Chapter 11
Selling Beautiful Births: The Use of Evidence by Brazil's Humanised Birth Movement

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Introduction

In February 2018, the World Health Organization (WHO) published its recommendations on *Intrapartum care for a positive childbirth experience* (WHO, 2018). This technical guidance—aimed primarily at healthcare professionals responsible for developing national and local health protocols and providing care to pregnant women and their newborns—came more than two decades after its previous iteration (WHO, 1985). During this period, significant new challenges have emerged in global maternal health, many of which result from the overuse of clinical interventions in healthy pregnancies and low-risk labour. This increasing medicalisation of childbirth "tends to undermine the woman's own capacity to give birth and negatively impacts her childbirth experience" (WHO, 2018, p. 1). The WHO guidelines reflect a consensus among global maternal health experts that maternal health care 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). Whilst acknowledging the importance of life-saving obstetric interventions for women with underlying health conditions or complications, the WHO guidelines draw on a woman-centred model, which takes a holistic

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approach to maