short-term risks for the infant include altered immune development, an increased likelihood of allergies and reduced intestinal gut microbiome diversity (Sandall et al. 2018). Emergency c-sections, in particular, can have an emotional cost. Women who have undergone emergency c-sections in various health system settings report feelings of distress and fear (Ryding et al. 1997, Yokote 2008). There is some evidence that women who have undergone c-sections find it more difficult to bond with their babies (Laronche et al. 2017). Women who experience difficult childbirths, including forceps delivery and emergency c-section, are at greater risk of poorer health and wellbeing compared to other modes of delivery (Furuta et al. 2012, Rowlands and Redshaw 2012). These risks should discourage the unnecessary use of c-section – also known as elective c-section – but elective c-sections are overused in many hospitals and health systems around the world.

Much of the blame for the excessive use of c-section (and other clinical interventions such as induction of labour with synthetic oxytocin) globally is attributed to the "medicalisation" or "biomedicalisation" of childbirth. Biomedicalisation is a central point of inquiry for medical anthropologists, many of whom are concerned with the negative impacts of seeing health and illness through one particular knowledge system: what is usually referred to as Western biomedicine (Hahn and Kleinman 1983). In theory, biomedicine can be distinguished from other healing systems by an extreme insistence on positivist materialism as the grounds for knowledge, and its focus on what is visible as the source of truth (for instance, confirming a diagnosis by viewing the pathogen under a microscope rather than by listening to the patient's subjective experience of the illness and its associated symptoms) (Kleinman 1995). The reductionist tendencies of biomedicine, which can fail to recognise the psychological, social and moral aspects of human bodies and experiences of health and illness, have been

recognised by Kleinman (1995) as “dehumanising” (the medicalised-humanised dichotomy used by the humanised birth movement will be explored further in this thesis). Furthermore, biomedicine has tended to consider the human body as everywhere essentially the same for the purposes of diagnosing and managing disease, which can have negative consequences for those whose bodies that do not adhere to the norm (Lock and Nguyen 2010).

The concept of medical pluralism – the coexistence of differing medical traditions – provides a more nuanced perspective, and gained currency among medical anthropologists in the 1970s. Medical pluralism implies that in any given community, patients and their carers can resort to different kinds of therapies even when there are incompatible explanations for the illness (Hsu 2008). In some settings, this resulted in a plural system of maternity services rooted in indigenous customs and Western obstetric science (Nguyen 2016). Kleinman (1995) and Lock and Nguyen (2010) also acknowledge the plurality of biomedicine itself, and the way that biomedical practitioners in any given setting may be influenced by local norms and practices in other medical systems (acupuncture, Chinese medicine and yoga are common examples of this cross-cultural perspective). Biomedicine itself is therefore not a rigid system, but is interpreted, altered and “indigenized”[4] in different ways in the multitude of contexts in which it is practiced (Kleinman 1995), a set of concepts and behaviours that have become normalised and “embedded” in clinical institutions. Instead of seeing biomedicine as a fixed system, it is more useful to analyse the application of biomedical technologies, and the way they are ‘emeshed with medical, social, and political interests that have practical and model consequences’ (Lock and Nguyen 2010: 1). Following Mol (2002) and Haraway (1988) I seek to examine the “situatedness” of biomedicalised practice in a particular context - that is, the way that it takes place in specific clinics and hospitals in São Paulo over a certain time period.

Much of the debate around medicalisation has focussed on the way that disease and illness are diagnosed, and patients are treated; but biomedical technologies are also widely used to manage pregnancy and childbirth (which are, of course, not diseases). The medicalisation of childbirth is understood as the encroaching of the biomedical model of medicine into the lives of healthy women, who, for the most part, are able to have babies without clinical intervention[5]. In this field, the “authoritative knowledge” of biomedicine has had the effect of

[4] Kleinman uses the term “indiginisation of biomedicine” to refer to the plurality of biomedicine as a knowledge system and the fact that different therapeutic technologies are perceived and employed in different ways in different contexts all across the globe.

[5] While there are a large range of clinical and socio-economic factors that influence maternal health outcomes, and huge variation in rates between countries, most experts concur with the WHO’s estimate that 85-90% of women should be able to deliver vaginally. To take the UK as an example,

delegitimizing other forms of knowing, including a woman's own knowledge about her body (Davis-Floyd 1994, Sargent and Bascope 1996, Jordan 1997). It also encourages us to see women's birthing bodies as machines that can be monitored and controlled, and to see birth as a mechanistic process (Martin 2001). In practice, this might take the form of continuous observation of foetal and maternal heart rates for abnormal rhythms with a cardiotocograph (CTG), and checking contractions and dilation for "efficiency" against a universal norm. In an overly medicalised model, women's bodies are understood as 'inherently faulty and in need of medical management' (Cheyney 2011: 520). As many "normal birth" proponents have pointed out, this overly medicalised management is not actually evidenced-based, but instead reflects a larger patriarchal and technocratic society that has a long history of trying to control women's bodies (Davis-Floyd 2004a, Diniz 2012).

In recent years, the most vocal of these critics have been critiqued in turn for failing to acknowledge the positive effects of advances in biomedical knowledge in managing complex high-risk pregnancy and labour. Almost all maternal health experts will agree that in some instances c-sections delivery is essential to save the mother's and/or baby's life. What constitutes medicalised maternal healthcare is, therefore, not clear or universally agreed upon globally or in Brazil specifically. In my fieldwork, the term *medicalisado* (medicalised) is widely used to refer to an excessively medicalised model of care, where birth takes place in hospital with routine or unnecessary interventions carried out by obstetricians. It is often positioned as being in binary opposition to care that is *humanisado*, but in practice the differences are more nuanced, as some clinical procedures are considered humanised, probably because they are non-invasive, with minimal side effects. These include the use of a Doppler ultrasound machine, which monitors the foetal heart rate intermittently without constricting the woman's movement, and analgesia in the form of Entonox, a mixture of oxygen and nitrous oxide, which women can control the intake of.

Having studied this area for many years in different country contexts, and witnessed quite a number of births, I would argue that whether "medicalised" interventions are viewed as

according to 2019 data from 131 NHS service providers on mode of birth, 57% were spontaneous vaginal births, 11% had instrumental assistance, 14% were elective caesarean sections and 16% were emergency caesarean sections (NHS Digital 2019). Here the c-section rates are higher than clinically essential, but not by a huge amount. Women who are multiparous, low-risk, and opt to deliver at home or at a midwifery-led unit, have significantly better outcomes and are more likely to have a "normal birth" than those who deliver on an obstetric unit (Birthplace in England Collaborative Group 2011). This suggests a vast majority of low-risk women who have adequate support will not need clinical interventions. A similar study in Brazil found that 84.4% of 667 women who planned a homebirth gave birth at home, with none having an episiotomy, and the rate of c-section for those who started at home was 9% (Koettker et al. 2018).

negative and damaging is primarily a result of how women and their families perceive their experience. If women feel like they are well informed, have choice in their care, and have a supportive team of health professionals, they are likely to feel their birth was “humanised” even if medical interventions were used. This shifts the focus away from the actual technologies used, and onto the care provided by doctors, nurses, midwives and doulas. As Mol (2008) notes in her discussion of ‘the logic of care’, care is often (falsely) cast as “other” to technology, and is distinguished from “cure” in medicine. Mol (2008) argues that care is not just what takes place *around* interventions, but that it includes technology, and that technologies have to be handled with care. For most of the women I met pursuing humanised birth, the relationship with caregivers was central to the experience. This was why doulas (non-clinical birth attendants) have such a significant role in humanised birth movements in Brazil and globally: their central responsibility is to care for women, through emotional support and advocacy.

The overuse of interventions is a focus of global policy drives, research studies and social movement campaigns. Global health institutions have issued stricter statements and changed official guidelines to discourage the overuse of c-section. The 1985 WHO guidelines on the optimum c-section rate (aimed primarily at healthcare professionals and those responsible for developing national and local health policies) have remained in place for more than three decades, but recently the language around them has changed remarkably. Until now, the supporting literature for these recommendations consisted of quantitative assessments of risk for poor clinical outcomes. In February 2018 the WHO published *Intrapartum care for a positive childbirth experience* (WHO 2018). Over this time period there has been greater recognition of the problems that result from overuse of clinical interventions in healthy pregnancies. The revised guidelines promote a woman-centred model of care, recognising that the increasing medicalisation of childbirth ‘tends to undermine the woman’s own capacity to give birth and negatively impacts her childbirth experience’ (WHO 2018). Woman-centred care also prioritises women’s social, cultural and emotional needs, and the importance of comfortable surroundings and supportive birth attendants for a positive childbirth experience (WHO 2018). These recommendations are closely aligned with the aims of the Brazilian humanised birth movement. Some aspects are particularly relevant, such as the focus on women feeling respected and cared for, rather than just receiving high-quality technical interventions. The acknowledgement of the important role of continuous emotional support during labour (which has been long been supported by scientific evidence, as summarised in systematic reviews such as Bohren et al. 2017) has been taken up by Brazilian doulas, which I will explore in detail in Chapter Seven.

The disrespectful and abusive treatment of women during childbirth is also increasing recognised as a global problem (WHO 2015). A mixed-methods systematic review found that around the world, 'mistreatment can occur at the level of interaction between the woman and provider, as well as through systemic failures at the health facility and health system levels' (Bohren et al. 2015). A meta-ethnography of ten qualitative studies examining women's experiences of traumatic birth identified cross-cutting themes, including: 'feeling out of control', wanting to be treated humanely, and 'disrupted relationships' with their partner and baby (Elmir et al. 2010). The authors conclude that traumatic birth can have debilitating consequences for women even if they have clinically satisfactory outcomes (Elmir et al. 2010). In some countries, including Brazil, activists and policymakers identify this mistreatment as obstetric violence, drawing associations between abuse during pregnancy and childbirth, and other forms of gender-based or structural violence. While this term has been widely used in Latin America for some years, more recently it has been taken up by normal birth campaigners globally, including in the US and Europe. Supporters argue that this opens up new opportunities for maternal rights advocacy, including an engagement with bioethics and human rights discourses (Erdman 2015).

There are useful lessons to be learned from examining Brazil's successes and failures in addressing the over-medicalisation of childbirth that might be applied in or adapted to other health system contexts. Several non-Brazilian health professionals I met in São Paulo considered Brazil a leader in tackling the excessive use of c-section. There are numerous examples of policy successes, including the introduction of normal birth centres under the *Rede Cergonha* national policy, and the *Parto Adequado* programme discussed in this thesis. The fact that obstetric violence has been incorporated into public policy and legislation puts Brazil ahead of most countries in formally recognising the damaging effects of disrespectful treatment during childbirth, and may be a model to learn from in this regard, along with its Latin American neighbours who have passed specific legislation on this (discussed in depth in Chapter Two).

This thesis contributes to the literature that studies how policy guidelines, recommendations, and programmes move internationally or translate between different health systems. Researchers from the field of policy studies have described the different ways in which policies travel, including: policy transfer (where policy knowledge from one government is used by another, usually unidirectionally), policy diffusion (the adoption of policies by a cluster of countries) and policy circulation (which emphasizes the role of ideas and underlying meaning, attempting to deconstruct the linear rational views of policy transfer and diffusion) (Porto de Oliveira 2017). Olivier de Sardan et al. (2017) describe the proliferation

of “traveling models”: standardised interventions developed by international experts, introduced in an almost identical format to improve aspects of maternal health systems in low- and middle-income countries. The authors are critical of the ways in which these policy models are taken out of context, replicated, and then do not ‘work’ as the experts have anticipated, sometimes having negative consequences. “Best practices” in maternal health, for example, are translated into abstract global recommendations so that they can be adapted to different country contexts. While this might make them more adaptable, the ideological content underlying them might be lost (Porto de Oliveira 2017). Maternal health priorities set at the global level are extremely powerful and can determine the kinds of research that is done and where budgets are allocated, which in turn shapes the kind of care women receive at the local level (Storeng and Béhague 2014). Particular policy programmes and models that had originated elsewhere (particularly the UK) were frequently referred to by my participants, and in some case, translated for use in the Brazilian context (hospital midwifery-led units and the creation of an institute to develop national health guidelines are two examples). In the conclusion I return to the question of whether Brazilian policy interventions might be models for other health systems around the world.

## 4. A crisis of democracy?

Studying a specific area of policy can provide a window through which to examine broader social, cultural and political changes (Shore et al. 2011). The trends I observed when studying specific policy ideas and interventions reflected broader societal shifts in São Paulo, and even changes in global maternal health policy priorities. These included how people understood their relationships with the state, other citizens and health institutions; how they searched for information; how they campaigned for change; and the extent to which they saw childbirth care as a right or as a commodity. For example, the Volunteer Doula Programme reflected a growing acknowledgement of the value of continuous support during labour at the global level, and the increasing popularity of doing voluntary work in the SUS in São Paulo. The growing discontent with state institutions and the political establishment could be seen in the way in which citizens interacted with participatory policymaking institutions. For this reason, it is important to understand relevant historical and socio-political events that took place before my fieldwork, as well as those that occurred during it.

Since the military dictatorship (1964-1985) two main political parties – the centrist *Partido da Social Democracia Brasileira* (PSDB, Brazilian Social Democracy Party) and the left-wing

*Partido dos Trabalhadores* (PT, Workers Party) – have dominated the political scene, with a large percentage of the votes being split fairly equally between them. Democratisation in 1988 was followed by several successive socially conservative and economically free-market administrations, which invested little in health services and social welfare programmes. In 2002, the left-wing PT President Luiz Inácio Lula da Silva (popularly known as Lula) came to power with a sweeping majority. Over two terms the Lula administration brought in major national redistributive policies such as the *Bolsa Familia* and the Family Health Program, which lifted 28 million people out of poverty (Doniec et al. 2018). His successor, Dilma Rouseff (Brazilians refer to her by her first name only), won the presidency in 2010 with a large majority. Broadly speaking, under the two consecutive PT presidential administrations and PT-led municipal governments, a relatively high number of policies and laws were passed that furthered the aims of the humanised birth movement and led to wider improvements in maternal health in general.

More recently, over the past decade, Brazil has experienced overlapping political and socio-economic crises (Hunter and Power 2019) and a dramatic shift to the political right. One of the catalytic events for this happened in June 2013 as I was flying over the Atlantic Ocean from London to Rio de Janeiro to begin my preliminary fieldwork. I arrived just after dawn local time and took a taxi to my hostel in the *Centro* neighbourhood, an area known for its wild all-weekend street parties. Rubbish was strewn across the streets, there were broken bits of placards and cardboard hand-scrawled signs, as well as a heavy police presence. “Was this just a normal weekend in Rio?” I asked the taxi driver. He explained that there had been protests the previous day that had gotten out of hand. Protesters had taken to the streets to complain about a hike in bus fares, which would disproportionately affect poor Brazilians who used public transport networks. What started off as a protest movement by the working class and leftist students became a public outpouring of discontent. Hundreds of thousands of Brazilians displayed their frustration with high taxes, poor public services and deep-rooted corruption in the political establishment.

From this point on, the Dilma administration’s approval ratings dropped dramatically. A new political right-wing emerged, known as the *Movimento Brasil Livre* (Free Brazil Movement) with rallying cries of “family, god and freedom” that echoed the conservatism of the military dictatorship, but with free-market liberalism as its central focus (Anderson 2016). Dilma was re-elected in 2014 with a slim majority, and subsequently launched a programme of austerity which plunged the country into a full-blown recession (Anderson 2016). At the same time, the *Lava Jato* (Car Wash) corruption scandal broke. The *Lava Jato* investigation was led by former federal judge Sergio Moro, whose findings led to criminal proceedings against more

than 300 people, many of whom were politicians from the main political parties, including Lula. Dilma herself was accused of being aware of graft that occurred while she was chair of the board of directors at the state-owned oil company Petrobras between 2003-2010. After a strategic campaign by opposition parties and her own vice-president Michel Temer, Dilma was impeached and ousted from the presidency in 2016. Temer assumed the presidency and was then himself accused of accepting bribes, leading to a plunge in his approval rating. He remained in position until the election of the current far-right president Jair Bolsonaro in January 2019. The Lava Jato scandal resulted in a steep decline in trust in the political establishment, which was only exacerbated when it emerged that Moro himself had been caught passing on advice and inside information to Lula's prosecutors.

Over the years of my doctoral research, I watched Brazilian society become increasingly partisan. The left stayed strongly in allegiance with Dilma throughout a lengthy impeachment process. There were regular *petista* (supporters of the PT workers party) marches in support of her and Lula. The *petistas* were adamant that Dilma's impeachment was a "coup", and drew parallels between the right-wing bloc that had assumed power and the military dictatorship that ended in 1985. More and more protesters turned out for counter-marches against PT, wearing the Brazilian flag colours of yellow and green and aligning themselves with the *Movimento Brasil Livre*. Eventually, this widespread disillusion with the political establishment and state corruption led to the election of Bolsonaro. Bolsonaro was elected around nine months after I left the field, so my data do not refer to his administration. Given the relevance of his taking office for women's health policy and the political climate more generally, however, I discuss his election and relevant policies thus far in the coda of this thesis.

The broader legislative environment has shifted from being progressive under PT (where there was substantial financial investment in women's health services and a series of policies favourable to humanising birth) to being regressive under Temer, and outright hostile under Bolsonaro. Critics have argued that the wider crisis is diverting attention from the government's efforts to resume a neoliberal model of healthcare, whilst implementing austerity, privatisation and deregulation policies (Doniec et al. 2018). The PEC-55 constitutional amendment introduced in December 2016 freezes the federal budget for 20 years, and the government failed to meet the minimum health budget guaranteed by the Brazilian Constitution by approximately $210 million in 2017 (Doniec et al. 2018). The government is also withdrawing from social welfare programmes and is introducing commercial health plans to replace public health system services and deregulating health

spending, giving more power to the private sector and potentially diminishing quality and accountability (Doniec et al. 2018).

Overall there appears to be a profound public disillusionment with the political system and frustration towards the mainstream parties. Many people I spoke with during fieldwork were exasperated at PT for becoming embroiled in corruption scandals but continued to support the party because they felt the alternative was far worse. Those on the right, fed up with "politics as usual", took part in *Movimento Brasil Livre* protests, and voted for Bolsonaro as their new president. Many voters admitted that while they might not agree with his views (which are often homophobic, misogynistic and pro-dictatorship), they thought he would be the best option to tackle the high levels of crime and sort out the failing economy. In 2020, Brazil is a deeply divided society.

All of this took place before the COVID-19 coronavirus epidemic swept around the world from January 2020, with Brazil's first case recorded in late February. As I finish writing this thesis from lockdown in London, Brazil has become one of the epicentres of the pandemic, fast approaching the US in numbers of cases and deaths. The government's response has been disastrous, and globally condemned. The friends and colleagues I stayed in touch with on social media post daily about their struggle to continue to provide adequate care to women during childbirth, at a time when the entire health system is on the brink of collapse. I return to their current plight in the conclusion, with the hope that some of my observations and analysis might help in even the smallest way.

## 5. Thesis structure

This thesis begins with a chapter on methodology, in which I set out my ethnographic approach to studying policy, justifying the importance of this field of anthropology. Here I also discuss the details of my fieldsite, study participants, and ethical considerations. Before moving into the next chapter, I share my experience of an art exhibit on humanised birth, which touches on many key issues covered in this thesis. Chapter Two explains the two-fold problem of care around childbirth in Brazil: the intervention epidemic and obstetric violence. Chapter Three explores the broader social and political context, focusing in particular on shifting meanings of citizenship as a lens through which to understand people's engagement with policymaking. Many of the issues that emerge in the following chapters are reflections of these broader societal changes. Chapter Four properly introduces the humanised birth movement and their activities. Applying the ethnographic methodology to the movement

here, I outline and provide examples of the various strategies movement activists employ to work towards their goals of humanising birth and reducing unnecessary interventions. The final three chapters each explore one of these strategies in depth. Chapter Five considers the role of scientific evidence in supporting movement members both in humanised policy development, and in their encounters with resistant *cesarista* doctors. Chapter Six follows one particular movement subgroup, who use marketing strategies to incentivise demand for private humanised birth services, with the aim of inducing private hospitals to supply these. Chapter Seven discusses the role of doulas in the movement, and raises the question as to whether the movement provides new opportunities for female solidarity and a new kind of sisterhood-based citizenship. This thesis ends with a coda, outlining two hugely important events since that took place since the end of my data collection, which both have implications for this field: the election of President Bolsonaro in October 2018, and the Covid-19 global pandemic in 2020. The conclusion summarises the main arguments and lessons drawn from this research, and discussed its implications and directions for future work.

# **Chapter One:** Methodology

This chapter sets out the methodological approach of my research. It begins with a discussion of the anthropology of policy, with a view to justifying my decision to choose a social movement as my fieldsite, and to highlight what this can contribute to anthropology as a discipline. I then provide details of the fieldsite – both in terms of the characteristics of the movement itself, and the city of São Paulo: the main geographical setting in which I followed the movement's activities. I also provide details of my data collection and reflect on various ethical challenges that I faced before and during fieldwork.

## 1. An anthropological approach to studying policy

The anthropology of policy belongs to a relatively new field of research that applies anthropological methods and theory to political institutions and processes. Anthropologists have long engaged in research that implicitly deals with public policy and its effects, but anthropology as a discipline has not given policy the explicit attention it deserves, considering the role of the latter in shaping mass society (Wedel and Feldman 2005). There has, however, been a long history of debate and dialogue in the fields of public health, epidemiology and medical anthropology, where anthropologists have played important roles in designing, adapting and critiquing health policy interventions.

Studying policy points directly to central anthropological concerns regarding norms, knowledge, power, discourse and meaning in societies (Shore and Wright 1997). Policies then, are 'inherently and unequivocally *anthropological* phenomena', to which comparisons can be drawn with Malinowski's (1926) notion of 'myth' as validations of established social practices and Mauss's (1954) concept of 'total social phenomena' which can create whole new sets of relationships between individuals, groups and objects (Shore and Wright 1997: 7). Policymaking and anthropological knowledge are both concerned with categorisation and social ordering, but while 'anthropology interrogates categorical constructions with a view to disassembling and hence render meaning explicit, policy makers are concerned with reassembling and reconstruction' (Green 2011: 48). This makes policy an important and legitimate field of study for anthropologists who seek to understand the way that people live their lives in modern democratic societies with state governance structures and social welfare systems.

In two edited volumes on the anthropology of policy (Shore and Wright 1997, Shore et al. 2011) the editors and their contributors argue that policies, and the "policy communities" that grow up around them – the multitude of actors and organisations that produce and are affected by these projects – are important subjects for anthropological attention (see also Wedel and Feldman 2005). Wright and Reinhold's (2011) chapter on "studying through" policy was particularly influential for my methodological approach. It captures how policies develop and the real-life impact they have as they are implemented, how they are perceived, potentially manipulated, and shape people's everyday lives – aspects that are often missing in more traditional methods of studying policy (as covered in Walt et al. 2008).

Like Shore and Wright, I see policies as embedded within particular social and cultural worlds, as 'productive, performative and continually contested', and creating 'new social and semantic spaces, new sets of relations, new political subjects and new webs of meaning' (Shore and Wright 2011: 1). I take a similarly critical stance of the dominant view of policies as entities (normally documents) that are the result of rational decision-making by an authority (normally governments or managers). Of course, policy documents do exist, and they are useful objects of analysis – but they do not accurately capture the complexities of real life nor translate seamlessly into practice. Documents are just one aspect of a broad range of policy activities that are the focus of my analysis, which also includes relationships between policy actors and how policies are perceived by those on the receiving end of interventions.

This thesis is therefore an exploration of how policies – in the broadest sense of the word – are changing as a result of the actions of the humanised birth movement[6]. It is not an

[6] In this thesis I refer to the influence the movement's activities have had on clinical *practice* as well as policy, by which I mean any kind of service or care provided by health professionals and doulas, in clinics and hospital settings. Clinical practice is, in theory, meant to adhere strictly to public policies (national, state and municipal), institutional policies and protocols/guidelines for obstetric care. But because practice is ultimately the behaviours and actions of people, it is more flexible and open to interpretation. This can go both ways, in terms of individuals practicing in a more or less humanised way than policy sets out. Some *cesarista* doctors ignore or refute policy in order to practice in a more medicalised form, whereas doulas taking part in the Volunteer Doula Policy might in practice go beyond the role set out for them in policy documents, going further in challenging obstetric violence. Anthropologists have examined clinical practice in a range of settings, with ethnographies of clinical spaces providing fascinating insight into relationships of care and institutional culture (Good and Good 1980, Gibson 2004, Tanassi 2004, Long et al. 2008, Livingstone 2012). Because my data was not collected in a single institution, I have not provided this level of detail about practice in one setting, but instead attempt to draw more general observations about practice by groups of health professionals and types of institution.

evaluation of the success of policy interventions, but an attempt to look at the behaviour around and the meanings attributed to them. If we take the example of policies that aim to reduce c-section rates and increase access to and desire for humanised childbirth – the policy field that I intend to "study through" – we can see the profound effect policies can have on the lived experience of thousands of pregnant women and mothers, health professionals and other stakeholders and how policies impact upon their everyday lives. This might include: what information they receive and how this effects their actions and perceptions of their body; their access to particular pre- and post-natal services, the medical interventions they might undergo during childbirth, and thus their embodied experience of birth itself. These policies involve numerous researchers, campaigners and decision-makers who conceive and "implement" them. They have led to protest movements and demonstrations both on the streets and on social media, creating new discourses and terms (*parto humanisado*, *cesarista*, *multiplicar*). They involve artefacts such as policy documents, protest placards, news articles, online posts and tweets. Policies are, therefore, not simply regulations designed and implemented by governments, but complex phenomena bringing together networks of actors and institutions.

Policies are also of anthropological interest because they are "windows" on to broader political and cultural shifts (Shore and Wright 2011). We can look at the SUS as an exemplary case study in itself. The SUS was founded during a cautiously optimistic period of democratisation (at least for the majority of the population opposed to the dictatorship), and reflects the ideological values of that moment in time. The actions of left-wing activists, who had campaigned for years to bring an end to the dictatorship and to install a public health system, were highly important in establishing the SUS. The rights enshrined in the 1988 Citizen's Constitution supported further advances in decentralising and expanding services, changing care models and facilitating social participation (Machado et al. 2017). The conservative political and medical establishments, however, resisted the creation and expansion of the SUS using neoliberal economic policies in the 1990s (Machado et al. 2017). Under President Lula, the leftist PT government prioritised broader redistributive social policies targeting poverty and education, meaning that health was 'put on the back burner', while his successor Dilma struggled with a turbulent political environment and financial crash, leaving little opportunity to further health system improvements (Machado et al. 2017). The SUS is also an example of how policy ideas travel and translate internationally (it is widely acknowledged that the SUS was inspired by the British NHS). Citizenship, and the rights of citizens to participate in policymaking, were fundamentally important concepts in this newly democratic society, and for this reason they were built into the very structure of the SUS itself, in the form of the Conselhos and Conferências de

Saúde. We can see here how broader social and political shifts have significant implications for SUS-related policy.

Three decades after the founding of the SUS, the efforts of the humanised birth movement to change national and local level policy take place in an unstable environment, where Brazilian citizens are deeply disillusioned with the political system. Their willingness to engage with established participatory policymaking processes of democracy is in question. Broader societal shifts of rapid modernisation, capitalism and the growth of consumer culture in São Paulo have led to a trend of commodifying childbirth itself, in which women and their families spend large amounts of money to acquire the birth they desire. Private hospitals increasingly develop policy programmes with international partners, drawing on the strength and legitimacy of policy models from other national contexts to address the c-section epidemic rather than developing policy specific to Brazil. Under Bolsonaro's administration, the continued existence of the SUS is under threat. Looking through the policy "window" of the SUS and its participatory structures provides a viewpoint on these changes. The table below shows a rough delineation between the policy context at the time of the foundation of the SUS, and the decade in which I carried out fieldwork.

| Late 1980s-early 1990s | 2010s |
|---|---|
| - Post-dictatorship low-income country<br>- Central role of state in healthcare<br>- Social movements primarily focussed on addressing denial of citizenship rights<br>- Citizen as a key identity<br>- Access to knowledge through education system and participation in society<br>- Sociality based on neighbourhoods and employment<br>- Public policies developed around rights claims and moral arguments | - Established "BRIC" middle-income country<br>- Large role of private sector in healthcare<br>- Social movements primarily focussed on issues, including claiming new rights<br>- Consumer as a key identity<br>- Access to knowledge through internet and smart phones<br>- Sociality based on interest groups, including online<br>- Public policies evidence-based and internationally influenced |

*Figure 2: Table outlining broad societal shifts from when the SUS was founded to the present day, which have implications for studying policy in this setting.*

These shifts in policymaking necessitated that I conduct fieldwork beyond formal political institutions, across multiple kinds of sites, including online and at home. However, this did not mean that the forms of policymaking processes used in the 1980s and 1990s have become obsolete. Indeed, as I will show in Chapter Three, the participatory policymaking councils and conferences continue to be important spaces for citizenship practice and political debate – primarily for left-wing activists who have been involved in PT since its beginnings. This is one of the primary drivers for the ambiguity around citizenship for Brazilians: different segments of the population have distinct forms of identity, political practices, uses of technology and so on. This determines how they engage with policymaking processes and the policies themselves.

Shore and Wright (2011) argue, making use of Latour's (1996) work on actor-network theory, that policies are 'actants'. They have agency, and are able to create, shape and disrupt the worlds in which they unfold by shifting action and performing tasks (Shore and Wright 2011). The potential "runaway effect" of policies draws attention to unpredictable outcomes – for instance, when participatory policy making structures are too slow to bring about change, actors from the movement have formed new partnerships with non-state actors to work more effectively. Thinking of policies as actants encouraged me to focus on them as central points of research interest, working outwards to examine the processes of change and people around them, rather than starting with human actors. Taking this methodological approach was precisely what led to me to discovering the limitations with Brazil's processes for citizen policymaking. The *Conselhos* and *Conferências de Saúde* were not functioning in the linear, rational fashion they were intended to (where movement actors could bring certain issues forward for debate, which would eventually be developed and implemented by consensus). The councils were messy, and made up of people who had their own agendas, who disagreed, and who sometimes acted irrationally in attempts to meet their political goals.

Finally, it is important to point out the limitations of this methodological approach. Studying such a broad field is challenging, and in some cases can result in a lack of depth. After a short time in the field I realised that applying this methodology had led me to identify a huge number of strategies that the humanised birth movement used to influence policy (listed in Chapter Four). For this reason, I decided to focus on three of these areas in more detail (Chapters Five, Six and Seven). Another challenge was that in some cases policy professionals and formal institutions were fairly difficult to access, due to the demands of their work or security measures. This meant that fostering relationships with key interlocutors was essential, as accompanying them could open doors, quite literally.

# 2. My fieldsite

## A social movement

I followed the activities of my policy community of interest – the humanised birth movement – across multiple sites in the city of São Paulo, in the southern Brazilian state of São Paulo, as well as various other locations across the country and online. A multi-sited ethnography was required because the women, health professionals and policy-makers involved in childbirth move between different spaces as they seek, provide, and attempt to improve care. For instance, the same women may be 'patients' on the labour ward, voice their concerns on social media, participate in a municipal health conference or a research study within a relatively short time period. The essence of multi-sited research is 'to follow people, connections, associations, and relationships across space' (Falzon 2009:1). The problem under investigation is *trans*local, as 'sites are connected with one another in such ways that the relationships between them are as important for this formulation as the relationships within them' (Hannerz 2003:206). This kind of research 'moves out from the single sites and local situations of conventional ethnographic research designs to examine the circulation of cultural meanings, objects, and identities in diffuse time-space' (Marcus 1995: 96). It can be immensely rewarding – so long as researchers avoid the dangers of spreading themselves across so many sites that any depth of understanding is lost (Falzon 2009). The anthropology of policy builds on multi-sited ethnography by taking into consideration 'a history of the present', which aims to capture 'the emerging contours of ideological formations and emerging systems of governance' and accepting that the field might grow or reshape, that new sites might become relevant (Wright and Reinhold 2011: 92-93).

Multi-sited ethnography also avoids presuming a hierarchical relationship between policymakers (such as professional state employees who have significant power in determining policy) and those that are supposedly governed by policy (Wright and Reinhold 2011: 101). During my fieldwork, however, I found that hierarchies were still present. Leading political figures and academics could more swiftly and easily influence public policy and legislation than "non-experts" such as women living in the *periferia*. Despite this, individual citizens (be they pregnant women, mothers, health professionals, doulas, activists) still had an impact in the ways that they interpreted, manipulated, reformed and resisted policy.

At the same time as being a policy community, my "fieldsite" was also a social movement. Since the 1960s much of the academic literature on social movements has come from social and political scientists, while anthropologists have been largely absent (Escobar 1992, Gibb

2001). Escobar has argued that anthropology, as a discipline, 'is not well equipped to examine the ways in which contemporary social actors shape their world through collective political action' (1992: 396). Gibb suggests that for much of the 20th century, political anthropologists have 'tended to define politics in opposition to culture, and to ignore the institutional or organisational aspects of mass politics' (2001: 9). In the 1990s, the emergence of left-wing social movements in Latin American countries (particularly the Zapatista movement in Mexico) and the globalisation of social movements began to attract greater anthropological attention (Edelman 2001). Over the past two decades, the subfield of the anthropology of social movements has developed further, alongside the anthropology of democracy and of citizenship (Salman and Assies 2010); the latter of which is discussed in Chapter Three of this thesis. There are a growing number of ethnographies of institutions and organisations (Tsing 2004, Devault 2006, Cunliffe 2010, Chong 2012), and other forms of political ethnography (Auyero 2006). Ethnographies of Brazilian social movements include Wolford's (2006) study of the *Movimento Sem Terra* (MST, Landless Movement) in northeastern Brazil and Biehl's (2007) work on HIV activism and Caasah, a community-run AIDS hospice in Salvador, Bahia. Like the ethnographies mentioned here, this one also counters the popular image of social movements as 'well-bounded entities consisting of individuals committed to the goals of the collective' (Wolford 2006: 335), and instead attempts to capture the messiness of the humanised birth movement, the diverging views as well as the unifying aims.

Like many other social movements, the humanised birth movement makes rights claims in order to work against abuses of power and the maltreatment of women, linking it with broader global movements for women's rights to health, bodily integrity and freedom from violence. The humanised birth movement is also different in several ways. Firstly, the movement's aims are not explicitly political (for instance, they make no mention of changing the political system or party politics) but are focussed on changing clinical practice and care indirectly, through policy. Secondly, some activists completely avoided formal political processes, institutions, and interactions with the state. Because of this, a broader approach was required that also allowed me to examine strategies that took place outside of the public sphere and in private healthcare markets.

## A city

I made five trips to Brazil from February 2015 to March 2018, a total of 12 months of fieldwork. The first of these was a short scoping trip to identify a suitable geographical area to base myself. It was during this trip that I decided to focus specifically on maternal health

because it emerged as an issue of substantial public concern. I then chose to conduct the majority of my research in the city of São Paulo because the state, and the city itself, have some of the highest rates of c-section and obstetric violence in the country. Because of this, and the fact that São Paulo is an urban centre with an educated and politically active middle-class, it is considered a hub of activity for the humanised birth movement.

São Paulo is the most populous city in the Southern and Western hemispheres, with a population of 12.25 million (IBGE 2019). It is the most ethnically diverse city in Brazil, with large diaspora populations of Italian, Portuguese, German and Japanese descent, among others. In the 2010 census, around 60% of the population identified as *branca* (white), 30% *pardo* (mixed), 6.5% *negra* (black), and the remaining percentages Asian and indigenous (IBGE 2010). It is also the wealthiest South American city, and the country's financial, commercial and knowledge centre. Growing levels of wealth and an influx of multinational companies and designer goods have made São Paulo a centre for luxury commerce. Enormous high-end shopping malls are popular destinations for the wealthier *paulistanos* (residents of São Paulo city), and there are plenty of cheaper malls and markets selling counterfeit versions to meet the demands of all income levels.

*Image 2: A view of the São Paulo skyline*

There is a large, educated, politically progressive middle class who are either directly involved in the movement or use humanised services. Leading research in maternal health generally, and normal/humanised birth initiatives specifically, are conducted at the *Faculdade de Saúde Pública* (Faculty of Public Health) at the *Universidade de São Paulo* (USP) and other research institutes located in the city such as *Centro de Estudos e Pesquisas "Dr. João Amorim*" (CEJAM) which organised the *Parto Seguro* policy programme that I discuss as a case study. Humanised birth centres such as *Grupo de Apoio à Maternidade Ativa* (GAMA) and *Casa Moara,* which play a key role in the movement, are located in the middle-class neighbourhoods of *Vila Madalena* and *Pinheiros*.

São Paulo is geographically enormous and travelling across it for one site visit or interview from my flat in Pinheiros could take up most of a day. The humanised birth clinics were relatively close to Pinheiros, but the public municipal hospitals were almost all located some distance from the centre in the city's *periferia*. There is a sprawling public transport network, but the traffic is notoriously terrible and buses are very slow. Sometimes, despite the smog and heat, I would walk for several hours to get to appointments faster. I also visited other sites of interest across the country, namely the 2015 National Health Conference in the capital Brasília, and *Hospital Sofia Feldman* in the neighbouring state of Belo Horizonte, a centre of reference for the movement due to its work in instituting humanised birth protocols.

## 3. Data collection

I began my main period of fieldwork in October 2015. I set out to construct a map of the policy community in São Paulo, also including key figures in the national movement whom I met at conferences or who were particularly vocal on social media. I chose multiple sites to conduct participant observation that were all associated with the humanised movement. I visited a mix of public and private institutions, large hospitals and small birth centres for comparison. I observed the São Paulo state-level *Conselho de Saúde* meetings and *Conferências de Saúde* at the municipal and national levels to research participatory policy processes of interest. I also attended various relevant academic and policy conferences, partly to improve my own understanding, to meet people and to observe interactions between attendees.

My sites included:

- Five large municipal public (SUS) hospitals implementing humanised or normal birth promotion policy programmes
- Three humanised birth centres that ran regular antenatal classes and private consultations (one public – Casa Angela, two private – Casa Moara and GAMA)
- A private hospital maternity ward (Hospital Israelita Albert Einstein, a large hospital in São Paulo that is considered to be one of the best in Latin America)
- Multiple São Paulo state health council meetings
- Two municipal level health conferences and the 2015 National Health Conference
- Five academic conferences on themes related to maternal health, obstetric violence and humanised birth and campaigning events
- Training sessions for health professionals for *Parto Adequado* at Hospital Einstein
- Training sessions for the volunteer doulas involved in the Volunteer Doula Programme
- Protests and demonstrations for women's health rights as well as more general political issues

The profile of the people I observed at these sites differed substantially. Brazil is considered one of the most unequal countries in the world, with a GINI coefficient of 53.90 based on 2018 data (World Bank 2020) and an inequality-adjusted human development index of 23.9 (HDR 2020). These indicators represent vast inequalities in income, health and education, and the overall loss to human development that results from these. Because of these intersecting socio-economic factors (including living and working conditions, nutrition, and access to high-quality antenatal care) women using the public hospitals tend to have higher risk pregnancies, compared to wealthier women using private sector services (Leal et al. 2017). Most public service users are black and brown women, many of them from poor neighbourhoods surrounding the hospital sites in the *periferia*. In contrast, the vast majority of women using private sector hospitals and humanised services are white, educated, and middle- or upper-class.

The majority of my interviewees explicitly identified as being part of the humanised birth movement, with a small number who did not identify as members explicitly, but were largely sympathetic to the cause. I recruited participants by identifying key members of the movement at academic conferences, at the municipal government health department, and at Hospital Einstein. I then used snowball sampling to meet other stakeholders, most of whom were *humanizada* health professionals. I met doulas (many of whom were also mothers) on the various doula training courses at which I conducted participant observation. I asked these key contacts to post on relevant social media groups about my research. I also invited

mothers at the humanised ante- and post-natal classes I observed to participate in interviews. This meant that I was mainly speaking to mothers who were self-selecting for participation, potentially bringing about some bias in their positive attitudes toward the movement. I attempted to control for this by asking interviewees to reflect on the negative aspects of the movement and its relevance for different population groups.

In total, I conducted 45 in-depth semi-structured interviews, most lasting 60 to 90 minutes. These were conducted either in the interviewee's workplace (a meeting room at a hospital or university) or in an informal setting such as a cafe or women's homes. These were with a diverse range of actors including:

- Women who had given birth in public/private sector hospitals in the past five years but who were not currently hospitalised (n8)
- Doulas and trainee doulas (n15)
- Midwives (n10)
- Obstetricians (n5)
- Senators and politicians (n4)
- Academic researchers (n4)
- Policy programme leads (n3) at CEJAM (*Centro de Estudos e Pesquisas "Dr. João Amorim"*, a not-for-profit population health research institute), Hospital Einstein (the largest private hospital in Brazil) and the São Paulo municipal health department.

I developed a core set of interview questions that generally covered: how the interviewee perceived the humanised birth movement, why they thought there was more demand for humanised birth, how they sought to influence policy or improve services, the importance of scientific evidence and guidelines in achieving this, and what they thought of specific programmes (Irvine 2021). I would use these questions to guide my interview, but my discussions were loosely structured and I would add or occlude topics when appropriate. I also conducted shorter informal interviews during participant observation (n5) with women who had recently delivered their babies in public hospital. I did not record these in order to make the women feel more comfortable, and my questions were mainly focussed on their experiences in birth and of the health services rather than broader ethical or political questions. I conducted two focus groups – one with a group of 6 trainee doulas from the private sector, another with 3 trainee doulas from the Volunteer Doula Programme. These allowed for an alternative form of conversation to take place, with potentially different insights to individual interviews (Morgan 1988).

The limitations of this research result from difficulties in accessing two groups of participants I would have liked to interview. Firstly, my efforts to recruit *cesarista* doctors and women using their services were unsuccessful. Despite the objective tone in my attempts via email to contact them, it was likely these doctors assumed I was involved with the movement and that they would face criticism, as they had in much of the academic research on childbirth in Brazil. This meant that the information I had about why some women chose c-sections and why some doctors promoted them so fiercely was either from other peer reviewed research, or second-hand reports through those linked to the humanised birth movement. Fortunately, this topic has been well explored in the literature, and the reasons behind these trends are fairly well-established (I discuss this literature in Chapter Two).

It was also difficult for me to speak to the those most at risk of obstetric violence – particularly Black women from lower income neighbourhoods – at length. I encountered these women in SUS hospitals, but due to their being in various stages of labour I decided it was inappropriate to conduct a formal interview that might have caused discomfort (there is little privacy on the SUS wards). I was, however, able to speak to some of them briefly and informally about their experiences of care. This meant that the interviews I conducted with the small number of Black humanised birth movement members were particularly important. In these, we discussed issues such as racism and intersectionality, and the lack of representation in the movement. These interviews informed some of the central ideas in this thesis, especially the limitations of citizenship and the potential of *sororidade* (sisterhood).

It is of course crucial to recognise my own white British/Irish ethnicity and the implications of this for my positionality. The historic associations between whiteness and medical authority were one of the reasons I felt it was inappropriate to interview women on the SUS wards about anything deeply personal or political (also evidenced by the anecdote in my ethics section below). In my interviews with Black movement members I hoped that my status as a non-Brazilian meant that I they could discuss racism in Brazil more openly than they might a white upper-class Brazilian woman; but of course, my whiteness and European upbringing could not be entirely put to one side.

I conducted participant observation at three different doula training courses in São Paulo in order to study their different approaches to *doulagem* (the work of doulas). The first was a well-known course at GAMA, which took place once a month with around 20 trainees. This course was fairly expensive - the current cost is R$930 (around £150) for four days - and is aimed at those looking to work as a doula in the private sector. I attended the full course and therefore became a certified doula as part of my participant observation. The second course

was part of a public policy programme - the Volunteer Doula Programme - run by the municipal health secretariat. Doulas who wanted to volunteer at SUS hospitals had to undertake this training course. I observed the practical training sessions at one large municipal hospital in the east of the city. The final course I participated in was *Multiplicando Doulas* (MD). The course founder, Fernanda, had set up MD as an alternative to the previous two courses mentioned, because she felt there were political and financial incentives involved in their design and execution that obstructed doulas from fulfilling their role and their proper support of women. In all of these sessions, I observed and participated to some extent, sharing my own experiences and opinions when appropriate. Training as a doula also gave me a well-defined professional role in my conversations with women, one which signalled to many movement members that I was sympathetic to their goals and aware of relevant debates.

I was able to speak Brazilian Portuguese at a conversational level when I arrived in the field, and this improved steadily to a point where I was fluent in my subject matter and in daily interactions. This was of huge benefit for my data collection, and meant I did not need to rely on a translator. It was much easier to build trust and to encourage people to participate in my research, and allowed for a natural flow of conversation in my interviews. A small number of participants wanted me to conduct their interview in English. This brought even greater clarification as I was able to see how native speakers translated key Portuguese terms into English.

I translated and transcribed my interviews and focus group sessions from Brazilian Portuguese into English. From my early fieldnotes and interview notes, I had developed a sense of the key themes I wanted to explore both in ongoing interviews and in the thesis. Throughout this process, I used *NVivo* qualitative data analysis software to organise and code interview transcripts to compare interviews through connected themes. As I have explained here, “citizenship” was an important starting point for my research. Through conducting interviews and reading around this theme, I developed sub-themes, such as “formal citizenship” and “citizenship practice”. Other themes also became apparent early on in fieldwork, such as incentivising demand for humanised birth as “a product”. In an iterative process, I developed questions on these early themes that I asked participants in later interviews. Another theme, “sororidade”, emerged later on in fieldwork, which meant that I had fewer opportunities to explore it in interviews, but it was such a powerful theme that I chose to include a chapter on it nonetheless. To support my primary data, I analysed relevant policy documentation, including those which referred to legislation and policy interventions that are case studies in this thesis.

Because a significant theme in this thesis is the use of evidence, I think it is important to state my own position on “what counts” as evidence. The field of maternal health makes use of a large number of quantitative indicators to measure health outcomes and the impact of interventions. There is also a wealth of qualitative research by anthropologists and political scientists that is of great value in understanding people’s perceptions and experiences of childbirth and obstetric care. Finally, there are other ethnographic studies, conducted in Brazil and in other relevant international settings. All of these forms of data are important, and none should be discounted. They should however, be properly framed and analysed, rather than being used as objective “proof”. This thesis is an effort to explore the power of different kinds of evidence and how people in the humanised birth strategically use it to achieve their goals. Throughout this thesis I use statistical data and results from clinical trials where relevant, alongside ethnographic data, interview excerpts and my own observations.

## 4. Ethical considerations

The people I met over the course of my time in Brazil were, in general, extremely friendly and forthcoming. People involved in the humanised birth movement were more than willing to share details of their birth experiences. Women who have opted for humanised birth post their ‘birth stories’ and videos of their labour and deliveries on social media platforms to raise awareness. Many of my participants are public figures (politicians, activists and academics), who saw my research as another platform for their cause - and potentially one with more international reach. These people regularly posted on social media or spoke in the press about obstetric violence and humanised birth. For the most part, and with some specific exceptions, what they were saying to me was also what they regularly said in public.

One central ethical question emerged from this openness, which was that the majority of these participants wanted their names to be included in my thesis and any publications. Early on in my research, I considered not anonymising their data. I strongly believe that research should benefit participants where appropriate, and I thought that if my publications could bring even a small amount of attention to their cause, then I should do so. By 2019, the situation had changed. Bolsonaro had been elected. I had left the field but was still in contact with friends I had made during fieldwork and I continued to follow developments on social media. Several of the most vocal activists told me they were considering moving either away from São Paulo or abroad, due to threats they had received as a result of their work. For this reason, I decided to anonymise all of my data, including these activists. The

only exceptions are public figures, whose comments are available to view in publicly available documents and/or online.

Another ethical issue was the way my official position as an anthropologist was perceived in the field. A small number of my participants - mainly those working as academics themselves - had a clear understanding of what ethnographic research involved and helped facilitate opportunities for participant observation. Others, such as health professionals, understood that I was doing research, but because it had become known among my informants that I had begun training as a midwife back in the UK, they would present me with “clinical” information. For example, they would give me tours of the hospital and present me with outcome data, but found it strange that I would sit in the corner and simply observe. I would repeat my explanations of ethnography and insist I was there as an observer, which was eventually accepted.

The ethical approval I obtained from the public hospital administrations permitted me to conduct observation on the obstetric wards, but not to conduct formal interviews. The women who delivered around the time I was observing were considered potentially vulnerable participants, and I was particularly careful when speaking with them to not ask anything controversial or potentially upsetting. I was, however, able to informally discuss their experiences of care to document how they perceived existing services and new policy interventions.

Halfway through my PhD, and after six months of fieldwork, an opportunity arose for me to train to be an NHS midwife in the UK. This was something I was planning to do after my PhD, but this was an opportune moment before the Conservative government introduced large student fees. With the support of my funders and university, I enrolled in a Midwifery BSc and put my doctoral research on hold. In the end, due to various bureaucratic challenges, I decided to return to my PhD after just one year of midwifery training. The experiences I gained in this year, however, had significant and beneficial implications for my research.

Firstly, the value of frontline healthcare experience for someone conducting anthropological research into health services cannot be overstated. The same goes for anyone developing policy interventions. Health professionals have rightly criticised academics and policymakers who are completely removed from the reality of delivering care. Happily, with the growing trend for interdisciplinary research, and the acceptance of researchers who have multiple professional “hats” (clinician, researcher, policy advisor etc), understanding of what each of

these roles requires and involves is improving. Suffice to say, spending the best part of a year on maternity wards in London gave me important insights about the challenges frontline staff faced, even in a relatively well-resourced and technologically advanced health system.

Secondly, the training helped me develop my own position about childbirth care further. I had always supported the normalisation of birth, whilst also recognising the need for life saving interventions where necessary, but my own experiences providing care gave me a more nuanced perspective. 'Humanised' 'normal' or 'natural birth' are very subjective terms, and a positive experience is largely determined by how women feel they are treated, rather than the actual route of delivery. C-sections can also be 'humanised' when women can make well-informed decisions and clinicians are supportive. To limit the influence of my own views on childbirth, I made efforts to remain impartial in interviews until explicitly asked about my own opinion. Many people I met in Brazil were curious about the NHS in England because it is internationally recognised for its model of midwifery-led care. In response to questions, I would direct people to key research studies on this topic, framing my own experiences as my subjective viewpoint.

Finally, undergoing this training altered my position in the field. A short time into my fieldwork period, I was a partially trained midwife and a doula, as well as an anthropologist. I constantly reiterated to my participants that the "hat" I currently had on was the latter, but of course, my other experiences shaped their perceptions of me. I was considered an "insider" in the movement, in that my training and interests were indicators of my support for the movement's cause. There were great benefits to this, as having some clinical experience meant people felt more comfortable discussing their experiences of delivering and receiving obstetric care. I was simultaneously an "outsider", being British and having experiences of the NHS. On the whole this was useful, and meant I was able to navigate a politically delicate field and ask sensitive questions that I may not have been able to if I was positioned fully inside the policy community (Walt et al. 2008).

In some settings, my participation was necessarily partial, in that at no point was I myself a pregnant woman or mother. Nor was I *officially* practicing as a midwife or doula at any point during my fieldwork. As such, I was only able to understand clinic settings and antenatal classes as an participating and interested observer. Nonetheless, I worked to contribute in a positive way to the lives of the women I encountered, particularly those who had shared their personal stories and given me their time in interviews. I provided food and lots of coffee, a sympathetic ear, minded children, and shared information about my own life so that our relationships were more reciprocal.


*Image 3: The researcher with trainee doulas on their orientation as part of the Volunteer Doula Programme. We were required to wear scrubs when on the ward.*

On a small number of occasions, I was asked to step beyond my position as an ethnographer, and support women in labour. In her ethnography of a cancer ward in Botswana, Julie Livingstone reflects on the role of anthropologists in clinical settings where there are limited resources (2012). I was faced with a similar ethical dilemma regarding whether I should do more than simply observe when help was needed. I was observing the implementation of the Volunteer Doula Programme, attending with a group of trainees, when I was asked to assist with a delivery. The ward was short staffed and the midwife was alone with the woman in labour, and shouted to me urgently to come and help her by supporting the woman's leg during contractions and holding her hand. The woman's partner could not take the time off work and she was labouring alone. I did not perform any clinical procedures but did support the woman physically and emotionally through her delivery and recovery. While I felt confident in my abilities to do so, and was able to communicate fluently with the woman and the hospital staff, this did raise some ethical concerns. It seemed that most patients in Brazil's public hospitals did not have a clear understanding of the distinct

professional roles and responsibilities in the hospital environment. While I explained that I was a researcher there to observe, I was in scrubs, which have a strong association with the wearer being clinically qualified, and part of a professional hierarchy. The lead researcher (and also a trainee midwife) in Altaweli et al.'s (2019) ethnographic study of labour wards in Saudi Arabia had a similar experience, where she was viewed on the ward as a student midwife despite wearing different colour scrubs to indicate her position as a researcher at the time. While I was concerned about the woman understanding what my role as an anthropologist meant, I felt that it was more important to assist her during her labour, and she assured me afterwards that she was glad of my presence. This experience has shaped my view on the position of the anthropologist. Like Livingston (2012), I think the limitations of the ethnographer's role can shift in different settings. When wards are short of staff and women or patients are alone and in need of company, I would argue it is more unethical to withhold support than to move, temporarily, outside of the boundaries of observation.

# Interlude: Art as activism

I walked through the dark red tunnel, surrounded by the deep pulsing sound of a heart beating, and pushed myself out through a giant vagina into the open air. This wasn't quite the experience I had imagined having while attending the 2015 National Health Conference. For the past hour I had been immersed in the dark, transitioning through the different interactive scenes of the *Sentidos do Nascer* (Senses of Birth) exhibit. There was a satirical supermarket display, where an actor advertised various childbirth related consumer goods: "the caesarean selfie stick", "scheduled birth capsules" and a "half-price caesarean between 6-10pm" offer. The exhibit poked fun at many of the stereotypes associated with the Brazilian c-section epidemic, particularly at the commodification of birth and the expectations by some women, and some parts of society, that they should remain composed and "made-up" while in labour. My co-participants were completely engaged with the exhibit. A couple in their 30s lounged on the uterus sofa. An older woman started bargaining with the actor over the "painless birth pills". The exhibit seemed to be extremely effective in its tactic of using humour to address these very serious issues.


*Image 4 and 5: The satirical supermarket in Sentidos do Nascer. In the left image, an actor pretending to be a doctor points to a satirical sign about c-sections being discounted by 50%*

*from 6-10pm. On the right are supermarkets shelves stacked with products such as a "cesa-selfie stick", "painless birth pills", and a "birth spa package".*

*Sentidos de Nascer* was an initiative led by a key figure in the humanised birth movement, Sonia Lansky, a doctor and public health expert, as well as other well-known academics and activists as advisors. The exhibit had funding from the Brazilian Ministry of Health and the Bill and Melinda Gates Foundation. Their aims were 'to broaden the debate on issues related to birth in Brazil…(and take a) critical look at the scenario of hypermedicalization of childbirth, the loss of women's protagonism and the exploitation of childbirth as a business' (Sentidos do Nascer 2019). The exhibition was touring the country, staying for several weeks at various SUS conferences, universities, and other health events, ensuring it reached a wide audience. During the national health conference it was located immediately outside the exhibition centre. With a bright purple exterior, it was visible from afar and was attracting plenty of attention and a steady stream of visitors. As well as the amusing scenes, the exhibit had a full timetable of lectures and discussion groups, covering a range of topics, including: the role of the doula, 'What is humanised birth?', feminine protagonism, and 'giving new meaning to birth in health professional training'. Each time I passed the exhibit there was a large crowd of people listening to these talks.

The exhibit seemed to be a more effective way of raising public awareness about humanised birth than the conference – though of course, the conference was an excellent way for the exhibit to reach a large audience. Milling around the conference rooms over the three days of the conference, I overheard lots of people talking about the project, and the Minister of Health himself visited during one lunch break, camera crews in tow. Lanksy had taken the decision to install the exhibition at the national health conference so that she could raise the profile of the movement, despite, or perhaps because of the fact that specific humanised birth policies were missing from the National Health Plan document.

# **Chapter Two:** Childbirth in Brazil: The intervention epidemic and obstetric violence

## 1. Introduction

This chapter provides an overview of maternal health in Brazil, the structure of the Brazilian health system and the problems that many Brazilian women face, including vast inequalities in access to quality obstetric care and relatively high rates of maternal morbidity and mortality compared to other middle-income countries. The central focus of this chapter is the "two-fold problem" of care during childbirth: that is, the problems associated with the overuse of c-section and other medical interventions, and the problems associated with maltreatment of women during childbirth – what is widely referred to in Brazil as "obstetric violence". I consider the argument that these problems are caused by the over-medicalisation of childbirth. I also attempt to give voice to women by citing qualitative research that has examined their views on birth and services, including a short section with my own ethnographic data.

The problems in Brazilian maternity care are understood and addressed in different ways by distinct subgroups and actors that make up the movement. These include seeing poor maternity care as clinical mismanagement (that requires retraining of doctors and obstetric nurses), a public health issue (that is best addressed through education campaigns and public policy interventions), a rights issue (where maltreatment is a human and/or women's rights violation), and as a wider societal issue that requires multi-sectoral intervention. It is important to note that for the humanised birth movement, the overuse of medical interventions *and* the maltreatment of women (including the denial of interventions such as pain relief) are considered obstetric violence. Until recently, most of the national and international media coverage focussed on the c-section epidemic, probably because it has been easier to define and measure, and because it is a problem that largely concerns wealthy women using the private sector. But for movement activists whose main focus was improving public policy and care in SUS hospitals, excessive c-section use is one part of a much larger problem of disrespect and violence towards women.

# 2. Childbirth in Brazil: An overview

Despite overall improvements in life expectancy, nutrition and communicable disease control in Brazil over the past half century, significant problems remain, including in the area of maternal and child health. At 60 per 100,000 live births[7], Brazil's MMR remains relatively high for a middle-income country, though it is lower than many of its South American neighbours (Central Intelligence Agency 2019). Unsafe abortions[8] are the main direct cause of maternal death in Brazil, and the complications caused by this type of procedure represent the third leading cause of obstetric bed occupancy (Pacagnella et al. 2018). There are significant inequalities in health service access between urban and rural areas, and between the poorer northeastern and wealthier southern states such as São Paulo. In remote rural areas women may be unable to access basic antenatal services. An application of the 'Three Delays' model in Brazil (Thaddeus and Maine 1994) found that a delay in accessing maternity care occurred in 54% of cases in the study, with 34.6% related to health service accessibility, and 25.7% related to the quality of medical care, including adequate facilities, resources and clinical training (Pacagnella et al. 2014). Data from the national *Birth in Brazil* study suggest that while prenatal care coverage is almost universal in Brazil (where women have at least one antenatal appointment), only a quarter of Brazilian women have *adequate* prenatal care (Leal et al. 2020). These disparities are also evident within relatively small geographical areas between women in the highest socio-economic group who have private health insurance, and those in the lowest who are dependent on the SUS (Torloni et al. 2016). Around one third of women using the SUS with high-risk pregnancies were treated in hospitals without intensive care units, an indication that the public system is not able to provide high complexity care when necessary for all women who need it (Bittencourt et al. 2016).

Homebirths attended by traditional midwives (*parteiras*) were common in Brazil until the 1970s, but today the vast majority (98%) of births in Brazil take place in a hospital setting

[7] There are limitations to using MMR as an indicator of service quality, both in terms of data collection and in the limited way we can deduce what it means for women's experiences of care. This issue has been covered in critiques such as Storeng and Béhague (2016) - but it nonetheless remains a widely accepted metric for comparing country health system performance.

[8] Unsafe abortions are a serious concern in Brazil, but are not within the scope of this research. This is partly due to the fact they were not a central issue in the humanised birth movement's campaigns. While some of the women's health rights NGOs such as Artemis did raise awareness about abortion rights, most of the movement did not. When this came up in interviews, some people explained that because of how controversial abortion was in Brazil, it was easier for them to gain political support if they distanced the movement from reproductive rights more broadly. This echoes the findings of Storeng and Béhague at the global level, where maternal health was seen as less controversial than reproductive health (2014).

(Leal et al. 2012). In most cases babies are delivered by an obstetrician, with only 9% of vaginal births attended by an obstetric nurse (Victora et al. 2011). At present the midwifery profession is relatively weak in Brazil compared with other health systems that train and employ midwives. In the rural northern Amazonian states, among indigenous populations, around 50% of births are still attended by *parteiras* and homebirths are considered safe, humanised options for delivery (Rattner et al. 2009). However, this is uncommon in urban areas and the southern region, where even technically trained midwives (*obstetrizes*) struggle for recognition. The University of São Paulo began the first direct-entry *obstetriz* degree in 2005, but graduates have faced obstacles to entering the workforce. The organisations representing nurses and doctors do not accept midwives, despite the fact that their qualification is legally recognised (Gualda et al. 2013). Professional interests are a significant public health challenge in Brazil, with doctors lobbying against authorisation for nurses and midwives to perform normal births and opposing newly qualified *obstetrizes* finding work placements in São Paulo. Public and private hospitals have refused doulas entry for questioning the overuse of clinical interventions, even when women have requested them as a birth companion. All of these are barriers to low-risk women being supported by midwives and doulas, and are a likely factor in the excessive use of interventions.

In São Paulo there are a small number of midwifery-led *Casas de Parto* (birth houses) that are separate from hospital sites. One of these is *Casa Angela*, a centre of reference for the movement that was founded by a German midwife in *Monte Azul,* a low-income neighbourhood in the southeastern *periferia* of São Paulo city. During my fieldwork *Casa Angela* won a contract to accept referrals from the SUS, meaning they would also be funded for these patients. The rest of the care they provided was paid for through small fees paid by women using the services, or in some cases through fundraising and donations to the associated charity.

There are also *Centros do Parto Normal* (Normal Birth Centres, CPNs) within public hospitals, which have been implemented under the overarching national *Rede Cergonha* policy, or local variations of this programme such as *Parto Seguro* in São Paulo. Participating hospitals have constructed normal birth centres by refitting other parts of the ward for normal deliveries. Care in these centres is normally provided by obstetric nurses because there are so few *obstetrizes*. Public sector CPNs are managed by doctors, who ultimately make decisions about policy and practice. This is another example of resistance to change according to the movement. In most countries that have implemented this kind of policy, midwives manage normal birth centres, but in Brazil this authority is retained by doctors. Private normal birth centres have appeared much more recently. When I visited in

2016, Hospital Einstein was in the process of building theirs, and were swiftly followed by Hospital São Luiz.

Along with the c-section epidemic, there is also an epidemic of early-term births (associated with c-section rates) and an epidemic of preterm births (linked to poverty risk factors) (Barros et al. 2018). From a public health perspective, the most concerning consequence of the high rate of elective c-sections is the shift of full- and late-term (39-41 weeks gestation) to early-term (37-38 weeks gestation), because of the increased risk of mortality and cognitive impairment and morbidity for early-term babies (Barros et al. 2018). Preterm births following spontaneous labour are highly prevalent among poor and less-educated women, likely as a result of known risk factors such as infections during pregnancy, underweight and pre-eclampsia (Barros et al. 2018). Brazil's prevalence of early term births following c-section was high compared to 34 high income countries, resulting in an estimated 220,682 extra early term newborns (Barros et al. 2018). This research supports the claims made by the humanised birth movement that c-sections are not occurring out of medical necessity and that elective c-sections have worse outcomes for mother and baby.

I observed the following patterns of use among the women I encountered during my fieldwork. Poorer women who lived in the *periferia* usually could not afford health insurance, and so would use the SUS hospitals. In some cases, they were able to access high-quality humanised care if they went to a hospital that was part of the *Parto Seguro* programme. Those with a slightly higher income would opt for a basic insurance plan that covered care at specific private hospitals. In these cases, women were likely to deliver via c-section or instrumental delivery with episiotomy. The wealthiest women would pay directly out-of-pocket for the highest standards of care, choosing their own team of health professionals, and at which of the best private hospitals they would deliver. There was an increasing number of middle-class women who wanted a humanised birth and were choosing to deliver in SUS hospitals that had normal birth centres. A small number of middle- and upper-class women contracted a humanised homebirth team and delivered in their own homes. Finally, because around half of all Brazilian doctors are active in both the public and private sectors (Miotto et al. 2018), many pregnant women would access both sectors at some point in their pregnancy (Béhague 2002), a trend that occurs generally across other health sectors in Brazil.

The quality of obstetric care varies enormously across the Brazilian health system, in terms of the comfort and cleanliness of the facilities, the availability of medical technology and drugs, and the care delivered by health professionals. The private health system is made up

of two subsystems: the private sector where people pay out-of-pocket and the insurance sector. There is a broad range of insurance plans, with the most expensive covering world-class hospitals and a wide range of services, to the most basic that cover more limited options. The most exclusive private hospitals resemble five-star hotels where São Paulo's wealthy elite can afford world-class treatment, hiring their own birth "apartment" with a bar, birth pool, luxury bed linen, and a team of professionals of their choosing. The cost of delivering at hospitals such as Einstein and São Luiz can range from between R$10,000 and R$15,000 (£2500 and £3750 in 2016 exchange rates when I visited these wards), depending on the obstetrician contracted and the exact procedures used. Most private hospitals offer lower quality facilitates at cheaper prices, and it is at these mid-range hospitals that care is poorly regulated and substandard.

The SUS provides universal coverage to health services that are free at the point of use. It was formed in 1988 during Brazil's transition to democracy, and is an institution of great importance to the political left. In the 1980s the *Movimento Sanitarista*[9] (health sector reform movement), made up of academics and researchers, formed an alliance with progressive members of congress and municipal governments and instituted the SUS, despite resistance from two socially conservative presidents that invested little in healthcare throughout the 1990s (Paim et al. 2011). The federal level health department defines policies and guidelines, the state level is responsible for technical and logistical organisation within each state, and the municipal level is responsible for primary care; meaning that prenatal care is offered at the municipal level, whereas obstetric services and childbirth are provided at either the municipal or state-level (Rattner et al. 2009).

The SUS is used regularly by around 75% of Brazilians, and serves the least wealthy and underprivileged in Brazilian society, many of whom have poorer health outcomes associated with poverty and social exclusion. The SUS is dangerously underfunded, and wards are generally overcrowded, short-staffed, and lacking in material and human resources (Paim et al. 2011). The public hospitals I visited were fairly dilapidated and some of the areas cramped, with old but still functional equipment. Women who use the SUS can struggle to secure a bed, and they may have to try several hospitals before finding one – this delay can

[9] The *Movimento Sanitarista* formed in the 1970s during the struggle to restore democracy, bringing together different social and political groups, trade unions, left-wing political parties and grassroots organisations (Paim et al. 2011). The movement viewed health not as an exclusively biological issue to be resolved by medical services, but as a social and political issue to be addressed in public (Paim et al. 2011). The movement was centrally important in the foundation of the SUS and the creation of its structures for participatory democracy.

be fatal (Tanaka 1995), and also incentivises doctors to induce women to speed up delivery and clear beds faster (Diniz and Chacham 2004).

## 3. The biomedical model of childbirth

According to the humanised birth movement and academic commentators, medicalisation is a key factor driving the problems in Brazilian obstetric care. It has resulted in many unnecessary and iatrogenic procedures, the overuse of c-sections, women having to labour in unpleasant or unsafe conditions alone, and women and their families lacking decision-making power over their own bodies and births (Rattner et al. 2009). In response, one of the aims of the movement is to promote the humanised model as an alternative to what activists refer to as the *modelo medicalisado* (medicalised model). As laid out in the introduction, this is a call to reduce the routine or unnecessary use of medical interventions in childbirth, ensuring that these technologies are used appropriately in cases of genuine clinical need.

Legitimized by scientific evidence and accelerated through technological advances, the biomedical model of childbirth became the international standard for obstetric clinical practice throughout the 20th century. In this model, pregnancy, labour and birth are seen as pathological events that are best carried out under the care of an obstetrician on a hospital ward. While this is certainly the safest place for women with complications and “high risk” pregnancies, in many postmodern societies it has become standard practice for healthy women with healthy babies. Women are at risk of what critics refer to as a “cascade of interventions” (Jansen et al. 2013) in which one straightforward intervention can necessitate others. For example, if labour is induced using synthetic oxytocin, this requires further monitoring with a CTG, potentially a move from midwifery-led to obstetric-led care, and could ultimately require delivery by forceps or c-section (Irvine 2021).

The medicalisation of childbirth has long been a topic of interest for anthropologists and feminist writers, who have drawn attention to the ways in which scientific progress and the development of certain technologies led to the rise of “techno-obstetrics”, where women’s birthing bodies were monitored and held to rigorous expectations of efficacy and time schedules in labour (Davis-Floyd 1994, Jordan 1997, Martin 2001, Klassen 2004, McCourt 2009). In this model, women are “processed” through workstations (pre-delivery, delivery, postpartum) as though on an assembly line (Martin 2001), and hooked up to machines such as the cardiotocograph (CTG) to monitor contractions and the baby’s heart rate. Many of these critiques draw on Foucault’s theory of biopower to draw attention to the disciplining

techniques of this technology and the resulting objectification of the birthing body. Doctors watch the CTG for numerical information that determines when the woman is allowed to push, rather than paying attention to her physical and emotional responses to labouring (Davis-Floyd 1994). The woman's own knowledge and bodily urges to push are suppressed or ignored, and she is expected to submit to the "authoritative knowledge" of the doctor (Jordan 1997).

Another example of excessive medicalisation is the lithotomy birthing position, where the labouring woman lies on her back, legs elevated in stirrups. In this position it is much easier for health professionals to conduct examinations, episiotomies and instrumental deliveries than if the woman is on all fours or crouching. But for the women it can feel extremely uncomfortable and disempowering. Her movement is restricted, she cannot make use of gravity to assist the descent of the baby, and she is in a vulnerable position, submitting herself to the needs and the view of the clinician conducting the procedure. The lithotomy position is now contra-indicated in clinical evidence-based guidelines[10], but continues to be practiced in many settings.

Critics have connected the overuse of clinical technologies with the economic interests of individual doctors and hospital administrators. Private healthcare providers tend to use a fee-for-service payment model that incentivises doctors to use a large number of tests and procedures. Technologically complex procedures also cost more for the patient or health insurance company. This trend has been observed in countries that have large private healthcare markets for obstetric care, such as the US. The global c-section epidemic has also been partly attributed to financial incentives for clinicians, where in some settings, private maternity care sustains the finances for whole hospitals (Betrán et al. 2018).

The medicalisation of areas of life that were previously not considered to come under the remit of medicine is a phenomenon observed across various fields, and critiqued by anthropologists and other social scientists when this has potentially negative consequences for people involved. These areas include mental health and wellbeing (Calabrese 2013, Duncan 2017, Marlovits 2020), sex and sexuality (Foucault 1998), fertility (Ginsburg and Rapp 1991, Morgan 2019), and death (Illich 1976, Clark 2002) among others. This a rich field of research and commentary, well explored by other authors.

[10] A 2013 Cochrane review found that women in upright and ambulant positions had shorter labours, and were less likely to have a c-section or epidural compared to recumbent positions such as lithotomy (Lawrence et al. 2013).

I set out to examine the situatedness of medicalisation in the specific context of São Paulo and with regard to the work of the humanised birth movement. For the humanised birth activists, the *medicalisado* doctors and the model of care they offered were to blame for the overuse of interventions of epidemic proportions.

## 4. The intervention epidemic

One of the first and most disturbing examples of the intervention epidemic I came across was the story of Adelir Carmen. Early on in my fieldwork I was invited to attend an event to celebrate the 10th anniversary of the *obstetriz* degree at the University of São Paulo. The stage was covered with balloons and the atmosphere was celebratory. I sat with two *obstetrizes* who had been in the original class of 2005, and were now heavily involved in the movement, working as doulas, researchers and running the *Parto do Princípio* network. A younger *obstetriz* joined us and explained that despite the jovial mood, she thought I needed to know more about why *obstetrizes* were so important, and what they were up against as normal birth advocates:

> Adelir wanted a natural birth, and had a healthy pregnancy. When examined in hospital, in the southern state of Rio Grande do Sul, the doctors found that the baby was in a breech position. They informed Adelir she needed to have a c-section, but she wanted to try and deliver vaginally. When she was told there was no other option, she signed herself out of hospital. A court judge then granted a court order to overrule her wishes. On April 1st 2014, in the middle of the night, during labour, Adelir was forcibly removed from her home by armed police, in front of her older children. She was denied a companion and was not taken to her preferred hospital. She was then operated on against her will, forced into having a c-section.

This case resulted in public outcry, especially among the movement and women who had similar preferences for their own births. Peaceful protests took place in various cities throughout the south of the country, alongside social media campaigns (see the hashtag and image below). Artemis, the NGO that specialises in legal assistance for those who have suffered obstetric violence, took Adelir's case to the public prosecutor's office and made official complaints to national human rights bodies. Expert commentators from the movement condemned the forced surgery in the press as a violation of the right to bodily

integrity (Barifouse 2014). I was horrified by this story, but the *obstetrizes* I was with looked back at me with raised eyebrows and shrugged: this was not a unique case.


*Image 6: A screenshot of the #SomosTodasAdelir (We are all Adelir) campaign (Source: #SomosTodxsAdelir 2014)*

Brazilian and international activists, researchers, humanised clinicians and public health experts agree that there is a grave overuse of medical interventions in Brazil. As I have pointed out elsewhere, 'there is strong evidence to support the movement's claim that this excessive use of technology is driven by political, economic and cultural factors, rather than clinical need' (Irvine 2021).

In the 1970s and 1980s Brazilian maternal healthcare became increasingly medicalised, privatised and deregulated, which led to a rapid growth in c-section deliveries in urban hospitals. In the private sector c-sections were promoted as a 'safe, painless, modern, and ideal form of birth' (de Mello e Souza 1994:358). The c-section rate grew rapidly from 15% in 1974 (Chacham and Perpetuo 1988), to between 80 to 95% in most private hospitals in 2012 (Leal et al. 2012). C-section rates in the SUS have remained lower at around 30% for low-risk women (Leal et al. 2020), bringing the national average down to roughly 55% today (Rudey et al. 2020).

The 2012 *Birth in Brazil* national survey confirmed that “aggressive management” of childbirth with excessive intervention was the norm (Diniz et al. 2018). The biomedical model of childbirth is now normalised throughout Brazil’s health system, to the extent that clinical procedures such as episiotomy and c-section have become routine practice. These interventions are performed by choice, sometimes of the mother, more commonly of the doctor. Brazilian medical schools continue to teach an interventionist model, and surgical ability is highly valued, resulting in resistance to the incorporation of global evidence-based recommendations that promote woman-centred midwifery-led care (Diniz and Chacham 2004).

In the private sector, c-sections and other clinical procedures are overused due to a combination of factors that include: financial gain for clinicians or hospitals, patient demand, cultural and professional norms, lack of practice by the clinicians of difficult vaginal deliveries, and the threat of litigation if doctors are not seen to “do everything possible” (Irvine 2021). Private obstetricians are expected to be proactive and “hands-on” in a delivery. Most will not have an opportunity to practice complex normal deliveries such as breech position, making them even less inclined to perform one. Doctors fear being sued if they attempt a normal delivery and something goes wrong. This is a trend in many countries, where legal malpractice lawsuits make normal birth providers vulnerable even if they deliver high-quality evidence-based care (Studdert et al. 2006).

Convenience is also a key issue. While private doctors are paid less per procedure for a c-section than a normal delivery, they can perform multiple operations per day, during normal working hours during Monday to Friday (Gomes et al. 1999). Members of the humanised birth movement joke in exasperated tones about the spikes in birth rates immediately before the Christmas holidays. Private obstetricians will have multiple clients, all of whom expect them to be present to deliver their babies, which can lead to scheduling difficulties. In this instance, elective c-sections are easier to plan than normal birth (Bessa 2006). For these reasons, c-section is the preferred mode of delivery for many doctors, despite the serious adverse effects for women and their newborns (Souza et al. 2010).

Other medical interventions, including episiotomy and the use of synthetic oxytocin to induce labour are also overused. The rate of episiotomy was around 94% of vaginal deliveries across public and private hospitals, despite its routine use not being clinically justified, and the increased pain and risk of complications (Diniz and Chacham 2004). This has fallen more recently in hospitals that have implemented humanised protocols, but is used routinely in some settings – going against the scientific consensus that episiotomy should only be

used selectively to avoid more severe perineal trauma (Jiang et al. 2017). Interventions that have been ruled dangerous and obsolete in EBM best practice guidelines, such as the Kristeller manoeuvre (where fundal pressure is applied to force the baby out faster), are still used in some hospital settings in Brazil (Diniz and Chacham 2004) and are documented in the humanised birth movement's campaign media (such as the *Renascimento do Parto* documentary film series).

Finally, and importantly, are the subjective experiences of women who have undergone excessive interventions. In the campaigning material and reports collected by the humanised birth movement, Brazilian women describe their experiences of interventions as traumatic, frightening and violent. Some women opt for an elective c-section because they have had a traumatic vaginal delivery, and others look for humanised birth services because they feel they were given no other choice than a c-section, and have questioned whether surgery was necessary. I discuss women's own perspectives and desires at the end of this chapter, after first discussing the other side of the two-fold problem: obstetric violence.

## 5. Obstetric violence


*Image 7: Screenshot from a campaign by the NGO Artemis (Source: Artemis Facebook page 2018), graphically depicting an episiotomy. It reads: "Performing an episiotomy without*

*the use of anaesthesia is obstetric violence". This image is one of a series of multiple depictions of different forms of violence.*

Obstetric violence is a contested term, but is increasingly popular among normal birth advocates who draw links between maltreatment during childbirth and other forms of gender-based violence and human rights abuses (Jardim and Modena 2018). This new legal term emerged in Latin American countries 'out of concerted efforts by women's groups and networks, feminists, professional organisations, international and regional bodies, and public health agents and researchers to improve the quality of care that women receive across the region' – specifically through the dissemination of evidence-based guidelines (Williams et al. 2018). The scrutiny these movements draw to the mistreatment of women during childbirth has resulted in obstetric violence specific legislation and policy in Venezuela, Argentina, Panama and Mexico (Williams et al. 2018). The origins of this activity in Latin America could arguably be attributed to particularly high levels of gender-based violence in the region, along with a history of strong civil rights and feminist movements. Obstetric violence has also been reported in countries as diverse as Ecuador (Brandão et al. 2018), Ethiopia (Mihret 2019), Croatia (Twigg and Singh 2019), the Dominican Republic (Castro and Savage 2019), and the United States (Diaz-Mello 2016).

I use the term obstetric violence because it is widely employed by my interlocutors throughout my fieldsite. In doing so, I also recognise that it is a politicised term and that violence is not always inflicted by health professionals directly onto women in their care out of malice, but is often an outcome of systematic power imbalances that become normalised in healthcare settings. Some organisations and individuals involved in the movement choose not to use the term "obstetric violence" so as to avoid hostile reactions from the medical establishment, with whom they were trying to work cooperatively to change practice.

Obstetric violence is becoming more widely recognised in global health policy. In 2015 the WHO published a report on *The prevention and elimination of disrespect and abuse during facility-based childbirth* (2015), which states unequivocally that women all over the world experience disrespectful, abusive and violent treatment during childbirth. This 'violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity and freedom from discrimination', and leads to a breakdown in trust between women and their healthcare provider (WHO 2015:1). In many settings women experience 'instances of mistreatment, including physical and verbal abuse, a lack of supportive care, neglect, discrimination, and denial of autonomy' (Bohren et al. 2015: 21). This can occur at the individual level between the woman and provider, but is also attributable to systemic

failures at the levels of the facility and health system, including 'poor supervisory structures, insufficient staffing, inadequate supply chains, poor physical conditions, and policies, facility cultures, and power dynamics that systematically disempower women' (Bohren et al. 2015: 21). Obstetric violence is therefore inextricably linked to the processes of medicalisation of childbirth and unbalanced power dynamics that stem from a combination of institutional and structural violence (Castro and Savage 2019).

The prevalence data for obstetric violence in Brazil varies. One national study suggests around 25% of Brazilian women who underwent a normal delivery experienced obstetric violence in some form (Venturi et al. 2011). Sonia Lansky (et al. 2019), a leading figure in the movement, summarises the feedback given by attendees of her exhibit *Sentidos do Nascer*, an interactive art piece that raises awareness about obstetric violence and humanised birth. In post-partum interviews conducted with women who had attended the exhibit, only 12.6% of women responded that they had experienced some kind of violence during childbirth – despite 46.4% of those interviewed saying that they were in the lithotomy position at delivery, that in 23.7% of labours the Kristeller manoeuvre[11] was performed, and in 30.4% the episiotomy was performed (Lansky et al. 2019). This suggests a differing perspective on what constitutes obstetric violence between campaigners and women using birth services, and potentially that some women are not claiming they experienced "violence" out of fear of the repercussions.

Nonetheless, reports of violence across the public and private sectors are frequent. Complaints include: refusing entry of the woman's companion, lack of information given to women, unnecessary c-sections, deprivation of the right to food and movement, routine and repetitive vaginal exams without justification, frequent use of oxytocin to accelerate labour, episiotomy without the consent and the Kristeller manoeuvre (Jardim and Modena 2018). Some SUS hospitals are infamous for the institutionalised maltreatment of women, particularly women of colour and low economic status (Diniz et al. 2018). Birthing facilities here are fairly basic and there is usually limited access to analgesia (pain relief options such as birth pools, massage, Entonox) or anaesthesia (epidural). Trichotomy (shaving of the pubic hair) is a routine practice in many SUS hospitals[12]. In the private sector obstetric

[11] The Kristeller manoeuvre is an outdated clinical intervention where the doctor, nurse or midwife pushes down on the top of the uterus to speed up the baby's passage through the birth canal. It is not recommended in international best practice guidelines due to the potential risk of tissue damage and increased pain for women (WHO 2018).
[12] The WHO recommends against shaving public hair prior to childbirth due to there being no evidence of any clinical benefit (WHO 2015).

violence tends to manifest in routine and unnecessary procedures, but there also are reports of verbal abuse in lower quality private institutions.

The overuse of clinical procedures in the SUS has been attributed to inappropriate or outdated training of health professionals, underfunded and understaffed wards and the general cultural acceptability and high value attributed to “hi-tech” clinical procedures. Clinical staff have routinely used invasive procedures despite being aware that the medical science literature does not support this. In some cases, it appears that nursing staff are influenced by popular (and inaccurate) ideas about hygiene, associating pubic hair with uncleanliness and poverty (McCullum and dos Reis 2008). Hotimsky (2008) notes that despite up-to-date clinical evidence being available in online journals, much of the training for medical students is based on out-of-date textbooks that do not include information on women’s psychosocial needs in childbirth. These training materials ‘have reinforced the idea that vaginal birth is unacceptably painful for the mother and risky for the baby, as well as a threat to women’s pelvic continence and sexual attractiveness’ (Diniz et al. 2018: 21). This is all the more surprising given that universities and teaching hospitals should be institutions that continually improve and progress towards the highest standard of care in alignment with international best practice guidelines (Diniz et al. 2018).

In sum, in most public hospitals, women are at risk of having a difficult, painful and even traumatic experience. They will be more likely to have a vaginal birth that is of lower health risk for them and their babies, but they are more likely to suffer disrespectful and violent treatment. Many women, having experienced this themselves or have heard about the negative experiences of friends, will go to great lengths to avoid normal delivery in SUS hospitals, seeking out and paying for an elective c-section in the private sector if they can afford it (Béhague 2002, McCallum and dos Reis 2008). In the private sector, women may be less likely to experience physical and verbal abuse, but are subject to another kind of obstetric violence: the intervention epidemic. In both public and private hospitals, women reported being told they were putting their babies at risk by going against medical advice, even if the diagnosis was vague or unsupported by evidence.

Obstetric violence has been a focus of the humanised birth movement since its beginnings. ReHuNa took a leading role in this with the creation of its founding letter, which denounced the violence circumstances of birth in Brazil, transforming birth into a terrifying experience for women (Tornquist 2004). The problem has also been recognised at the highest levels of government. In 2014, the São Paulo State Ministry of Health produced a memo on obstetric violence, which defined it as:

> The appropriation of women's bodies and reproductive processes by health professionals through dehumanized treatment, drug abuse and pathologization of natural processes, the loss of women's ability and ability to decide freely about their bodies and sexuality, which negatively impacts women's quality of life (Ministério Público do Estado de São Paulo 2014).

That the State Ministry of Health published policy documentation explicitly defining obstetric violence indicates how widely used and acceptable this term had become in formal governance institutions at the time. Since then, under the subsequent conservative administration, its use has been revoked and disallowed in policy - to the ire of the humanised birth movement (Cancian 2019). This has been formalised in an official recommendation from the *Ministério Público Federal,* which declared that the term "obstetric violence" has an 'inadequate connotation, does not add value and undermines the search for humanized care in the childbirth' (Ministério Público Federal 2019: 2). The Brazilian Medical Association (CFM) argued that the term is too judgemental and attributes poor service quality solely to doctors. Most movement members felt this was an accurate attribution, and blamed *cesaristas* and the system that enabled them for obstetric violence.

There have also been three attempts by progressive council members and legislators to pass *Projectos do Lei* (law projects) regarding obstetric violence (PL 7633/2014, PL 7867/2017 and PL 8219/2017). All three of these are attempts to have obstetric violence legally recognised and addressed by Federal and State governments, and none of the three have been approved at the time of writing.

The maltreatment of women around the time of childbirth is not just poor clinical practice, but is a type of gendered and sometimes racialised violence that occurs when women and their families are in a particularly vulnerable position. Brazilian academics refer to 'a sexist and authoritarian system of medical practice,' in which women are understood primarily as mothers (Diniz 2012: 5). Diaz-Mello (2016) documents obstetric violence in the United States, focussing on instances of health professionals coercing or forcing women to undergo procedures against their will. Forced c-sections, she argues, are a form of gender-based violence precisely because they take place 'in a setting where women hold less power than doctors, in a society where women's capacity for pregnancy has been historically used to sanction their exclusion from full citizenship' (Diaz-Mello 2016: 57). In their study of obstetric violence in the Dominican Republic, Castro and Savage argue that 'mistreatment is based not only on the large socio-economic, educational, and gender distances that exist between

health care providers and female patients…but on a racist, prejudicial treatment according to which those of higher socioeconomic position identify with the “white” colonialist identity in opposition to, and above, the “blackness” of the population whose rights continue to be infringed’ (2019: 125). In Brazil too, poorer Black, brown and indigenous women are more likely to suffer violence. Data from the *Birth in Brazil* survey showed that Black and brown women had fewer prenatal appointments, poorer access to maternity hospitals and received less advice, were less likely to receive analgesia, and were more likely to be denied companionship (Leal et al. 2017).

Campaigners, rights groups and feminist academics connect obstetric violence with wider structural and gender-based violence, drawing on the existing legitimacy of these terms in global and public health. Structural violence – a term originally coined by John Galtung (1969) and later applied to the field of medicine by Paul Farmer and colleagues (2006) – draws our attention to the seemingly ordinary social structures that impair human life and prevent people from meeting their needs, which can be difficult to change. Racism and sexism are forms of structural violence that are particularly relevant here, and allow us to see the ways in which obstetric violence stems from these embedded social constructs – where women, and poor black women in particular, are stripped of their agency and treated disrespectfully during childbirth.

Understanding obstetric violence as a form of gender-based violence means that we can situate the former in a wider Brazilian socio-cultural context that is unfavourable to women – where national rates of violence against women are high, where there is a large gender pay gap, and where women are often expected to be the primary caregivers. Brazil has some of the highest rates of domestic violence and rape in the world. 66,041 incidents of sexual violence were reported in 2018, of which 82% were against women and girls, a 4.1% rise on the previous year and the highest number ever registered (Phillips 2019). In the same year, there were 263,067 reports of domestic violence, meaning that on average a woman was attacked every two minutes (Phillips 2019). These statistics suggest a considerable percentage of pregnant Brazilian women are likely to have been or continue to be in abusive relationships. Globally pregnancy has been identified as a key risk factor for domestic violence beginning or escalating (WHO 2011, Dahlen et al. 2018). A WHO report on intimate partner violence during pregnancy stressed that policy efforts to address maternal health need to include issues of violence against women (WHO 2011).

Members of the movement associated patriarchal attitudes with the way that male doctors behaved towards other female health professionals and women in their care, attributing

instances of patronising language and an attitude of assumed superiority to a culture of *machismo* (misogyny) within medicine. Taking a feminist phenomenological approach to obstetric violence, Cohen-Shabot argues that 'laboring bodies are at least potentially perceived as antithetical to the myth of femininity, undermining the feminine mode of bodily comportment under patriarchy and thereby seriously threatening the hegemonic powers' (2016: 231). Violence is therefore necessarily 'to domesticate these bodies, to make them ''feminine'' again' (Cohen-Shabot 2016: 231).

Online tools and social media have been useful for the movement in combatting obstetric violence. Initiatives include the Obstetric Violence Test and the documentary film *Obstetric violence – the voice of Brazilian women*, which have shown the potential of the internet to highlight and problematized violence, encouraging new research in the area (Sena and Tesser 2017). Artemis has a section of their website dedicated to obstetric violence, with key statistics, a map of Brazil with 'hotspots' where violence has been reported, research articles, a link to access the WHO declaration on c-section rates, and the emergency phone numbers for the *Defensoria Pública'*s (public defender) office (Artemis 2020).

In sum, obstetric violence is 'at the nexus of gender-based violence and clinical malpractice, and interweaves elements of both respectful treatment and quality care' (Williams et al. 2018: 1208). Its origins in and connections to legal practice and legislation give it political weight and public recognition. I regularly observed movement members strategically use the term alongside wider rights-based arguments – for example, arguing that obstetric violence was a violation of human rights, of a woman's right to bodily integrity, and of the right to health. It was also deployed alongside arguments about evidence-based medicine and best practice guidelines, in a way that resulted in each strengthen the authority of the other. What is important to note here is that alone, each of these strategies might not have been as effective – for instance, *cesaristas* might dismiss complaints of obstetric violence as being purely subjective. But backed up with legislation and policy, with statistical evidence, and with the accounts of women publicly available on social media, it was far harder for them to dismiss the claims and concerns of the movement.

## 6. What women want

Women are not necessarily passive recipients of poor care, nor do they lack knowledge about what different modes of childbirth involve. Researchers have recorded different forms

of resistance and strategies employed by women to get the care that they want, that correspond with my own findings discussed in this thesis.

There is a widely-held misconception among doctors, the mainstream media and some members of the public (both in Brazil and internationally) that the high c-section rate is a result of demand from women. This is often attributed to cosmetic concerns: because of women's preoccupation with upholding particular standards of bodily beauty, their desire to emulate famous figures who can afford to pay for c-sections, or because women don't want to 'stretch' their vaginas and lose sensation during sex (Rattner et al. 2009). These are no doubt influenced by stereotypes of Brazilians being obsessed with bodily beauty and the high rate of cosmetic surgery (see Edmonds and Sanabria 2014 for a discussion as to why the latter is presented as a means of managing women's reproductive, sexual and psychological health). The high prevalence of caesareans can, according to Diniz (2004), be *partly* attributed to the belief that vaginal births makes the vaginal muscles flaccid, compromising a women's ability to enjoy sex and to stimulate her (male) partner. Several qualitative studies where women were interviewed about their preferences found that, contrary to these beliefs, the majority of women preferred vaginal birth[13], and when questioned specifically about the statements above, stated that this has played little or no role in their outcome (Rattner et al. 2009).

Obstetricians interviewed by McCallum (2005) claimed that the mode of delivery was a women's choice, one that was culturally generated by their participation in the project of modernity. Studies carried out in Rio de Janeiro and Maranhão states, however, found that 70-80% of women desired to have a vaginal birth at the beginning of their pregnancies (Silva et al. 2001, Dias et al. 2008). By the end of their pregnancy (after months of doctor's consultations) only 30% still wanted this mode of delivery, and only 10% had vaginal births (Dias et al. 2008). Many of the upper- and middle-class women I interviewed had sought out an alternative to the medicalized model after having undergone traumatic c-sections where they felt they were not properly informed about their choices. A particular concern for lots of women was that they were not permitted to do "skin-to-skin" contact and breastfeeding immediately after the birth, and that their babies were kept separate from them in the neonatal intensive care unit (NICU) for multiple days even if there seemed to be no clinical indication for this.

[13] Potter et al. (2001) found that out of 1136 women throughout Brazil who had delivered by c-section, 70-80% would have preferred a vaginal delivery. Barbosa et al. (2003) found that 75% of 909 women in Rio preferred vaginal birth.

Previous experiences and perceptions of pain were a key factor in women's decision making about their pregnancy and labour, and in what type of services they pursued. While pain is a neuro-physiological process, pain behaviour is a voluntary expression of this, and is culturally determined (Singh 2017). My participants referred to a culturally specific negative relationship with pain. *Brasilieras* were 'afraid of pain', 'afraid of birth', or 'poorly adapted' to deal with pain. This was usually explained in contrast to women from Europe, who, in this narrative, had a more positive view of pain, and could cope easily, and that there, vaginal delivery was the accepted norm.

The association between vaginal deliveries and pain can be at least partly explained by clinical practice. Epidurals and other pain relief options are rarely used in public sector births, despite the frequent use of oxytocin to induce labour, which increases the intensity of contractions. In her research on childbirth in Bahia, Béhague (2002) found that women in Pelotas perceived vaginal delivery to be extremely difficult and painful, while c-sections were safer and "pain-free". They also considered c-sections as a way to avoid what they considered poor quality care, and medical neglect that was based on social and economic prejudice (Béhague et al. 2002). In Salvador, Bahia, women admitted to secretly unhooking the oxytocin drips that are used to accelerate contractions and tend to increase pain levels in labouring women (McCullum and dos Reis 2008). One doctor claimed that in Brazilian culture 'entry into motherhood is supposed to involve extreme suffering,' whereas most women tried to avoid pain (McCallum and dos Reis 2008). In this hospital most women were unaware of the option of anaesthesia (the cost of which is covered by the SUS), and were not offered it by clinical staff due to the administrative effort of ordering the drug and the insufficient staffing levels (McCallum and dos Reis 2008). In the private sector, on the other hand, most doctors routinely use spinal anaesthesia. Private obstetricians described their use of anaesthesia as an act of beneficence through the removal of pain, meeting the goal of medicine (de Mello e Souza 1994). Well aware of the importance of the narrative of pain running throughout women's perceptions of birth, the movement was addressing this as a priority. One of the central messages of humanised birth professionals, dispersed in antenatal classes and on social media, was a reconceptualization of pain. "Pain makes your baby come...pain is natural...women are strong enough to withstand pain" and so on.

These examples show that women were not without agency in instances of obstetric violence. Instead, it would appear that the majority of women begin their pregnancy with a preference for normal birth. Over the course of their pregnancy, or perhaps beforehand, many reach a position where they are concerned about the risks of having a normal delivery, whether this be the risk of obstetric violence, of pain, or of concerns about the implications of

vaginal delivery for their sexuality. Women then strategically engage with health services, “playing the system” in some instances in order to achieve what they feel is a preferred outcome.

## 7. Conclusion

In this chapter I have provided an overview of maternal health in Brazil, particularly the two-fold problem of excessive interventions and obstetric violence. I have shown that none of these problems are simple ones, and that there are subtleties and contradictions – for instance, where women desire c-sections to avoid obstetric violence, pursuing one problematic outcome to avoid what they perceive to be a worse one. Overall, though, we can see that many women are unable to access high-quality woman-centred care, despite the political will in some cities and hospital teams, and among individual humanised doctors. The humanised birth movement therefore plays a crucial role in uniting somewhat disparate causes and interest groups, bringing them together under the broader goals of providing respectful care to women. In Chapter Four I discuss the activities of the movement that are responses to the problems described above. First of all, in the next chapter, I set out the broader societal trends and shifts in Brazil’s political landscape that are highly significant for movement activists, and which determine what kinds of strategies they deploy to change policy in this field at this time.

# **Chapter Three:** Participatory policymaking, citizenship and a crisis of democracy

## 1. Introduction

In this chapter I explore the use of different interpretations of citizenship as strategies to change childbirth policy and practice. Members of the humanised birth movement have a complex relationship with citizenship; some participated in participatory policymaking spaces to aid their cause, while others saw citizenship in Brazil as a tainted form of political identity due to Brazil's history of colonialism, dictatorship, and the continued failure of the state to provide citizens with equal access to public health services. Since Brazilian independence in 1822, certain groups of citizens have been denied full rights or been excluded from society – meaning that citizenship has never been a guarantee of entitlements as it has in other countries. More recently Brazil has become famous for its experiments in participatory policymaking, and citizenship has been the cornerstone for Brazilian social movements in making claims for social justice and universal rights, including for the *Movimento Sanitarista* that led to the founding of the SUS (Mitchell and Wood 1999). As a strategy for the humanised birth movement then, it is contested and contradictory – but as I argue here, there is still potential in citizenship as a unifying concept for the movement's policy work and political activism.

I begin this chapter with a discussion of theories of citizenship, including the development of "citizenship as status" to "citizenship as practice", and anthropological approaches to citizenship that highlight the benefit of examining citizenship as situated in specific political and historical contexts. Ethnographic studies like this one demonstrate that citizenship is not a universal principle, but that it is constituted of the actions of people, and therefore has a distinctive capacity to connect diverse settings, struggles and strategies (Neveu et al. 2011). To properly consider the various meanings of citizenship and to study the ways that it is practiced in daily life calls for the adoption of a non-traditional view of citizenship: where it is not only a status of belonging to the nationstate, but a system of practices and ways of relating to others. Following Isin's (2008) work on acts of citizenship, I view citizenship as a set of political behaviours and actions, that can include activism in public spaces and participation in formal policymaking procedures, but can also consist of more "everyday" behaviours where people act politically, for example, to raise awareness of women's rights with regard to childbirth.

Following this, I take a genealogical approach to citizenship in Brazil, tracing its development over history to draw attention to the reasons the concept has different meanings for different social groups – particularly those relevant to humanised birth activism, including Black women and those who were involved in the *Movimento Sanitarista* social movement during democratisation. I then discuss four ethnographic moments from my fieldwork with very distinct perspectives on citizenship. The first and second are from periods of participant observation at the *Conselhos* and *Conferencias de Saúde.* The third and fourth are from in-depth interviews with two members of the humanised birth movement, who are sceptical of citizenship for very different reasons. Julia speaks to important themes around the legacies of colonialism and the racism experienced by Black Brazilians today, which has implications for political action, including in social movements such as the humanised birth movement. Isabel talks about her disillusionment regarding claiming health rights through the SUS and its inability to meet women's needs, which has led her to focus her activist efforts on incentivising demand for humanised birth in the private sector.

I end this chapter by discussing the political situation immediately preceding and during my fieldwork. One of the key elements of Shore et al.'s (2011) theoretical approach to studying policy is their argument that policies provide a window through which to examine wider societal and political change. I happened to arrive in Brazil at a particularly critical moment: the start of a shift to the political right that resulted in the election of far-right President Bolsonaro. These changes had direct and indirect implications for maternal health in general, and the work of the humanised birth movement in particular.

## Citizenship "*é muito fraca*"

It is important to stress that Brazil is an enormous and diverse country, and just as there is no single "Brazil" or *brasiliera*, there is no single form of citizenship. The citizenship I refer to in this chapter is based on first-hand observations over the particular time period of my fieldwork, mostly in São Paulo, and also on shorter trips to the states of João Pessoa, Bahia, Rio de Janeiro and Minas Gerais. While the places I visited are separated by thousands of kilometres, there seemed to be a common theme that arose when I asked people about citizenship: that at this point in Brazil's history, citizenship "*é muito fraca"* (is very weak). This was in direct contrast to much of the global health and political science literature, in which Brazil has been presented as a leader in public healthcare innovation in general (Crisp 2010, Johnson et al. 2013, Syed et al. 2013) and in citizen participation in health policy specifically

(Cornwall et al. 2008, Coelho 2013). Based on my reading of this literature, I expected to find a politically active public that participated regularly in health policymaking processes. What I found instead was that there were dramatic differences in participation between social and professional groups. What could explain this difference? I wondered if the aforementioned researchers had exclusively focussed on the more successful of Brazil's experiments, such as the well-known participatory budgeting mechanisms, which had successfully channelled funding into sanitation and health services (Gonçalves 2014). In the case of Cornwall and colleagues, their positive view could be at least partly down to having conducted research at the peak of PT's popularity in the early 2000s. The majority of people I met who identified as *petistas*, anyone working in government, and those who sat on the health councils would insist citizenship was hugely important both in policy development, and in Brazilian society more generally. But outside of these institutions, in everyday conversation, and in my interviews with most members of the humanised birth movement, people told me that citizenship 'doesn't have meaning here anymore,' as if the idea had once mattered, but had lost its significance.

This was evident from my very first visit to Brazil, when I visited Recife in the state of Pernambuco, before I had narrowed my policy case study to humanised birth. After attending the State Health Council, I arranged to visit a local HIV/AIDS NGO in an attempt to understand the civil society perspective. I sat in the NGO's café, where its *clientes* (customers) were served wholesome food by NGO volunteers, many of whom were HIV positive. I spoke for several hours with the NGO's director, Miguel, and a staff member, Paula, both of whom were also HIV positive, and Paula a *trans* sex worker[14]. I had assumed they would find the *Conselhos* useful in some way, given their work in health activism. Miguel explained that the NGO did not participate in these kinds of supposedly participatory structures, because it was a waste of their time. There was so much corruption, he explained, and any activity by the government that supported disadvantaged populations was just for show. Paula acknowledged that Brazil had a positive image from the outside, especially regarding the SUS. But she felt that in in reality, it did not serve the most marginalised groups. The *Conselhos* were meant to act as a bridge between the *povo* (the people) and the government, she added, 'but the bridge breaks', because the population doesn't have confidence in the *Conselhos.* 'The *Conselho* meets, sends its policy recommendations…and nothing', Paula went on, 'The government doesn't want to respond

[14] In Brazilian Portuguese the term *trans* is widely used to refer to transsexuals and transvestites. Paula identified herself using this term, so I have replicated this here.

to the needs of the lowest in society. The Brazilian culture is that those who have, hold on to what they have. Don't worry about those below.'

My initial response to this conversation (along with several other similar discussions) was to wonder whether it was still worth investigating citizen participation in policy as a theme in my interviews. Over the following years of fieldwork, however, I saw that the idea of citizenship was still fundamentally important in how people negotiated access to resources, including healthcare. The loss of meaning that people described was a valid subject for analysis because it reflected people's shifting relationship with state institutions, and how they saw themselves in relation to others in society. Furthermore, there was evidently still potential for people in acting collectively to shape policy and politics – and it is for this reason that a broader theoretical perspective on what we define as citizenship is key.

# 2. Theories of citizenship

## Citizenship as status, citizenship as practice

In the most traditional and narrow sense, citizenship is understood as a legal status that is granted to individuals by the nation-state, which guarantees certain rights and is bound up with nationality. This legal status has been used in some instances as the basis of inclusion or exclusion of certain groups, preventing the latter from accessing resources or moving freely around the world (Schneider 2000). In other instances, it has taken on a broader meaning, includes various social and economic rights, and is a tool to combat political oppression. Marshall's (1950) seminal work traced the development of citizenship in the United Kingdom from limited political rights to a broader notion of social citizenship that defines the responsibilities of the state towards its citizens. In the latter, citizenship is a means to challenge exclusionary practices and press for equal representation in contestations about human rights and social policy (Navarro 1994, Mitchell and Wood 1999).

State-citizen relations have changed fundamentally since the birth of the modern nation-state in the 19th century and the development of the welfare state around the time of Marshall's essay. In many countries private sector involvement in governance has diffused state responsibility for citizens (Eckert 2011) – such as where governments have failed to provide universal healthcare while allowing private providers to dominate healthcare markets. The modern era of globalisation has also shifted people's political identities and

relationships. Much of the world's population lives in societies where communication is near instantaneous, the use of social media platforms ubiquitous, and political action is not confined within national borders. Transnational connections, alliances and networks connect citizens all over the world in international solidarity around unifying causes (climate change, human rights, addressing inequalities) to make people 'global citizens' (Carter 2001). These imagined communities 'reframe ideas and practices of citizenship in non-national ways' – and people's imagined connections to these global communities break the ties that bind citizenship to the nation-state (Clarke et al. 2014). Citizenship is therefore 'an institution in flux' in a global economy that creates adaptable and movable citizens (Isin 2009).

To properly capture the ways people in São Paulo were participating in politics or seeking to shape healthcare policy I needed to move beyond the traditional model to a broader, more flexible understanding of what citizenship might entail. Scholars in the field of citizenship studies have developed new theories of citizenship to analyse how modern citizens interact with modern states, and one another. I have found them extremely useful in my efforts to understand the meaning of citizenship to Brazilians I encountered and interviewed.

Isin (2007, 2009) proposes that instead of basing our understanding on existing institutions of citizenship such as the nation-state, imagining it as a container of citizens with fixed boundaries, we should begin with thinking about the fluid 'sites' and 'scales' in which people struggle for rights or act politically. Isin argues that citizenship is constituted by practices and acts of citizenship, which are the 'deeds by which actors constitute themselves (and others) as subjects of rights' (2009: 371). Even those who are excluded from citizenship status can make claims for citizenship rights, and it is through their actions and behaviours that they actually become citizens (Isin 2008). This conceptualisation encourages us to focus on the behaviour of and relationships between people rather than viewing citizenship as an abstract concept. There are citizenship acts that we might expect in a functioning democracy, such as voting, protest marches and (particularly important in the Brazilian case) taking part in deliberative democratic processes. These normally occur in the "public sphere": in official spaces for politics (parliamentary institutions, voting, and the courts); as well as less traditional sites, including on the streets, in the media, and through social networks. These acts of citizenship are publicly visible and involve making bold claims for rights and resources. They include the kind of citizen activism that uses formal institutions to challenge the state, such as legislation or appeals to declarations of human rights (see Biehl 2013 on the role of the judiciary in Brazilian health politics). More recently, social media is playing a centrally important role in raising awareness of protest and abuses of rights in Brazil (Stalcup 2016, Nunes 2020).

Viewing citizenship as involving *only* those acts which are public and radical, however, diminishes everyday actions and practices that are more difficult to define and to observe (Neveu et al. 2011). Feminist authors argue that viewing citizenship exclusively as active participation that takes place in the public sphere means we may overlook the citizenship acts of women, who are traditionally associated with the "private sphere" (home and personal life). Beasley and Bacchi argue that it is in fact possible 'to take this association [with the private sphere] seriously as involving a crucial form of embodied social participation which is both imbued with power/politics...a resource as well as a limitation' (2000: 342). Holston also gives central importance to the everyday practices of citizenship: 'Although grand national events, like Lula's election, certainly put citizenship into practice, most of its performances involve commonplace encounters' (2008:15).

This is a particularly fruitful perspective when used to understand what citizenship means for the humanised birth movement, which is predominantly made up of women. In order to capture female participation in citizenship, we need to broaden our understanding of what constitutes political acts (Beasley and Bacchi 2000). There are citizenship acts that are more subversive or discreet, which might take place at home or on the street, in a discussion between friends, in WhatsApp groups, or with a trusted *obstetriz* in a local health centre. They might involve the sharing of knowledge about rights to health services during and after birth, information about policies and politics, invites to groups of shared interests and events. Despite not being overtly public acts, many of these practices nonetheless lead to a change in opinion and policy at localised levels. From this perspective, many movement activists were enacting citizenship even if they were not explicitly calling it that.

## Anthropological approaches to citizenship

Citizenship is always situated in particular socio-cultural, political and historical contexts. The history of Brazil, including the colonial period, the military dictatorship, democratisation and neo-liberalisation, have profoundly shaped the way people understand democratic institutions, citizenship, and political rights. Ethnographic research is highly suited to capturing these shifts through specific times and places. A growing body of anthropological literature calls for and demonstrates the benefits of ethnographic research in the field of citizenship (Whyte 2009, Coll 2011, Das 2011, Neveu et al. 2011, Ossipow and Felder 2015). Ethnographers are able to trace the particularities of how citizens relate to one

another and social institutions in different settings, as well as how people understand themselves as citizens – their rights, roles and responsibilities.

In their introduction to a special edition of *Citizenship Studies*, Neveu et al. (2011) set out entry points to studying citizenship which have proved highly useful for this research. They suggest comparing different levels and sites of citizenship production; how they engage and contest one another, allowing us to think about citizenship as being 'constantly redefined and reformulated through a diversity of interactions between states, institutions and societies' (Neveu et al. 2011: 946). We can then move away from thinking about state and citizen as dichotomous, abstract entities in a "vertical topography of power" (Ferguson and Gupta 2002), and instead try to grasp the tensions between national and localised negotiations with citizenship. It also requires critically revisiting sites that are "foreign" to a traditional understanding of citizenship, including the domestic and personal (Neveu et al. 2011: 948), and corresponds with Beasley and Bacchi's (2011) call to broaden what we consider political acts.

Biehl's work on AIDS activism and "biomedical citizenship" (2004) and his ethnography of *Caasah* (2007), are important studies of the ways in which sites and citizenship come into play in accessing healthcare in the Brazilian context. The original residents of *Caasah* (a community-run AIDS hospice in the northeastern state of Bahia) were former "non-citizens" – homeless people who had been living on the streets. Their transience through physical spaces meant that they were not granted the formal status of Brazilian citizens that would technically grant them access to life-saving treatment. By learning information about their disease, Caasah's inhabitants constitute themselves as biomedical citizens. Their coming together socially in an abandoned maternity ward in Salvador led to a shift in how they could navigate their relationship with the state and claim the right to use the health care system. In this biocommunity, 'citizenship is articulated through pastoral means, disciplinary practices of self-care, and monitored biomedical treatment' (Biehl 2004: 122). Biehl's work sits alongside other key literature in medical anthropology which has explored new forms of citizenship and sociality that develop around biology and health, including biosocialities and therapeutic citizenship (Petryna 2002, Rabinow 2005, Rose and Novas 2005, Gibbon and Novas 2008, Nguyen 2008, Whyte 2009). This body of work was hugely influential in how I sought to understood the humanised birth movement: not only as a social movement, but also as a potential biocommunity or an expression of biocitizenship. Although the terms 'biocitizenship' and 'biosociality' were not explicitly used by my participants, I wondered if childbirth (giving birth, being pregnant, supporting other women through birth) could be

analysed as a collective identity formed around the biological experience of pregnancy and labour.

Taking an anthropological perspective of citizenship also allows for the analysis of its relationship with cultures, including the political cultures that are bound up with citizenship status and practice. Culture has generally been a contested concept for anthropologists, difficult to define, and subject to wide debate in the field. Following Neveu et al. (2011) I see it as a dynamic and contested process, constituted in and through political, economic, historical and social relations. Citizenships and cultures are intertwined and mutually constitutive – a cultural group may use specific terminology to refer to citizenship and membership of this group may determine whether an individual is granted or denied certain rights. Culture can also provide resources for formulating new citizen identifies, and the possibility of legitimising demands made by disenfranchised groups (Rosaldo 1999). Studying citizenship as situated in culture meant I could understand the different meanings it had for different groups of actors – for instance, why the term had such strong significance for people who fought for democratisation as part of the *Movimento Sanitarista* social movement.

Drawing from these works, my theoretical approach means understanding citizenship as:

- Situated in particular socio-cultural and historical contexts that shape peoples' perceptions of and engagement with citizenship and other democratic institutions.
- Involving 'acts of citizenship' where people act politically to make claims for rights – these acts include participation in official policy making spaces, as well as more discreet, private and interpersonal acts that nonetheless constitute political acts.
- Feminist, in that it accounts for the citizenship acts of women that may not take place in traditional public and political settings.

Applying this approach, in the following part of this chapter I discuss the historical development of the concept of citizenship to identify why different groups within Brazilian society in general, and in the humanised birth movement specifically, perceive it differently.

# 3. A genealogy of citizenship in Brazil

Historical, social and political factors determine how an individual or social group might perceive and utilise the notion of citizenship. Brazil was ruled by Portuguese colonists from 1500 to 1815, who settled in order to mine for natural resources. An estimated 4.9 million people from the West Central African region were enslaved and forced to work on sugar and coffee plantations and in gold and diamond mines during this period (Levine et al. 1999). Indigenous people were also enslaved, and their populations decimated due to their lower resistance to European diseases (Skidmore 1999). The Portuguese enslaved more people than any other colonial regime, and Brazil was the last country in the Western hemisphere to abolish slavery, on 13th May 1888.

At the inception of the Brazilian nation-state and its independence from Portugal in 1822 citizenship was specified to include all those born in Brazil, including “free-born” and freed slaves – meaning that *ius soli* (birthplace) citizenship was inclusive regardless of racial profile (Holston 2008). Not all citizens had equal and uniform rights, however, creating a distinct form of national citizenship that was ‘universally inclusive in membership and massively inegalitarian in distribution’ (Holston 2008: 7). This formulation of citizenship used social differences – education, property, race, gender and occupation – to distribute differential treatment and rights, thereby legitimising inequality (Holston 2008). Slaves and autonomous Indians were excluded from the constitution, meaning that the existence of slavery itself was not challenged, ensuring its expansion into postcolonial Brazil (Miki 2018). During the period of modernization in the 1930s, certain occupational categories received financial guarantees while others were excluded altogether, creating a hierarchy of citizenship categories and an unequal distribution of welfare benefits (Mitchell and Wood 1999). In practice, this has meant that citizenship is not the mechanism through which people are denied their rights – instead, many groups of people in Brazil are discriminated against *despite* being Brazilian citizens.

Brazil was under military dictatorship from 1964 to 1985 after the army seized power in a *coup d’etat*. The regime was deeply nationalist and authoritarian, stifling freedom of speech and torturing political opponents (Zirker 1988). Conservative values were enshrined in policy, and women were expected to take up a ‘traditional’ role, as housewives and mothers. Under military rule citizenship ‘was either conceived of as an exclusive privilege or a limited right used for purposes of social control to maintain order and stave off more profound transformations in society’ (Dunn 2011: 79). Writing shortly after the end of the dictatorship,

Da Matta (1987) described the “relational” nature of Brazilian citizenship, where rights are determined by power relationships between actors and the ability of individuals of high social standing to behave as though they are above the law.

Holston (2008) explains that when he first went to Brazil in 1980 he rarely heard the word *cidadão* (citizen), and when he did it was being used to indicate distance and define who was ‘other’. Twenty years later, when Holston returned to observe Lula’s victorious presidential campaign, *cidadania* (citizenship) was of ‘overwhelming concern’ to people, and a central part of political discourse (Holston 2008). Writing around the same time, Cornwall and colleagues note that in the 2000s citizenship was associated with democratisation, leftist politics, policies, and the social movements that had campaigned to end the dictatorship. For those on the political left and those who were part of the *Movimento Sanitarista,* citizenship had been a powerful tool to claim the rights that they had been denied under military rule (Dagnino 2005, Cornwall et al. 2008, Coelho 2013). The founding of the public health system (SUS) was a central tenet of the Citizens Constitution of 1988. The right to health, and the right to participate in deliberations regarding public policy and budgetary spending, became closely connected with citizenship (Paim 1997, Fleury 2011, Coelho 2013). In the following section, I examine these participatory processes in more detail.

## 4. Participatory policymaking: The Conselhos and Conferências de Saúde

Democratic theorists argue that citizenship should mean more than enjoying certain rights and electing officials, and that citizens should have the potential to mobilise and be directly involved in decision-making on policy issues that affect them (Gaventa 2002, Avritzer 2009). Since the 1990s, the terms citizen participation and patient empowerment have become global health buzzwords that reflect the goals of international health organisations and national governments to make health providers more accountable for service delivery. Brazil is recognised internationally as a leader in citizen participation in policymaking, and in participatory democracy more generally (Baiocchi et al. 2011). Particularly noteworthy examples have been in participatory budgeting in and around the southern city of Porto Alegre (Koonings 2004, Cornwall et al. 2008). The most relevant institutions for health are the *Conselhos de Saúde* (Health Councils) and *Conferências de Saúde* (Health Conferences), where health policy plans are discussed, debated, and put together with some citizen oversight.

Brazilian citizens are guaranteed the right to participate in these processes of deliberative democracy and to have some influence on policy through participatory institutions. This right was established during democratization and is guaranteed in the *Citizen's Constitution of 1988,* but there is huge variation in how citizens have been able to activate it (Wampler 2015). The participatory architecture permits citizens and civil society organisations to 'deliberate in public fora, vote on public policies, monitor public officials, and forge new networks' (Wampler 2015: 3). Figure 2 below is a diagram of the flow of policy decision making in the health system.

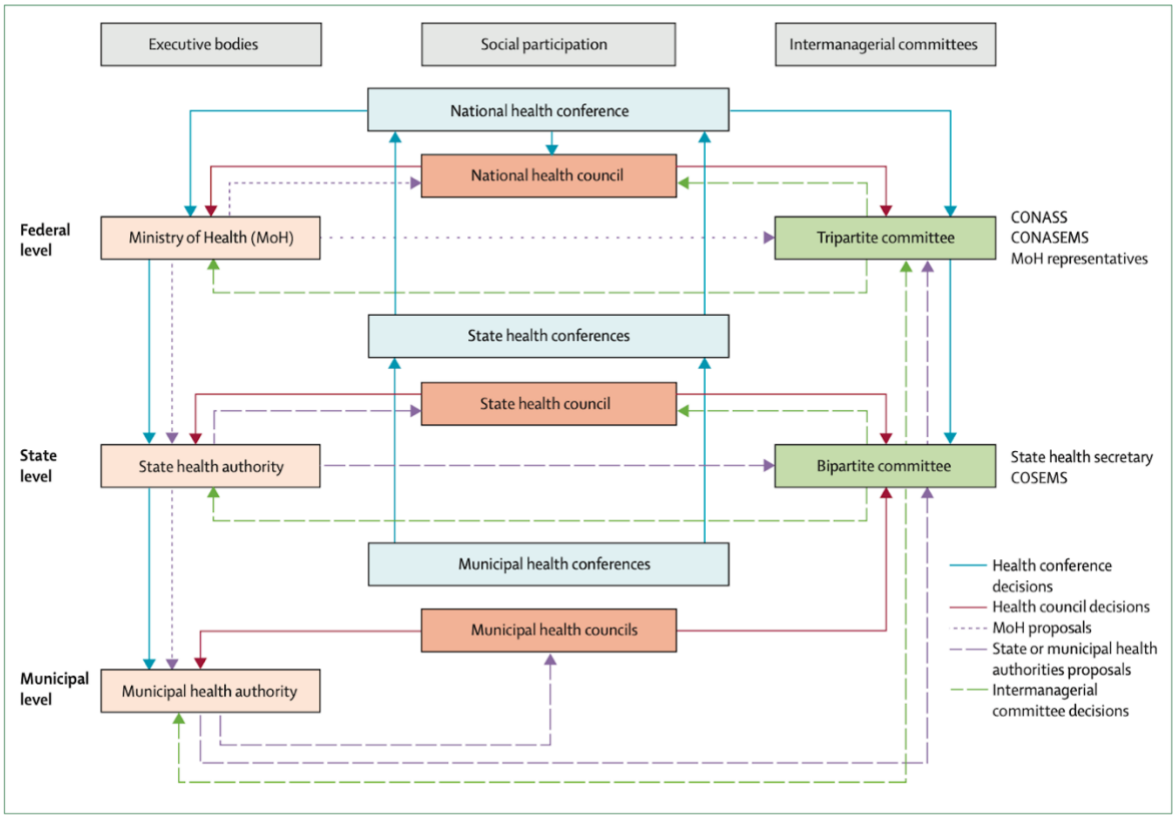


*Figure 3: SUS policymaking and social participation process (Source: Paim et al. 2011).*

The *Conselhos de Saúde* meet monthly to debate and approve health policy plans and budgets, only receiving federal funding once they have reached some level of consensus and approved the budget allocation (Cornwall 2008). Members of the public can attend, but not participate in voting (it was in this capacity that I attended meetings as a participant observer). Brazilian law requires there to be a *Conselho* for every municipality and state across the country. Each is made up of 50% *usúarios* (representatives of service users), 25% health professionals, and 25% representatives of the health secretariats and private

sector providers (Cornwall and Shankland 2008), and the number of members differ according to the size of the population they represent.

The councils are designed to provide citizens with *controle social* (social oversight) over executive proposals and the performance of government (Fleury 2011). They are described as “schools of citizenship,” where members – many of whom have received little to no formal schooling – can learn about their rights as citizens and the mechanisms of health policymaking; and also where those who have historically been denied a political voice are able to interact with those who govern them (Cornwall et al. 2008). The councils have a limited impact on the technical part of the policymaking process, given the expertise required to design specific health interventions, but they do provide citizens with the opportunity to work directly with government officials and their fellow citizens, allowing them to develop the necessary connections to gain public goods and health benefits (Wampler 2015). They are also intended to make policies more relevant to local contexts through the participation of the stakeholders affected by them.

Brazilian and international academics have assessed the effectiveness of the councils and conferences, looking at socio-political contexts, stakeholder participation, accountability, representation, and effect on policy to evaluate whether or not they are fulfilling their mandate. In many aspects, the health councils and conferences represent an idealised model of deliberative democracy, creating a space for citizens to discuss policy proposals as (supposedly) equal members, and reach consensus using rational argument. But in practice, they rarely function as genuine sites for participation. Wampler (2007) notes the considerable variation in how well the *conselhos* achieve equal participation of different actors and argues that the extension of accountability to citizens depends on their ability to be actively involved in monitoring the actions of government officials, while officials must be willing to subject their actions to examination. Guizardi and Pinheiro (2006) are deeply critical, arguing that the *conselhos* are essentially instruments of state control over Brazilian society. Coelho (2013) is more positive, finding that having citizen/user involvement in the health councils improved the distribution of public health services. Cornwall et al. explain that ‘few participatory councils appear to have achieved sufficient independence from political interests and sufficient citizen competence in relation to the technical, managerial and financial aspects of the health system to serve as genuinely deliberative spaces’ (2008: 2176). There are dense linkages between civil society organisation and political parties, especially PT (Cornwall 2008). Three main problems emerge in research into the councils: real autonomy from the state, genuine representation of diverse social actors, and embedded inequalities of knowledge and power between members (Cornwall et al. 2008).

While the councils and conferences face many challenges in achieving genuine and equitable citizen participation, they retain importance for social movements such as the humanised birth movement because they give its advocates a platform to raise awareness of their cause. Policies related to maternal health and humanised birth policies have been introduced at the municipal and state-level structures, and are eventually discussed at the National Health Conference every four years, from which the *National Health Plan* is formed.

## 5. Views on citizenship: holding space, forgotten histories and "doing citizenship" in São Paulo

A decade and a half after Holston, Cornwall, and colleagues examined citizenship and participatory policymaking in Brazil, I went to São Paulo to investigate the current state of and perspectives on the participatory policymaking. In the following section, I discuss four different examples from my ethnographic data to demonstrate the diversity of people's views on citizenship. During this time, under successive PT governments, Brazil had established itself as a prospering middle-income country, and had made drastic improvements in addressing poverty and poor health. Despite this, after the 2008 financial crash, PT began to lose popularity, and corruption scandals seeped public trust out of the political establishment. By 2015, São Paulo had become a cosmopolitan metropolis with a population of over 20 million people. The signs of mass consumption were everywhere, reflecting both the increased average income and how people were choosing to spend it. People were glued to their smartphones, there were enormous luxury malls dotted throughout the city, as well as trendy pop-up boutiques in the bohemian neighbourhoods. Instalment plans (*parcelado*) made almost everything available on credit. Even the cost of essentials at the chemist could be split into multiple instalments to be paid over the following months. Alongside this luxury, extreme poverty continued both in the city *Centro* region, and in the *periferia*. The gap between rich and poor seemed to be growing, as did the ideological distance between those on the political right and left. This made for a tense policy environment against which debates around citizenship and rights played out.

Unlike the c-section epidemic, about which everyone seemed to agree, citizenship was a polarising subject. Being a PT supporter was a strong indicator that someone felt more positively about citizenship, whereas many of the movement members who worked primarily

in the private sector were highly sceptical. Here I attempt to capture some of these views and connect them back with specific aspects of Brazil's history and society.

## The Conselho Estadual de São Paulo

I conducted participant observation at the São Paulo State health council on several occasions, the National Health Conference in 2015, and at two municipal health conferences in São Paulo city.

The São Paulo State health council meets in a long, stuffy, wood-panelled room at the State Department of Health, a tall grey office building nestled among the sprawling post-modernist complex that houses *Hospital das Clínicas*, one of the main teaching hospitals in São Paulo. To arrive I would walk past large crowds waiting outside the hospital wards, some queuing to be attended at the accident and emergency department, others smoking, others hawking snacks and children's toys.

Council members were seated at desks arranged in a rectangle, facing each other, while observers sat in chairs behind them or stood around the edges of the room. People were constantly moving about and helping themselves to small shots of sugary coffee from a pump dispenser. The meetings were chaired by a soft-spoken diplomatic man named Dr B, who maintained a calm objectivity throughout. There was a complex set of rules that determined who could speak and when, and how they communicated their point. At the first meeting I attended relatively little time was spent debating the actual health policy issues on the agenda – which was clearly frustrating to many of the members. Most of the 40 or so council members did not seem particularly enthusiastic about the proceedings, and some were clearly bored, staring at their phone screens. Several speakers interjected regularly and spoke passionately, to which others would groan quietly and roll their eyes. A small number clearly commanded respect and would receive applause, including an elderly woman who was a well-known community leader, and an excitable former lawyer who had been a council member for ten years.

At the end of the first council meeting I attended, I sat down with Lara, a middle-aged woman who had spoken often during the meeting. She was there as a citizen member of the council, and she participated because she wanted to secure better resources for children with learning disabilities. Lara was deeply frustrated by what she saw as the failings of the council and its members. She explained that she was one of the only people not affiliated

with a political party, and that the regularity of political in-fighting meant that health policy issues were often not discussed at all.

> Lucy: Is there not an agenda for the meeting?
>
> Lara: There is. But they do not comply. Everyone makes politically partisan speeches. The people here do not understand anything at all about the state health plan (a key policy document)…I've never gotten anything done through the council itself. So where I get public policy to happen is in the committee meetings. And a representative of the government is invited, and I can deliberate with them directly about public policies for people with disabilities. I deal directly with the manager.

Much of the criticism of the councils has focussed on their becoming dominated by discussions about the actions and policies of political parties – sometimes subtly, in that members tend to support propositions by those who they are politically affiliated – and sometimes more overtly, proudly proclaiming their party membership or even wearing party colours to meetings. This conflict was visible at all of the council meetings I observed. Dr B continually stressed his independence and apolitical position as Chair, explaining that he was a 'technician' and had to be to bring the council to consensus.

While meeting attendance might not be the most efficient way to get a specific policy passed into law or implemented in practice, in attending the participatory spaces, people were enacting their citizenship nonetheless. This was described by one of my key informants as 'occupying the space'. Daiane, a doula heavily involved in the development and implementation of the Volunteer Doula Policy, regularly participated in the conselhos.

> I'm a *conseleira participativa* [health council member] of my region. Why was it I went? To guarantee that I understood that there are other ways to change politics than to go and protest on the street. We have to occupy this space of *controle participaçao social* (participatory social oversight) to guarantee that humanised policies are created.

There was a concern that if members of the movement did not attend at all, the 'held space' would be lost, humanised birth would be omitted from the agenda, and not included in policy proposals that slowly worked their way into local and national health plans.

I asked Dr B about his views on citizenship. He explained that participatory democracy was still in its infancy post-dictatorship, and as a result 'the Brazilian people are learning what it is to be political citizens'. For him, citizenship was a 'strong concept' in Brazil, but one that still needed strengthening.

> Dr B: Citizenship is in the process of construction, for the individual, but also for the collective. Let's think collectively…this is what it means to be a citizen, *né*? Much more than searching for what you yourself need, but what do we need to construct collectively.
>
> So some cultural questions come in to play. And when I say cultural, I'm saying the following: we have to improve health for all social groups – black people, gay people, immigrants, women, children – everyone. So this exercise, to look beyond myself, is an exercise of citizenship. Which we have to stimulate here [in the conselho], between these diverse political groups.

Dr B explicitly refers to exercises of citizenship, which are reminiscent of Isin's acts of citizenship, and to questions regarding who is included in citizenship. Dr B's view is in stark contrast to the idea of citizenship as Brazilian national status, which has done so little for the most marginalised in Brazil. Instead, he describes 'looking beyond oneself', and to the health of the other, which speaks to the idea of citizenship as practice in the sense that it prioritises the collective needs of other members of society, rather than the rights that citizenship as status guarantees the self. The two State council meetings I attended also seemed to echo the findings of Wampler (2015), in that few in attendance had the expertise to design specific health policies or interventions, but that the meetings were important sites for people to network. As "schools of citizenship" they allowed participants to practice being citizens, to build important relationships with others and to learn about political systems and ideals, even if they had relatively little opportunity to shape policies directly.

## The Conferência Nacional de Saúde 2015

The National Health Conference (CNS) is held every four years in the capital, Brasília. I attended the 15$^{th}$ CNS in December 2015. The 42-degree heat did not stop thousands of attendees from milling about the conference centre on the first day, greeting friends from other states, taking selfies and complaining about the temperature or their hotel roommates (randomly allocated by the conference organisers). This was a particularly dramatic week for

national politics. The conference took place as the deputy of the *Câmara* (Chamber of Deputies, a federal legislative body) Eduardo Cunha instigated impeachment proceedings against President Dilma Rousseff. On the official schedule was a 'March in Defence of the SUS,' evidence of the feeling among those on the political left that the SUS was under threat by the growth of the conservative right. The vast majority of attendees appeared to support Dilma, as evidenced by their wearing of PT colours (red and white), waving flags and banners, and in the content of their speeches during debates. There was a palpable tension, with lots of hushed discussion in the corridors, heckling, demonstrations and people carrying placards urging #*ForaCunha* (Cunha out).


*Image 8: A rally outside of the conference centre in support of Dilma. The banner reads: "Health and Democracy. #There won't be a coup".*

People had come from across the country and many wore traditional dress or customised t-shirts to show what state or municipality they were there to represent. Every attendee was assigned a copy of the *Plano de Saúde* (Health Plan), a lengthy policy document put together from all the policy proposals that had been voted upon during earlier phases of municipal and state conferences, which people held onto carefully. The thousands of attendees were split into four groups along themed axes: the right to health and the guarantee of access and attention to quality; participation and social control; valuing work and education in health; and financing the SUS and public-private relations. These were split

into smaller group sessions so that each room had around 50-70 people. Here the coordinators would read out each proposal in the Health Plan, and people would either approve or amend and then re-vote. In general, the proposals were quite vague: 'to strengthen social participation in public policies, increasing channels of interaction with the population, with transparency and citizen participation' or 'to democratise and popularise the health conferences' (CNS 2015). While some approvals were straightforward, the debates I observed in the participation and social control stream were very animated, with repeated calls for order from the facilitators. Citizenship and its associated rights were key themes in these debates; but as with the proposals, these key concepts were rarely analysed, nor were particular actors or institutions identified as being responsible.

When I arrived at the conference centre on the final day, there was an air of tense excitement and hushed whispers. *Dilma is here!* At the end of the closing session in the main auditorium, the President came onto the stage. The crowd went wild, and a sea of camera phones were held aloft. Dilma spoke passionately for 45 minutes, thanking her supporters and stressing the importance of the health conference and its role in Brazil's democratic system.

> Dilma: Brazilian citizens! I want to thank the *compañeros* and *compañeras* in the social movements, unions, managers, and health workers. This conference is of huge importance to the life of our country. The movement that created this conference came from below. This is a democratic process. I know about all the conversations you have had to work here. Lots of ideas, lots of suggestions, lots of decisions in the conferences, to form the best public policies for health that our country has adopted.
>
> *(screaming and cheering)*
>
> This conference is composed of citizens - Brazilian citizens. I say this because it takes place at an important moment for our country's history. A moment in which it is necessary, and obligatory, to reaffirm principles, preserve rights, and reinforce the fight for democracy, for all Brazilians.

Dilma continuously reiterated the bonds between the conference and citizenship, and framed the impeachment proceedings as a threat to democracy in Brazil. For most of the audience, already on her side, this reaffirmed their understanding of the CNS as a key democratic institution, in which they had the right to participate as citizens – a right which was now under threat. At various points in the speech, the crowd took up the chant of '*Não*

*vai ter golpe'* or '*Fora Cunha'*. There were arguments breaking out in the audience between *petistas* and those critical of Dilma and her party.


*Images 9 and 10: President Dilma addresses the National Health Conference.*

The health conference served to reaffirm the critical importance of citizenship for the participants, continually rearticulated in casual conversations, formal debates in the conference proceedings, and in the powerful speech of the president. However, it seemed that to a large extent this was a case of preaching to the choir. The vast majority of attendees were *petistas*, who saw participatory policymaking as an important facet of their citizenship. There were some doubts raised by the movement members I attended the conference with, as to how effective this process was. By the time they reached the national level, policy proposals were so watered down, with no organisation or individual identified as accountable, that implementation was extremely difficult. This further supports the idea that a large amount of the value of participatory processes is that they are schools of citizenship where people practice political acts; but that they are mostly about holding space rather than genuinely productive sites of policymaking.

## The Tree of Forgetting

My interviews with members of the humanised birth movement gave a strikingly different perspective on citizenship. These discussions took place after I had been in the field several months, and had noticed that citizenship did not come up regularly at humanised birth meetings such as antenatal groups and on the doula courses. I wanted to understand

whether citizenship held the same importance for these activists as those who participated in the councils and conferences.

Julia is a successful filmmaker in her 30s who attended the GAMA doula course with me. She was the only Black woman on the course, and as she noted, was one of only a small number in the broader humanised birth movement. We discussed the topic of citizenship and racism at length, and she drew my attention to the relevance of the colonial era for how she understood her own citizenship. The colonial era was described as shameful by my interviewees, but its legacies of institutional racism and social inequalities were not regular topics of conversation among the movement's mostly white and wealthy members. Julia's views on citizenship, as well as the racism Black women experienced specifically around childbirth and when they participated in birth activism were therefore hugely important.

> Julia: I think here in Brazil…it's complicated. If you talk about countries where people respect one another – then you have citizens who have *direitos e deveres* (rights and responsibilities). If you take the history of Brazil, we were colonised, we lost our roots, we lost our history, truly.
>
> What I'm saying is that Brazil *é muito novo* (is very new/young), and it was born deprived. So for example…maybe you've seen some people saying "My grandparents came in a boat from Spain" and so on. They have a story about how their family is constituted. Black families can't do this…I don't know where my grandparents came from. I don't know, and I'll never know. *Porque nossa história foi arrancada da gente* (Because our history/story was torn from us).
>
> So I start my story with my grandparents. But there was a whole world before that! And I don't know what there was. I won't have this to tell my children. My husband, he's proud to say, "My grandpa was from Ohio, my grandma was German". But you never see someone proudly talking about their ancestors that came on the boat from Africa. Because we can't be proud. *Entendeu*?
>
> How can we know what citizenship is? You enslave a people, and create an *árvore de esquecimento* (Tree of Forgetting)...[they did this] when they brought Africans here...to make them forget where they came from. Black people were obliged to do this, by their *señores*. They had to pass around this tree. It was psychological torture – they made them believe they would forget... you passed around it 5 times, and in this way, you left behind all of your past. You left behind your culture.

> So to respond to this question – what is citizenship, how do we exercise citizenship. We only have this when we recognise the 'other'.

The forced forgetting of one's family history meant that Julia felt she did not have a sense of 'Brazilian citizenship' that made her feel part of a national collective body. The absence of family history and the resulting absence of a feeling of belonging had a clear impact on her sense of being a part of Brazilian society. Julia's narrative is suggestive of Holston's (2008) differentiated citizenship – the fact that Julia had no information about her ancestors, and that the continued racism and inequalities in Brazil meant there was no possibility of addressing this loss of meaning. Over the 20th century, the term 'racial democracy' was used by some scholars and politicians to describe a Brazil that they believed has escaped racism. Today this is widely considered false. Racism is bound up with class inequalities of access to rights and resources, and underlies the differences in outcomes for Black and brown Brazilian women. It is unsurprising that women like Julia found citizenship a deeply problematic strategy or form of identity, when certain groups of Brazilian citizens have been denied their rights despite their being citizens.

Julia's account shows a profoundly different perspective to those attending the *Conselhos* and *Conferencias*, and gives us some sense of the overlapping and blurred lines between political, class and race identities. There were many people from marginalised populations at the National Health Conference: Black, brown and indigenous people, and people from low income communities. But what united these groups in a positive view of citizenship was their political beliefs in participatory democracy, and for many, their affiliation with PT. Could this mean that their conviction in citizenship rights overshadowed the events in history where these populations were deliberately excluded from having them – or was this the very reason they so fervently fought to uphold them? I wondered if the fact that Julia was a middle-class woman, progressively minded but not strongly supportive of PT, mean that she could take a more critical perspective on politicised identities.

## 'They are still "doing citizenship", whether or not they know what it's called'

An interview with one of the key members of the humanised birth movement was exemplary of the complex attitude towards citizenship held by many Brazilians. Isabel is a midwife and one of the founders and directors of the GAMA humanised birth centre. Because she

defined herself as an activist, I was initially surprised when she told me how insignificant she thought citizenship was for most Brazilians. She was deeply sceptical about the power of state institutions to bring about positive change.

> Isabel: [Citizenship] is not significant now in Brazil. The era of dictatorship removed this from Brazil, destroyed lots of things, including this feeling of *ser brasiliera* (being Brazilian)". What does it mean to be Brazilian? It's not just having been born here. But the dictator reinforced this idea, that it was linked to being born here.
>
> This feeling of belonging to the country doesn't exist anymore. When you go to a *Conferência de Saúde*, you are working with an intellectual micro elite, of poor and rich, from the ultra-left, who work with this concept of citizenship. But I say to you if you were to ask 100 people randomly selected, "What is citizenship?" 99% will not know what to say – including educated people.

Isabel had more or less given up on trying to influence policy and change practice through traditional mechanisms, including spaces for participatory policymaking in the SUS. But much of the work she described sounded very much like collective political action. I asked her if she was not encouraging citizenship in some form:

> Isabel: It's more subtle – and it's a consequence of the movement. Through this [humanised birth] movement, you unite people. You bring people together for a national cause, one that unites all women. So it's not something that I show specifically – "Look, everyone, we are building our citizenship, what a beautiful thing!" – I don't do this, it already happens. *People already understand, subjectively, without knowing that the name for this is citizenship, that they are exercising their rights.* And that they are changing things, through this exercise of demanding their rights. I think the name [citizenship] is unimportant if they are still achieving this.
>
> My focus is to say to women – "It's your right. Go there and demand it, take your birth plan, ask someone to sign it, if no one does, change hospitals, go to the *Ministério Público"*. I only have limited time so I have to do what works best. I have five minutes to talk to her. I'm not going to talk about citizenship, I'm going to say: "Look, your baby will be born in two months, you don't have a birth plan, you're counting on the hospital to choose for you – let's change this fast, we don't have a lot of time - what do you want for your birth?"

> The midwives leave the *concurso* [entrance procedure for public sector jobs] saying – "Ah, but this is really for nurse-midwives, what about us? – I'm not going to talk about citizenship, I'm going to say – "Quick, go to the judge and ask to change the *concurso*. Go, it's your right." So they organise themselves and go and do this. *They are still "doing citizenship", whether or not they know what it's called*. What is important is that they do.

Despite Isabel's claims that citizenship isn't relevant, she simultaneously explains that the actions she encourages women to take (claiming their rights, invoking legislation) are indeed acts of citizenship. Where I have added emphasis, she clearly states that the women are still "doing citizenship" – enacting or practicing citizenship, and naming it as such is less important. This again places significance not on the status of citizenship, but on its acts and practices. In fact, Isabel deliberately chooses not to use the term 'citizenship' because of the negative connotations it has for her, and probably for the women she is advising. But the practice of citizenship is still important, because these are the ways that these women claim their rights to healthcare. Isabel's responses are similar to many movement members I spoke with, who were not strongly committed to changing policy through participatory institutions alone. Many had learned through experience, that in order to change policy and practice in maternal healthcare, they need to draw on a range of strategies and tactics across public and private sectors.

# 6. Discussion

What is the meaning of citizenship in contemporary Brazil, and what are the implications of this for the movement? Are the ethnographic accounts above representative of the wider sentiment in Brazil? The current "crisis of democracy" has huge implications for these questions.

Between 2003 and 2015, over four terms under two presidents, the PT administration brought in major national redistributive policies that dramatically improved the standard of living for millions of Brazilians (Doniec et al. 2018). This broader progressive policy environment facilitated the development and implementation of normal birth policies at the national and municipal levels of government. The *Rede Cergonha* national policy for humanisation was established in 2011 under Dilma. Her Minister for Health from 2011 to 2014, Alexandre Padilha, is a key member of the movement, and played a central role in supporting the passing of humanised birth legislation at a high level of governance (which

continued in his subsequent role as Secretary of Health at the São Paulo Municipal Government from 2015-2017). At the municipal level, Fernando Haddad (Mayor of São Paulo from 2013 to 2017 and also affiliated with PT) was also supportive of the movements aims. He had lent his support to humanised policies and legislation including the construction of normal birth centres, the companion law (guaranteeing women the right to a companion during labour) and the volunteer doula law that I explore later in this thesis. Broadly speaking, under the PT administrations there was a relatively large number of policies and laws that furthered the aims of the humanised birth movement and led to wider improvements in maternal health in general. Many of these policies were the outcome of movement activists working closely with government policymakers and state representatives, through mechanisms including the municipal, state and national conferences, as well as the Public Prosecutor's office (Diniz et al. 2018). At some points in the past few decades then, citizenship rights to participate in policy have been at least somewhat useful for the movement.

Attending the *Conselhos* and *Conferências,* I could see that citizenship was historically important for *petistas,* especially those who were old enough to have been involved in the democratisation process. They lamented the growth of consumerism in Brazilian society and wanted to strengthen citizenship. In their view, neoliberal reforms have been used to 'erode the boundaries between public responsibilities and private roles' (Wheeler 2005: 100), and the only way to salvage citizenship and its associated rights was to "hold space" in participatory structures. The councils and conferences, however, did not seem particularly useful in the actual development and implementation of policy. The small number of policy proposals that referred specifically to issues around humanised birth, developed at the municipal level health conference in São Paulo, were so diluted by the time they reached the national level that they were almost impossible to implement. They were, nonetheless, important sites of citizenship *practice*; where ordinary citizens could network with government officials and health sector representatives, and where they could learn about the ideological and historical value of *controle social* even if it was limited to voting on watered down proposals.

Citizenship rights, including the right to health, are supposed to guarantee that any Brazilian woman can access high quality obstetric care on the SUS without charge. But if citizenship in Brazil is "differentiated" then some categories of citizens are less able to claim their rights or influence decision-making processes than others. For much of Brazil's history, having citizenship status did not mean that women, and Black women in particular, were full bearers of rights – in some instances it actually legitimised their othering. To this day, women, and

especially women of colour or low social class, are not treated equally to men, and particularly men in the political elite who dominate political institutions and hold significant decision-making power. Even women who are educated, white, and upper class have reported instances of being unable to access the kind of care they want or even breaches of their rights. The legacies of colonialism and the dictatorship taint any positive use of the citizenship identity with historical associations of suffering and exclusion. Julia, for example, has a complex relationship with citizenship: she was aware that her citizenship granted her certain rights, but did not feel that it was a positive form of socio-political identity that could bring her closer to other citizens and people in her community. Instead, as I show in Chapter 7, the sense of feminine solidarity or *sororidade*, that she experienced through her involvement in the movement and in working as a doula, was a more positive form of political sociality that held far greater potential. It is for this reason that citizenship as status is insufficient both as a *lived reality* for Brazilian women (in guaranteeing their rights), and as an *analytical concept* for understanding how people act politically in this setting (because it does not capture the many other acts and practices in which people in São Paulo enact to change policy and claim their rights).

While many of the previous studies of citizenship and participatory policymaking in Brazil have focussed on citizenship acts that take place in the public sphere, including the *Conselhos*, I found that in some cases, women's association with the private sphere actually led to greater opportunities for political activity – for example, women on maternity leave had more time available to participate in online or face-to-face humanised birth groups, sharing information and resources, or even becoming active in lobbying. Young progressives were united around a political cause, but many expressed a distaste with the political establishment. Social media groups on Facebook and Whatsapp were particularly popular among pregnant women and mothers I spoke with, which connected them with others having similar experience across Brazil. Other anthropologists studying social media in Brazil have also commented on the ways in which it 'provides new means for the cultivation of collective and traditional networks of support' (Spyer 2017: 1). Social media networks provide a platform for interest communities which pursue rights claims to better care during childbirth, promote natural birth techniques, and share clinical research papers or international guidelines. People using these groups will usually have more in common with other members than they do with their fellow constituents in a particular *barrio*. Sites of political activism are no longer geographically constrained, or necessarily focussed at state institutions. They might include actions in the media, art exhibits, the use of outdoor spaces, online networks, and even physical bodies.

These observations led me to the conclusion that forms of politicised sociality are increasingly important for pregnant women and mothers in São Paulo – but that the term citizenship might not resonate with them. Wanting to have a child, being pregnant and going through childbirth were potent experiences that united women across social, class and even racial divides, giving them a cause for which to act politically to improve policy and services. These experiences were centred around the shared female experience of birth and a sense of sisterhood (which I explore in greater depth in Chapter 7). There is, therefore, still potential in shared political socialities in São Paulo and in Brazil more widely. But instead of taking the form of traditional citizenship activities in formal political spaces, they are far more fluid, and fit with the theories of citizenship discussed at the beginning of this chapter: acts and practice. Perhaps the naming of political behaviour itself, or choosing not to, is a policy strategy in itself. If vocalising the word “citizenship” rallies people around it to fight for improvements in humanised birth policy, then it is useful. But for Julia, and others who experience racism and classism, calling on the power of sisterhood and avoiding the term citizenship appears to be more effective in uniting people around the cause.

This chapter has demonstrated the value of anthropological approaches to studying citizenship. By broadening our view of citizenship from a legal status to a relational concept that takes place in everyday spaces, we can develop a rounder picture of how citizens claim their rights or act to bring about political change. It strengthens the call for anthropologists to investigate citizenship ethnographically, as a form of identity whose meaning is embedded in cultures and histories, which changes over time. Anthropology can bring insights to this field, which has more traditionally been the domain of political scientists. Focussing on how different people perceive citizenship in one relatively small policy area demonstrates the huge divergence of viewpoints on what is supposedly a static, unifying concept. This approach also sheds light on the potential in other collective identities to bring people together for positive political action and progressive policy change.

# **Chapter Four:** The humanised birth movement and its strategies

## 1. Introduction

In this chapter I introduce the humanised birth movement: the fragmented but hugely influential social movement preoccupied with the problems in maternal healthcare in Brazil. As I explain in my Methodology chapter, the movement was my fieldsite, in the sense that it was the community of people and institutions I researched. The movement was not fixed at a single geographical location, but the majority of sites at which I conducted participant observation and interviews were in São Paulo. I also followed their activities at different locations across Brazil and online. This chapter is an overview of my findings from applying my ethnographic approach to policy. The nature of this methodology meant I identified a huge range of activities that were part of the policy process. I "followed through" several specific policy programmes, but also documented the social aspects of policymaking, the relationships that formed around them, and the alternative strategies movement members enacted when formal policymaking processes were ineffective.

The humanised birth movement has long been of academic interest to Brazilian and foreign scholars. Several of these have studied the movement extensively, primarily concerned with its history and successes (Tornquist 2004, Diniz 2005, Rattner 2009, Rattner et al. 2010, Carneiro 2015, Diniz et al. 2018). The majority of these texts are from a public health/feminist theory perspective, though Carneiro (2015) conducted an ethnography of women's humanised antenatal groups. Diniz (2005), for example, examines the various meanings of humanisation throughout the history of the movement, including: humanisation as scientific legitimacy and evidence-based care (closely linked to the strategy I discuss in Chapter 5), and humanisation as 'a more dialogic and diplomatic, less accusatory way of speaking about gender violence and other violations of rights practiced by health institutions' (2005: 633). Rattner et al. (2010) explain the important role the civil society organisation ReHuNa (The Brazilian Network for the Humanization of Childbirth) has in structuring the humanised birth movement as it is today. More recent papers have evaluated and compared the impact of the movement on public policy and training programmes (Diniz et al. 2018) and compared specific policy interventions (Leal et al. 2019). I draw on these last two papers to outline the current policy landscape later in this chapter.

I aim to provide a novel perspective on the humanised birth movement in the following ways. Firstly, my anthropological approach allowed me to take a broader view of policymaking, incorporating the "everyday" activities of the movement, and analyse these alongside formal political actions. Secondly, while the authors above have provided excellent evaluations of various public and private policy initiatives, my primary focus is on the strategies of the movement - that is, *how* they have achieved progress towards their goals. Finally, I feel that being an "outsider" and British allowed me to take a different viewpoint, with the benefits of having experience and understanding of another health system with a very different model of care.

This chapter begins with an explanation of the movement's goals and definitions of key terms used by its members, and throughout this thesis. I then discuss the characteristics of those involved, and give a brief history of the movement since its inception, before moving on to outline the humanised policy landscape. In the second half of this chapter I explain the results of my application of the "studying through" methodology – which resulted in the identification of many different activities, behaviours and strategies to address the intervention epidemic and obstetric violence. I discuss all of these briefly here, but given the large number, I decided to prioritise the most innovative and interesting to examine in depth in the subsequent three chapters of this thesis.

## 2. Goals, motives and definitions

Members of the movement attest that the excessively medicalised model of care common in Brazilian obstetric institutions is 'designed to meet providers' and institutions' needs, rather than women's bio-psychosocial needs' (meaning a holistic and multi-faceted meeting of a woman and her family's needs) (Diniz et al. 2018: 20). They believe that in both public and private sector hospitals, women are suffering from iatrogenic harm; that is, they are being made unwell as a result of medical treatment. The movement is unified around its goals to normalise vaginal delivery for low-risk births, and want women to feel empowered and supported during childbirth, so that they are less likely to be pressured into or request unnecessary clinical interventions.

The fact that there are differences in approach and opinion among sub-groups and individuals in the movement has led to some people suggesting there are multiple humanised birth movements. The divide seemed to mainly be between those who worked to improve access to women using the SUS, and those who felt this was not productive and

chose to focus on the private sector (the marketing subgroup that I discuss in Chapter Six). Therefore, the difference was in strategy rather than goals, as both sides of this divide believed all women should have access to high quality humanised birth care. While I acknowledge the differing views and strategies among these sub-groups, for the purposes of this paper, it is more useful to analyse the humanised birth movement as one social movement with different factions.

The movement uses several terms which require unpicking. As I explain in the Introduction chapter, *parto humanisado* (humanised birth) usually refers to childbirth free from unnecessary clinical interventions, where the woman is well informed about her choices, and where her needs and wishes are respected by the health professionals attending her. It is possible to have a 'humanised' hospital birth or c-section if the woman's wishes are respected and any interventions are genuinely necessary. *Parto normal* usually refers to a vaginal delivery that may involve a manual extraction with forceps or an episiotomy, but does not necessarily include all of the protocols associated with humanised birth (a calm respectful environment for example). *Parto natural* usually refers to a vaginal delivery without any interventions, so this was the "most natural" of the three. The term medicalised tended to refer to things that were *excessively* medicalised or biomedicalised, or what feminist anthropologists of childbirth have called 'technocratic' practice or 'techno-obstetrics' (Jordan 1997, Davis-Floyd 2001).

Tornquist's paper on the humanised birth movement describes the way the diverse members engage with the term 'natural':

> The category *natureza* (natural) appears frequently in [humanised] ideology, and seems to be a point of agreement between the biomedical aspects and alternative approaches…Both labour and birth are seen by both alternative practitioners and by health professionals as physiological and natural events on which highly technologized medicine acted inadvertently, turning what would be simple and healthy into complex and pathological. Thus, criticism of the excessive medicalization of childbirth are useful in the defence of humanization…campaigns such as the Ministry of Health "natural childbirth is normal" are examples of such initiatives.

From these debates come labels for clinicians: *cesarista* and *medico/a humanisado/a* or *medicalisado/a*, which translate as "caesareanist," "humanised doctor," and "medicalised doctor". Medical technologies were not in themselves bad, and as I mention throughout this

thesis, many of them had become acceptable to normal birth advocates because they were non-invasive, or because they were used *with care.*

## 3. Who makes up the movement?

Members of the movement include activists and campaigners, academics, politicians and civil servants working in maternal health, humanised health professionals (doctors, midwives, nurses and doulas), as well as pregnant woman and mothers who have sought out a humanised birth who practice according to this model (Diniz 2005, Diniz et al. 2018). I use the term "activist" to refer to anyone who is engaged in raising awareness about the movement and its goals or to further its political aims, whether online, at humanised birth appointments or group sessions, at academic conferences, or in formal policy spaces such as giving evidence at CONITEC (the Brazilian equivalent of NICE). Some activists were involved in the movement full-time, usually as humanised health professionals or academics who were also involved in campaigning work. There are several *humanisado/a* obstetricians, many of whom have been championing normal birth for decades. These include Dr Jorge Kuhn who trained in normal birth techniques in Germany, and became a humanised doctor after meeting activists in 2003 (and who is known as a *vaginalista* by his colleagues). Another was Isabel, a leading activist, *obstetriz* and doula, who had established the humanised birth centre GAMA. Other people are more peripherally involved in the movement. They might be full-time civil servants with an interest in the topic, or women who opt for humanised birth whose involvement mainly consists of sharing information about the movement and its causes on social media. The movement can also be usefully conceptualised as an "issue network" (Walt et al. 2008) with a dominant core of stakeholders who were instrumental in the development of multiple, clearly defined policy programmes, as well as peripheral groups and individuals who were working towards a common cause (humanising childbirth in Brazil), but who may have differing values (such as choosing to work in the private sector or public sector), and levels of participation (from weekly participation in policy development meetings, to occasional comments on Facebook groups).

*Obstetrizes* have faced challenges from both the doctors' and nurses' unions, who have resisted their being licenced and fully professionalised (Gualda et al. 2013). At the time of my research, there were only a handful of *obstetrizes* working in SUS hospitals in São Paulo. Others worked as part of humanised teams in the private sector. There were many more obstetric nurses (nurses who had specialised in maternal healthcare) whose training and practice prioritised technical skills, and who usually assisted obstetricians during

delivery. Obstetric nurses have different areas of responsibility in the clinical setting, and are therefore not well placed to advocate for midwifery-led woman-centred care. Because there are so few midwives, having a doula has become a popular choice for women interested in a humanised birth. Most doula training courses take less than a week to complete, and there are many running across the country. In São Paulo city, there were at least three taking place at the time of my research, which I discuss in depth in Chapter Seven. Quite a few of the doulas I met in São Paulo had trained abroad, mostly in the US, and were thus connected with international natural birth networks and influenced by the global natural birth movement.

Different subgroups within the movement hold different ideological perspectives about both the problems in maternal health (the intervention epidemic and obstetric violence) and the solutions. This means that different members take distinct strategic approaches in their efforts to improve maternal healthcare. Some movement members direct their attention towards developing public policies in women's health, campaigning for the rights of women to humanised services in SUS hospitals, and sharing information about humanised birth with women in poorer areas of the city through outreach programmes. These members usually invest time in more traditional mechanisms for policy change, such as the SUS health councils and lobbying the government. There are others who, in contrast, are deeply disillusioned with public participation in policy. They often work as doulas or doctors in private humanised birth centres, and explain that they are behaving in line with the consumerist culture of Brazil. They seek to influence hospital practice and public opinion by inducing a rise in demand for humanised birth and believe private services will necessarily adapt and provide more facilities and health professionals for normal birth in the private sector. Despite these differences, my research participants, and other Brazilians I met during my fieldwork, were aware of a distinct humanised birth movement and most self-defined as members or supporters willing to spread the messages of the movement.

The movement is affiliated or works closely with a range of civil society, academic and political institutions, including humanised birth clinics, NGOs, public and private hospitals, research organisations and universities. I worked closely with a research group at the University of São Paulo, which included Professor Simone Diniz (who has written extensively on humanised birth and the movement) and other key informants whose interviews I draw on throughout this thesis. These women were exemplary of the ways in which movement members wore multiple "hats": they researched topics related to humanised birth, spoke regularly at conferences and public events, contributed to Facebook and Whatsapp groups, some worked as doulas, others were involved in campaigning

organisations such as *Parto do Princípio*[15] and attended meetings for shaping policy interventions such as the *Parto Adequado* project. As Diniz herself confirms: 'social movements, dissident providers, academics and public policy officials have also created mutually influencing networks where sometimes the same individuals can move freely between different professional/social identities, helping to disseminate innovative concepts and initiatives' (Diniz et al. 2018: 20).

As briefly outlined in the Introduction, there are general characteristics attributable to the majority of people involved in the movement. They are predominantly middle- and upper-class women, well educated, who identify as *branca* (of European descent), and carry 'cultural capital', understood as the capacity to critically challenge certain social regulations (Carneiro 2015). Many have had the opportunity to live abroad and are able to speak English well, allowing them to access popular literature from the international natural birth movement such as Ina May Gaskin's *Spiritual Midwifery* and Michel Odent's *Birth Reborn*[16]. It is common for those that pursue a humanised birth to pursue an alternative 'holistic' lifestyle, taking part in other activities that complemented their views on childbirth. They are likely to practice yoga, be vegetarian and use naturopathic treatments for ailments (acupuncture, aromatherapy, reiki and so on). They live and congregate in particular *barrios* (neighbourhoods) of the city. Vila Madalena and Pinheiros were central hubs for this kind of lifestyle, with bohemian cafes, health food stores, artistic graffiti and yoga shalas reminiscent of Southern California or East London. GAMA, one of the most influential humanised birth clinics, was located in this area. There were differences between humanised birth professionals and activists, and women who sought humanised birth. Professionals would more strongly reject the use of interventions, whereas, for women, it was more important that they were recognised as individuals with needs and expectations than whether or not they undergo a particular procedure (Carneiro 2015).

These common characteristics shared by the majority of the movement raise important questions about representation. The first is the concern about whether these women can claim to speak for all birthing women in São Paulo or Brazil, when their own experiences of maternity services, and of participating in policymaking and activism are shaped by their appearance and position in society. The second is whether the shared experience of

[15] A network of women, consumers and users of the Brazilian health system, offering information on pregnancy, childbirth and birth based on scientific evidence and WHO recommendations, with 300 members across Brazil, disseminating information about the benefits of "active birth" (Parto do Princípio 2020).
[16] According to Tornquist (2002) many earlier key international texts on natural birth were also translated to Portuguese and widely read in Brazil.

suffering during childbirth from obstetric violence unites or further divides privileged and underprivileged women. In Chapter Two I discussed how wealthier (mostly white) women are at higher risk of unnecessary clinical interventions in the private sector, especially c-sections – whereas Black and poor women from the periferia are at higher risk of obstetric violence in the form of maltreatment, denial of companionship and anaesthesia, as well as unnecessary procedures such as synthetic induction of labour and episiotomy. The movement campaigns against both of these, describing them *collectively* as obstetric violence, despite their distinct drivers and affected populations. In highlighting the shared experiences of women in suffering, there are more opportunities to challenge class and racial inequalities by bringing the goals for all women into alignment, to fight for humanised birth. But this could be further improved by actively elevating the voices of marginalised women, including within the movement.

The Brazilian movement is connected to and influenced by the international natural birth movement, and other national movements, like those observed in Mexico (Vega 2006), the USA (Davis-Floyd 2004) and Canada (MacDonald 2006). Vega (2006) describes how the Mexican humanised birth movement inadvertently commodifies indigenous culture, excluding indigenous women from the humanised birth community. While the capitalisation of Mexican indigeneity is specific to Mexico, the negative effects of commodifying natural birth and the ways in which this can limit access for non-white women parallels with the Brazilian case. It could also be argued that the Brazilian humanised birth movement has taken inspiration from the birthing techniques used in indigenous Brazilian communities, but from my observations this did not seem as widespread and exploitative as the Mexican example.

Private sector humanised birth activists in Brazil looked frequently to the US movement, and many well-known figures were invited to give talks and training sessions to a Brazilian audience (midwives from Spinning Babies® has run multiple classes in several Brazilian cities over past few years, for example). Those focussing their efforts on humanising care in the SUS tended to work with midwifery colleagues from the UK, partly because the two public health systems were comparable, and because there is a long history of international research and collaboration in health policy in maternal health between the two countries.

In 2009-2010 large teams of academics in both Brazil and England undertook comprehensive national cohort studies into how women give birth (Leal et al. 2011, Birthplace Collaborative Group 2011). Several of the leading academics involved in these studies have worked with one another to develop research partnerships between the two

countries, such as those between the University of São Paulo, Kings College London and City University London. Academics I spoke with in Brazil explicitly stated that several policy initiatives, such as the construction of normal birth centres (*Centros do Parto Normal* or CPNs) in SUS hospitals, were modelled on NHS alongside midwifery-led units (AMUs). Those initiating this policy drive in Brazil explained that they were strongly influenced by their experiences of healthcare in the UK during periods of study exchange or through visiting UK based colleagues. Upon returning to Brazil these women began looking at how they could create similar hospital birth centres in São Paulo. They invited a delegation of British academics and policymakers to Brazil for a series of seminars and discussions about the NHS models for care and how these could potentially work in the Brazilian context. A team of Brazilian policy makers also came to the UK making visits to hospitals, universities and the Royal College of Midwives. This is a clear example of policy ideas moving between health system contexts. But interpreting this as a simple transfer of policy models from A to B, from one political system to another (as one might in a traditional policy analysis) is inadequate. As Shore and Wright explain, 'policies are not simply "transferred", they are reinterpreted as they travel across cultural boundaries', the effects of which are rarely neat or rational (2011: 20). This is further evidence of the benefit of an anthropology of policy: we can see the value of relationships, of how people try to make sense of things, how abstract models look in practice, and how policymakers might adapt "cultural" aspects of policy. In this instance, policymakers needed to compromise to make their goals a reality, and as such, doctors are still the "managers" of CPNs, unlike midwifery-led units in the UK and other settings, which are managed by midwives.

## 4. The movement's history and the policy landscape

The movement's activities include a range of actions and campaigns, many of which have directly led to or influenced public and hospital policy at the national, state and municipal levels. These are instigated, developed, implemented, evaluated and altered by a variety of stakeholders from government, civil society, and private and public research institutions.

Since the demand for c-sections began to rise in the 1970s, the federal government has initiated various policy drives to try to address this trend. The higher rate of pay to doctors and hospitals for c-sections was amended in 1980, and an equal rate of pay for all types of delivery introduced – but this only halted the rise in demand temporarily (Victora et al. 2011). Around the same time, the movement grew up slowly, when dissident health professionals were inspired by indigenous childbirth practices and the global feminist movement (Diniz

2005). Together with alternative health practitioners and public health officials, they formed ReHuNa in 1993. Since then, many other overlapping networks and initiatives have sprung up, some with slightly different methods, but all with the same overarching goals of humanising birth and addressing violence and disrespect during childbirth. From the late 1990s, the humanised birth community met several times a year at conferences and has communicated online through email lists, and more recently, social media platforms (Irvine 2021).

The first humanised public maternity hospital opened in Rio de Janeiro in 1994. In 1998 the SUS introduced a maximum percentage of 40% of deliveries to be c-section, later reducing this to 30%. In 2000 a *Pact for the Reduction of Caesarean Sections* aimed to reduce the frequency of caesarean sections to 25% of all births by 2007. Initially, this was fairly effective, as the proportion of c-sections in the SUS decreased from 32·0% in 1997 to 23·9% in 2000. The *Pact*'s effect was short-lived, however, especially in the private sector, and the rates increased steadily after 2002 (Victora et al. 2011).

According to key actors in the movement, one of the key factors driving policy change has been Brazil's MMR, which has hovered between 60 and 70 per 100,000 women since 2000. This is considered high for a middle-income country, leading to the government introducing compulsory investigations into maternal deaths (Ministerio de Saúde 2009). The Brazilian government signed a *National Pact for the Reduction of Maternal and Neonatal Mortalities* in 2004, with the aim of reducing avoidable deaths to internationally acceptable levels (Rattner et al. 2009). Brazil also committed to reducing MMR under the Millennium Development Goals, but has seen little change since the turn of the century. Brazilian health experts fear the MMR will rise again due to the cuts in social welfare spending since Brazil entered a recession in 2014 (Collucci 2018).

Other initiatives include the creation of prizes for humanised maternity wards that acknowledged good practices based on adherence to WHO recommendations for promoting normal birth, the professional development of obstetric nurses, and the introduction of freestanding normal birth centres (Diniz et al. 2018). In terms of legal responses, the first federal law related to humanised birth – guaranteeing women a companion of their choice during labour and birth – was introduced in 2005. There have been several other key laws, including the doula law. The NGO Artemis, founded in 2013 by activists and lawyers, works to address all forms of violence against women and rights violations and has been instrumental in helping women to prosecute and defend themselves in legal processes around humanised birth (Diniz et al. 2018).

The Ministry of Health established the *Rede Cergonha* (Stork Network) in 2011, to implement a network of care to guarantee women's rights to reproductive planning and humanized care during pregnancy, childbirth and the postpartum period (Secretariat de Saúde 2016). *Rede Cergonha* is a national level policy that aims to reduce the number of unnecessary c-sections and promote normal birth (Giovanni 2013). Various municipal and state-level programmes come under its remit, including the establishment of the CPNs in SUS hospitals across Brazil. Internationally, normal birth centres are usually midwifery-led wards within hospitals that are separated, but near to obstetric wards. This means low-risk or medium-risk women can opt for midwifery-led, minimally interventionist care, but that they are in close proximity to the facilities and doctors on the obstetric ward if a transfer is needed. There are 23 CPNs across the country, and 18 *Casas de Parto* (freestanding humanised birth centres) (Ministerio de Saúde 2018a).

The private sector has been more resistant to change, but there has been progress nonetheless. *Parto do Princípio*, a network made up of healthcare consumers (women paying for private services) was founded in 2006 and has been working through the Public Ministry (an agency of the judiciary that defends the rights of citizens) to challenge public and private sectors to address the c-section epidemic (Rattner et al. 2009). In 2018 the Ministry of Health announced it would create an electronic monitoring system to monitor the number of c-sections in the SUS, which it estimates as being 41.9% in public sector hospitals.

A new policy named APICE-ON (Improvement and Innovation in Care and Education in Obstetrics and Neonatology) was being implemented around the time I left the field. APICE-ON's focus was the training of health professionals. The Ministry of Health is working in collaboration with the department for education, universities and research institutes, with the aim 'to contribute to the implementation and dissemination of obstetric and neonatal care and care practices - based on scientific evidence, on the rights and principles of humanization'. Members of the humanised birth movement were cautiously optimistic about this program. Medical training was a key area that they felt required attention, but several attendees of the launch conference were exasperated that the panel of speakers included doctors they felt were not in line with the humanised cause, leading them to suspect their whether they would fully commit to the proposed changes to medical curricula.

# 5. Studying through policy change: identifying the movements strategies

"Studying through" policy involved following policy interventions across different sites and levels and over time. In my definition of "policy" I included changes in public policy, institutional policy, related laws and institutional practice related to addressing the overuse of interventions, obstetric violence, and/or promoting evidenced-based woman centred care, humanised, normal or natural birth. I began by following three specific policy case studies. This meant attending meetings and events associated with the policies, observing and interviewing policy leads and participants, and asking questions on these specific examples with other people in the field. Going through this process allowed me to identify a much wider range of activities that took place around these policy interventions, which I list in the following section.

## Policy case studies

I followed two humanised policy case studies in the public sector. The first was the *Parto Seguro* (Safe Delivery) programme, a policy initiative to promote humanised childbirth run by CEJAM, a not-for-profit women's health research institute, and the São Paulo Municipality health department. The programme aims to 'provide humanized, differentiated and friendly assistance at all stages of care' for women and their families (CEJAM 2020). The programme is comprised of various actions: triaging and care according to risk, obstetric admission, pre and postnatal care, care during childbirth, and neonatal intensive care in the 8 public sector hospitals involved in the programme. It seeks to change entrenched care practices linked to the overmedicalisation of childbirth and to ensure high quality obstetric and neonatal care based on scientific evidence.

The *Parto Seguro* programme is the São Paulo municipality's effort to adapt and implement the national policy directive on *Centros do Parto Normal*. It builds on this by also training health professionals to use evidence-based practice (such as the Robson Classification system) and humanised protocols based on WHO guidelines. It is funded and legally supported by the municipal government. A team of researchers and coordinators based at CEJAM are responsible for the implementation and management of the programme. A coordinator from CEJAM is based at the participating hospital wards for 3-5 days per week to oversee implementation, provide support and training, and to monitor and collect programme data.

I interviewed three of the *Parto Seguro* policy leads at CEJAM as a starting point. The importance they placed on evidence-based guidelines was one of the first indicators that I should closely examine EBM as an important tool for the movement. I visited several of the participating hospitals, and observed how proud the obstetric nurses were of new CPN rooms, with all of the equipment needed for humanised delivery – this encouraged me to think about the rituals of birth positions and question how this knowledge was being disseminated. The programme director, Maria, gave me the contact details of several other key actors in the field she thought it would be useful to speak to, who she knew personally. These are just some of the ways in which I began studying through these policies.

My second public sector policy case study was the *Programa de Doulas Voluntárias*. Over the course of 2017 a pilot policy programme to train and integrate doulas into municipal public hospitals in São Paulo was established by the Municipal Health Secretariat. The policy authors' personal experiences as health professionals or mothers, and their familiarity with current academic research, informed their belief that all Brazilian women should have access to emotional and physical care during labour, particularly marginalised women using the SUS who might not have a wide support network, or whose partners might not be able to get time off to attend the delivery. The policy was an outcome of campaigning by the movement to raise awareness and gather public support, backing from key political actors who championed the cause in formal policymaking spaces, and the use of existing policy structures that could be built upon – most importantly, the existing volunteer network in public hospitals. The policy was supported by a law passed on 23rd December 2016, championed in the Senate by a councilwoman who was involved in the movement, which gave legal grounding to the doula public policy initiatives (Câmara Municipal de São Paulo 2016).

The doula policy was a particularly productive case study because I arrived back in São Paulo at the beginning of its second intake of trainees, and was therefore able to observe various stages of the policy, from training the volunteers through to their orientation in the SUS hospitals. I was also able to interview a diverse range of stakeholders, including the programme leads, trainee doulas, and women receiving their care. The policy's content was highly contested, as I discuss in detail in Chapter 7, providing an interesting example of the ways in which different actors struggled with one another in policy design.

My case study in the private sector was the *Parto Adequado*[17] policy programme. In March 2015, the Ministry of Health, the Agência Nacional de Saúde (ANS - health regulatory authority) and Hospital Israelita Albert Einstein in São Paulo announced that 23 private and 5 public institutions were selected to participate in a pilot study to incentivise normal birth, named *Parto Adequado* (ANS 2015). Developed in partnership with the US-based *Institute for Healthcare Improvement (IHI),* the initiative seeks to identify innovative and high-quality approaches to care during pregnancy and childbirth. The goal is to encourage normal delivery and reduce the occurrence of unnecessary c-sections, both in the private and public systems. The strategy involves ensuring adequate human resources, incorporating multidisciplinary teams into hospitals; professional training to improve vaginal deliveries; and a broad review of practices related to the care of pregnant women and babies, from prenatal to postpartum (ANS 2015). An evaluation in 2016 showed that participating hospitals had performed around 10,000 fewer c-section births (Diniz et al. 2018).

Attending *Parto Adequado* meetings early on during my fieldwork, I was able to meet a wide range of policy actors who were active in the public sector, including several of my key informants who I would interview multiple times over the years. Here I was also able to see the relevance of international policy models for the movement, because of the role of quality improvement methodology played in the design and implementation of the programme. These are just some of many key issues and strategies I identified by studying through these specific examples, which I now discuss in full below.

## The movement's many strategies

Below I list of all of the initiatives and strategies that I identified that contributed to changes in policy and practice. The three most important strategies: employing scientific evidence, incentivising demand, and the "multiplying" work of doulas, are each covered in the subsequent three chapters of this thesis with discussion of ethnographic data that demonstrate their central role in the movement's work.

Evidence-based humanised birth – activists drew on the power of scientific evidence to support their claims about the humanised birth both in policymaking settings and in encounters with individual doctors, positioning themselves in alignment with international

[17] The programme leads did not use the term humanised birth, arguing that all birth was "humanised" due to the fact that we are human beings (but also perhaps because its "alternative lifestyle" associations might be off putting to some of their clientele). Instead, they opted to name the programme 'Suitable Birth'.

best practice guidelines, and highlighting examples of where *cesaristas* were going against the evidence. This strategy is explored in depth in Chapter 5.

Stimulating demand in the private sector – the marketing birth group would "sell" humanised birth as an attractive product using imagery online and on social media. At the private humanised birth centres women would also share positive humanised birth stories in antenatal groups, and doulas trainees were given lessons in "marketing". This strategy is discussed further in Chapter 6.

*Multiplicando* – the idea of "multiplying" knowledge, ideas, policy and action. This strategy was more difficult to define, but was regularly referred to by my participants. It generally included everyday conversations between activists and members of the public, as well as the work of humanised health professionals – especially doulas – in providing care, which led to women *experiencing* the humanised model for themselves, and spreading this information by word-of-mouth, changing public opinion little by little. Multiplicando has also been recorded as an activist strategy in Perry's (2016) ethnography of Black women's activism in Salvador, Brazil. Here students involved in local community organisations become 'multipliers of political knowledge in the poor black neighbourhoods where they live' (Perry 2016: 102). *Multiplicando* foregrounds the political activity of individuals and their relationships with others in their immediate social sphere, and gives weight to the slow and steady change that can occur at this level. This strategy is explored in Chapter 7.

Research – academics who were involved in the movement were known to design and run research trials as a way to change practice in clinical settings in university hospitals, as well as adding to the body of evidence in favour of humanised protocols. *Multiplicando* was also used to refer to research conducted by movement members, in the sense that they "multiplied" the evidence that supported humanised birth. This knowledge was also disseminated at lectures and public events, including:

- Academic events at universities, to engage across disciplines and with students.
- *Siaparto* – a yearly symposium with international speakers, with around 1500 attendees, helped disseminate information to mainstream care providers.
- *Forum Perinatal* – another conference series with academics and policymakers working in the field of maternal health.

Movement "leaders" – there were a number of leading figures in the movement who were in positions of power, either in government, the legislature, academia or medicine, who were instrumental in supporting change from within these institutions. They included: Juliana, a

prominent councilwoman in the São Paulo legislative chamber; Adalberto, a paediatrician who supported the movement and was, at the time of my fieldwork, head of the department for women's health in the São Paulo Municipal government; and Alexandre, a São Paulo health minister under Dilma who continued to participate in politics. These people and others were in positions of power and could champion the humanised cause in formal political spaces and processes.

Celebrity role models – Famous women, including models and actors who had had normal and humanised births were interviewed on television and in magazines. The supermodel Gisele Bündchen, in particular, was regularly referred to as an inspiration for other women by movement members. This linked back to the power of consumerism in society, where celebrities endorsed consumer products. Here, celebrities used their fame in support of the humanised model of care. While they did not usually identify specific health professionals, they would have certainly delivered with a private humanised team at the best hospitals or at home.

Centres of reference – these are leading institutions that are well-known in the movement and outside of it for having successfully implemented humanised birth protocols. They include *Hospital Sofia Feldman*, a public hospital in the city of Belo Horizonte, Minas Gerais state and Casa Angela, the freestanding humanised birth centre in the *periferia* of São Paulo. The centres were cited frequently as success stories, and the outcomes of care for women were very positive. Importantly, they were well-known among the local communities in which they were located, meaning that awareness of humanised birth was increasing beyond white middle-class women.

Participating in SUS *Conselhos and Conferências de Saúde* – despite the generally pessimistic view of these processes outlined in Chapter Three, some leading members of the movement continued to participate in the municipal, state and national level councils and conferences. Deborah, one of the activists from *Parto do Princípio*, managed to get approval for her proposal to implement a *Forum Perinatal* for the municipality of *Santo André* (the idea of which was a regular meeting of health experts to develop policies to reduce maternal and infant morality).

Legislation and rights-based arguments – the movement worked in collaboration with lawmakers to ensure public policy drives were unwritten by law, meaning that they could take those who violated these laws to court. This process normally involved councillors proposing *Projectos do Lei*, of which quite a number are mentioned in this thesis. A small percentage of these have been approved and written into law, including the right to a

companion and the doula law, permitting doulas to enter public hospitals. Rights-based arguments – activists used the term 'obstetric violence' to draw attention to the intersecting forms of violence experienced by Brazilian women, connecting maltreatment during pregnancy and labour with international human and women's rights movements.

Social and mainstream media – Online activities by the movement have addressed humanised birth and obstetric violence explicitly, indicating that social media and the Internet are important tools to draw attention to women's health rights violations (Sena and Tesser 2017). These include an "Obstetric Violence Test" and the video documentary "Obstetric violence – the voice of Brazilian women" (Sena and Tesser 2017). Newspapers have also covered particularly shocking cases relating to c-section, including that of Adelir Carmen in 2014, who was forced to have the surgery against her consent (Filipovic 2014, Turner and Hill 2014). Key members of the movement have also spoken to news outlets to raise awareness of the problem, and advise the public on how to find normal birth providers.

Art and film – *Sentidos do Nascer,* a travelling interactive art exhibit, has "scenes" that the viewers walk through. Actors perform and take a comic approach to raise awareness of the c-section "industry" and the benefits of vaginal delivery. The exhibit also hosts seminars and discussion groups, and travels across the country. Films and videos made the movement's messages easily accessible to wide audiences. These include:

- *Renascimento do Parto* (The Rebirth of Birth) – a series of three documentaries about the intervention epidemic, obstetric violence on the humanised birth movement, which are widely viewed and available on Netflix with subtitles.
- *Violência Obstétrica – a voz das brasilieras* (Obstetric Violence – the voice of Brazilian women)
- *Parto Natural* (Natural Birth)
- Individual women would share videos of their humanised birth on online platforms such as Vimeo and Facebook.

Studying through policy resulted in my finding a wealth of activities and behaviours that movement members used to work towards their goals. Given the limits of time and space, and heeding the warning of other anthropologists who have used similar methods and caution against studying "too wide" and not deep enough, I decided to prioritise three of these strategies. The movement's use of evidence seemed a crucial issue to explore further. I was already aware of some of the debates around EBM and whether it fuelled medicalisation, and I was confident that examining the use of scientific evidence

ethnographically would contribute to this debate. I was also fascinated by the behaviour of some members of the movement who refused to engage with public policy making, and were adamant the most effective way to change hospital policy and practice was through inducing demand amongst paying clients. I decided to focus on this subgroup in Chapter 6, where I consider the problems with birth consumerism and resulting inequalities of access. Finally, it became clear quite quickly that doulas played a central role in the movement's work. I participated in three separate doula training courses to understand what doulagem involved and how multiplying knowledge about humanised birth was a slow but sure tactic in changing public and professional opinion.

# **Chapter Five:** Evidence-based humanised birth[18]

## 1. Introduction

This chapter examines the ways in which the humanised birth movement employs scientific evidence in their efforts to change policy and practice. One of the movement's central claims is that their aims to humanise obstetric care are in line with "the science"; that is, the best available international scientific evidence produced in quantitative research studies and clinical trials. Movement activists draw upon a wealth of locally and globally produced evidence to argue that their model of childbirth care, free from unnecessary interventions, has better outcomes for the mother and baby. Furthermore, they posit that the *cesaristas* who insist on continuing to practice routine episiotomy, inductions and elective c-sections without medical indication – are going against the evidence. Evidence-based medicine (EBM) and its associated research techniques, guidelines, and outputs are therefore important strategic tools for the movement. Activists employ this strategy in conversation and consultations, at academic and political events, on social media, and when formulating specific policies in their attempts to overcome the resistance of individual doctors and the powerful medical lobby. In this chapter I respond to an ongoing debate in medical anthropology and global health about whether EBM is limiting our view of what kinds of information are useful in designing health interventions by providing a nuanced perspective that examines the strategic ways scientific evidence is used by the humanised birth movement.

The underlying rationale of EBM is, in its simplest form, that healthcare practice should be based upon the best available scientific evidence, which will continually advance as research leads to greater objective knowledge about a particular illness or intervention. Proponents of EBM argue that 'treatments should only be administered if there is adequate evidence of benefit,' ideally in the form of systematic reviews and meta-analyses that collate and summarise evidence (Darzi 2008: 342). Lambert argues that in social-historical terms, EBM is not only a methodology but also 'a pedagogical movement, aimed at unseating the traditional authority of medical consultants through the introduction of rigorous scientific evidence based on epidemiological research' (2009:17). Given the huge volume of medical research published every day, EBM is also an attempt to condense and summarise findings

[18] The ethnographic data and themes discussed in this chapter and Chapter Six are also discussed in a forthcoming book chapter (Irvine 2021).

for busy clinicians through meta-analyses and systematic reviews such as those available on the Cochrane Library (Ecks 2008). The implications of EBM (and statistical reasoning more generally) for how decisions in healthcare and health policy are made, what kinds of research are financed, and how those working in this field derive meaning from data, are enormous.

At first it appears counterintuitive that the humanised birth movement would need to deploy evidence to argue against *cesaristas*. Surely all health professionals must "follow the science"? Why would doctors ignore or refute best practice, when it was so clearly in the best interests of their patients? From my own experiences training in the NHS, I would argue that the culture of EBM has become so strong in modern health systems that you would be very unlikely to encounter a healthcare professional who is not up-to-date with the guidelines and continually adapts their practice accordingly. But as I demonstrate in this chapter, this is not always the case, and there was certainly resistance to adhering to EBM guidelines from individual doctors and the medical establishment in Brazil.

A second question I consider here is whether the strategic use of EBM is helping or hindering the humanised cause. Anthropologists have raised concerns about the ways in which EBM has upheld, and even advanced medicalisation. The goal of EBM is to create a stronger scientific foundation for clinical work, in which statistical, experimental and epidemiological models of evidence are taken as the "gold standard" (Adams 2013). The primacy given to RCTs means that qualitative and ethnographic research findings tend to be seen as lower quality by clinicians and health policymakers, and that as a result, interventions that are effective but difficult to test using RCTs may be overlooked in public and global health policy planning (Johnson 1997, Ecks 2008, Adams 2013, Nichter 2013, Adams 2016a) and in obstetric care (Wendland 2008). These other forms of knowledge include low-tech behavioural interventions, many of which form the basis of midwifery-led care.

How do anthropologists challenge the misconception that only the evidence produced in RCTs matters? Ecks (2008) proposes an 'evidence-based medical anthropology' in which anthropologists not only study EBM and use it to reflect on how we collect evidence, or provide ethnographic evidence about socio-economic factors, but in which we go further and strengthen social perspectives *within* EBM. Ecks insists that 'evidence is not only selective; it is also strategic, and always used in relation to a particular audience. These performative aspects of evidence…can be studied ethnographically only by an evidence-based anthropology' (Ecks 2008: S85). It is this exact challenge posed by Ecks that I seek to

undertake here. Over the course of my fieldwork I was able to observe and investigate how evidence is *performed* amongst the policy community I was researching by taking note of the way in which evidence was deployed at public events and online, and the way in which my participants reflected on evidence in our interviews.

In this chapter I document the various ways in which movement activists draw upon the academic legitimacy and power of scientific evidence and EBM to further their aims. They use this evidence selectively, strategically, and in combination with other powerful discourses, particularly rights-based arguments such as the right to be free from obstetric violence. Ethnographic studies of specific policy communities demonstrate that scientific evidence can be used in alignment with policies that aim to reduce clinical interventions (such as midwifery-led care), and that this kind of evidence does not necessarily limit policymakers to top-down quantitatively measured interventions.

# 2. An ethnography of evidence-based humanised birth

## Evidenced-based humanised birth

For the past three decades international best practice guidelines and global health policy frameworks relating to maternal health and childbirth have largely been based on quantitative data and RCTs (such as the UN Millennium Development Goals relating to maternal mortality, and earlier iterations of the WHO guidelines for obstetric care which focussed on clinical safety rather than women's experiences of birth). These dominant knowledge systems, or "master narratives" (Nichter 2008) determine how, where and when policies are implemented. In maternal health, this tends to mean that shorter-term programmes testing a single intervention that can be easily measured and analysed for cost-effectiveness (for example, giving women tetanus shots in pregnancy to prevent maternal death) take preference over programmes that involve longer-term change and which are measured qualitatively (such as training doctors in patient communication skills).

This has changed significantly in more recent iterations of recommendations for best practice (WHO 2018) as I discuss in the introduction of this thesis. Anthropologists and social scientists have long worked to incorporate ethnographic evidence into RCT research, which can improve care practices (Adams 2016). The Cochrane review of continuous support during childbirth (Bohren et al. 2017), which movement activists draw upon heavily, is an update of long-standing reviews and evidence that is now used to support the work of

doulas in many different contexts. Qualitative data, women's experiences of care, and behavioural change interventions have all taken on a far greater importance in the global maternal health community in recent years. This suggests that at the global level, beliefs about "what counts" as acceptable evidence are shifting, and researchers are continually improving structures and methods for testing midwifery-led care and behaviour-change interventions in order to prove their efficacy.

How are best practice guidelines used in relation to childbirth policy and practice in Brazil? Do they have the name problematic effect of narrowing the agenda? Over my time in the field I observed movement activists speaking extremely positively about scientific evidence and international guidelines. Movement members and their supporters in government were using scientific research findings to design and implement policies with both broad and narrow objectives, using quantitative and qualitative data to inform their decision-making. The WHO's ideal rate of c-section (10-15% of births), for instance, was useful because of its simplicity and quantitative nature. There was a widespread understanding among the Brazilians I met over the course of my fieldwork that the country had a c-section rate that was problematic and which differed from the global norm. Even those who were in favour of a more medicalized model acknowledged the WHO's advice, but would go on to explain that 'Here in Brazil, it's just different…it's our culture,' and that 'Brazilian women can't cope with the pain like Europeans'.

Most of my interviewees were optimistic about the potential for *evidência científica* (scientific evidence) and *boas práticas* (best practice) to help Brazil move in the right direction, reducing unnecessary interventions and obstetric violence. Many of them referred to evidence 'helping' the cause, or that the 'evidence says' intervention was wrong or abnormal. Elena, the director of the Sao Paulo doula's association explained that:

> With humanised birth…you have scientific evidence that helps you. You have a huge box of scientific evidence which the World Health Organisation affirms...So I think this is why [the movement] is moving forward.

Marina, a mother and doula, also alluded to the central authority of the WHO evidence-based guidelines in the movement's messaging:

> ...we see a movement being driven by people who want to change the world...we need to change this, [obstetric] violence is not ok. We are getting more and more people to complain about what they see. As more and more information gets shared

> in society, [women] are seeing that - "Oh, what happened to me [during childbirth] it's not normal." - *The WHO says that it's not normal*. And we see that change happening because we are pushing it. Not only doulas, but also pregnant women who had their babies respectfully. We see it from midwives, nurses, and doctors.

Bianca, a leading *humanisada* doctor commented on the long-term relationship between EBM and the humanised birth movement:

> Cochrane, and the evidence movement, arose with the humanised birth movement…The first research in this area was done by midwives, because of the demand for midwife-led birth. Today it has spread to other areas of medicine.

This claim is supported by early publications by key actors in the movement, who have engaged with the EBM discourse and supported their arguments with scientific research since the 1990s. For example, ReHuNa's (the Brazilian Network for the Humanisation of Childbirth, est. 1993) main objective is 'to publicize evidence-based perinatal care that is in accordance with the World Health Organization guidelines' (Rattner et al. 2010: 215). Tornquist (2002) argues that scientific legitimacy has been explicitly sought by the movement, who have, since the beginning, entered into dialogue with the biomedical field, producing and disseminating epidemiological studies in perinatal and public health.

Maternal health researchers, many of whom are also obstetricians and *obstetrizes* involved with the movement, have generated much of the evidence that informed their activities (Diniz and Chacham 2004; Rattner et al. 2010; Niy and Delage 2015; Diniz et al. 2018). There is a significant body of research on the introduction of the Centros do Parto Normal (Machado and Praça 2006, Riesco et al. 2009, Lobo et al. 2010, Bonadio et al. 2011). More recent work has examined the perceptions of doulas (Lima et al. 2019) and the impact of the *Sentidos do Nascer* exhibit (Lansky et al. 2019). All of these studies have produced evidence that strongly supports the movement's work. A leading academic midwife, Vitoria, explained that many women from the movement had undertaken postgraduate studies in this area '*se tornarem pessoas multiplicadoras'* (to turn themselves into multipliers) of this evidence, thus adding to the pool of knowledge about humanised birth in Brazil. The idea of "multiplying" captures the sense that individual activists can still play a significant role in spreading the messages of the movement – in this case, by multiplying supportive research evidence.

Brazilian authors have also contributed to recent special journal editions on the global c-section epidemic, recognising the country's position as having one of the highest c-section rates, but also a potential leader in addressing the problem. The now former Brazilian Minister of Health, Gilberto Magalhães Occhi, published comment pieces in the *Lancet* about 'Brazil's strategic measures to reduce the c-section rate,' referencing CONITEC (the National Committee for Health Technology Incorporation, see below), *Rede Cergonha* and *Parto Adequado* by name (Occhi et al. 2018). This exemplifies strategic engagement with EBM as a discipline – movement members have developed a stance based on their hypotheses about the benefits of humanised birth, and actively seek to validate this through the scientific method. Or perhaps, more cynically, they have developed a political stance against obstetric violence, and use research methodologies to support their claims. Either way, the outcome is that they have evidence to utilise in their efforts to change policy and practice.

Clearly scientific rationale did not limit humanised birth proponents to top-down, technocratic policy approaches. Instead, clinical research and EBM guidelines were crucial tools that the movement used to bolster the authority of their claims regarding the benefits of humanised birth and to critique the overuse of clinical interventions. Evidence also supported the development of bottom-up and system-wide policy programmes such as the introduction of normal birth protocols and the Volunteer Doula Programme.

## Evidence-based humanised policy interventions

Over the past two decades, the techniques of EBM have gradually been applied more frequently across the disciplines of public and global health, and in the development of health and social policy. The use of EBM methods for developing, testing and evaluating policy interventions is known as evidence-based policymaking (EBPM). This extension into other fields has led to concerns that the methodological rigour of EBM does not sufficiently capture the complexities of human behaviour or the specificities of context (Béhague et al. 2009). Historically, these fields have valued and utilised qualitative data alongside statistics to assess the efficacy and value of health interventions. Today, quantitative studies are widely seen as more reliable, particularly by research and project funders.

Maternal health and obstetrics are included in this regime (Adams et al. 2016), making EBM and EBPM important subjects for a discussion of humanised birth. One particularly relevant example is the assessment of interventions based on their impact on maternal mortality ratio

(MMR), the indicator of choice for the Millennium Development Goals and other large-scale policy programmes. MMR requires a huge population sample to make estimates (due to it being a measure of the number of women dying of pregnancy-related causes per 100,000 live births), and is plagued by problems related to poor quality data. Despite this, it has continued to dominate maternal health metrics, partly due to the need to secure political support and funding in a competitive global health arena by using a comparable quantitative indicator (Oni-Orisan 2016, Wendland 2016, Storeng and Béhague 2016a).

EBM holds significant sway in developing national level health policy, with many countries – including Brazil – forming institutions that issue "best practice" guidelines for clinical practice[19]. While these institutions offer guidance rather than rules, this is usually closely adhered to (there are many examples where the NHS policy closely followed NICE guidelines). Movement academics and health professionals have designed and implemented humanised policy interventions at the national and local levels that are clearly informed by best practice guidelines and influenced by successful initiatives in other national health systems.

In 2011 the federal government established CONITEC to make recommendations for the use of medicines and procedures in the SUS based on the best available scientific evidence. Vitoria explained that CONITEC and its guidelines are modelled on the UK's National Institute for Health and Care Excellence (NICE) and similar initiatives such as the Belgian Health Care Knowledge Centre. In 2016 CONITEC published best practice guidelines for c-section and normal birth (Ministério da Saúde, CONITEC 2016) after a public consultation process that brought in several thousand professionals and members of the public, many of whom were members of the movement. Despite this, CONITEC does not hold sufficient political power to make these guidelines enforceable. At this point, there is not a sufficiently strong culture of support for EBM as seen in other countries with similar institutions (such as the UK and Belgium). Despite this, many activists expressed confidence that this culture was growing.

*Rede Cergonha* the national level programme for humanisation, included recommendations for the implementation of *Centros do Parto Normal* (CPNs, normal birth centres) a policy intervention that has been implemented in many health systems successfully over the past couple of decades, including the UK (McCourt et al. 2018), Australia (Laws et al. 2009) and

[19] The UK's National Institute for Health and Care Excellence (NICE), for example, evaluates clinical research and publishes guidelines that shape government health policy and NHS practice, and increasingly shape policy in other national health systems.

Japan (Iida 2012). Comprehensive research has concluded that for low-risk women, giving birth in a midwifery-led unit has better outcomes for the mother than the obstetric unit (Birthplace Collaborative Group 2011). The aim of the CPNs is expressed in quantitative indicators, such as: to reduce the maternal and neonatal mortality rate, and to reduce the number of unnecessary caesarean sections in the public health system (Área Técnica de Saúde da Mulher 2013). This is despite the fact that CPNs are a relatively “low-tech” intervention, usually involving larger rooms with space for women to move around during labour, and simple infrastructure to support them, such as birth pools, stools and other supports.


*Image 11: Taken in the obstetric ward of one of the hospitals participating in Parto Seguro. The heading reads ‘Indicators’ and the various graphs demonstrate the quantifiable progress this hospital has made in implementing humanised protocols to reduce the rates of c-section and episiotomy, and increase breastfeeding rates and so on.*

Local level humanised policies, including *Parto Seguro* and *Parto Adequado*, were based on WHO recommendations and NICE guidelines such as freedom of movement and positioning during labour, water birth facilities, non-medical analgesia, delayed umbilical cord-cutting and breastfeeding support. *Parto Seguro*’s aim is to ‘ensure high quality humanised obstetric

and neonatal care based on scientific evidence' (CEJAM 2019). The programme director, Maria, repeatedly stressed the importance of clinical evidence and internationally recognised models of care in the programme's design:

> We're leaving the biomedical model behind and advancing towards the humanised model. And what helps us in this process are our indicators and goals. We use the Robson classification system[20] now too…I say to the doctors – "You're doing caesareans on group two – who are low-risk women!"

Carolina, an obstetric nurse who led the Volunteer Doula Programme, spoke about how best practice recommendations had informed the policy protocols, pointing to the Cochrane review of continuous support for women during childbirth (Bohren et al. 2017). This systematic review summarises findings from 27 clinical trials, and finds that one-to-one continuous emotional support during childbirth has favourable outcomes, including decreased caesarean rates (Bohren et al. 2017). The Cochrane Library of systematic reviews is a key institution in the global EBM movement, and exists to provide summaries of published data and research in specific health policy and practice questions. *Cochrane Brasil* is an associated national non-profit NGO whose objective is to develop and disseminate systematic reviews of RCTs (Cochrane Brasil 2020). Because such a large proportion of global health research and best practice is written in English, Cochrane Brasil is also working to translate some of the most accessed systematic reviews, the first of which is highly relevant to the movement, entitled 'Early skin-to-skin contact between mothers and their healthy newborns' (Moore et al. 2012).

Movement activists were conscious of the academic weight of successful international policy models, and were working to translate and adapt these into the Brazilian context. This is another example of how the movement members drew on powerful international examples to bolster their own activities. Here then, the "master narratives" of EBM (embodied in institutions such as Cochrane and NICE), were not a hegemonizing force, but instead could be used to show resistant doctors that they were not in line with the evidence.

[20] In 2015 the WHO proposed the Robson classification as a global standard for assessing, monitoring and comparing caesarean section rates (WHO 2017). It helps health professionals to classify women into risk categories, and to subsequently identify which groups of women contribute most to c-section rates.

## Evidence-based advocacy

In their ethnography of the international *Safe Motherhood Initiative* (SMI), Storeng and Béhague (2014) describe how global health actors engage in "evidence-based advocacy" (EBA) – that is, the use of quantitative scientific evidence, rather than moral arguments, to support policy change in maternal health. EBA is related to the broader shifts of EBM and EBPM in that the gold standard is quantitative cost-effectiveness evidence, which is used to calculate the value of health interventions for reducing maternal mortality (Storeng and Béhague 2014). EBA has profoundly affected evidence production and research design, bringing about a "technocratic narrowing" of the policy agenda, in which international responsibility for women's rights are downplayed, and policy is less ideological.

EBA is not an objective knowledge system removed from ideology, however, but is in fact contested by the global health actors who utilise it. EBA is embraced in order to bolster the SMI's scientific credibility and to demonstrate its "value for money", and also used cynically 'to highlight that the use of evidence to "sell" safe motherhood to global donors sits in detrimental contradistinction to the more necessary problem-solving and analytical form of evidence-based policymaking' (Storeng and Béhague 2014: 262).

In Brazil, rights-based arguments have been employed *alongside* evidence-based justifications for improving maternal health services since the beginning of the humanised birth movement's activism (Irvine 2021). Like the actors in the SMI, many of the movement's founding members participated in the feminist movements in the 1970s and 1980s, and their ethical stance on childbirth continues to be informed by moral arguments. Storeng and Béhague identify ways in which some safe motherhood experts have resisted "technocratic narrowing" by 'couching [their] ideological and moral convictions in the language of scientific evidence for the sake of political expediency' (2014: 274). My findings suggest that the humanised birth movement has employed this strategy from its beginnings in the 1990s (Irvine 2021).

The term 'obstetric violence' (discussed in depth in Chapter Two), founded in a rights-based legal approach, has been a centrally important concept in their efforts. Activists would use the term 'obstetric violence' to indicate that they saw the poor treatment of Brazilian as a violation of rights, in addition to describing the issue as a public health problem (the c-section "epidemic"), and referring to systematic reviews that supported a humanised model (such as Sandall et al.'s 2016 systematic review of midwifery-led care). Members would decide which strategy to use (or whether to use them all in the same speech, legal

document or social media post) depending on its perceived effectiveness and on who the audience was.

Maria was deeply enthusiastic about the evidence that the programme was based on. She explained:

> In the universities, doctors continue to maintain the biomedical model. So when they arrive here with me...we run a course on different birth positions...they want to learn how to do the lateral birth position, it's wonderful! Then they sign everything, all the documentation, against obstetric violence. All this to diminish obstetric violence...For a doctor to use [synthetic] oxytocin, he has to justify it. After informing the woman of her rights.

Rosa, a young pregnant woman who had recently trained as a doula, described specific clinical interventions that are contraindicated in best practice guidelines, such as routine use of episiotomy, as obstetric violence: 'women, principally black women from the periphery, suffer [obstetric violence] the most…we have cases where women have had the cut on the perineum without anaesthesia, and this is recurrent'.

Obstetric violence was a recurring theme at public academic events on maternal health and childbirth, which were clearly framed as being informed by scientific evidence. In November 2015 the University of São Paulo Faculty of Public Health hosted a conference entitled 'Best practices to counter obstetric violence'. High profile speakers from academia and government, such as Professora Simone Diniz (a leading academic involved in humanised birth) spoke about the effect of obstetric violence on physical and mental health indicators. Most of the seats were empty, but those who attended listened carefully. Simone spoke first about the progress made so far by the movement in 'changing the culture' around obstetric violence, before going on to refer to the 'maternal health research that discusses obstetric violence, and the women's and human rights movements that have focussed on this since the 1990s', again drawing together the discourses of evidence and rights. The State Secretary for Health, Dr Alexandre Padilha, gave a plenary speech discussing the 'gold standards and best practices' to reduce obstetric violence. Dr Adalberto Aguemi, the director for women's health at the Municipal Health Secretariat, spoke about *local* best practices in place at the *Casas de Parto* (Birth Centres) of *Saboipemba* and *Casa Angela*, such as the non-pharmaceutical methods for analgesia used by the *obstetrizes* and obstetric nurses. He also mentioned the municipal hospitals participating in the *Parto Seguro* programme, proudly announcing that 86% of normal births were attended by obstetric nurses at these facilities.

For these humanised birth movement members, evidence and best practice had not narrowed the agenda, and could be used in close proximity to moral and rights-based arguments, as well as in highlighting the successes of local level system wide interventions.

Elsewhere, *Rede Cergonha'*s programme website states that: 'Every woman has the right to reproductive planning and humanized attention to pregnancy, childbirth and the puerperium (postpartum)' and that 'the implementation and expansion of the program follows an epidemiological criterion, infant mortality rate and maternal mortality ratio'. References to rights are again alongside explanations of quantitative parameters that inform and measure policy design and successful implementation.

The right to quality humanised care came up frequently in interviews. When discussing the Volunteer Doula Programme, a leading academic argued: 'doulas improve outcomes for babies and women, so a doula should be a right in the SUS'. One of the few working *obstetrizes* described the movement as a 'battle for rights', another explained that women had 'the right to a home birth,' and another still stated that a woman has 'the right to a professional companion of her choice'. These activists consistently referred to rights at the same time as the clinical evidence that supported these interventions. Some would mention specific well-known studies (international guidelines, Birthplace in England, Cochrane reviews), and others would just refer to 'the literature' or 'science,' indicating that from their perspective, their aims, women's rights, and evidence in the most general sense were all aligned.

Like Storeng and Béhague, I found that members of the humanised birth movement strategically use the power and perceived objectivity of scientific evidence to further their goals, many of which might otherwise be seen as principally the concern of feminist and human rights movements. While the authors observe that "playing the numbers game" with EBA has brought about a technocratic narrowing of the policy agenda, they note that 'some experts are making new and creative uses of evidence in their efforts to reintroduce justice, equity, and rights into maternal health policy debates' (Storeng and Béhague 2014: 262). The humanised birth movement has explicitly framed their campaigns as *combining* evidence-based and women's reproductive rights perspectives this strategy from its beginnings in the 1990s (Diniz and Chacham 2004, Rattner et al. 2010).

## Lay understandings of evidence

The evidence produced in research, and disseminated through platforms like Cochrane, had trickled down to non-expert movement members and wider populations of women who were seeking humanised care. These lay movement members shared clinical evidence through social media and personal networks in order to disseminate knowledge. The frequent citation of scientific papers and best practice guidelines on these groups meant that doulas and women who sought out humanised care were familiar with and confident using scientific terminology, despite not being clinically trained. Vitoria explained:

> …women already know how to translate this information. What is a meta-analysis, what a study with *x* number of participants means, what strong evidence is…this entered into the imagination of women, and they began to use these terms, and these became part of the political strategy of these [humanised] groups.

Her observation that the scientific method 'entered into women's imagination' hints at how women have taken up the powerful discourse of clinical research to legitimise their support for normal birth. Marina, a biologist by training, had given birth to her 1-year-old daughter at home with a humanised team. Initially, her colleagues told her she was crazy for attempting a homebirth. Her positive experience had led her to undergo doula training herself, at GAMA. She elaborated on the importance of evidence in her work:

> I refer to the scientific information. But it's funny that doctors don't use that. Doctors use fear, and their own experience, to say that something is right or wrong and that their way of doing something is the best one...I use real scientific information.
>
> Those that are open to listen to it, they are going to hear me out. Those that are not open, I can suggest papers, but they won't listen to me. Because it's a door that only opens from the inside. But I can try to plant that seed inside of her. And the next time that she's pregnant she might remember what I said. And she might think, maybe my doctor was not right...There are better ways of doing things.
>
> Evidence has power, because it's not me just thinking it's the best. Studies have shown that those are the best policies. They have better outcomes for health, for results, so we need to use that. Because that information is being shared, it's available for more and more people…that is what's driving the change.

Another doula, Clara, was based at Casa Moara, and had incorporated a wide range of "alternative" practices into doula work. She explained that her courses on humanised birth and hypnobirthing were 'a way of bringing people closer to scientific evidence'. Mothers and pregnant women had taken to using scientific evidence to promote the movement's messages among their friends. Luiza, an upper-class mother who had had a humanised birth with her six-month-old son, explained that she would share the WHO recommendations with people and that she had 'bought a book just about c-sections. I would bring the book with me and would tell my friends who are pregnant about it.' Here we see another example of evidence being used strategically, with a specific audience (upper-class mothers) in mind. However, Luiza found her friends were unconvinced: 'Because I am not a doctor. Because there is this insane blind trust in doctors today.' This suggests that people attached importance to *who* was delivering scientific evidence - in this instance it was not powerful enough to stand on its own, or be communicated by a lay-person.

Facebook and Whatsapp groups were used as platforms for the dissemination of research and evidence. Open access articles and Cochrane reviews were regularly posted, framed by comments encouraging people to read them and a liberal scattering of emojis. In one widely shared Facebook post from 2018, a midwife involved with the movement exclaimed "We here are submerged in the "coup" (the impeachment of Dilma) but at least we have Cochrane!", above a link to a Cochrane webpage explaining that a new national licensing agreement provides Brazil with unlimited access to the Cochrane Library.

One mother explained that Facebook was a "tool" for the movement where women could exchange information and share their birth narratives, as well as warning about *cesaristas* who claimed they would provide humanised care but continued to have high rates of c-section. Social media platforms were extending the movement's reach to poorer women in the *periferia*. These women, almost all of whom used SUS services, were not as familiar with EBM terminology as middle-class members of the movement. According to obstetric nurses in hospitals in the *Parto Seguro* programme, however, they were certainly aware of the positive stories passed on from friends and relatives about the hospitals that had introduced birth pools and allowed partners to enter. Access to and awareness of this kind of "expert" knowledge and evidence gave women and humanised health professionals greater power in encounters with resistant doctors.

## Resistance from doctors

Despite the evidence supporting the movement's claims, its members experienced varying degrees of success in confronting *cesarista* doctors. Humanised obstetricians, midwives and doulas all spoke about *cesaristas* being aware of the evidence but refuting it by either dismissing it as insignificant or insisting that it was unreliable. Fernanda, who ran *Multiplicando Doulas*, described her use of a birth plan 'as the WHO recommends' with a woman she was supporting: 'The woman did not want an episiotomy – I told the doctor this and showed him the birth plan and he said "Oh but it's just a little cut" and does it anyway'. It is unclear whether this doctor really believed episiotomy is a minor event, or if he is trying to justify behaviour he knows is incorrect. Bianca, a leading humanised doctor, explained that many doctors refute EBM:

> There are lots of doctors who unfortunately think that this evidence is not reliable, that the evidence is manipulated...The oldest ones, the professors, from famous universities here in Brazil, defend caesarean. They defend lots of interventions. It's difficult for someone who has practiced in a certain way their whole life to change...In the long term I think all practice will be evidence-based. But today there is still a bit of resistance. A lot less than before though, because this message from the WHO is huge.

Others felt that doctors still had sufficient authority to blatantly ignore guidelines:

> The doctors have access to the same scientific evidence that we doulas, and humanised doctors have. But they keep telling the pregnant women that episiotomy is better, that it's necessary...They lie.

Fernanda pointed out that according to the Brazilian medical ethics code, doctors have a responsibility to stay up to date with the best available evidence, but that 'episiotomy has gone from the guidelines and still doctors do it. How can it be a rational decision to do an episiotomy without anaesthesia? I have various scientific articles, with all this evidence about these things.' Another doula had shown multiple doctors international policy guidelines only for them to shrug her off and say 'Brazilian women are different – this doesn't apply here.' Sara told me it was common for doctors to perform a c-section because of "foetal distress" when none had been recorded, or because the baby's umbilical cord was wrapped around its neck (not an indication for c-section).

Movement members who spoke out against malpractice risked a backlash from the powerful medical establishment, particularly if they were “non-experts”. A woman who denounced her obstetrician on Facebook for performing an unnecessary episiotomy without anaesthesia, was accused of being ‘hormonal’ and ‘unethical’. ‘Being an activist in this area is horrible,’ a doula told me, ‘this is what it’s like to be a woman, and the doctor being a man, with power, money and connections’.

The movement blamed the self-interest of doctors and considerable political influence of the Brazilian Medical Council (CFM) for the resistance to evidence-based policy change. In recent years they had fought against handing over management of the normal birth centres to midwives, allowing homebirths, and the introduction of volunteer doulas. Doctors were seen as powerful political figures with considerable influence over policymaking, who fought aggressively for their professional interests at national and local levels. Isabel, the midwife who ran GAMA, explained: ‘In Brazil, doctors are very mixed up in politics. So when you offend the doctors, you lose votes…and the doctors are strong, they have money, they have power’.

A well-known politician involved in the movement explained that scientific evidence was very valuable to the movement because it opened up space for political debate with doctors.

> The doctors’ associations strongly defend their beliefs about the role of the doctor in ‘driving’ the process of birth, about surgical intervention – and they mobilise around these interests. They feel they must defend the figure of the doctor. And the humanised model threatens them, because they have a diminished role. Instead, the obstetric nurses, obstetrizes, doulas have an important role. They fear dividing their power with other professions. And of course, there are clear financial interests. So evidence, such as the recommendations from the WHO, and Cochrane, are very important for this technical-political debate – to sustain the defence of humanised birth. But evidence on its own is not enough to confront the c-section industry.

Despite the resistance reported in Brazil, almost all movement activists were optimistic that the strength of the evidence was a slow but unstoppable tide of change. When I interviewed Marina in February 2018, she told me that the Ministry of Health had just published the revised WHO guidelines for respectful birth on their website.

> So we are using it to say – “See people, the Department of Health, it's telling you what I've been telling you, what the studies have been telling you”. Unfortunately, a lot of people are still saying – "Well, my doctor knows best". And what we try to say is that their doctor may not be up-to-date, and we recommend other guidelines. Information is everything. Like, she's not going to trust me because my homebirth was amazing, but she's going to trust me that the percentage of fatalities are bigger in c-sections than in vaginal births. Because that's a study. That has power.

# 3. Discussion

My research findings demonstrate how important evidence was for the humanised birth movement. Activists used evidence strategically depending on the target audience, employing different forms of language, or referring to different types of evidence if they were speaking to mothers, challenging doctors, or seeking to influence formal policymaking processes. Academics might refer to specific studies or data to inform specific policy designs. Non-experts tended to simply deploy the strength and power associated with a vaguely defined “evidence”, or to personify “science” as a force that could prove their claims and help them confront *cesaristas.*

Scientific evidence was one of several crucial tools that the movement used to bolster the authority of their claims regarding humanised practices, and to develop bottom-up and system-wide policy programmes. Movement members used evidence creatively, and in combination with other arguments, including rights claims against obstetric violence. Here, moral claims have not been superseded as they have in the global health arena (Storeng and Béhague 2014), but were used by members of the movement alongside references to EBM guidelines. In research papers, key actors have explicitly framed their campaigns as combining evidence-based and women’s reproductive rights perspectives (Diniz and Chacham 2004, Rattner et al. 2010). For instance, using the term ‘obstetric violence’ to indicate the poor treatment of Brazilian women as a violation of rights, a public health problem and a contradiction of strong scientific evidence as laid out in various systematic reviews.

Storeng and Béhague (2014) argue that political struggles for influence and funding at the global level can have the negative effect of narrowing the agenda, meaning less attention is given to broader political and social changes that are needed to improve maternal health. In Brazil, the movement has incorporated EBM language and methods into their work in

response to politics at the *local* level, for example, in their efforts to overcome the professional interests of individual doctors and the broader conservative medical lobby. In response to the question of whether this narrows the agenda in Brazil, I have argued that for the most part, evidence is used to support policy interventions that are broadening the agenda, in that they are often horizontal programmes that involve retraining staff and reforming practice across multiple hospitals. In these, some, if not all of the necessary social changes are considered – such as changing the 'culture' of medical practice and improving public awareness of the benefits of normal birth.

In Brazil movement activists face an ongoing struggle with resistance from doctors and politicians, who have openly refuted the applicability of globally produced evidence in the context of Brazilian hospitals. This is one of the reasons why the movement employs various strategies in their work – where evidence itself is not enough, they appeal to rights-based discourse, market mechanisms and even external global health actors to support them. The dismissal of evidence described by my participants is supported in other research in Brazil (Tornquist 2004). McCullum and dos Reis found that 'some doctors prefer to disregard the literature', and that 'a senior medic insisted that the WHO recommendations on oxytocin do not apply to public maternities in Brazil' due to institutional "reality" and to the 'nature of the clientele' (2008: 45). In their interviews, doctors would often give the "correct" answer about whether a practice was in line with best practice guidelines, but would then continue to perform unnecessary procedures, seemingly with the belief that the specific circumstances of Brazilian public hospitals justified this (McCullum and dos Reis 2008). These findings echo Ecks' (2008) vignette from his ethnographic research into evidence-use by doctors treating depression in India. Ecks found that GPs and psychiatrists had very differing views on whether reliable evidence existed on this topic, and that neither group quoted any medical evidence. He also observed that GPs cited their own observations or interactions with patients, admitting social factors to count as evidence, whereas the psychiatrists stressed the lack of any reliable data (Ecks 2008). This work is further evidence that even when doctors are aware of EBM and required by their professional codes of conduct to follow it, they might still not use it, or even refute it due to their own personal views and biases. Resistant health professionals and the institutions that represented their interests were in some circumstances able to reject global best practice guidelines, refuting their suitability for Brazilian women in their care. In response to this, some subgroups of the movement have turned their efforts to other strategies, such as the marketing strategy discussed in Chapter Six.

The concerning and blatant disregard of scientific evidence in Brazil has been noticed by other commentators. In her research on forestry and pesticides policies in Brazil, Donadelli (2020a) warns against assuming that given the right conditions of scientific consensus and communication, the evidence-policy gap will narrow. The specific history and political context of Brazil (outlined in Chapter 3), mean that Brazil has low levels of political openness and consensus in decision-making (Donadelli 2020b). When combined with a highly conservative political establishment, these factors 'have proven particularly disastrous for the incorporation of scientific evidence in processes of policymaking in the country' (Donadelli 2020b: no page).

The links between scientific evidence and birth consumerism are explored by Rossiter (2017) in her work on the ecstatic birth movement in the US. She observed that the feeling of ecstasy that some women experience during labour – which many seeking a natural birth desire – is portrayed as a biological fact, which further enforces the self-discipline (pregnancy yoga, a specific diet, hypnobirthing) required by mothers. In contrast, Wendland (2008) finds that the cultural values that surround market capitalism are visible in the previously dominant evidence-based calls for caesarean. Here 'safety and consumer ideology inter-penetrate with the veneration of technology, the institution, and patriarchy in such a way that they become located in the hospital and embodied in the doctor, whose tools and technological expertise become the safe fetal space to be purchased by expectant mothers' (Wendland 2007: 225). In the final chapter of this thesis, I discuss these connected themes in more detail, drawing together the discussions of birth consumerism, scientific evidence and clinical practice.

The growing body of evidence regarding the risks of non-essential interventions has given movement activists material to work with in terms of proving their methods are safe. For the most part, the science seems to align with their goals to normalise birth, rather than to contradict them and further the reach of medicalisation. This has been observed in other similar movements around the world. Writing in 1997, Johnson observed that 'science-based evaluation of care has proven strongly supportive of many aspects of woman-centered, low-intervention midwifery care' (1997: 352). More recently, Basile observes a similar trend in the US, where the natural birth movement has 'relied increasingly on the science-based evaluation of obstetric practice' and that the results of RCTs and systematic meta-analyses, in particular, in 'have become central components of the critique of the medical management of labor and birth' (Basile 2012: 77). She notes that while there is some concern among birth advocates that 'dependence on EBM might ultimately undermine the hard-won value, within natural birth communities, of nonscientific, embodied forms of knowledge about birth', these

women acknowledge the power in the language of science, and that they must 'speak to biomedicine in its own language' (Basile 2012: 77). The DONA (the world's leading doula certifying organisation) website states that 'countless scientific trials examining doula care demonstrate remarkably improved physical and psychological outcomes for both mother and baby (DONA 2020). Macdonald found that natural birth was being redefined by midwives in Canada as 'a version of nature that makes room for biomedical technology and hospital spaces, underpinned by the logics of caring and choice within midwifery' (2006: 236). Moving beyond imagined lines drawn between 'natural' midwifery-led care and 'medicalised' obstetrician-led care, and doing so by following a *broad* range of evidence, is demonstrably improving the services available to women in different health systems, including Brazil's.

In contrast to the concerns of critics of EBM, it is at best overly simplistic to paint EBM as an extension of biomedical logic. Such an oversight misses the important work of maternal health activists who strategically draw on a complex array of scientific evidence, moral arguments, rights claims and personal experience to advocate for improvements to obstetric care. In fact, some of the best available international evidence supports low-intervention, midwife-led care for low-risk women. In the field, I found many examples of ways in which activists were, in fact, using scientific evidence intelligently to support normalising birth and the reduction of unnecessary medical interventions. The movement is, essentially, making use of the scientific method to prove that less "science" (in the form of obstetric technology) is needed to support healthy women in giving birth to healthy babies.

Another important finding is that evidence and scientific data are no longer considered as being exclusively for the use of academics, but for wider use by "non-experts" in supporting their work (in the case of doulas) or in accessing the kind of care they want (in the case of pregnant women). Arguably, this has not gone hand in hand with information or training on how to assess the validity and meaning of research outputs. This links back to some of the criticisms made by anthropologists about the generalisability of research findings and how they are widely interpreted. Epidemiologists themselves acknowledge that trials which show efficacy among participants may not have "external validity" in distinct or distant populations (Lock and Nguyen 2010). Some writers in this field have warned about the dangers of universal access to scientific evidence, without the tools needed to interpret it (Oliver K, personal correspondence, 2018). Nonetheless, the awareness of the outputs and methods of research among members of the public as well as academics and health professionals was an overwhelmingly positive development for the movement and once which aided the dissemination of their key messages.

While the concerns of Ecks (2008), Wendland (2008), Adams (2012, 2016) and Adams and Biehl (2016) about the negative impacts of EBM and its extension into global public health and obstetrics are valid in some instances, I wish to make a more nuanced argument. EBM is continually evolving, by the iterative nature of research and the dissemination of the evidence. While there is undeniably a dominant "mainstream" way of conducting research that prioritises RCTs, over the past decade the EBM movement has broadened to incorporate a wider range of evidence (including qualitative and even ethnographic findings), and to test non-pharmacological interventions that are relevant to childbirth. More recent critical works, however, such as Adams and Biehl (2016), Briggs (2016) and Kaufman (2016), do not acknowledge this evolution. For instance, in Brigg's (2016) ethnography of a rabies epidemic in Venezuela, he argues that specific types of evidence (clinical medicine and epidemiology) were 'made mobile' while others (observations from parents and healers) are demoted to the status of ignorance or superstition. Kaufman (2016) reflects on the use of implantable cardiac defibrillator in the US, and argues that the 'cultural capital' of evidence-based medicine can be a source of anxiety for patients and families making decisions about what treatments they find acceptable. It could be the case that in these two specific settings, EBM continues to lead to problematic hierarchies of evidence and dangerous 'regimes of truth'. Based on my own research experience, I would argue that portraying EBM as a homogenous movement that furthers medicalisation and private sector interests fails to capture its power for good. EBM is not an autonomous force, with agency. It is enacted by people, and is therefore necessarily dependent on the specificities of context, and influenced by behaviour and normative values at the level of local governance and individual relationships - in the case of childbirth, most importantly, between the woman and the professionals providing care. Some of this difference can be explained by context – for instance, the ways in which evidence is deployed on the global health stage in a context of philanthrocapitalism is quite distinct from how it is used in the development of public policy where there is a national health system and strong academic tradition in collective health and activism, as in Brazil. Within the specific circumstances of the humanised birth movement in São Paulo, EBM and its correlates are predominately used to improve maternal health services, measurable by a wide range of outcomes (including the subjective experiences of women).

This ethnographic exploration of evidence captures the varying and contested meanings it carries in a real-world context. Far from a clean, rational process, evidence-based decision-making is actually observed to be complex and manipulated – not in the sense that the evidence itself is altered, but that specific elements are selected or highlighted depending on the purpose and audience. Returning to Parkhurst's (2017) contrasting critiques of evidence

use in policy making (where evidence is either manipulated for political purposes and therefore not adhering to scientific best practice, or where social values are obscured through the promotion of certain forms of evidence), it seems that the use of scientific evidence is somehow both of these at once, but for positive results. Social values (reducing obstetric violence and improving women's experiences of birth) are in fact, given prominence through the promotion of scientific evidence, and this is done for political purposes (to change health policies).

Hacking (1990) famously observed that the systematic collection and categorisation of data has transformed how we view others and ourselves, how we think of our own possibilities and potentials. In taking a historical approach, Hacking shows the erosion of determinism in the 20th century and the shift to understanding events in the world around us as a matter of probability, of society as knowable through statistics. Numbers are interpreted as being apolitical and morally neutral, which is, according to Wendland, 'precisely why they can be mobilised so effectively for moral and political projects' (2016: 61). EBM is therefore, only a recent development in a much longer history of counting and categorising all aspects of our lives. One relevant example here is the way we determine whether women are "high-risk" in pregnancy. Based on statistical information, we assign them a category even if they are not (yet) unwell, determining where and how they give birth.

# **Chapter Six:** Humanised Birth Consumerism: Stimulating Demand as a Strategy for Change[21]

## 1. Introduction

This chapter explores the activities of the humanised birth movement in the private sector, and considers the extent to which stimulating demand for private humanised care is an effective way for the movement to achieve their goals. Over the past decade there has been a surge in demand for private humanised birth services in São Paulo and other wealthy urban areas in the South and Southeast of Brazil. These services involve women and their families hiring their own private birth team, usually including an obstetrician and/or midwife or obstetric nurse, a doula, and sometimes a paediatrician, photographer and videographer. Women using these services usually deliver in one of the private hospitals that permit humanised birth teams to work on their wards. A smaller number of women opt for a homebirth with private midwives and doulas[22]. In delivering high-quality humanised care, opportunities arise for humanised health professionals to *multiplicar* the messages of the movement, demonstrating that this model is safe, and a positive experience for women in their care.

All of the humanised health professionals that I interviewed reported a growing number of requests for their services. The most well-known doctors and doulas were so in demand that they were unable to respond to all enquiries, and instead would pass on the details of trusted colleagues in the humanised movement. The membership of Facebook and Whatsapp groups where women ask for information and find the contact details of private humanised health professionals has soared over the past five years. The Facebook group '*Parto Humanizado - Brasil*' has around 15,000 members, and the humanised birth centre *GAMA*'s page has 32,000 followers. The page for '*O Renascimento do Parto*', the famous documentary series about the c-section epidemic and the humanised birth movement, has over 300,000 followers.

[21] The ethnographic data and themes discussed in this chapter and Chapter Five are also discussed in a forthcoming book chapter (Irvine 2021).

[22] Homebirths are a legal grey area in Brazil. Data on place of birth includes only all births not taking place in hospital in the same category, and does not differentiate between which professional provided care. Despite this, a recent study found that homebirth care was evidenced based and high quality, with low levels of unnecessary intervention (Koettker et al. 2018).

The supply side of this market is growing to meet demand. Over the years immediately preceding, during and after my fieldwork, rates of vaginal delivery in both public and private sector were rising, in some cases dramatically (Leal et al. 2019). Research into these shifts suggests these vaginal deliveries are increasingly "humanised' in that they follow international best practice guidance, such as allowing a companion and movement throughout labour, and that they do not include routine unnecessary procedures (Leal et al. 2019). Doula courses are now held at São Paulo's private humanised birth centres monthly, with 20 newly trained doulas graduating each time. While some of these trainees attend the course because they want to support a friend or family member, many aspire to become a doula for private clients. Other doulas expressed an intention to multiply humanised birth for disadvantaged women in poorer areas of the city.

Obstetricians and private hospitals that have predominantly provided c-section deliveries until very recently claim they are willing to perform normal births in order to attract clients. However, at least four women I interviewed had had similar experiences with their family obstetricians[23], who claimed that they would provide a normal delivery but then performed a c-section delivery at the last minute, insisting it was clinically indicated. These women, who had subsequently become aware of the humanised birth movement and its messages, felt that upon reflection this may not have been the case. At the same time, private hospitals had begun to provide "packages" of humanised birth services and products, refitting existing delivery rooms with birth pools and wall supports, and retraining in-house on call teams to follow normal birth protocols. One key example of this is the *Parto Adequado* programme at Hospital Einstein, which I discuss as a case study in this chapter.

This rise in demand can, in part, be attributed to the deliberate "marketing"[24] of humanised birth as a desirable birthing option by members of the movement. A subgroup of movement members, which I call the 'marketing birth group', was deeply disillusioned with trying to change public or hospital policy through political procedures or appeals to rights-based discourse. Members of this subgroup tended to work as doulas or doctors who provided private consultations either in women's homes or humanised birth centres. Many were well-known figures in the movement and had a significant online following on social media platforms. They sought to influence hospital policy and practice, and public opinion, by

[23] Many wealthier Brazilian women have a family obstetrician and/or pediatrician who provides care for family members across multiple generations. Women therefore have a long-standing relationship with their family doctor and may feel a certain level of allegiance to them.
[24] Interestingly, the English word 'marketing' has been directly incorporated into Brazilian Portuguese.

inducing a rise in demand for humanised birth. They believed private services would necessarily have to adapt to this demand, and thus care would become more humanised as a result of market forces. São Paulo was a consumer society, they argued, and therefore the way to change public opinion and hospital practice was to stimulate demand among paying clients. Some even speculated that this would have a secondary effect on public sector policy, as humanised care became more desired and accepted.

However, concerns were also raised among other movement members about the negative impacts of humanised birth consumerism – particularly that it compromised the core ethical principles of the movement, which are centred around caring for women and fostering a trusting relationship between healthcare provider and mother. Would this kind of commodification make it more difficult for poor women to access adequate care, rather than reducing inequalities? Was this trend inevitable in a health system like Brazil, where private provision is so deeply entrenched?

In this chapter I examine this marketing strategy and the effects of consumerism in the humanised birth movement. I begin by situating the commodification of humanised birth within wider global discourses regarding the privatisation of maternal healthcare and the role of consumerism in natural birth movements. I then demonstrate that movement members were aware of and implemented marketing as a strategy to increase awareness of and demand for humanised birth. What I want to show here is not just that private humanised birth services existed, but that movement members saw it as an effective tactic to change hospital policy and practice. I discuss the impacts of this strategy to date: that humanised birth has been taken up as a 'trend' by celebrities, that *cesarista* doctors have falsely claimed they are happy to offer vaginal deliveries, and, most significantly, that the largest private hospital initiated the *Parto Adequado* policy programme to incentivise normal birth. I then go on to consider the negative implications of this strategy, including how it shapes individual womens' expectations and experiences of birth, and reinforces class-based inequalities in access to high quality care. There has been some resistance to this model, which I cover towards the end of this chapter, before discussing the wider implications of the privatisation of the movement and how this reflects upon the commercialisation of healthcare and consumer society in São Paulo more broadly.

## 2. Healthcare consumerism and natural birth movements

The introduction or extension of neoliberal reforms into health systems has created financial barriers to access for economically poor populations, and has in many instances lowered the quality of care and compromised citizen's rights to health (Berer 2010, Chapman 2014, Massuda 2018). Anthropologists and sociologists studying reproduction and women's health have drawn attention to the unequal access to quality care that often results from private sector involvement in service provision, granting those who can consume greater choice, while limiting others (Ginsburg and Rapp 1995, Taylor et al. 2004). This body of research 'has been central to the expansion of the anthropology of reproduction beyond studies of the physiological dimensions and diverse cultural practices surrounding reproduction toward more nuanced analyses of the social, political, and economic realities that permeate women's experiences of reproduction throughout the world' (Craven 2007: 702). This chapter contributes to this area of critical medical anthropology by examining the wider societal implications of privatisation, as well as how social class and income can determine what kind of birth women in São Paulo experience.

The privatisation of Brazilian maternity services since the 1970s has had two main outcomes, which have been touched upon throughout this thesis. Firstly, poorer women cannot afford private sector care, which in many instances means their only option is to use the public sector, potentially exposing them to obstetric violence if the SUS hospital in question has not implemented humanised birth protocols. Secondly, privatisation has, at least in part, driven the excessive use of unnecessary interventions through financial incentives for doctors, as well as contributing to the widespread view of childbirth care as a consumer product. The relationship between the privatisation of maternity services and the c-section epidemic is widely acknowledged and has been studied by Brazilian and international researchers (de Mello e Souza 1994, Chacham and Perpétuo 1998, Béhague et al. 2002, Occhi 2018). This phenomenon is referred to by the movement as the *indústria da cesárea* (caesarean industry), encapsulating the capitalist logic underpinning the overuse of c-section delivery.

The privatisation of humanised or natural childbirth care, however, has been examined less frequently. The existing literature has predominantly focussed on high-income countries with sizable private sectors and established natural birth movements, particularly in North America and Australia (Zadoroznyj 2001, Davis-Floyd 2004b, Macdonald 2006). More recently, natural birth movements have emerged and are growing in popularity in low- and

middle-income countries (LMICs), usually where there are middle- and upper-class women with access to the literature, materials and services that have inspired these movements globally. This chapter therefore also contributes to the growing discussion of private humanised birth sectors in LMICs (Jerez 2015, Vega 2017).

Despite the aforementioned associations between privatisation and an excessively medicalised model of care, the shift towards healthcare consumerism in the late 1960s and early 1970s was also instrumental in the rise of natural birth movements. Benoit et al. describe this period as a 'general lessening of trust in professional authority, an unprecedented decline in respect for medicine, and a growing recognition of the emotional, social and spiritual components of life and healing' (2010: 476). Feminists and women's health movements in North America and Europe initiated the slogan "a woman's right to choose" to demand reproductive rights (Craven 2007). This shift led to a "birthing consumer movement" in many high-income countries, in which women were no longer passive recipients of doctors' services, but self-identified as active consumers; and in some cases developed activist roles to shape women's experiences of childbirth (Benoit et al. 2010: 476). The rise of the consumer as an active agent 'paralleled the new feminist conversation about women's rights to agency and choice' (Davis-Floyd 2004b: 2).

Over the following decades, the global natural birth movement has evolved differently in different health system contexts. In the UK, for example, where there is a strong midwifery profession and a universal healthcare system, the birthing consumer movement has influenced publicly provided midwifery care to become more 'consumer-led' and woman-centred (Sandall 1995). Here, market logic has influenced the organisation of services, but healthcare remains a public good, free at the point of use, and a right of citizens. Capitalist structures are more deeply embedded in the US health system. Davis-Floyd (2004) details the ways in which US midwives position themselves as healthcare commodities, adding their services to the list of options women have the right to choose from. In her ethnography of midwifery advocacy meetings in Virginia, Craven found that midwifery supporters 'characterized themselves by their interest in (and ability to hire) midwives, rather than as individuals who deserve reproductive rights as citizens' (2007: 701). In Australia, Zadoroznyj (2001) observed women's consumerist behaviour and attitudes as they sought out the services of obstetricians and midwives. She notes that the most important factors for these women were the 'interwoven elements of talk, time and trust', and that the encounter between them and the professional was not just an exchange of services, but an exchange where personhood was central (Zadoroznyj 2001: 126).

This global trend raises a host of important questions: What are the effects of consumerism in natural birth? Does commodification of these services undermine their core ethical principles and methods, which are centred around caring for women and fostering a trusting relationship between healthcare provider and mother? Do humanised birth activists have any other options in health systems like the US and Brazil where private provision is so deeply entrenched?

Critics of birth consumerism have expressed concerns that it works against the goals of natural birth movements and the midwifery profession. Commodification involves the standardisation of production. The product should be 'measurable, purchasable, undergo quality control, and to be embedded in the local/global political economy' and its 'symbolic worth will reflect market fluctuations, competitive pressures, government priorities, political realities and tensions, and…cultural biases and beliefs' (Davis-Floyd 2004b:11). All of which is antithetical to the original ethos of lay midwives (and natural/humanised birth movements in general) who opposed standardisation and would readily provide care to women who could not pay (Davis-Floyd 2004b). In her study of the Mexican humanised birth movement, Vega notes with irony the way that wealthy Mexican couples see themselves as critics of late capitalism, while 'their very rejection of consumerism bolsters ongoing commodification of culture, reinscription of racial hierarchies, and (false) appropriation of indigenous midwifery practices' (2017: 500). The commodification of birth services means that they will necessarily be unavailable to those who cannot afford to pay for them. Private humanised birth care in Brazil (as elsewhere) is expensive. A private obstetrician alone costs around R$5000 (around £1000 at 2016 exchange rates), and together with an obstetric nurse up to R$10000 (£2000). A doula costs around $R2000 (£400), and a homebirth team at least $R7000 (£1400). Most of these services are multiple times the monthly average salary in São Paulo (R$2600), and the majority of the city's inhabitants earn far less than this. Private humanised care is therefore accessible only to those in the upper and upper-middle classes. Some humanised birth professionals in São Paulo volunteer their services occasionally, for instance, working for one day a week at a public hospital without reimbursement. Others might provide care to particular couples who could not usually afford their care. But this voluntary work is sporadic, and does not compensate for the inequalities of access that are an inevitable outcome of the private market.

On the other hand, humanised birth consumerism has raised the profile of and demand for normalised childbirth and higher quality care. The efforts of natural birth activists working in the private sector have had a demonstrable effect in different countries around the world, including Brazil. What I want to explore here in more detail is the way in which natural birth

advocates are doing what is possible within the limits of a market-based system, which may indeed lead to a wider range of options for women to choose from, if not an improvement of the quality of maternity care for all. Davis-Floyd describes this trend in the US, where lay midwives formalised and professionalised in the 1980s and 1990s, commodifying themselves while trying to preserve the essence of their practice and the goals of midwifery (Davis-Floyd 2004b). In her book *Consuming Motherhood,* Taylor (2004) argues that:

> ...we must understand consumption itself as a site of cultural creativity and political agency, and also (at least potentially) of subversion and resistance. Consumers are neither passive nor without agency, but rather appropriate mass-produced goods to their own projects and purposes, producing selves and making worlds in the process.

If this is the case, we should understand the commodification and marketing of humanised birth not as an inherently negative trend that mirrors mainstream privatisation of maternity care. Instead, those marketing natural birth in this way have political agency and are appropriating the language and techniques of capitalism to a more admirable end. Davis-Floyd argues that:

> ...by appropriating certain aspects of mass production to their own projects and purposes, [contemporary home-birth midwives] are using consumption as a site of subversion and resistance to create new selves and alternative worlds. Starting out at the margins of a consumer society they view with a jaundiced and critical eye, these midwives came to realize over time that their survival as viable practitioners requires participation in the technocracy's core processes of commodification and consumption (Davis Floyd 2004b:1).

Subversion does not just come from those participating in humanised birth consumerism by selling services. Brazilian women have been known to resist and negotiate access to the kind of birth they want, for instance to access c-section in public sector hospitals (Béhague 2002). Later in this chapter I discuss findings from my fieldwork that indicate women in São Paulo were undergoing private doula training with the ultimate aim of providing care free of charge or cheaply to make it more affordable for women in the *periferia*. Another woman ran her doula training collective on a sliding pay scale for the same reason.

Despite the fact that natural birth proponents in many different contexts are adapting and resisting commodification in order to preserve their underlying principles, consumerism in this field has had demonstrably negative effects. Its encroachment therefore, needs to be

continually challenged and negotiated even as the global health policy landscape moves in the direction of a rights-based approach to health, promoting women is the central actors in birth.

## 3. Stimulating demand for 'the other product': Humanised birth as commodity

I have noted throughout this thesis that the humanised birth movement is in fact a collection of smaller subgroups of activists with different strategies. While they may be aligned in their overarching goals to reduce the numbers of unnecessary clinical interventions and to provide high quality woman-centred care, the subgroups go about reaching these goals in different ways. One of the key subgroup strategies I focus on here is the creation of demand for private humanised birth services by marketing humanised birth as a "product" that women desire. Members of this marketing birth subgroup referred to their tactic of using market mechanisms to increase numbers of humanised births, and to incentivise private hospitals to allow humanised teams to operate on their wards. Some described how they themselves put this strategy into practice, whereas others seemed more cautious or concerned about the effects of presenting humanised birth in this way.

Stimulating demand as an activist strategy emerged in an early interview with one of the key figures in the movement, Isabel, an obstetriz and doula who had set up GAMA, the humanised birth centre in Vila Madalena. I had been asking Isabel about how she tried to change health policy and whether she participated in the SUS health councils and conferences. Isabel was adamant she had 'nothing to do with the SUS', and explained she had never been to any of the participatory meetings - 'my role is being an activist. I'm never going to work with the SUS.' I was surprised by how strongly she rejected any association with the public health system. At this point, many of the movement members I had spoken with were involved in SUS political structures to some degree, and also considered themselves activists. Isabel went on to explain that she was aware of the intended purpose of the *Conselhos* and *Conferencias de Saude*, but that 'it's another thing to have people arrive at a consensus...and the SUS doesn't have money to make these things happen…I can't work like this, I want things to happen quickly, happen now.' So how did Isabel work instead, I wondered. I asked her to explain.

> Isabel: We work *with* women, *com a criação e fortalecimento das demandas das mulheres* (to create and strengthen the demands of women). We want women to demand what they want...Past experiences have shown me that if you approach doctors trying to change their behaviour it won't work at all. You have to create a demand. The doctors then understand that if they don't change they are going to lose their clients, and then they will come and look for training on how to provide what these women are asking for.
>
> I don't work with politicians, and I don't work directly with doctors, trying to change doctors. I only want to work...with women. It's they who learn how to make claims, how to organise themselves, it's they who change doctors. Through their agency, I think the system will change.

Creating demand amongst women was a key strategy for humanising birth, rather than trying to change behaviour through other means. This not only 'changes doctors', but also brings women agency. This agency though, is clearly a market-based one, in which power comes through wielding capital as a consumer with various choices. Isabel went on to explain how she saw the humanised model slowly replacing a medicalised one:

> Birth as a medical event, the woman's body as a machine which produces the baby, the perfect baby being the only objective of birth – it's this model I think we are in the process of changing. Another model of assistance exists. My wish is to strengthen this model, to show that this model of birth is beautiful so that more people look for it. The idea is that this model will grow and grow until it becomes commonplace in our health system, both public and private.
>
> I don't believe any more in *mudar as pessoas* (changing people)...I believe in creating *um producto atraente* (an attractive product). So that people think "I want this product. I want to sell this product". One day our society will evolve so that it doesn't function any more in this product mentality. But at the moment it works like this. Creating desires. Working with image.
>
> The image of a woman covered in sheets, everyone in face masks, the baby coming out quickly all clean, made hygienic – this is the product that was being sold, still is being sold, in the Brazilian *telenovelas,* for example. But the Youtube videos that have the most success are not the ones that show this product, but another. And people see this other product and it moves them. In the first product you see in the

> *novelas*, people are tense, they are worried, asking if everything's going to be ok. This other product that I promote – *não é um produto no sentido mercantil* (it's not a product in the market sense*)* – it's a product in the sense of *um desejo* (desire), to produce desire in a person. This other product, people don't feel fear. And they like this, this image, and say – "*Eu quero este produto*" (I want this product). I don't want to be lying there with my legs open with doctors, shouting, forcing – I don't like this anymore. I was one of these people, who thought this was how it was done. Now I only believe in the other model. Smoother, sweeter, aesthetically more agreeable, which promotes good emotions rather than fear and tension. So I think this product can be bought, not in a monetary sense, but in that it can be acquired, appropriated – not only by users, but also by professionals.

The visual 'image' of these two different birthing models is important. The hospital birth image has 'dehumanising' negative visual symbols: face masks, the woman lying with her legs open. Isabel does not give as much visual detail about what the 'other product' (humanised birth) looks like, but assures me that it is 'aesthetically more agreeable'. From seeing many of the humanised birth videos, I assume this means: low lighting, relaxing music, a calm atmosphere, and a birthing team (including the partner) surrounding the woman, *supporting* her through labour. Importantly, she is the focus and in control. Isabel chooses to refer to women as 'users' of services, a term normally used to refer to women using services in the private sector – but it does not have the same consumerist connotations as *clientes*, which many others in the marketing birth group use.

Isabel clearly outlines how she thinks marketing this other product can change practice, by creating something attractive that people desire. Interestingly she acknowledges that this 'product mentality' is not a good thing, and that one day society will evolve beyond this. Perhaps this is why she argues that this is a product that can be 'acquired' but not 'bought' with money. There are some important nuances here: technically, humanised or natural birth services can be bought with money, but of course the experience of birth and the outcome cannot be guaranteed through this purchase. Like the midwives in Davis-Floyd's (2004b) account, Isabel's personal views do not seem to align with what she is advocating. Instead, she is trying to survive and work towards the movements aims within a capitalist system, beyond which she hopes we will evolve.

The themes that emerged in this early interview with Isabel came up frequently throughout my fieldwork in discussions with various movement members. Bianca, a leading humanised

obstetrician, confirmed the importance of demand as a strategy for changing doctors' behaviour:

> It's a question of the market exactly…Past experiences have shown me that if you approach doctors trying to change their behaviour it won't work at all. You have to create a demand, the doctors then understand that if they don't change they are going to lose their clients.

Bianca attributed institutional policy changes in private hospitals (such as whether or not they allowed humanised doctors to practice there, or if they allowed doulas into the delivery room) to the rise in demand from women: 'Ten years ago, rupturing membranes to induce labour was considered absurd in these hospitals. This has changed a lot…In 2006 [Hospital] São Luiz opened the first *sala de parto* [normal birth room] with a bath. It started there'.

This view was also expressed among mothers who had used humanised services in the private sector. Luiza agreed that 'demand is going to make the doctors want to pursue a different path'. Sara, who was also a doula, explained:

> ...pregnant women are going to be the bigger voice to change things. If they start complaining, and going "No, I don't deserve this, I know what I can have and what I can't have," then the hospitals are going to start changing...more than if we go and try to change policy.

Marina, another mother who had also trained as a doula, elaborated on how this market functioned:

> When we (doulas) see that this hospital is doing something good for humanised birth, we're going to recommend that hospital. And they are getting more money because of that...And then other hospitals see that and decide they will also allow humanised birth to meet demand...The private hospitals are being driven by money, because their clients are coming to them and saying: "I want this, if you can't give me it I'm going to take my money somewhere else."

Humanised health professionals, doulas and mothers identified the importance of demand as a strategy, with several describing the way they enacted it. In these statements is the idea that demand worked to change the behaviour of doctors and private hospitals indirectly, because they are 'driven by money' and don't want to lose clients. This would be an ideal

functioning of a private market, where supply adjusts to meet changes in demand, to the benefit of both consumer and provider (Smith 1979). But healthcare is a hugely complex good, and there are various barriers to the market functioning perfectly (Rice and Unruh 2015). Writing about the logics of care and choice in healthcare more generally, Mol argues that the problem with the logic of choice 'is not that the market abandons people…(but that) a market requires that the product that changes hands in a transaction be clearly defined', and has a beginning and an end – which means that health services do not translate well into products (2008: 20). Later in this chapter I discuss the negative effects of commodifying humanised birth, after first looking at a centrally important physical site for incentivising demand: the private humanised birth centres.

## 4. Humanised birth centres: Spaces for support and selling services

São Paulo's private humanised birth centres are physical hubs for the movement. Most operate as private health clinics hosting group meetings and individual consultations with midwives, humanised obstetricians and doulas. The two centres where I conducted participant observation and interviews were located in the wealthy neighbourhoods of *Vila Madalena* and *Brooklin Paulista*. The walls of the entrance halls are covered in information leaflets about humanised birth and associated practices such as pregnancy yoga, massage and hypnobirthing, as well as the business cards of private practitioners. The humanised birth centres and some of the humanised birth interest groups such as *Maternamente* hold weekly or fortnightly antenatal and postnatal group sessions free of charge. Each week would focus on a different topic, such as birth physiology, pain relief techniques or breastfeeding. These classes were opportunities for women to access information about what to expect from pregnancy and labour, as well as about the humanised services available.

All of the antenatal and postnatal groups I observed were packed full, with around 40-50 women sitting on chairs in a large circle or on the floor on cushions, at various stages of pregnancy. Around half of the women came with their partners, who would often sit in between their legs for the two hours that the classes lasted. At the beginning of the classes everyone would go around the circle and introduce themselves, and say how many weeks into their pregnancy they were, with some also introducing their 'bump' with a name. I noticed that women would often affectionately stroke their partners and run their fingers through their hair as they sat listening and talking. Many women would share their birth

stories, including previous bad experiences where their care was too *'medicalisado*' or they felt mistreated by their doctor. Others had already had humanised births and wanted to pursue this option again. And for others still, this was their first pregnancy and they had heard positive reports about humanised birth from friends or online. All of the women in the antenatal groups spoke about their plans for their upcoming births, all aiming to be *'humanizado'* to some extent.

The doulas, *obstetrizes* and other professionals who ran these classes provided women and their partners with knowledge about various aspects of birth, while simultaneously promoting the messages of the humanised birth movement and private humanised services (Carneiro 2015). For example, discussions included information on contracting humanised birth professionals, and on what to expect from hiring a doula. Though this 'marketing' was never done in an explicit or aggressive way, it was nonetheless implied in the way conversations were framed by those leading the sessions. The default was hiring a private humanised team. Using the SUS was an alternative, a less-than-ideal backup option, which came with a warning: '*If* you do decide to have your baby in the public sector, you run the risk of not having an obstetrician who is *humanizado'.* At each group, it seemed that at least half of the women in attendance had already contracted the health professionals who worked at that particular centre. Women would often mention their *obstetriz*, doula or obstetrician by name. In this way, the groups served as learning opportunities for women and their partners, as well as opportunities to attract new clients for health professionals; they were both educational and promotional.

I wondered why women at these groups were not informed about exactly which public hospitals had implemented normal birth protocols. Some members of the marketing birth group I spoke to individually did seem to be aware of public sector policy initiatives like *Rede Cergonha* and *Parto Seguro*, but they did not seem to come up in the group discussions I observed. It would be extremely cynical to assume this was a kind of calculated decision to not provide women with information about public sector options for their delivery, in order to retain their custom. Instead, I think this was another instance of a lack of communication and collaboration between the subgroups within the movement, the public sector and private sector activists. Isabel and her colleagues had neither been shown, nor sought out information about *Parto Seguro*, and were therefore unlikely to recommend women attend a service they were not familiar with.

Despite the arguably limited reach of these groups due to the upper-class neighbourhoods in which they were located, and the underlying assumptions that most people attending would be contracting a private team, these groups affirmed a sense of community and shared

interest for those involved. Attendees were involved in the humanised birth movement through their interest and attendance, but they did not necessarily have to identify as movement activists to take part.

Several of the humanised birth centres also offered doula training courses, which are covered in depth in Chapter 7. One important point relevant to this discussion, however, is that one entire day of the GAMA course was dedicated to the 'business side' of being a doula, including how to market your services, what to charge people, and how to navigate the moral challenges around charging money for a relationship that was primarily about love and trust. '*Doulagem* (doula work) is not a sacrifice, it's a service', explained Maya, a lawyer involved in the movement (and a marketing consultant in her previous career). Maya stressed that 'building personal networks' was important, and that attracting clients was often based on personal recommendations. Some of the messages from this session seemed contradictory. The trainee doulas were continually being told the importance of love and presence – but at the same time they needed to be conscious of marketing themselves in order to gain recommendations for the future. And underlying this, unspoken, was the fact that these doulas would have to compete with one another in the market. Being loving and compassionate to others did not seem to fit with this capitalist logic. The idea of "being there" for the woman and providing unconditional support seemed to conflict with financial compensation, because of course, it brought in a condition. I wondered how doulas reconciled this contradiction in their practice. Those I asked explicitly about this said that although they sometimes felt conflicted, charging families for their services was an acknowledgement of the value of their work, in a monetary and moral sense. As Grace, a doula/academic/activist pointed out, you wouldn't expect any other health professional to give their time voluntarily. Natalia, a midwife, said she thought doulas should be paid, but that it would better if they were remunerated through a salary in the same way that *obstetrizes* were, so that payment was one-step removed from relationship between woman and doula.

The humanised birth centres were just one site at which the effects of selling humanised birth were evident. In the next two sections I discuss other notable trends in the uptake of private humanised services.

## 5. Celebrities champion the humanised birth “trend”

Humanised birth professionals and mothers described the important role of celebrities in creating demand, speaking to their powerful influence in popular consumer culture, via magazines, TV and social media. The Brazilian supermodel Gisele Bündchen was regularly mentioned, as was ‘Princess Kate’ (the Duchess of Cambridge), who made headlines in Brazil for opting for normal birth in the UK. Two doulas I interviewed saw celebrities as instrumental in the movement:

> Clara (doula): I think things are always moving forward, but recently they are improving a lot faster. We have more professionals working, people are starting to hear and talk more about this [humanised birth]...people are flying the flag. Actresses, singers, talking about normal births, homebirths, and this in Brazil is very relevant. Every time that a celebrity chooses something, it's a window, a door, for people to think about the subject. It's a good thing, and it's also something so-so, at the same time. Because some people will only join the wave because it seems in fashion, or a status. But at the same time it's an opportunity for people to open this door and access the subject, and make a different choice.

> Elena (Director of the São Paulo Doulas Association): You have Gisele Bündchen, who had a natural birth with a midwife. You have famous actresses doing the same thing. This influences public opinion. And enhances the movement, and increases the number of women searching out this kind of care.

Both Clara and Elena were adamant that these well-known figures had a demonstrable impact, setting the ‘trend’ for humanised birth. Brazilians are well known for their love of *telenovelas* (soap operas), and a huge variety of celebrity fashion and gossip magazines. Over recent years, much of this content has moved online, making it more accessible than ever before. Others I interviewed offered a more nuanced view:

> Luiza (mother): I think what it takes for this culture to change is, for example, you know Gisele Bündchen, she had a baby by humanised birth. She made other people listen, because this is how it works. You need a celebrity to go do that. Bela Gil (daughter of Brazilian musician Gilberto Gil) also. But then she made the mistake of telling the world that she ate her placenta. Now people don't take her seriously.

Despite the fact that people listened to celebrities, according to Luiza, there are some aspects of humanised birth that are considered a step too far - namely eating one's own placenta. This poses an interesting question as to what aspects of humanised birth were becoming more widely accepted and why, and whether this would change in the future.

Marina, a mother and doula, explained that in her work as a doula she used celebrity stories, but that sometimes people felt they could not relate to them:

> I love examples. But they can work either way. You have Princess Kate, you have Gisele Bündchen. She gave birth at home. And people say - "Yeah but she had a personal helicopter, an ICU unit waiting for her." And I think "No! People stop making things up, it's not only for the rich. We can have great care without paying anything. We have the birth houses here in São Paulo. We are spreading that.

Another doula, Sara spoke about the 'trickle-down' effect more generally:

> I think we have to change the elite, because the lower classes want to copy them, they're like "I want a c-section too, if she can have a c-section". So if the elites start going "No, natural birth is the best" ...this will influence the lower classes.

These comments suggest the increasing uptake of humanised birth by celebrities is a progressive trend which will continue moving towards a normalisation of vaginal delivery and midwifery-led care. But there is also the potential danger of swinging back in the other direction, if its advocates appear too "hippie", or if humanised birth appears beyond the reach of anyone outside of São Paulo's elite. This celebrity endorsement echoes what takes place with commodities in consumer society, where famous figures are paid to advertise all kinds of products. Here, they are not being hired, but are lending their name to a cause. While this has the positive effect of raising the profile of the movement, it runs the risk of perpetrating the ideas mentioned by those interviewed here – that people come to believe this "product" is only for the elite, and is out of the reach of normal women.

# 6. Humanised birth for the elite: rising demand in private hospitals

The changes in hospital practice that Isabel, Bianca, Luiza and Marina predicted were in fact already taking place when I arrived in São Paulo. Hospital Israelita Albert Einstein (widely known just as 'Einstein'), the largest private referral hospital in Brazil, was in the process of implementing the *Parto Adequado* (PA) policy programme to introduce normal birth protocols under the guidance of Dra. Marcela, the head of the maternity ward.

Hospital Einstein is considered a regional centre of excellence for South America, and was certainly the most prestigious hospital in São Paulo. Those who could afford the high prices delivered in one of its birthing 'apartments', bringing their own team of doctors and nurses. These suites are fitted with air conditioning, bathrooms, sofa beds for partners, cable TV, sound systems and minibars (Einstein 2020). Einstein had catered to Brazil's elite families for decades, and until recently, babies born there were almost all delivered operatively.

I visited Einstein in October 2015 to observe a staff training session for PA, and was given a tour of the obstetric ward. One of the first things I noticed was that the waiting room opened onto the consulting rooms, where women in labour were assessed, which then opened through another set of doors directly onto the operating theatres - a fluid progression from entrance hall into surgery. The normal delivery rooms were on a different floor. This physical layout was noticeably different to the obstetric wards I had trained on in the UK, most of which have midwifery-led units that doctors do not enter unless there is an emergency. The physical organisation of the Einstein ward was an architectural signifier of the underlying logic of care - one where caesarean section was the norm.

But a cultural shift was taking hold. Dra. Marcela assured me that PA involved a reorganisation of the layout and construction of normal birthing facilities, alongside staff training for the clinical management of normal deliveries. Given just how entrenched routine interventions were in hospital practice, it was remarkable that the Einstein administration was now attempting to reduce their c-section rate and normalise birth. The changes taking place were a result of the strong leadership of Dra Marcela and her team, and, at least in part, to the shifting demands of São Paulo's upper-class women which justified the introduction of PA. Dissenters would find it hard to argue against the evident rise in requests for normal deliveries.

I followed the progress of PA after my fieldwork period ended. The programme led to the creation of a normal birth centre at Einstein, with five delivery rooms equipped with maternal and foetal electronic monitoring devices, chromotherapy, birthing balls and stools, and space for an inflatable bath (Einstein 2020). It also led to changes in practice across the participating private hospitals in several southeastern Brazilian states. As a result of PA, there was an 85% increase in vaginal delivery rate from 12.3% to 22.8% between 2011 and 2017 in these private hospitals (Leal et al. 2019). Einstein itself has achieved positive results in increasing vaginal birth rates, from 35% in 2013 to 44% in 2015 (ANS 2016).

I also noticed that another of São Paulo's biggest private hospitals, *São Luiz*, had begun creating some of the same services available to private customers wanting c-sections for private customers wanting humanised birth. It is a significant indicator of progress for the movement that the top private hospitals in Brazil began to offer normal birth alongside c-section delivery. The normal birth centres are being marketed - with the same luxuries as elective c-section "packages" - to São Paulo's elite. The fact that São Luiz and other private hospitals are following Einstein in building and marketing new birth centres suggests there is sufficient demand for these services. The declining rates of c-section in these hospitals provides further evidence of effect. While it would be overly simplistic to argue that this shift is solely due to humanised birth activists' efforts to stimulate demand amongst paying clients, it certainly contributed to this change. Alongside a supportive hospital administration, Einstein has led Brazilian private hospitals towards an alternative model of care where women have more options, and in which many more have been opting for normal birth than in previous years. They are, to quote Isabel, offering women the "other product".

These changes were also visible in the behaviour of individual private doctors. Demand for humanised birth among paying clients had risen to such an extent that doctors who preferred to deliver by c-section – the *cesaristas* – had begun to promote themselves as normal birth providers. Unfortunately, there were many reports of these claims being false, with some of these doctors delivering via c-section at the last minute, telling women that it was medically indicated. The movement was working to counter this kind of practice by creating and sharing a list of genuine humanised doctors who could be trusted. Sara, a doula and mother explained how this worked:

> Sara: The movement has a list of doctors that are *humanizado*, so those are the only doctors that we recommend...the doctors that are actually following the latest scientific evidence...The list is getting bigger...a few years back it was like ten, twelve, and now it's probably twenty something, here in São Paulo.

> ...because of this whole *humanizaçao* movement, there are some doctors that are not part of the list, that say that they are *humanizados*. They sell themselves as *humanizados* because they know that women are more interested. But then you see that they have a 60% c-section rate, they do episiotomy...so when women come to us and say “Oh have you heard of this doctor” we try to look him up and go “Well he has a rate of 30% normal birth, do you really want to take that chance to have a normal birth?”

The work of Isabel and her colleagues in the marketing birth group was having a demonstrable impact throughout São Paulo’s private maternity care system, and society more broadly. Celebrities were opting for humanised birth, and encouraging their many fans and followers to do the same, ‘flying the flag’ for the movement. The most prestigious private hospitals had begun implementing normal birth protocols and marketing luxury humanised birth care, with all of the expected comforts the elite were accustomed to.

## 7. The dangers of humanised birth consumerism

I observed some concerning and negative effects of humanised birth marketing and consumerism, linked to the promotion of the idea that the perfect birth was attainable as a product, the focus on consumer rights rather than the right to health, and questions of class-based inequality of access. One instance occurred during a visit to one of the humanised birth centres to observe a post-natal group session. This group had seven women, with their babies – far fewer than the antenatal group. The session was led by one the members of staff, and another mother who was a regular and a kind of lay representative who shared her (very positive) experiences at many of the sessions. As with the antenatal classes, the women took it in turns to introduce themselves and share their birth story. The lay representative spoke extensively about how transformative and empowering her homebirth had been. She talked about the role of the humanised birth professionals in supporting her, and the profound joy and love she experienced with the labour and delivery of her baby. The third woman to speak had been very quiet up until this point. She began her story, in a low voice, on the edge of tears. ‘*Não consegui ter parto normal’* (I didn’t manage to have a normal birth). She started crying, and one or two of the other women came and sat next to her to comfort her. The woman explained she had set out to have a humanised birth, but her obstetrician told her the baby couldn’t be delivered vaginally, and she had ended up having to have an emergency c-section. She felt she had failed. While the rest of the group were

very sympathetic and comforted her, I could not help but think that the very messages espoused in these antenatal and postnatal groups had contributed to her feelings of inadequacy. The moderators of the group nodded and smiled in confirmation as other women spoke about their positive experiences, acknowledging their 'success' at achieving a humanised birth. While they were sympathetic to the crying woman, telling her that sometimes this happened, the message conveyed was that this outcome was unwanted and abnormal.

There are aspects of the humanised or naturalistic model that 'potentially disempower women by encouraging feelings of shame, failure, and isolation when medical technology is necessary' (Charles 2013: 215). Charles (2013) notes that the uniformity of natural birth stories – the rejection of technology, the symbiosis with nature, and the transformative experience of birth – play a key role in setting the expectation of women, and can contribute to feelings of failure when their story deviates from this norm. She argues for a diversity of stories to help women make more sense of their experiences, including c-section. Humanised birth consumerism exacerbates this problem, because women have been sold their ideal birth, and are therefore expecting a certain outcome.

This dangers of this kind of natural birth perfectionism have been studied in other comparable contexts. Rossiter (2017) writes about the construction of the 'good mother' in the ecstatic birth movement in the United States. The ecstatic birth movement is connected to the wider natural birth movement, but takes some of its core beliefs about the benefit of birth free from interventions to the extreme. This movement suggests that 'women's bodies are not only built to have babies, but indeed, to enjoy having babies', and that they can and should find birth a transformative and even organismic experience. Rossiter dubs this '*mama economicus*', a play on Foucault's *homo economicus*, a product of neoliberalism which views human bodies as an asset. Here, women's labouring bodies are constructed as working bodies that need to be attuned to productivity. The ecstatic birth movement (and similar groups) makes individual mothers responsible for maintaining their bodies in a state in which they can attain ecstatic birth.

There are parallels between Rossiter's observations and my own in São Paulo. One of the most striking is that this trend is 'tied to an underlying model of consumption/gratification where an ecstatic birthing experience is sold as a non-material, yet highly desirable, commodity' (Rossiter 2017: 42). Rossiter also observes the selling of a kind of natural birth experience as a consumer product. The "responsibilisation" of women for self-care during pregnancy was also highly visible in São Paulo. The humanised birth centres themselves

were covered in promotional material for pregnancy yoga, nutritionists and other alternative health practices. Many doulas were also trained in acupuncture or yoga, and offered these sessions alongside doulagem. Pregnant women were encouraged to self-educate about birth, reading key texts such as Ina May Gaskin's *Spiritual Midwifery* as well as online articles. This reinforced the idea that women were responsible for maintaining their own health and improving their own understanding in preparation for birth – and paying for all of this.

There is a concerning blurring of the line between the idea that a woman can purchase the kind of services she prefers – which will of course give her a *better* chance of achieving her ideal birth – and that in paying for this product, she will be guaranteed her desired outcome. While many of the midwives, doctors and doulas I observed did explain to women in the antenatal classes, and in private consultations, that c-section and other interventions might be needed, these were usually presented as a unfortunate and unlikely possibility. The telling of birth stories at antenatal groups seems to reinforce the view that beautiful, empowering humanised births are achievable by anyone, especially if women are able to spend money to get the best of everything (nutrition, yoga, humanised team). In her analysis of birth narratives in antenatal classes in the UK, De Quattro observed that 'stories (re)shaped expectations, shared practical techniques, navigated different truth claims and approaches to knowledge, and helped build supportive communities of parents' (2019: 1). This makes it all the more important that the full spectrum of experiences are shared and normalised, to avoid the exclusion of women who must necessarily undergo interventions. The birth narratives in almost all of the humanised birth centres and meetings I observed were as Charles (2014) describes – overwhelmingly positive, non-interventionist and transformative, with women frequently invoking the natural-ness of their labouring bodies. Those whose stories did not fit into this dominant narrative were left feeling ashamed and like they had failed. As Charles suggests, a foregrounding of a more diverse range of birth narratives might be an important way for movement activists to mitigate this negative experience for women who genuinely require intervention.

## 8. Resistance to commodification: *multiplicar* and *quanto puder*

While this approach was being used by the marketing birth group, many others in the movement were critical of what they saw as an extension of the privatisation of birth into the humanised movement. These critiques and resistance went beyond the kind described by Davis-Floyd (2004), where midwifery supporters worked within the capitalist system. In São

Paulo, women were training in the private system in order to provide care for those who could not normally access it, by renegotiating the traditional boundaries associated with profit making in supply and demand markets.

Natalia, one of the few *obstetrizes* working in the SUS, explained:

> ...with this marketing group, you have a "package", with things you want. It's very consumerist. And I think the doula has entered into this...In whichever of these humanised birth groups you go to, and say you want a *parto normal*, someone will say "contract a doula". I know she can give information and other things, but it seems that it's something like a product, something you have to have, in order to have a good birth experience…within this business, you need to stimulate a market, so that other people also look for doula training.

This view was expressed by other members of the movement who worked in the public sector and tended to see the humanised birth cause in terms of women's rights to high quality healthcare. As such, they were sceptical of a market system that did not provide this to all women.

Despite the underlying assumptions – evident in the GAMA doula training course material – that trainees would want to work in the private sector, my interviews revealed otherwise. When I spoke with the focus group of doulas at the end of the final day of the course, most of the group said they had trained with a mind to working at least partially voluntarily in order to support women who could not afford most services.

> Rosa: I'm pregnant with my first child, now I'm a doula...The course motivated me to want to *multiplicar* this assistance for other women who are pregnant. Principally women who are in disadvantaged situations, who are most vulnerable to suffer obstetric violence. Because all women in Brazil are *sujeitas* (subjects) *ne*? Just by the fact that if you enter a hospital, even if you have planned everything, you are subjected.

> Nina: I think that in the near future, I will do a project in the *periferia*, perhaps in the area of *Saúde* (a neighbourhood) there. To raise this question of women in the *periferia* having voices. Because I think that where information doesn't exist, things won't change. Whichever minds we play with, they will change, and they will act.

Carmen: ...the big challenge is to make sure this message reaches people who aren't necessarily looking for it...making this message visible for people who aren't already into this. And from there, they can go and participate.

Bia: My idea is to disseminate information, to take it to others in a voluntary service... for women who have limitations in access to care.

Alice: I'm part of a humanised birth team - well, a team, not really, it's just me and a friend! Still very small - and we have a project called *Parto para todos* (Birth for all). Because *parto humanizado* or a homebirth for some social classes, is too expensive. We have a research form about income. So we have women who register in this project, and we reach a [financial] agreement...we make it much cheaper. It's about 10% of the market price today. Because we truly want to take humanised birth to everyone.

These newly trained doulas all expressed an intention to provide their services to disadvantaged women, not as a for-profit product, but voluntarily or for a fraction of the normal cost. They wanted to "multiply" the care they had learned, and to disseminate information to change minds and encourage action. This was one of the strongest depictions of activism I encountered in my fieldwork, and suggested that the movement really was a kind incubator for change. These women could afford to pay to train in the private sector, and they were using this opportunity to essentially redistribute what they had benefitted from to others who could not pay for humanised birth services. Reflecting back on the different views of citizenship in Chapter Three, this seems to be a perfect example of a citizenship act that takes place in the private sphere – the kind of activism that is not a bold public statement, but is powerful nonetheless. *Multiplicar* was in many senses the embodiment of *sororidade*, sharing knowledge and providing care for other women who were disadvantaged.

Other practising doulas I met who worked in the private sector for the most part, volunteered one or two days a week in public hospitals, providing their services for free. It seemed there was a disconnect between those offering the training and the trainees. The option for working as a doula in the periferia or on a voluntary basis was never discussed in the course sessions. I wondered how much the course content was influenced by Isabel, who had set up GAMA, and had so clearly stated she did not think working in the public sector was an effective way to change things. In contrast, many other doulas and parteiras sought out ways to share their skills with disadvantaged populations. In doing so, they were consciously addressing and overcoming some of the barriers created by humanised birth consumerism.

Natalia felt that the Volunteer Doula policy provided an alternative model to counter the negative effects of humanised birth consumerism.

> Natalia: It's almost as though this [policy] is a resistance to the business model...I think whatever advance we make in this area, it has to be a right. If it's a right, then you aren't dependent on payment, or of social class. You can't exclude women. So I see it as a very important advance, *quebrando essa lógica capitalista* (breaking this capitalist logic) in relation to training and care.
>
> …these doulas trained in the private sector help…lift up this [humanised birth] movement. But I see that it's just in one direction. Because if you pay someone, you will receive her company. So it's this kind of logic, *né?* Of the market, of capitalism.

Julia, the doula who had set up the alternative doula training programme *Multiplicando Doulas*, (discussed in detail in Chapter Seven) took this further by creating a new curriculum that worked against the encroaching privatisation of humanised birth. She used a sliding pay model that she called '*quanto puder*' (literally, 'how much you can') for the doula services she provided and the doula training course she organised. Julia felt that profiting from providing humanised birth services was not just an inevitable trend, but a dangerous extension of patriarchal and capitalist tendencies that were damaging to society in São Paulo, and further afield.

> Julia: I think the minimum I can do is offer this 'pay what you can' service...I think this (profiting) comes from a colonialist perspective. Arrive here, invade here...this idea that people can do whatever they want...

Julia comments on a particular trend within the movement - that of middle-class privileged women training to be doulas in order to profit rather than providing an affordable service. For Julia, charging high prices was a barrier to knowledge that should be shared.

> Julia: I learnt about encapsulating the placenta when I was in Mexico - and I asked one of the *placenteiras* here in São Paulo about it - she told me she was running a course to teach these techniques...If I want access to this knowledge, I have to do this course, which costs 1000 Reais...So it's a very cultural thing. Colonisation happened there (in Mexico), but not with the same strength that it happened here.

> ...all of the tradition that I pass on, is through *quanto puder*. There is no barrier for people to access this knowledge. Medicine is the same, an empirical knowledge, *né*? There are various forms in which you can have control over this, you can commercialise knowledge. It's crap. All of these techniques, these categories, they distance the autonomy of the person from her own body. From her culture, from her traditions. I think it's very dangerous. I think if we are not careful, *doulagem* will soon become like this too.

Despite this, Julia was optimistic about the role of MD:

> Julia: It could be the first movement for real change. That for me, is what's happening...with *Multiplicando Doulas*. Many women benefitting, lots of women managing to pay what they can.

Julia's comments demonstrate an extension of humanised birth consumerism beyond the actual provision of care itself, but to *knowledge about* humanised birth and its associated practice. She draws a comparison with the empirical knowledge of medicine, which is commercialised, and behind barriers. She expresses her concern that *doulagem,* a centrally important practice in humanised birth, is being kept from women due to its commercialisation. Julia and other critics show they do not think humanised birth consumerism is improving the existing inequalities of access to information and care.

# 9. Discussion: The dangers of demand and the potential for change through humanised birth consumerism

The ethnographic data discussed in this chapter demonstrate some of the ways in which humanised birth is sold as a commodity to those able to afford it. In some instances, this had had a demonstrably positive outcome: the championing of the cause by celebrities has raised the profile of the movement, the rise in demand for humanised care among wealthy women has led to private hospitals providing a huge increase in numbers of vaginal delivery and refitting their wards with normal birthing rooms, and even *cesarista* doctors recognise that many of their clients want normal birth. Over the past years the rates of c-section in the private sector have fallen, and more births follow humanised protocols such as having a partner in attendance and not using routine episiotomy (Leal et al. 2019). The efforts of the

marketing birth group have, in various ways, taken the movement some way towards their overall goals of humanising care and reducing unnecessary interventions.

The concern of many others in the movement, however, is the effects this has on women's views on and experiences of birth – such as whether they need to pay to achieve their ideal birth, and what happens if their labour does not unfold in the way that they want and paid for. Others have expressed unease that humanised birth consumerism is exacerbating existing inequalities in access to high-quality health services, determined by income and class. Finally, some critics question the extension of market logic into an area of healthcare and birth support (such as *doulagem*) that is supposedly based on love, sisterhood and generosity. In the private humanised birth sector, are women cast as the consumers of birth rather than producers (Hunter and Hurst 2016), just as they are in the private c-section market? Julia, in her discussion of the 'quanto puder' financing model, goes further still and draws a connection between the current expectations of how much doulas should charge and to whom, and colonial abuses of power. Julia's comment raised another question: whether the current differentiation in access to services along class lines was reproducing the kinds of racialised inequality that had existed since the colonial era.

In an interesting mirroring of the more established privatisation of highly-interventionist obstetric care that drives up Brazil's c-section rates, women interested in a more natural birth are also being sold the idea that they can buy their way out of a painful childbirth. In the mainstream private sector there is a widely held belief that a c-section is less painful than a vaginal delivery, and many women are attracted to a "hi-tech" mode of delivery option where they are told they will not suffer (as discussed in detail in Chapter Two). In the private humanised birth market, women are sold beautiful births as a product which they can buy, or aspire to achieve. This echoes Rossiter's (2017) work on the ecstatic birth movement in the US, which conveys the message: if you invest enough effort and capital you can achieve a birth that is not just free from suffering, but is a transformational and ecstatic experience. Davis-Floyd makes a similar observation about the growth of birth consumerism, where:

> Birth itself was redefined as a purchasable commodity: with the right obstetrician and the right health care plan, accompanied by enrolment in the right childbirth education classes and at the right hospital, a good birth seemed to become something that money and careful planning could buy (Davis Floyd 2004b: 3)

The intentions of many humanised birth movement activists are to improve women's experiences of childbirth and reduce unnecessary interventions - but their 'selling' these

services to private clients has the potential to reinforce the myth that women's bodies are dysfunctional. While in the mainstream private sector, money can buy you surgery to circumvent this faultiness, the marking birth group arguably goes too far in the other direction. Here, the message is 'women's bodies are indeed able to give birth - if they invest enough in them'. As we have seen in this chapter, this message can also be damaging to care seeking women.

Another issue suggested by this ethnographic data is that when women are seen as the consumers, they are less likely to be able to exercise power in their birth experience. This is clearly visible in the mainstream medicalised private sector, as explored earlier in this thesis. Women in labour are 'producers of children, they are commodities to the institutions of modern medicine, and they are consumers of their services but they are not considered experts' (Hunter and Hurst 2016: 55). While the overmedicalised model of care in the c-section industry delegitimises women's own knowledge and their embodied experiences of labour, does humanised birth consumerism run the risk of silencing women who, at some point in their pregnancy or labour, decide they do want clinical interventions, pain relief, or to give birth in a hospital. When women are pressured to feel they need to conform to one model or another because they are financially and emotionally invested in it, then the care they receive may become far from the humanised ideal.

Finally, the framing of humanised birth as a consumer product encourages both women and health and care providers to understand their relationship as one of client-provider rather than women being citizens with the right to high-quality care over which they have informed choices, and where they are supported and respected. The market birth group and their supporters have decided that stimulating demand in the private sector is the most productive way to reach their goals. But as Craven observes 'with the increasing influence of neoliberal ideology on public policy decisions in recent years, activists must lay claim to rights not as citizens but, rather, as consumers of goods and services and the market becomes the final arbiter of such claims' (Craven 2007: 701). This means that women's claims to their rights to health as citizens are arguably made weaker, and they are left to depend on an imperfect market that necessarily excludes a large proportion of already marginalised women.

# **Chapter Seven:** The work of doulas: advocacy, *multiplicando,* and the potential of sisterhood

## 1. Introduction

Doulas are centrally important actors in the humanised birth movement. A significant proportion of people involved with the movement that I interviewed and observed during fieldwork had either trained as a doula in Brazil or abroad. Many others had hired a doula as part of their humanised birth team. Doula courses are usually only a week or two long (full-time), which means becoming a doula is faster than training as a midwife. This made becoming a doula an attractive option for women who wanted to participate in humanised birth in some way, but who had limited time or financial constraints. Some women told me that they saw doula work as an attractive career (one which fitted well around childcare commitments), while many others explained that they trained in order to be a doula for a friend or relative, or to volunteer to support women who could not afford private services in their community or the *periferia.*

Doulas saw their work as an important part of promoting humanised birth and changing practice, and therefore as key strategy for the movement. Some believed that by simply caring for women – whether as a volunteer doula or a one who was contracted – they were demonstrating the benefits of the humanised model of care, bringing awareness of and "multiplying" support for the cause one humanised birth at a time. For many doulas an important part of their role was to be an advocate for the woman they were supporting, communicating her preferences and even challenging obstetric violence in the hospital setting. Other doulas openly identified as activists and campaigned for wider access to doula services, including in public hospitals. This range of perspectives and strategies, and their potential effects on humanising practice, led me to consider a question posed by another anthropologist doula, Basile (2012), who asks whether doulas can be 'agents of social change' in the context of the US (which has some differences but many similarities to urban centres in Brazil). To what extent are doulas in São Paulo agents of social change? How much of the change in childbirth policy and practice can be attributed to the work of doulas, and how many of them are working with the intent to change not only an individual woman's experience of birth, but wider birth culture?

In this chapter I argue that there are various forms of doula work taking place, but that the majority of doulas do take an ethical stance or political perspective, and seek to improve childbirth care beyond any one woman they are supporting. But while many doulas were reaching out to support marginalised groups, including Black and poor women who were most vulnerable to obstetric violence, questions remained over how meaningfully expressions of "sisterhood" could tackle entrenched racism and inequality. Doulas were certainly some of the most 'activist' members of the humanised birth movement. I found evidence that their collective work (*doulagem,* literally 'doulaing') has the potential to lead to more fundamental social change with regard to how birthing women perceive their own womanhood, and their relationships with other women – what was referred to by my participants as *sororidade* (sisterhood).

I begin this chapter by discussing what being a doula involves and their place in the wider movement, as well as the growth in the scientific evidence that supports doula's claims regarding the positive influence of their practice. I then discuss findings from three doula courses that I participated in or observed during my time in São Paulo, all of which offered different interpretations of what the role of a doula was, how they should act, what they were permitted to do by public or institutional policy, and the challenges they might face at work. The first was at the well-known humanised birth centre, *GAMA,* where I completed the course as a paying student. The second was the *Volunteer Doula Policy Programme*, where I observed some of the training sessions and the practical integration of doulas into municipal hospitals. The third was *Multiplicando Doulas*, a more radical course, for which I participated in several learning sessions. I interviewed the course leads for each of these case studies, as well as course participants.

Throughout this chapter I discuss several key themes, some of which echo wider trends that I had observed in other sites, and others that were distinct to *doulagem*. First, I look at participants' differing perspectives on the role of the doula and the extent to which they could and should be advocates for women or activists for the movement. As I have shown throughout this thesis, activism was an important strategy for change, but in doula work it is particularly complex because of their relatively low position of authority in clinical settings. Secondly, doulas, like other pro-natural birth advocates across the world, enact ritualised behaviours that centre the woman in the birth scene. These rituals have the potential to displace or challenge dominant medicalised rituals that prioritise doctors' preferences and technological interventions in birth (Cheyney 2012). Finally, I explore the theme of *sororidade* and reflect on the potential some women saw in feminine solidarity and the optimism for the future of the movement that came with this.

## 2. What is a doula?

Doulas are trained, non-clinical birth attendants, who provide care for women during and after pregnancy and birth. Their primary role is to provide emotional, physical and educational support for women. They do not provide clinical care, conduct physical examinations or administer drugs, but will work alongside doctors and midwives. Doulas also provide women with information about the physiology of birth and guide them in navigating health services. According to DONA, the leading international doula certifying organisation, doulas offer physical support (position ideas, touch, breathing techniques), emotional support (support families, 'creating a space where the hormones of labour can work at their best'), partner support, and evidence-based information and advocacy ('help families connect with evidence-based resources to they can ask great questions and make informed decisions about their birth…[serving] as a bridge of communication between women and their [healthcare] providers') (DONA Website 2020).

Doulas are expected to be familiar with international best practice guidelines and up to date with scientific evidence, while at the same time appreciative of the emotional and spiritual aspects of births – in line with broader efforts to normalise, naturalise and humanise birth. Doulas are usually not meant to persuade or advise women, but to give them all of the information available and to support them in communicating with clinical health professionals, acting as an advocate. For instance, if a woman has written a birth plan stating she does not want an episiotomy unless absolutely necessary, the doula might explain this to the doctors during labour, when the woman's attention may be on giving birth, and she is potentially in a vulnerable position.

The term 'doula' was first popularised in an anthropological study of breastfeeding practices (Raphael 1973), but doulas are considered to be an ancient profession. Female lay or traditional birth attendants (TBAs) have been recorded in societies all over the world in various forms (Jordan 1993, Langwick 2011), including in Brazil (Rattner et al. 2009). More than 85% of low-income countries reported having TBAs in 1994, and meta-analysis of research studies showed that their attendance at birth significantly reduced perinatal and neonatal deaths (Wilson et al. 2011). The modern incarnation of the doula became popular in the USA, Canada and some European countries towards the end of the 20$^{th}$ century. In most high-income health systems, doulas are paid privately by the woman to accompany her during labour while in the care of clinical health professionals, whether at home or in a hospital setting. Doulas are less common in settings where there is a strong midwifery

profession, because midwives assume some of the emotional one-to-one care that doulas provide. Doulas are more popular in countries such as the US and Brazil where obstetrician-led care is the dominant model.

DONA is the largest doula training organisation, and since its founding in 1992 it has certified more than 12,000 doulas (DONA 2020). There are many smaller training centres all over the world, three of which I look at in this chapter. In Brazil, the number and frequency of doula training courses like the one at GAMA have increased, especially in southeastern states where there is high demand for their services. The GAMA course now runs monthly, training a cohort of around 20 each time. Most of the 30 or so doulas I came into contact with during fieldwork reported no difficulty in finding work, and were often unable to meet demand, passing requests for their services on to doula colleagues in their networks.

Many doulas take on other roles in the humanised birth movement, such as being involved in political campaigning, raising awareness on social media and conducting academic research. From my observations, doulas tended to be of a particular profile that was similar to members of the broader movement. They were usually white, middle-class, and had finished high school, with some holding university degrees. In this regard, they tended to be from a slightly broader class and educational background than doctors and academics involved in the movement, most of whom had completed further education and earned higher salaries. Many doulas were already mothers, and were attracted to the doula profession because they had had a particularly positive or negative birth experience, and/or wanted to improve other women's experiences. The flexibility of working as a doula part-time fitted well with raising a family, which in São Paulo was still generally a responsibility taken on by mothers rather than fathers. Quite a number of the doulas I interviewed had done more than one training course, so could draw comparisons between their experiences. My overall impression was that most doulas tended to be among the most impassioned among the various movement actors. The majority of them worked independently from any clinical, academic or political body, so they could speak and act more freely and critically, at least outside of the hospital ward. Overall, they were instrumental in helping the movement advance towards its overarching goals of ending obstetric violence, reducing unnecessary interventions and normalising low risk birth.

## 3. Evidence-based emotional support

The benefits of the kind of emotional care provided by a doula is supported by evidence from clinical and qualitative research, most of which has been conducted and published in the past five years. It has generally been difficult to conduct clinical research into non-pharmaceutical maternal health interventions, partly because of the difficulty of assessing 'behavioural' interventions such as birth environment and the attitudes and actions of healthcare professionals supporting women, and partly because of the relatively large sample size needed to find effect (as discussed in Chapter Five, and in Storeng and Béhague 2016). Recently, with the evolution of the evidence-based medicine movement and an increased interest in testing behavioural interventions, there are more studies in this field. A randomised control trial of doula home visiting services in Illinois, examined the impact of this intervention on birth outcomes, maternal and infant health (Hans et al. 2018). The doula home visiting intervention was associated with positive infant-care behaviours, and the authors conclude that 'incorporating doulas services may confer additional health benefits to families' (Hans et al. 2018: S105). A meta-synthesis of experiences of continuous support during labour found that this kind of support was highly valued by most women in 12 different studies, and that doulas were considered the ideal person to provide this support, more so than the father/male partner or midwife (Lunda et al. 2018). A Cochrane systematic review of research into continuous support during labour (which is an update of long-standing reviews and evidence rather than new evidence) found that:

> Continuous support during labour may improve outcomes for women and infants, including increased spontaneous vaginal birth, shorter duration of labour, and decreased caesarean birth, instrumental vaginal birth, use of any analgesia, use of regional analgesia, low five-minute Apgar score and negative feelings about childbirth experiences (Bohren et al. 2017)

The findings of these reviews have been hugely important for natural and humanised birth movements around the world, and doulas in particular, as it collates evidence of the benefits for the care they provide. A Cochrane review that finds positive effect is a kind of "seal of approval" among fellow health professionals and researchers. It is therefore an important document with which doulas (and other proponents of humanised birth) can support their claims – in some cases quite literally; in the GAMA course we were encouraged to physically show these papers, either on our phones or printed out, to resistant doctors.

The way evidence is used strategically by the movement was discussed in depth in Chapter Five, but there are some aspects of my arguments about evidence that are specific to doula work. Doulas do not perform any clinical procedures or, arguably, use any medical technologies. Instead, their work is emotional and physical, and is therefore very much towards the "humanised" side of the humanised-medicalised spectrum of childbirth care. Despite this, their claims regarding the effect of *doulagem* is actually physiological and psychological; for instance, many doula techniques focus on creating a relaxing and safe environment to allow for the woman's body to produce more oxytocin more freely than if she is under stress. So perhaps more than any other professionals in the humanised birth movement, rather than employing the rhetoric of science in opposition to situated, bodily knowledge, doulas work instead to 'highlight the connections between scientific and embodied epistemologies' (Basile 2012: 78).

## 4. Three doula training courses

The first course I attended was the doula training course at GAMA, which was the most well known in the city of São Paulo. Its director, Isabel, was a key figure in the movement. GAMA was located on a quiet leafy street a few blocks away from the centre of the middle-class bourgeoise neighbourhood of Vila Madalena. The one-story building consisted of one large meeting room for antenatal group sessions and the doula course, several smaller rooms for private consultations, offices and a kitchen area where there would always be a large flask of tea or sweetened coffee. The walls were covered with promotional posters for the centre, and there was a notice board with flyers for private humanised services, as well as other 'alternative' therapies such as acupuncture and yoga.

*Image 12: Trainee doulas learning massage techniques on the GAMA doula course.*

The course lasted for one week, with classes most of the day. The topics covered included: the role of the doula, birth physiology, pain management, the content of sessions with the woman, marketing ourselves, scientific evidence, managing difficult situations, and the psycho-physiology of birth. Around twenty women attended the course I took part in. Around half of these were health professionals – mostly obstetric nurses – and the other half said they were taking the course because of their own (mostly positive) birth experiences, which they wanted to facilitate for other women. Around half of the attendees were from São Paulo state, while others had travelled from across Brazil to attend the course. The sessions were led by various speakers who worked in humanised birth as doulas and midwives, as well as a lawyer who worked for a well-known women's rights NGO. Most of the classes were theory-based, but there were some practical sessions, where we worked in partners to practice massage and experiment with different birth positions. The role of the doula and the evidence that supported doulagem were discussed frequently throughout the week.

The second course I attended was the training and orientation of volunteer doulas for the Volunteer Doula Programme (VDP). In 2017 a pilot policy programme to train and integrate doulas into municipal public hospitals in São Paulo was established by the Municipal Health Secretariat. The volunteer doulas did not have to pay for the course, but they would not be compensated for their work. The trainees were all women, most of whom appeared to be middle and lower-middle class. At least half of them had already undergone some kind doula

training in the private sector, and now wanted to share their skills voluntarily with women who might not be able to afford private care. The recipients of care in this policy programme were very different from the GAMA course; predominantly women from the *periferia* or poor neighbourhoods, with relatively little exposure to the concepts and literature of humanised birth. If they were delivering at one of the *Parto Seguro* hospitals, they may have been given the opportunity to write a birth plan, but from what I observed, almost none of these women were aware of what having a doula involved before encountering the volunteers.

The successful development of the VDP was an outcome of campaigning by the movement to raise awareness and gather public support, the backing of key political actors who championed the cause in formal policymaking spaces, and the use of existing policy structures that could be built upon – most importantly, the existing volunteer network in public hospitals. The policy was supported by a law passed on 23rd December 2016, championed in the Senate by a councilwoman who was involved in the movement, JC. The law gave legal grounding to the doula public policy, and was, according to its authors, extremely important in giving them authorisation to roll out the first cohort of doulas.

While many of the public hospitals had informally permitted doulas for years, their entry was not guaranteed, and could be declined by the hospital administration without notice. Several hospitals were known to have refused access to doulas based on past "difficult experiences" with doulas who had criticized decisions made by the clinical team. Establishing a programme in which the Municipal Health Secretariat took responsibility for doula training, and in which hospital administrators were allowed to run their own orientation and have control over scheduling, was an effective compromise to gain their support. The aims of this policy programme were therefore to train and certify doulas, to create a centrally organised volunteers, and to set out clearly the role and responsibilities of the doula, thus securing the approval of hospital administrators (Secretaria Municipal da Saúde de São Paulo 2017). The curriculum covered similar theory to the GAMA course, with advice on positioning and non-clinical analgesia. A unique component of this particular course was the practical integration into the wards. The doulas were required to complete 20 hours of observation and assistance on the hospital wards.

*Multiplicando Doulas* (MD), the third doula training course, was run by Fernanda from her home in the far northern suburbs of São Paulo. The financing approach Fernanda took for this course is discussed in Chapter Six. We have seen how the term 'multiplicando' was often used by movement actors to describe the spreading of (almost always positive) ideas and practices slowly and through personal relationships. For instance, every time a doula

attended a woman who had not previously been familiar with the benefits of normal birth, and then through her practice informed her, she was 'multiplying' knowledge and support for the movement. Here this concept was foregrounded in the name of the collective. MD was based on a collaborative learning approach, was designed to attract trainee doulas from a wider range of class backgrounds, and went further than the other two courses in terms of challenging obstetric violence. It was therefore the most radical, and attracted would-be doulas who considered activism a part of their role.

Fernanda had trained as a doula abroad, and had also taken the GAMA course, years before, where she had taken issue with the focus on marketing to middle- and upper-class women. Fernanda led the training sessions as a facilitator, and stressed to the attendees that there was no hierarchy in MD, as it was a collective. The sessions I observed were more like open conversation circles about ethical themes than classes. These took place weekly in Fernanda's small living room, with 5-8 women sitting on cushions on the floor, sometimes with babies of various ages in tow. Unlike the two other training courses, where most women were 'branca', the women who came to MD were more diverse ethnically, with around half of women there identifying in conversation as black.

## 5. The role of the doula: Advocacy and activism

One central aspect of doula work is being an advocate for the woman, that is, representing her interests and preferences about her care. Because doulas are often advocating for women in a high-pressure clinical setting, difficulties arise in deciding 'when to speak, when to be silent, and whom to speak on whose behalf' (Basile 2012: 102). The three courses I attended had very different approaches regarding the role of the doula in general and this problem in particular.

In the GAMA course, one of the tutors, Lena, discussed the central pillars of being a doula, the first of which was to provide information about all aspects of birth. This included birth physiology, what women should expect during labour, information about health services, and what women could expect moving through the health system. Doulas met with women early during their pregnancy multiple times to prepare them for birth. Part of their role was to communicate evidence and best practice guidelines about the technical aspects of labour, all of which was fairly straightforward given the widespread consensus on the evidence. Some knowledge, however, was more politically charged. One of the 'difficult situations' described in the course was how much 'privileged information' about other health

professionals doulas should share with women they were caring for. Many involved in the movement knew which obstetricians practicing in São Paulo were *cesaristas*. But should they tell them? Apparently one doula had been sued for this before, when the woman changed her mind and told the obstetrician. The doula students were told to 'be smart and strategic' – to not aggressively persuade a woman to leave her obstetrician, but to ask her questions about her relationship with them, and provide them all of the information about the risks and benefits of normal and c-section delivery. Lena repeatedly referred to the Cochrane Review on continuous support during childbirth, drawing on scientific legitimacy to support doula work, despite the fact that it was difficult to articulate in technical language. It was not the doulas role to persuade, manipulate, or even advise, but instead to share evidence-based knowledge and to ask questions about the woman's needs and preferences.

In the focus group I held with newly trained doulas at the end of the GAMA course, Pati, who was an obstetric nurse, spoke about the difference in her work at hospital and in her new role as a doula:

> Pati: I have 15 years' experience working in the hospital, so I really felt this issue of how doctors treat patients in a patronising way. If a woman wants to get up, walk, speak with the father...In the hospital this wasn't permitted. We were taught that this was the best model...where you didn't look at the woman, didn't perceive her or her needs, her conflicts, her limitations.
>
> I grew tired of this, and one day I exploded and said I was going to change my life...because I am *apasionada para doular* (impassioned to be a doula), to care for women, to be close to women in this precious, significant moment. And I couldn't do this inside the hospital. There the nurse is far away from the woman's bed. She has to look after paperwork, hair removal, who is arriving, who is leaving. This all distances the nurse from the woman's bedside. She knows the general technical procedures, but she doesn't know the psychological, emotional part of help. So she ends up being an incomplete professional. So another professional is needed…the doula.

Advocating for the woman by understanding her needs and concerns was something Pati felt unable to do in the other model, but she now could as a doula. In contrast, the extent to which doulas taking part in the VDP could be advocates for the women they supported was limited. In this course, doulas were instructed not to question any action taken by the clinical team. They were only there as an emotional and physical support for the women; the

advocacy aspect of their role had been curtailed. I found out after following the programme for some months that it had originally been designed differently, with a much greater space for advocacy, but the policy authors had had to make concessions to powerful political actors. Below I describe how this unfolded:

> The first I heard of the volunteer doula policy was upon my return to São Paulo from London in October 2017, when I met up with a key informant at the Municipal Health Secretariat to find out about recent developments. He immediately took me downstairs to a large conference room. At the front, two women were giving a presentation about the volunteer doula policy, with potential trainees attending to find out more about the course. The audience of around 35 women were sitting quietly, reading the slides about the policy's protocols, which set out in detail the techniques the volunteer doulas would be allowed to perform, and what they were expressly not permitted to do. Shortly after I arrived and sat down, one of the audience members (who I would later find out was the doula who ran the *Multiplicando Doulas* course) raised her hand. Fernanda was, at around 30 years old, quite a bit younger than the women giving the presentation. But her voice was tinged with disapproval and had an air of authority. She had picked up on one of the 'rules' of the VDP, which was that volunteers were not permitted to criticise doctors or the clinical team, or to interfere with their work in any way.
>
> 'What if we witness something we know is wrong? If we see obstetric violence occurring?' asked Fernanda. The course organisers argued back, saying the delivery room was not the place to contest interventions, and that 'the place for protesting was on the streets'.

There followed a tense back and forth between Fernanda, who argued that part of the doula's role was to advocate for the woman and to try to protect her from obstetric violence, and the policy leads, who had had to negotiate the finer points of the policy with powerful players in the medical lobby. One of their conditions for permitting the programme to run was that doulas would not be allowed to challenge clinical practice. Many course attendees who were already working in the private sector had, as they later explained in interviews, experienced this kind of dilemma on multiple occasions.

Through further investigation into the development of the course, I discovered that its original curriculum had been more progressive, incorporating many of the key values of the movement, including how to address obstetric violence. In 2017, however, the course

content was altered significantly under the new conservative mayor, João Doria. JC, the São Paulo councilwoman who supported the movement and her colleague had been involved in the early development of the course, and commented on the change:

> JC: When the new mayor came into office the feeling of this course changed completely. It became much more difficult for the women running the course to advance.
>
> João: …the course we imagined was a course about humanised birth, feminism, and was principally designed to combat obstetric violence. Now the content of the course has been tamed, under the administration of Mayor Doria.

The change in administration had a direct impact on the doula training curriculum for the policy programme, and therefore on the ability of doulas to advocate for women. The trainee doulas were told that instead of calling out obstetric violence in the moment, they should report the incident to the programme manager afterwards. Fernanda, and various other trainee doulas expressed their anger over this restriction of the role.

When I began observing the VDP it had recently finished training the first cohort of 16 doulas, who were all already volunteers in the SUS. One was a psychologist, another a nurse, and the rest were 'from the community', many of them mothers themselves. The trainees went to work at five municipal hospitals in different areas of São Paulo once they had completed the theoretical stage of training (10 lessons) and visited the Casa Angela birth centre. Then they had 20 hours of practical training in the hospitals as part of their orientation. I observed this final part of the training of a group of five doulas in a large public municipal hospital (Hospital C) in the *periferia* in the east of the city. The surrounding community was relatively deprived compared to the centre of São Paulo. Most women attending the hospital were poor but not severely impoverished. The building was old and much of the equipment dated, but the staff were efficient and cheerful. The ward was very busy and cramped, with four beds for women fully in labour in a room approximately three metres wide and four metres long. The beds were divided by curtains, giving women little privacy as they laboured. Around half of the women I saw giving birth there had a companion with them, normally their partner. The rest were alone. One woman explained that it was her fourth child and her partner couldn't take time off work to be there or he would lose his job.

The five trainee doulas I observed at Hospital C were full of praise for the course, and seemed fairly comfortable supporting women in labour. Eliza had completed the GAMA course four years before and had been working as a doula in the private sector. She explained she felt they had more freedom in their role as doulas in the public hospitals compared with private hospitals.

> Eliza: The *particular* [private sector] has lots of rules. The impression I had sometimes was that they don't accept us, the doctors...even though we registered and are supposedly allowed in. In the SUS, they have opened their doors to us…I think the reception has been wonderful, they help us and give us freedom to do our practice.

Eliza spoke positively about the reception of the other hospital staff, but went on to speak about the limitations of what they were allowed to do:

> Eliza: Everything we do, we ask them [doctors and nurses] first if it's ok. We can't do anything without their authorization. We don't interfere with their work. We don't hold them up, and they let us do our thing.
>
> In the [training] course, as Dra G said, it's very good that we have our limits, *né*? We practice up until a point, which we cannot pass. So we always ask the professional, what can we do, or what can we not do. And our function here is not to question the professional. So we stay within the function of the doula, which is not anything technical – in this way we can work peacefully together with the team.
>
> Lucy: Are there things that you want to do but feel you can't as a volunteer doula?
>
> Eliza: There are always things that could be better. But it's not up to us, *né*? Even though we can't interfere or question the professional, our presence is comforting for the woman.
>
> For example, if I say to the nurse that I would like to take the woman to use the [birthing] ball, but she says no, or the hospital doesn't permit it, even if I know it would help...Even though we can't interfere, to debate with the doctor, our presence there, comforting, speaking to woman, massaging, even without the ball – we are helping in some form.

Eliza seemed to wrestle with this question; on the one hand she says that they have more freedom to practice in the SUS, but even then, it sounds like their autonomy is very limited (or even non-existent) if they have to ask permission for every action. The power dynamics between the doula and other clinical staff are clearly set out in the rules of the programme. The volunteer doulas can only act with the permission of the doctors and nurses, even if they know that their action might help the woman. Her explanation that this is the 'function' of the doula confirms their role is limited, controlled, and not one in which she can be an advocate or challenge others.

Eliza felt that things might change in the future:

> Eliza: With time…we will conquer our space…with our practice, we will show that it brings results, and who knows, they might change their minds. But as we are in the first term of the volunteer doula programme, we have to be very careful. Not to be there questioning the technique, or invade the space of the professional. And with time, we will show that new techniques are better for women.

Eliza's conflicting statements suggest the mixed feelings she and other volunteer doulas had about their ability to do a central part of their work: to advocate for women in clinical settings. Like Basile finds in the US, doulas 'are consistently aware that even in an exceptionally friendly environment, their ability to practice is dependent on actively cultivating the benevolence of the staff by acting according to the hierarchy.' (Basile 2012: 104). Navigating these relationships and environments is therefore a key competency of doulas in many settings. For some, not being able to advocate for women was unacceptable, and they went on to practice and train other doulas to be advocates and activists.

In the Multiplicando Doula course, Fernanda was very clear that she believed doulas must advocate for their women, in the birth room *and* in political spaces. She spoke about the power dynamics of the clinical setting, and why doulas had a role to play in challenging the hospital hierarchy:

> Fernanda: In an interdisciplinary team, where you have a nurse, doctor...lots of power relations exist. There is a lot of ego...a competitiveness to claim responsibility...But when we look after another person, we have to *look* at them, and not force our needs on to them...in nursing, you have this technical responsibility,

> that a doula is not going to have. The o*lhar da doula* (gaze of the doula) is purely and simply focussed on the emotional help to the woman. It's not the same technical gaze that the nurse has.
>
> ...it's something really distorted, this question of "what is a doula"...because of this process of the medicalisation of birth, of this *horizontalizaçao do parto* (horizontalisation of birth) ...It makes you understand the need for a doula, you know? Because there is a real lack of "naturalness"... I think these people don't respect one another, inside the hospital. I think there is a lot of conflict. The problem is that so many of these health professionals aren't focussed on *serving*[25]. We don't focus on being there for that person, we focus on what we want to have in that moment. Health professionals need to remember they are there to be auxiliary, to be a support [to the woman].

In putting women first, the doulas are advocates for women, without limitations. Furthermore, in the MD course sessions, Fernanda and the trainees expanded the role of the doula out beyond the moment of birth, and into the realm of activism. Fernanda deliberately used the "quanto puder" scheme to enable women with lower incomes to be able to afford a doula, and to undertake training. This was in part, she explained, to account for a history of racism and oppression of Black and brown Brazilian women. Part of the role of the doula (especially privileged white doulas) was to be "allies" to marginalised groups, and to make racial and class-based inequalities in maternal healthcare a central part of their work.

From these discussions, it seemed to be that most doulas were initially and instinctively advocates and activists. Many women were drawn to training courses because they were already aware of the intervention epidemic and obstetric violence. Many had had a negative birth experience and wanted to help other women avoid it. Others had had a positive one, often having a doula themselves, and wanted to be able to provide this for other women. The three courses set out different rules and expectations for doula's behaviour, but evidently all of the trainees set out to effect positive change for women in childbirth.

[25] The original meaning of 'doula', from Ancient Greek, is 'a woman who serves'.

# 6. Rituals to re-centre the woman in birth

Being a doula involves a specific set of practices and techniques that they (normally she) enact in order to assist women during and after pregnancy and birth. In many senses these practices constitute rituals, in that they are symbolic and have meaning for the various actors involved. Anthropologists of childbirth have discussed the routines and repeated behaviours that constitute medicalised models of obstetric practice. Davis-Floyd's (2004) classic text *Birth as an American Rite of Passage* critiques technocratic birthing techniques as rituals that communicate the supremacy of technology over nature. Martin (2001) analyses the metaphors used in medical practice that portray the body as a machine; a focus on technology that diverts our attention from social relationships of power and domination in the medical encounter and in wider society. Understanding the birthing body as a machine leads to clinicians measuring the 'progress' and 'efficiency' of birth according to a certain pace: a pace that is determined by statistical averages, but fails to account for the individual woman and her needs (Martin 2001). In the UK, McCourt (2009) found that women's own experiences of the length of time of labour varied significantly from what was acknowledged or recorded by health professionals, leading to dissatisfaction with care. In obstetric units internationally, labour is defined as having started once the cervix has dilated 4cm, and progress is then measured and recorded on the partogram – but these quantitative parameters do not necessarily correlate with women's own experiences of labour, for many of whom the contractions begin hours or even days before (McCourt 2009).

Cheyney (2011) employs this concept in her study of routines and practices used by homebirth midwives in the US. For Cheyney, ritual plays a role in constructing homebirth as a 'transgressive rite of passage' through which they can 'peel away the fictions of medicalised birthing care' (Cheyney 2011: 519). She describes the ways homebirth midwives:

> …explicitly manipulate ritual in attempt to communicate the sufficiency of nature over the supremacy of technology, replacing mechanistic views of the body and birth with the language of connection, celebration, power, transformation, and of mothers and babies as inseparable units (Cheyney 2011: 520).

There are lots of similarities between the homebirth rituals Cheyney describes and doula work. In my observations of doulas, I saw practices that invoked feminine solidarity and

shared experience, encouraged women to have confidence and trust in their bodies and themselves, and celebrated pregnancy as natural and normal.

Doulas taking part in the three courses learnt specific *doulagem* techniques that consisted of patterned and repetitive behaviours. Among middle- and upper-class women, it was common to hold a pre-natal celebration with female friends in which they paint the woman's bump with swirling, nature-inspired patterns. Many of these women also attended pregnancy yoga and hypnobirthing classes where they could learn "breathwork", breathing in specific patterns to help with pain during childbirth. During labour women were encouraged to tune in to their bodies own timing and be responsive to the naturally occurring rhythm of contractions. In the GAMA course doulas were taught how to offer women physical support: making the woman comfortable, using non-medical pain relief techniques including rocking movements, water baths, trying different positions, massage and aromatherapy. The positions, in particular, were spoken about with great significance, and given names: 'on all fours', 'side lying', 'on the ball'. Each position was said to be good for different effects and different periods of labour (accelerating descent, slowing descent, widening the pelvis, the expulsion phase, reducing damage to the perineum). Our attention was drawn to the biological and physiological benefits of these positions, how they benefitted women's birthing bodies, and how this was underwritten by best practice guidelines – again drawing together the evidence-based and embodied epistemologies that informed *doulagem*. Similar instructions were given in the VDP and MD courses, though we were warned that there were space and resource limitations in many public hospitals.

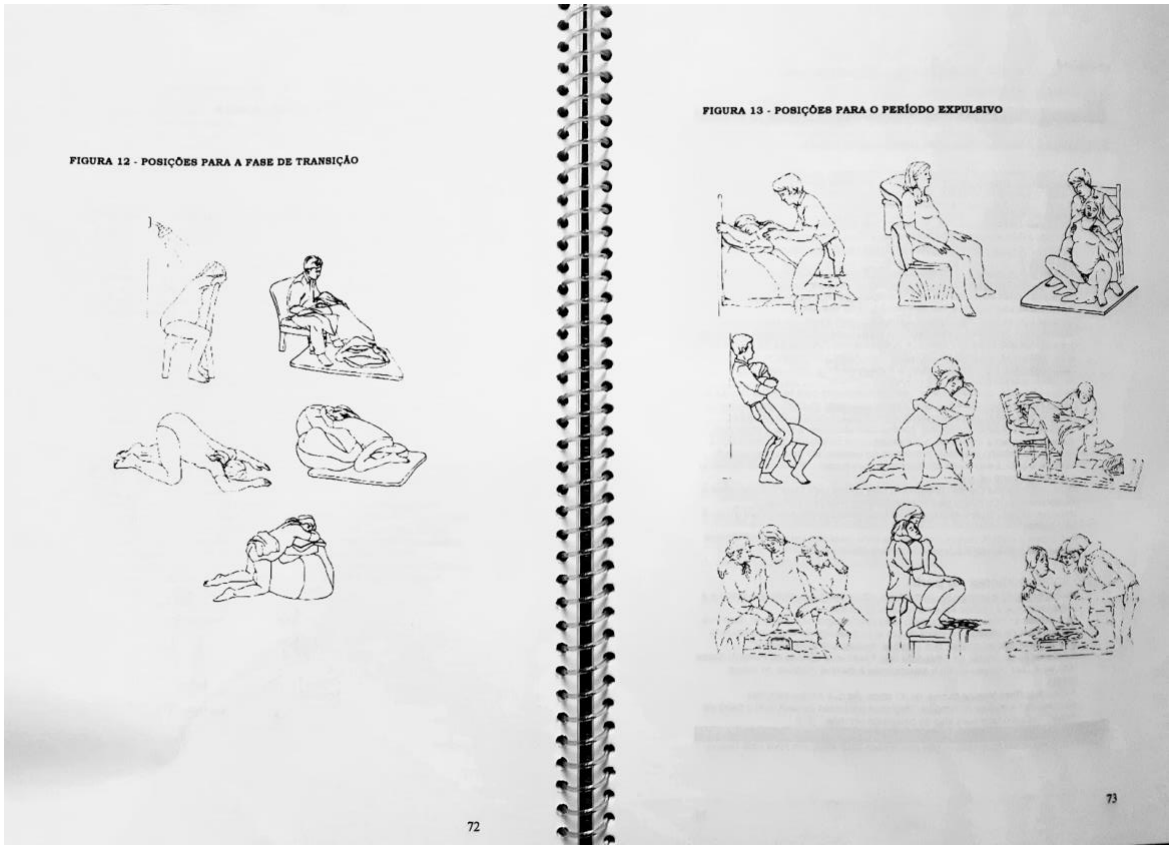


*Image 13: Birth positions - scan from GAMA textbook for the doula training course (GAMA 2017)*

Part of doula work is supporting the birth partner. It was well-known among midwives and doulas that (usually male) partners often found labour difficult because they didn't know how to help. In some cases, this made for a tense environment, which would not help the woman labour. Partners were therefore told that they had an important role, and this often involved sitting behind the woman supporting her back so that she could sit upright. Midwives and doulas would joke that this kept men out of the way and made them feel useful, but it was indeed beneficial for both the woman and her partner. Other rituals were linked to the environment: using candles and low lighting, music and aromatherapy to create a relaxing, even sacred, atmosphere. After the birth women and their families were shown how to make 'placenta art', which involved painting the placenta after delivery, then imprinting this onto a piece of paper, which usually resembled a tree.

It was also suggested that doulas 'take a history' – not just a medical history, as a doctor might in order to assess a patient, but also an *emotional* history: what did the woman fear, what made her upset or stressed? In this sense, doulas were encouraged to modify a type of medical technology (taking a clinical history) and make it into a ritual practice that fitted with the principles of *doulagem*.

Doulas were also trained in how to provide emotional help by being a 'continuous physical presence'. In the GAMA class Lena, a psychologist who was also head of the São Paulo Doula's Association, explained that the 'doula needs to love the woman during birth'. The presence of the doula was important, but not necessary touch. Eye contact was key. Above all, we were to remember that 'the woman is the most powerful figure in labour, and the most important'. We should not say *Eu faco um parto* (literally, I did a birth, but what in English would equate to 'I delivered a baby') because it was the woman who gives birth. The woman was understood as the protagonist in the birth scene, and the doula and her partner or companion, as well as other healthcare professionals, were only there to support what was a natural process. The reorganisation of these power dynamics between individuals present at a birth was striking, and very different to the medicalised model where the doctor was the protagonist, whether it was a c-section in the private sector, or a vaginal delivery in the SUS.

A central theme to the doula rituals was the idea that birth was a natural process, evident in phrases such as "our bodies are designed for this" and in the visual imagery used in promotional material for doula and humanised birth team services, which often had women entwined with plants or the earth itself. The ancestral element to birth was heavily emphasised: the fact that women had been giving birth for thousands of years, and that we women who were currently alive were the descendants of powerful female foremothers. Like the homebirth midwives in Cheyney's work, doulas in São Paulo encouraged women to "connect with their body", to trust in its naturalness and instinct.

The rituals of doula work – emotional, physical and partner support, and giving evidence-based information so the woman is informed – are all intended to make women the centre of their birth process and experience. Doulas were there to support women through this process as a female partner, or even a sister. They encouraged women to trust in their bodies, bodies that were strong and able and knew what to do. Doulas constantly drew connections between this embodied knowledge and scientific knowledge. This counteracted the dominant medicalised model in which women's bodies are constructed as essentially faulty, and childbirth fraught with danger, and in need of intervention by obstetricians (Macdonald 2006). As with the US homebirth midwives, women and doulas 'co-create, appropriate, and reinterpret meaning in childbirth,' using alternative rituals to challenge the dominant medicalised ones (Cheyney 2011: 520). Given that 'woman centred care' is now the dominant policy goal in the global maternal health sphere, doula work, and its associated rituals, should be of high political importance in attempts to implement woman centred care.

# 7. *Sororidade* and new spaces for femininity

*Sororidade* (sisterhood) was a complex and compelling theme that emerged in my interviews, and seemed to capture an idea at the heart of the movement: a shared feminine space and identity. It was something that attracted women to the idea of humanised birth and to having a doula support them through the experience.

I first heard the term *sororidade* in an interview with a doula I met during the GAMA course, but I would later see it used in other feminist initiatives that worked to counter misogyny and structural violence against women, as I discuss below. During our interview Julia spoke about how, as a middle-class educated *mulher negra,* she felt a responsibility towards other Black women who had not had the opportunities she had. She spoke extensively about the lack of feminine solidarity and sisterhood in Brazil:

> Julia: The 50,000 violences that I suffered for being a black woman, I now understand were nothing compared to some. My reality is very different from a *mulher negra peripherica* (black woman from the periphery) who is a SUS patient. But even so, I'm closer to them than any white Brazilian woman.
>
> Lucy: So you feel a responsibility to them?
>
> Julia: Yes, if there is something I can do. I want to be able to do this [doulagem] for just one woman, to serve, to greet her as a black woman. The same *sororidade* that people say there is between women.
>
> In Brazil we don't have this...women are competitive with one another. They are brought up fighting. We incentivise this in our children, in our girls.
>
> So today in Brazilian feminism, we talk a lot about sororidade. What is this? It's for women to look to another, and see a partner. A *compañeira*, a support, an ally. And not someone who could steal her boyfriend.
>
> Lucy: Do you think it is improving, sororidade?
>
> Julia: In the feminist movement, at a high level, women talk about this. If we are here now speaking about this, it's because there have been improvements. It's *very* far from the ideal... [Sororidade] involves setting down your preconceptions, and recognising these in yourself. This is very difficult, and that's why the road is still so long. But it's a path with no return, which is marvellous. So I think things are at an early stage, but there will be progress…

> ...sororidade comes from information...A woman only sees another woman as a friend when she has information. Because normally, the only information she receives is *"tem que ter cuidado*" (you need to watch out), because women are competitive. She's not born with this idea, she receives it.

The idea of *sororidade*, or lack of it, was very striking, and something that resonated with my own experience navigating social relationships and in participant observation in São Paulo. It was difficult to articulate, but was essentially a feeling that it was quite novel, but extremely powerful for women to be prioritising relationships with other women. This included two massage therapy courses I went on, yoga classes, conferences on subjects connected to women's rights and maternal health, protest marches I went on against the restriction of abortion laws, as well as the doula courses discussed here. Women were openly emotional about the profound change these kind of events, especially humanised birth and being a doula, had had on their lives and how they saw their own femaleness.

*Sororidade* has begun to be used more widely on social media, in women's rights movements, and in academia in Brazil. An article in one of the most well-known newspapers, El País, listed key feminist vocabulary 'that everyone should master', which included *sororidade*, defining the term as 'puts an end to the preconceptions that women cannot be friends, that they are rivals by nature' (Ferrero 2017). Author and journalist Paula Roschel's book '#*Sororidade*: When women help women' was published in January 2020. The lifestyle magazine *L'Officiel* ran an article in April 2020 entitled 'Sisterhood: 10 tips to put it into practice', which began '*Sororidade* is the word of the moment! After peaks of interest in search platforms such as Google, every day we find more debates about this term, which means unity and empathy between women, as leverage to achieve gender equity' (L'Officiel 2020).

*Sororidade* has also become an area of research interest. One study looked at *sororidade* in Brazilian nursing, where it was identified as a key behaviour in supporting black women who had experienced domestic violence – and was considered part of a wider model of humanised care (Oliveira et al. 2020). Others have examined its relevance in indigenous and afro-descendant political mobilisation (Carvalho and Rodriguez 2019). Most relevant for this study, Conceiçao and Mora (2020) found that the shared experience of gendered violence among black women in Rio de Janeiro led to the construction of a solidarity network in which they challenged disrespectful behaviours. These studies provide evidence that *sororidade* is a useful concept in feminist activist in Brazil, and one around which new forms of community and shared feminine identity emerge.

The GAMA doulas who took part in the focus group discussion spoke about humanised birth and doula work as a way of getting in touch with femininity, or as an opportunity to empower other women.

> Marcia: I'm an integrated therapist for women. And now a doula! I think humanised birth is important because in my work curing women, many times there are illnesses that women experience which are typically feminine, *né*? This is because she cannot find a way to be herself.
>
> The question of femininity, of creating...our truth is abused, and in birth this is still more abused...when we set this aside, it accumulates psychosomatically. So my work as a therapist is to help women to see this: what she has been accumulating for years, what she herself sees and what she can do to empower herself. What tools she can use.
>
> And humanised birth is a powerful curing tool for women. Because it is a portal through which she passes, where, perhaps for the first time, *ela consiga ser ela mesma* (she can truly be herself), in her whole life. It's where she can be wild. There's no problem in being wild. There is no problem shouting out loud in that moment (in labour), there's no problem pooing at that moment, being unreserved, without being worried about the clothes she is wearing, how she is presented to the world.
>
> So humanised birth is a huge opportunity for women, to really see herself as a woman. Because everything that has been taught to her about what it is to be a woman is not reality.

Another newly trained doula spoke in a similar way about her own birth experience:

> Aline: I had an incredible experience...My birth was in Casa Angela, it was a transformational experience. I would say it was the best experience of my life [starts crying and laughing]. It makes me very emotional! I think every woman must have the right to have this, to live this. Because it's the natural way for these things to happen. Our nature. It has to be this way. I think it's absurd when people say it can't be this way. How could it not be? We are programmed for this. And why not with a model where women are respected, full of love, dedication.

Aline draws on imagery of technology (programming) to imply that women are designed and organised in such a way that their giving birth is the most logical outcome. Two other doulas in the focus group added to this discussion:

> Evora: The humanisation of assistance in childbirth…contributes a lot to the feminist *luta* (struggle). It's important that we all participate. If not as activists, at least as *multiplicadores* (multipliers) of this system, of this special way of seeing people differently. To return to what is normal and natural. *Nós somos bestas!* (We are beasts!) We don't see animals giving birth in the way that we see women giving birth in hospitals. If you left a woman alone to give birth, with all of her natural bodily rights, assistance would be completely different.
>
> Paula: I think this [doula work] is extremely important for society...empowering women, giving women a voice. No one hears us, at this important moment in our lives [birth]. So I feel that doulas really brought me this vision. I hear this woman.

In a different setting, Ana, one of the policy authors who ran the Volunteer Doula Programme, explained that the main reason women were motivated to volunteer was out of compassion for other women:

> Doulas are were interested in helping other women...they identify with them. Some of them didn't have the birth they had hoped for. So they want to have the power to make a difference for these women

It was also common for women to refer to as *partolandia* (birth land) in antenatal classes and doula training courses. This term was used to describe the state that women reached at the final stages, when all of her attention was focussed inwards. It represented the idea that women had a territory of their own, one which only they could access during labour.

Despite this generally positive outlook, there have been criticisms of the terminology doulas employ because it rests on conventional gender norms, which reinforce the idea that motherhood is the central defining experience of a woman's life, while 'celebrating a feminine identity that is closely connected to nature and the body' (Basile 2012: 8). While this language seeks to celebrate motherhood, there is the potential for it to ostracize women who do not want or cannot have children, and women for whom things go wrong in pregnancy and labour. As I discuss in Chapter Six, when women who greatly desire humanised birth end up having to have clinical interventions, they can feel like they have failed. We see the potential for this negative response here too: when women are invested in the idea of a natural birth and believe that their bodies should behave a certain way, but they don't, they may feel there is something wrong with them or that they have not done things correctly.

Fernanda who led the MD course was less positive about the idea of *sororidade* in the movement:

> The humanised birth movement is still very masculine...It's not feminine, it's *feminist*. Because the movement as I see it today, here in São Paulo, it's very *elitista* (elitist)... I think this is very much a product of patriarchy, of a capitalist society...you will see a lot of power disputes, competitiveness, selection of who can and who cannot, a lot of violence. You will see reproduction of *machismo* from one woman to woman. So I think we still have a long way to go in this sense. And *sororidade* is something difficult to find in practice. It's often spoken of, but I think they don't have a practice of *sororidade*. I think *sororidade* is to accept, independent of [circumstances]...we are just beginning to understand it.

Evidently there was potential for the language and activities involved in doula work and informed by *sororidade* to perpetuate negative tropes around womanhood and childbirth. But Fernanda's views did not seem to be widely shared. She was someone at the forefront of feminist doula work, and I suspected she had aims that went far beyond just creating positive female relationships. For many women, especially those who were new to the humanised birth movement, the concept of *sororidade* held great power and potential.

# 8. Discussion: *Sororidade* and the role of doulas in social change

*Doulagem* work is emotional, physical and political. While much of the discussion about what doulagem involves focussed on the role of the doula in supporting the woman, "being there for her" and creating a safe and positive environment for labour, all of this is continually being supported with evidence of the effects of *doulagem* on physiological and psychological outcomes. For example, there was much discussion in all three doula courses of the *toque* (touch) between doulas and women – this would often refer to a reassuring gentle touch on the woman's body, rather than a touch to perform a clinical exam. The *toque* was one of many physical techniques that were said to diminish adrenaline, which in turn allowed for oxytocin release, which in turn alleviated pain. As Basile (2012) notes, doulas continually highlight the connections between scientific knowledge and the embodied knowledge of *doulagem*, and are therefore, despite their relatively brief training, well placed to contribute

to the evidence-base on humanised birth. Doulas are therefore centrally important agents in destabilising the medicalised-humanised dichotomy, instead embodying the logic of care. Furthermore, their independence from any professional body meant to some extent they could avoid being caught up in the politics of licensing and professional registration that had been so detrimental to the *obstetriz* profession. While their entry to hospitals was determined by doctors and hospital administrators, doulas could still strongly advocate for women in many circumstances. Judging by their interviews, many of them were playing the long game, set on proving the value of their work, and multiplying support for humanised birth as they went.

The doula training courses were microcosms of larger political debates about humanised birth and women's health rights in general. The volunteer doula policy had originally been quite radical, teaching trainees about obstetric violence and how to report it. But due to the shifting political environment and the election of conservative mayor, it had been watered down. The outcome was that doulas were told they could not challenge doctors and that the birth ward was 'not the place for activism'. Despite this, many doulas strongly advocated for their women, providing them with information and evidence they might not have otherwise accessed, and demonstrating the benefits of humanised birth and continuous support in childbirth through their work. Some doulas resisted unnecessary interventions in the clinical setting, if they considered this part of their advocacy/activism. Others saw it as their mission to change minds, one by one.

For many of the trainees, becoming a doula was a way for women to create a shared feminine space and experience in the traditionally male dominated clinical setting, and in wider patriarchal São Paulo society. Hospitals were described as places where men were in power, and women were ignored. Having a doula, and a humanised birth, was a place where women were listened to and respected, and where women supported one another. Enacting the associated rituals gave meaning to the practices of humanised birth and doulagem. They make the woman central to the birth experience, emphasising the naturalness of birth.

Despite the optimism shared by many of my interviewees about the potential of doulagem and sororidade for change, Julia and Fernanda – who as a middle-class Black woman, and a white feminist activist actively working to address racism around childbirth, were likely to have a more realistic view – had reservations. Of course, many doulas had expressed their admirable intention to work to provide humanised birth assistance to vulnerable women. But if their activism was limited to *multiplicando*, changing minds one by one, it was difficult to

see how this might lead to more fundamental change, particularly with regard to destabilising entrenched elitism and racism. This tension with regard to the activist role of doulas echoes that of the humanised birth movement more widely. The movement's goals are to ensure *all* women can access safe, respectful care with no unnecessary interventions. But some members and subgroups, in focussing their efforts only on private sector humanised care, are necessarily excluding women who cannot access it.

On the other hand, many members do prioritise tackling obstetric violence in the SUS hospitals, including issues which specifically affect marginalised women, such as differentiated access to pain relief. Furthermore, movement activists like Fernanda are directly speaking to issues of racism and structural inequalities in setting up an alternative doula course that includes these topics in its curriculum. The challenge seemed to be for these disparate groups within the movement – who might perhaps disagree with each other's methods – to work more closely and collaboratively for humanised birth to be a space for broader political pedagogy, anti-racism and ultimately, dismantling a system that permits *any* form of obstetric violence.

# Coda

## “Minority Report meets The Handmaid’s Tale”

When I left São Paulo in March 2018, it seemed that positive change really was taking place. Despite various challenges, the overuse of interventions and violence during childbirth were being acknowledged in the most prestigious international medical journals by former Brazilian health secretaries (Occhi et al. 2018), and policy programmes that had been created, implemented and supported by the movement were being praised in Brazil and abroad. The terms ‘obstetric violence’ and ‘c-section epidemic’ were being widely used in the Brazilian press and on social media. There was a strong sense of both the public and private health systems moving in a direction that would lead to improved care in childbirth, in terms of clinical outcomes as well as women’s experiences of care.

Around seven months after my departure, in October 2018, Jair Bolsonaro was elected as President of Brazil. When he had begun campaigning in early 2018 I was still in São Paulo, and most of my informants scoffed when I asked if they were concerned about the growth in popularity of such a right-wing candidate. They explained that they were confident in the evidence that supported their efforts in policy and campaigning, and that there was no possibility of going backwards. In hindsight, it appears their optimism was misplaced.

Bolsonaro is a far-right wing ex-army captain who served under the military dictatorship. He has publicly expressed misogynistic and homophobic views. In 2003 he told a female congresswoman ‘I wouldn’t rape you, you don’t deserve it…’ later elaborating that she was “too ugly” to be raped. He has openly praised the military dictatorship, saying that it ‘should have killed 30,000 more people’, and reinstated commemorations of the 1964 coup (Human Rights Watch 2019). His views and behaviour have been denounced by human rights organisations, world leaders and prominent Brazilian politicians, artists and academics. Despite his extreme position, he managed to secure an outright majority of 55.1% of the vote ahead of his left-wing opponent, Fernando Haddad, who stood in for Lula after he was jailed for corruption charges. Bolsonaro’s meteoric rise ‘was made possible by a combination of fundamental background conditions (economic recession, corruption, and crime), political contingencies (most notably, the weakness of rival candidates), and a shakeup in campaign dynamics produced by the strategic use of social media’ (Hunter and Power 2019: 70). While some of Bolsonaro’s supporters share his views, many who voted for him have explained that while they didn’t agree with everything he said, they thought Bolsonaro was

the better candidate; the kind of “tough on crime” president needed to bring an end to political corruption and the threat of everyday violence in people’s lives.

Bolsonaro and his government have passed increasingly regressive and conservative legislation and policy. The negative impacts of this have been documented in areas ranging from the environment (deforestation increased by 88% the year he came into power), the protection of indigenous peoples (violence towards and killings of whom have also risen rapidly) and police brutality (Stargardter 2019). Homophobic hate crimes rose by 75% in São Paulo in the run up to Bolsonaro’s election, which commentators have attributed to his openly anti-gay stance (Faiola and Lopes 2019). In April 2019 the government took steps to dismantle Brazil’s participatory structures with a Presidential decree (No 9.759), which acts on a broad range of structures, including the *Conselhos de Saúde*. While this decree is still being implemented, it means that out of 700 participatory groups and structures, only 50 will remain. Some council meetings and conferences have been suspended or cancelled. Civil society groups have been organising independently to continue in some form. At the time of writing the outcomes of this decree have yet to be seen. Without the existence of the *Conselhos*, the already limited civil society oversight of government policy could be lost. In response to this, a group of left-wing and progressive academics and academic institutions have formed a campaign, *#OBrasilPrecisaDeConselho* (Brazil needs the Councils).

While it is difficult to get a full sense of people’s perspectives just by observing responses on social media, in general it seems that the political left has continued to rally around the idea of their citizenship rights to participate in the councils and conferences, and are using it in their fight against the dismantling of said structures. In contrast, Bolsonaro supporters (*Bolsonaristas*) have tended to view citizenship as a form of nationalised identity rather than a communal responsibility for good. It does seem that the constitutional rights of citizens enshrined in the *Citizens Constitution of 1988* are fragile. In some cases, the judicial system has been used by civil society to limit the executive power of the president.

Around a year after I left the field the repercussions of Bolsonaro’s public policy changes were being felt. Most of my participants had hoped that the area of maternal health would, for some time at least, remain untouched, given that it is generally seen as connected to family life and is not as controversial as other areas, such as reproductive health. In the spring of 2019 it became clear this was not to be the case. A ‘Projecto do Lei’ (Law proposal) was initiated by Janaina Paschoal, a deputy of the state of São Paulo. Her proposal (known as PL 435/19), which came into effect in São Paulo state, was to guarantee all women using the SUS the right to an elective c-section. A former lawyer, Janaina had

been part of the legal team that brought the impeachment case against former President Dilma. She had also previously worked as a lawyer for CEM, the national medical council. According to her critics, there was video evidence of her attending meetings with the CEM, promising doctors better working conditions, including more convenient scheduling. In practice, this meant more c-sections, as they are easier to organise and faster to perform that normal deliveries.

Using the argument of women's 'right to choose', Janaina accused her opponents on the left of hypocrisy. In videos shared widely on her social media platforms, she told her followers that the humanised birth movement members 'think that you users of the SUS don't have the capacity to make the decision about your own body'. 'Strangely', she adds 'these same deputies say that you have to have autonomy to decide about abortion, and want the SUS to pay for abortions'. She claims that her project is 'more feminist' that those protesting against her bill. While all women should have the right to choose their mode of delivery, this PL (and the publicity around it) meant that more women using the SUS might choose an unnecessary c-section – especially given the reasons outlined in the beginning of this thesis as to why women might prefer that option given their concerns about poor treatment and pain during vaginal birth. This of course, goes against scientific evidence and the efforts of those working to normalise childbirth all over the world.

This particular law has proved popular among the general public, and has to some extent divided opinion in the movement. While many members of the movement were strongly against the PL, especially those from a clinical or research background, others, including a prominent and influential midwife who worked in the private sector, were more accepting. Interesting, the medical profession was also split on this topic. CREMESP (the regional medical council for the state of São Paulo) was in support of the PL, whereas SOGESP (the obstetrics and gynaecology association for the state of São Paulo) was strongly against it.

I questioned a key movement member about why she thought Brazil had ended up in this situation. 'People just don't believe in experts, in scientific evidence much anymore', Grace lamented. 'People here have even started saying that perhaps the world is flat'. Both of us, as researchers, had to accept the fact that our conviction in the power of evidence and knowledge was not enough to convince many Brazilians people about the importance of the humanised, woman-centred model. There is, Grace remarked, 'a disbelief in science. With so much evidence publicly available, I didn't think this was possible, that we would move backwards again, in my lifetime. But I am scared, I think it will take 30 or 40 years to get recover from this, and I may not see it happen.' The climate created by Bolsonaro's election

was one where far-right conservative politicians were able to pass draconian legislation and policy measures; and things were getting progressively worse. In the summer of 2019, a young *Bolsonarista* deputy in the São Paulo Municipality put forward a PL proposal stipulating that health professionals who suspect pregnant woman of considering an abortion during their consultation must refer the woman to a psychiatric ward. 'It's *Minority Report* meets *The Handmaid's Tale*,' Grace grimaced.

## Covid-19: Another epidemic

While I was writing up my thesis in London in the spring of 2020, coronavirus spread across the world, arriving in Brazil at the end of February. At the time of writing, Brazil is the second-worst affected country after the US, and recently passed the grim milestone of 100,000 deaths from Covid-19, on Saturday 8th August 2020. The 7-day average death rate has remained at around 1000 per day since the end of May, and has not yet begun to decline as it has in most other countries that have implemented social distancing and other protective policy measures. The number of cases in Brazil has passed 3 million, but this is likely to be an underestimate given the limited testing capacity. At the end of June, the testing rate in Brazil peaked at around 0.24 per thousand population, compared with around 1.85 in the UK. People younger than 50 years have been hospitalized and have died at higher rates than in Europe, China and the USA, suggesting that extreme inequality and poverty increase vulnerability to the disease (Ponce 2020). Similar to trends observed in other countries, Brazilians of Black and mixed ethnicity are at higher risk of severe Covid-19 related illness and death compared to white Brazilians (Baqui et al. 2020).

Bolsonaro's leadership during the outbreak has been widely condemned by national health experts and politicians, including within his own party. He has consistently dismissed the severity of the virus and shrugged off responsibility for the high numbers of deaths. Two health ministers, both doctors, left their posts in the first two months of the epidemic. Both had encouraged the population to observe social distancing and follow proven evidence-based guidelines and advice from public health experts, while Bolsonaro attended public events without a mask and endorsed controversial medicines (Malta et al. 2020). The interim Brazilian health minister is Eduardo Pazuello, an army general with no health expertise. The federal governance structure means that state governors and local mayors have been able to enforce lockdowns at the local level, but Bolsonaro has criticised their "overblown" responses. Bolsonaro himself tested positive for the Covid-19 on 7th July and has since recovered. Following Trump, Bolsonaro has endorsed and self-treated with

hydroxychloroquine. Despite the catastrophic impact of the virus on the Brazilian population, and the fact the death and case rates continue to be among the highest in the world, Bolsonaro's approval rating was rising slightly at the end of July. According to a nationwide poll, 25% of Brazilians say Bolsonaro's handling of the C-19 pandemic is good or excellent, up from 23% last month and the highest since April. This is likely due to his prioritising of the economy and encouraging people to go back to work. Many Brazilians work in the informal sector and have no social welfare support, making this kind of (often high risk and public facing) work essential.

Despite the fact that the daily national death rate has not declined since May, São Paulo and Rio lifted lockdown in early July, and on the surface, life appears back to normal. Participants that I am still in touch with have reported a sense of "lockdown fatigue". Shops and restaurants can open if they have been granted a certificate by the municipal authority to show they have implemented social distancing, but these are not being strictly enforced. Public transport, which tends to be used by the poorer and more vulnerable population groups, is crowded. Gyms and salons have reopened and people are now allowed back on to Rio's beaches to swim. As Brazil moves into summer in the southern hemisphere, people will be more likely to congregate in public.

The coronavirus outbreak has negatively impacted maternity care in Brazil, and in many other severely affected country health systems. Hospitals around the world have had to restrict visitors and, in many cases, women cannot be accompanied by their partner or doula (Coxon et al. 2020). Antenatal appointments have been reduced in number, meaning that avoidable problems are not being diagnosed. In some cases, homebirth and midwifery-led care in birth centres has been restricted due to reduced staffing or limited access to ambulance transfer (Midwifery Editorial 2020). Experts have voiced concerns about the risk averse decisions being taken in maternity care provision which may increase unnecessary medical interventions, and reduce women's options for delivering in the community or at home (Midwifery Editorial 2020, Renfrew et al. 2020).

The measures taken in response to Covid-19 are attributed to the need to slow the rate of infection in hospital settings, and are presented as temporary – necessitated by and lasting only for the duration of the current pandemic. However, critics from medical anthropology point out that 'they follow decades of institutionalization of childbirth, deeply rooted structural inequality, patriarchy, and neoliberal austerity measures' that have 'resulted in a situation in which disrespect and abuse in childbirth were common' (Drandić and van Leeuwen 2020). This includes 'episiotomies carried out without consent, fundal pressure, membrane

stripping, condescending remarks, and refusal to allow women to choose how they want to give birth' (Drandić and van Leeuwen 2020), all of which are forms of obstetric violence. These authors are among many others in the field of maternal health, midwifery and women's rights who are concerned that the pandemic will reverse global progress in moving towards a model of woman-centred, respectful maternity care.

Leading Brazilian maternal health researchers, several of whom are involved in the humanised birth movement, recently published a paper that found there were 124 deaths of pregnant or postpartum women with Covid-19 In Brazil up to June 18th 2020 (Takemoto et al. 2020). This is 3.4 times higher than the total number of *total* maternal deaths reported throughout the rest of the world at the time of writing. According to the researchers, Brazil's elevated Covid-19 mortality rate in pregnant women and women in the postpartum period might have several explanations:

> In Brazil, obstetric care is beset by chronic problems that can affect maternal and perinatal outcomes, such as poor quality antenatal care, insufficient resources to manage emergency and critical care, racial disparities in access to maternity services, obstetric violence, and the pandemic poses additional barriers for access to health care. Additionally, the rate of cesarean sections is among the highest in the world and questions remain regarding the increased risk of postoperative morbidity and mortality for patients with COVID-19 undergoing surgery (Takemoto et al. 2020).

Obstetric violence and excessive c-sections are therefore potential contributing factors to Covid-19 related morbidity and mortality, showing the far-reaching impact of the systemic problems coved in this thesis. As of yet there is no qualitative research evaluating the effects on women's experiences of care. Addressing these problems in Brazil could have a direct impact on maternal health outcomes related to Covid-19 and to infectious disease outbreaks in the future, as well as all of the benefits of evidence-based woman-centred humanised care outlined here.

Globally, two surprising positive outcomes of the coronavirus have been the rise of women expressing interest in birth outside of hospitals, especially homebirths. This has been reported in the media for a number of health systems, including the UK, the US and Brazil, probably due to women wanting to avoid the risk of contracting Covid-19 in hospital (Freytas-Tamura 2020, Hodson 2020). The number of women following through with this decision about place of birth is unclear so far, but the fact that more women are researching homebirth and considering it as an option may eventually translate to a decrease in

institutional births. The other outcome, which has surprised obstetricians, is the dramatic fall in numbers of pre-term births. A hospital in Ireland observed a 73% drop in very low birth weight infants from January to April (Philip et al. 2020), and a Danish nationwide birth register recorded a 90% decrease of pre-term births during the country's lockdown period (Hedermann et al. 2020). Researchers speculate that this may be due to reduced stress of commuting and the work environment, reduced air pollution, or better family support during lockdown, but the cause is still unclear.

Humanised birth movement members have been very vocal on social media platforms, over the Covid-19 outbreak. One particularly interesting example is a Facebook post by *Multiplicando Doulas* in May 2020:

> We, from Multiplicando Doulas, are thinking about how to act in this moment of global pandemic…Many texts are circulating about doulagem and Covid, about rethinking our role, about not putting people at risk…
>
> We at Multiplicando Doulas work with a very specific audience who are socially vulnerable. Some of us have the privilege of social isolation – but what happens to those who don't? Some people in the favelas are suffering at the hands of the military police, others are in prison or socially neglected, those who live on the street are even more invisible and unprotected than usual. In all of these situations, there are women, pregnant women and mothers. What is the role of the doula in this?
>
> We are an essential service. Taking care, understanding our limitations, but without forgetting our commitment to women. The doula does not just take care of birth, she fights for the autonomy of women before and after birth.
>
> Just as domestic violence and the truculence of the military police have increased during lockdown, the probability of obstetric violence is enormous.
> (Multiplicando Doulas/Facebook 2020, my translation)

This post includes several key points covered in this thesis, including that socially marginalised populations are at risk of intersecting forms of violence (structural, police and obstetric violence) and are thus particularly vulnerable to Covid-19 infection and severe disease. This supports my arguments in this thesis about the ways in which various forms of violence overlap to disempower poor, Black pregnant women and make them at high risk of deprivation and suffering. It also affirms that key actors in the movement think of themselves

as a “collective”, and that doulas are an “essential service” in protecting women from the worst effects of the coronavirus pandemic. Humanised birth activism has become increasingly politicised as a result of the pandemic.

Evidently, Covid-19 has already had a devastating impact on the lives of Brazilian pregnant women and mothers, as well as their families and care providers. Many movement members will have been working as front-line health workers and will have also witnessed avoidable maternal illness and death. It is likely to be many months before services return to some semblance of normality, and before research can provide evidence of the longer-term effects on service delivery, policy, and the lives of women and babies. In the following concluding chapter, I set out ways in which I hope my own research might contribute.

# Conclusion

Any lessons to be learned from this research take on a greater relevance in light of recent events. It is unfortunate for humanised birth activists (and the women they support) that just as the global health community reaches a consensus that a woman-centred, humanised model of maternal healthcare is best practice, Brazil is at risk of moving backwards, restricting women's rights to certain services and – in the case of PL 435/19 – promoting elective c-section in the public sector when there is already a national epidemic of clinically unnecessary interventions. Of course, a regressive political setting does not necessarily inhibit the efforts of social movements and individual activists to implement public policy and to change public opinion – especially not when so many are united around the same cause. The SUS, and its participatory structures, were founded during the decline of the dictatorship. Thirty or so years later, this thesis has explored the potential in the work of the humanised birth movement in yet another socio-political context hostile to progressive change in women's health.

Using an ethnographic approach revealed just how complex and "human" policymaking processes can be. Policymaking does not only take place in government offices and meeting rooms inaccessible to the average citizen, and it is certainly not limited to formal documents. Policies can be shaped at all stages of the design and implementation process by the "everyday" actions of a hugely diverse range of people. As Shore and Wright point out, anthropology's contribution to policy studies is in its 'sensitivity towards the ways in which policies work as instruments of governance, and its concern to explore how policies are understood by differently situated actors' (2011: 20). And while targeted efforts to pass humanised birth protocols into public policy and law may be the most efficient in some cases, all acts of policymaking can make a difference – whether these take place in participatory policymaking spaces, in antenatal classes, in humanised birth centres, on the street, online, and in between people. This last example is in some ways the most important, because it is the most overlooked in traditional forms of policy analysis. But what movement members called *multiplicando* was hugely important in their work: demonstrating the benefits of humanised birth and thus causing a ripple effect out from one activist doula or impassioned mother into her community of female friends, family members and colleagues. This kind of individual level opinion change is difficult to quantify, which is precisely why an ethnographic approach is so productive here. In the private sector the effects of multiplying were visible where women used their purchasing power to follow recommendations on where and how to give birth, often hiring the same doula who had provided excellent care to

friends or in previous pregnancies. In the SUS, women who had had a positive humanised birth experience at one of the *Parto Seguro* hospitals, for example, would then share this knowledge with women in their community, perhaps eventually leading to them being less fearful of painful vaginal deliveries, disrespectful treatment and obstetric violence.

My methodological approach also allowed me to trace the global movement of policies as they moved between country health systems, not as abstract linear models, but through international visits, people exchanging ideas, building professional and friendly relationships, and then adapting and situating these models into local contexts. Sociality was a key part of this process. Studying through policies at the international level can generate highly useful information that anthropologists can feed back into policy communities, ideally with the intention of improving these processes and making policy institutions more accountable to those on the receiving end of them. Ideas can also flow upwards, from local policy initiatives to the global health arena – as I discuss in the future implications section below – meaning that the successes of the movement could be adapted to other health systems where the overuse of interventions is a cause for concern.

In the preceding chapters, I have outlined the movement's strategies to humanise childbirth policy and clinical practice. Each of these strategies speaks to a different domain of activism: engaging in participatory democracy; drawing upon scientific evidence to support moral arguments and claims for higher quality care; stimulating demand in the private market; and drawing on new forms of sociality centred around the experience of childbirth. Each of these has limitations that are sometimes addressed through their synergistic interaction with one another. For Isabel and others in the marketing birth group, selling beautiful births to paying clients in order to raise the profile of and demand for humanised birth is far more effective than trying to change policy through participatory structures – but Isabel nonetheless acknowledged that she encourages women to claim their citizenship rights, even they don't call it by this name. Others in the movement use scientific evidence strategically to counter the overuse of clinical interventions, alongside rights-based arguments regarding obstetric arguments – the latter of which might otherwise be rejected as "unscientific" or discountable in clinical decision making. EBM is also used to support the work of doulas, which is becoming more widely recognised as an effective way of not only supporting women during labour, but also reducing poor outcomes. Doulas refer to the scientific evidence that supports their practice, but also recognise the value of *multiplicando*, where they prove the value of *doulagem* to women and to other health professionals one encounter at a time. In some ways these strategies, and the others listed in Chapter 4, are complimentary – but there are also tensions, as demonstrated in the contradictions between incentivising demand

in the private sector and the movement's ultimate goal of ensuring all women have access to humanised birth. As with many social movements, the humanised birth movement is comprised of a diverse range of actors with different priorities and tactics, which meant that their efforts to change policy were not always in perfect alignment.

In Chapter Three I explored different understandings of citizenship and reflected upon whether they were still significant activist strategies for the movement. My initial research interest in the *Conselhos* and *Conferências de Saúde* demonstrated the conflicted views of activists on the political left in general, and movement members in particular, regarding the effectiveness of citizen participation in policymaking. People's views on citizenship and citizenship rights were strongly shaped by specific political and historical events, many of which are stark examples of where citizenship as a status has failed to guarantee people a good life, or even access to basic entitlements. For Black women like Julia, citizenship as status could not become a positive political identity to rally around while the legacies of the colonial area and present-day racism remained unaddressed. Other movement members continued to participate in these spaces because they felt they had some positive impact, even if this was primarily in the social interactions that took place around these events, or in "holding the space" to ensure maternal health stayed on the policy agenda. Broadening the concept of citizenship to incorporate "everyday" political acts allowed me to see that there was still a great deal of "citizenship" taking place, and that it was in some ways equivalent to policymaking strategies. This more inclusive version of citizenship could perhaps begin to account for some of the intersecting inequalities that made citizenship-as-status so redundant for Black and poor women. The political acts and activism that Isabel described, but would not call citizenship, were politically motivated behaviours designed to change women's experiences of birth at the individual, but also the collective level. Furthermore, some of the discreet but effective everyday citizenship acts were made possible by the very fact that Brazilian women have traditionally found it harder to participate in formal policymaking processes, due to deliberate exclusion or insufficient time. Viewing citizenship as practice allowed me to capture everyday political acts that might usually go unnoticed, but which are important in a field of policy that is predominantly concerned with women. The fact that pregnant women and mothers had the time and interest in these issues made them all the more likely and motivated to enact their citizenship.

These interactions, and general observations from my year in São Paulo, brought me to the following conclusions. Firstly, citizenship still mattered to those who were in any way involved with the struggle to transition to democracy, those who were still active members of PT, and most (but not all) of those who participated in the *Conselhos* and *Conferencias*. I

suggest that this is because they understood what the alternative was (military dictatorship and right-wing conservativism). Attending these "schools of citizenship", gave participants an education about the values enshrined in the *Citizen's Constitution*, and a sense of duty in upholding citizen oversight. Outside of these particular groups, citizenship was not a useful or positive term. In the decades leading up to my fieldwork São Paulo transitioned into a hyper-consumerist city. The commodification of goods has filtered through into maternity services, and in many instances, consumer rights are now more potent than citizen ones. As Isabel explains, when she encourages women to claim their rights, she does not evoke the idea of citizenship, even though this is exactly what they are enacting when they demand to have a companion with them. This is a strange system in which women's access to high-quality, safe and respectful care is assured by citizenship rights – but where these rights are claimed through an opaque layer of consumerist and depoliticised language.

This was further reflected in the marketing birth group's strategy to sell humanised birth as a consumer product which was another effective strategy – explored in Chapter Six – that raised the profile of the movement and impacted upon private hospital policy in practice. Leading private hospitals in São Paulo had altered the physical infrastructure of their wards to accommodate normal birth rooms, and retrained staff in accordance with humanised birth protocols (although they did not use the term humanised). These changes were at least partially in response to the need for these hospitals to meet the demands of their clients, who wanted the beautiful, natural childbirths they had seen in promotional material disseminated by the movement. There were, however, negative impacts of this strategy, particularly that commodification reinforced existing barriers to access for poorer women. Failing to address, or even exacerbating inequalities in access, in many ways directly contradicts the central aims of the movement in Brazil, as well as overarching global policy ideals where all women can access high-quality respectful care.

Movement activists changed tactic as they transitioned between different spaces and engaged with different audiences. One of the most interesting examples of this was when key actors in the movement made use of the authoritative power of evidence-based medicine and quantifiable research results alongside rights-based arguments on obstetric violence, as discussed in Chapter Five. This is a key contribution to the anthropological literature on EBM and scientific evidence use in global and maternal health. It provides ethnographic data of the selective and strategic use of scientific evidence alongside moral and rights-based claims, where these are used side-by-side to support and reinforce one another (Ecks 2008, Storeng and Béhague 2014). This stands in contrast to earlier work that has drawn on Foucauldian theories of power/knowledge, where dominant knowledge

systems like biomedicine reinforce the objectification of bodies and the medicalisation of areas of life. These ideas have informed much of the anthropological work on childbirth and its medicalisation, as well as those concerned with the expansion of evidence-based medicine into global health and health policy. My findings suggest that in the context of São Paulo at least, EBM, EBPM and quantitative data do not necessarily limit maternal health policies to being narrow or top-down. Nor do their associated research outputs necessarily further medicalisation. Instead, the creative and strategic use of scientific evidence, and its academic weight, further the interests of the movement. This addresses a common concern regarding the limitations of Foucault's conceptions of biopower by acknowledging the agency of individual actors, who can strategically decide when and how they engage with different knowledge systems.

My findings on evidence-based humanised birth research and policy connect back to broader debates around medicalisation in and beyond anthropology. In this thesis I have situated this debate in the specific context of institutions and policymaking activities in São Paulo where "medicalisation" was used to refer to the excessive use of clinical interventions in pregnancy and childbirth. What was considered "excessive" differed slightly between individuals, but was very closely pegged to global evidence-based practice guidelines, especially when the WHO or systematic reviews had determined an ideal rate, as with c-sections and episiotomy. Humanisation, on the other hand, was used interchangeably with the idea of reducing clinical interventions, when for many women it was about whether or not they were cared for respectfully. Some practitioners on the extreme end of the movement based their views of what amount of intervention was acceptable on their own clinical experience, such as a midwife in Rio who was well known for never having performed an episiotomy in her many decades of delivering babies. In principle, most movement members accepted that there were occasions in which clinical interventions were indeed justified in order to save the life of the woman or baby, or to avoid a serious negative outcome. In practice, however, the discourse, imagery and practice of movement members reinforced the medicalised-humanised binary, leaving little space for women who genuinely needed interventions, let alone women who might have pursued a humanised birth, but at some point, opted for an elective c-section out of personal preference.

This polarising framing of care as either medicalised or humanised failed to capture what was in reality a complex set of practices, behaviours, outcomes and perceptions that took place during pregnancy and delivery. Tornquist (2004) reminds us that in the Brazilian context, "natural birth" is a meeting point between those on the extreme end of humanised birth movements, and many others activists and actors who try to find a compromise

between women's desires and their clinical needs. This includes, for example, obstetricians who do not routinely practice c-section and episiotomy, but who know that these procedures are necessary in emergencies. For extremists, nature can be imagined in opposition to (biomedical) culture, and natural birth as a transformative (even ecstatic) rite of passage. For the majority of activists, natural birth means seeing birth as a normal, healthy physiological process. They accept some level of intervention as being humanised, providing it is carried out respectfully. As MacDonald finds in her work on midwifery in Canada, 'medical interventions have increasingly become part of births that are regarded as natural' (2011: 394). When a woman feel that she has an "informed choice", she is 'carefully distinguishing her experience from the interventionist routine she has previously experienced or that she imagines characterises physician care in hospital and carefully separating the actual technology or technique out from the professional dominance of physicians' (MacDonald 2011: 394). The logics of caring and of choice thus 'emerge as key determinants of the naturalness of birth within midwifery' (MacDonald 2011: 394). In São Paulo, doulas are key actors in navigating these debates, bringing evidence and care into alignment.

The caesarean industry and the movement members involved in humanised birth consumerism argue that women paying for services should have the "right to choose" how and where their birth occurs. But Mol (2008: 14) warns of the dangers of celebrating individual choice in healthcare: 'the logic of choice suggests that, if supply were indeed to follow demand, care would – at long last – be guided by patients', who would be active consumers rather than passive patients. But the problem with this is that 'in one way or another a market requires that the product that changes hands in a transaction be clearly defined' (Mol 2008: 20) – whereas birth, health, illness, and the care provided by others during these moments, cannot be. The dangers of the rhetoric of the "right to choose" are also visible in Jainina's attempts to gather public support for her *Projecto do Lei*, which works in favour of the conservative medical lobby's interests, while it seemingly advances women's rights.

These logics of caring and choice take us back to the issue of private vs. public maternity services and the problem of inequality of access. In her ethnographic work in Brazil, Béhague (2002) found that women themselves would actively reject the birth model allied to their economic position. For low-income women, negotiating with the system to obtain a medicalised birth was a manifestation of their implementing their social power; whereas richer women who had normal births (like many of those I have discussed here) stated that they needed to be proactive in attaining the care they wanted, given that 'by virtue of their class position, they were destined to be "cut into"' (Béhague 2002: 497). In order to move

towards their goals of humanised birth for *all* women, humanised and natural birth activists must be wary of oversimplifying these models and accepting that women's *perceptions* about their care are of the utmost importance. It is ultimately women who decide whether they feel they are respected, and centred in their birth experience.

Unlike citizenship, which has problematic associations for many women, *sororidade* was a positive form of sociality that encouraged women to work collaboratively with one another to improve maternal healthcare – explored in Chapter Seven. Its significance is perfectly captured in the words of the doulas in the GAMA focus group, for whom humanised birth is a powerful curing tool for women and a place where a woman can truly be herself – the territory of *partolandia* – freed from the constraints of expectations about how women should behave in a patriarchal society. Doulas played a key role in creating these spaces, but all members of the movement played some part in fostering a sense of female solidarity. From high-level supporters in government and university professors to the women who sought care, women were driven to "re-centre" women in childbirth, and to properly acknowledge their power. *Sororidade* drove the movement towards its goals, and facilitated cooperation and collaboration between women in a society in which, as Julia explains, women have been raised to mistrust one another. This idea came up again and again in conversations with the movement members, and with a palpable air of excitement, sometimes verging on disbelief. This wasn't just sentiment, but a foundational political ideology for the movement. *Multiplicar* was in many senses the embodiment of *sororidade*: sharing knowledge and providing care for other women who were disadvantaged. It was a centrally important strategy for the movement, and one that was only discoverable through taking an ethnographic approach to studying policy.

Finally, I want to address the questions regarding representation and intersectionality I posed in Chapter Four, as well as the related limitations of this research. The first question was whether movement activists could speak for all birthing women in São Paulo or Brazil, when their own experiences of maternity services, and of participating in policymaking and activism are shaped by their whiteness and middle-class position in society. There is no simple answer to this question. Of course, many movement members were acutely aware of the inequalities in Brazilian society and the greater risk of obstetric violence faced by Black women. However, I did not witness many activists state that their work was explicitly anti-racist (other than those involved with *Multiplicando Doulas*). This could have been because white middle-class movement members did not see addressing racial inequalities in maternal health as a core objective of their work. It could also be because of historic failures by the Brazilian state to collect data on ethnicity, which could be used to inform policies that

would more openly address structural racism as well as class-based inequality. Representation was also a limitation for my own research. Despite my efforts to interview *cesaristas*, women who actively opted for c-section, and women from the *periferia* using SUS services, I could not access them in the time that I was there. I hope that future work by myself or other researchers could address this by conducting research using an intersectional lens that takes gender, class and race into account. This kind of ethnographic focus on black women's activism could advance our understanding of how intersectionality is mobilised for social and political change, as Perry (2016) has pointed out in her study of activism in Salvador.

The second question was whether the shared experience of suffering during childbirth from obstetric violence unites or further divides privileged and underprivileged women. In bringing all forms of mistreatment together as the target of the movement's activism, in a sense the movement is suggesting that womanhood is a greater force for unification than race and class are for division. The doulas in Chapter Seven spoke passionately about their intentions to provide services to women who would not be able to pay for them, to provide them with humanised care either without charge or in a way that they could afford. But this version of *doulagem* was still located within a consumerist paradigm – it was just that the doulas wanted to "work" the market in a way that improved access for those who could not fully participate in it. This was not the same thing as generating new systems and relationships for dismantling structural inequality and violence. I was left wondering how far women in the movement would go for their "sisters" – or whether *sororidade* was still in its infancy in this setting, as Julia had suggested. An obvious first step that was sorely needed was to bridge the divides in the movement between the marketing birth group who focussed their efforts on relatively privileged women paying for private services, and the work of other activists more concerned with obstetric violence against poor women in public hospitals. Future efforts could be made to actively elevate the voices of marginalised women within the movement, ensuring they are properly represented going forward.

## Future directions and implications

This thesis provides the groundwork for further research in several areas. Firstly, given the rapidly changing socio-political and policy environments, it would be useful to continue to observe existing and future policy interventions in this area; for instance, following up on the implementation and evaluation of the Volunteer Doula Policy and APICE-ON, to understand better the longer-term impacts of having doulas in the SUS and reforming the medical

curricula. Given the regressive policy environment under Bolsonaro, and the unprecedented impact of Covid-19 in Brazil, research into how these external factors have impacted upon childbirth and maternal healthcare will be crucial. Such research would provide further evidence to support the benefits of humanised birth and woman-centred care, perhaps mitigating some of the negative effects of the pandemic and the hostile policy environment. It would also be important to examine how humanised birth policy has changed more generally after nearly two years of Bolsonaro's administration – in particular, whether progressive policymakers and legislators at the municipal and state levels have been able to continue in a similar vein of work, or if the far-right conservative administration has limited or even reversed this progress. Other academics have commented on Bolsonaro's particular aversion to or stance against scientific evidence, sadly so visible in his government's response to the coronavirus outbreak (Donadelli 2020).

Secondly, my findings have implications for social movements, activists, health professionals and policymakers working towards similar goals to the humanised birth movement in different health systems. The c-section epidemic is a global problem that requires coordinated global action and shared learning. In some country health systems, including the UK, the c-section rate continues to climb. People working to reduce unnecessary interventions in Brazil have had years of experience in testing out what works and what doesn't. While there are, of course, some aspects of successful policy measures that are context-specific, other elements might be transferrable. One example is the Volunteer Doula Policy. There is a concerning shortage of midwives in the UK, and in the current system midwives are unable to give continuity of care (where women see one midwife for the duration of pregnancy and labour). There are opportunities for the NHS to fund and train doulas to provide additional emotional support to women in labour, and to support overstretched midwives. I have volunteered as a doula for friends in NHS hospitals, and also worked with doulas when training as a midwife. From both perspectives, having a doula was a positive experience for everyone involved. Research into this kind of additional support could provide evidence for future policy interventions.

This thesis has demonstrated the value of using ethnographic methods to study policymaking processes and is thus a contribution to the anthropology of policy and political institutions. Such an approach captures the broad and diverse range of strategies that a social movement or interest group might make use of to influence policy at different levels. Traditional policy analyses that assess interventions based primarily on quantitative metrics over a short time period do not sufficiently consider the complex social relationships and political histories that influence how people perceive any given intervention. Studying

through policy case studies reveals the events that led up to the policy's creation, how certain actors contest it, and how it is perceived by those on the receiving end of the intervention. Lessons might be drawn from this to inform policymaking processes in global and maternal health, where similar stakeholders and issues exist. In particular, this could improve the acceptability of policies in settings where policymakers are trying to reduce iatrogenic harm from unnecessary interventions in childbirth and for supporters of normal birth working to reduce barriers to access to midwifery-led, woman-centred care.

This research is also a contribution to several subfields of anthropology. It engages with long running debates within the anthropology of health and medicine, in that it adds nuance to polarised debates on the medicalisation vs. humanisation of childbirth and maternal healthcare. In taking a culturally and historically situated perspective on citizenship, it also contributes to the relatively small field of the anthropology of citizenship, which can provide hugely important and novel perspectives on an ancient political concept. This thesis also adds to the many variations of multi-sited ethnography that others researchers have undertaken, each with a distinct and important reconceptualization of what "the field" might be. By choosing physical sites to study based on their association with an abstract notion of the field (the humanised birth movement), I hope to have provided another example which might assist future researchers of policymaking processes.

Finally, I hope this work will have provided a novel perspective on the humanised birth movement for who are actually part of it. Many of the academic work referenced here has been conducted and written by key members of the movement, some of whom directly participated in my research. By providing an outside perspective of the movement, this thesis aims to feedback useful insight into my fieldsite, fully aware that the efforts of the movement's activists are ongoing.

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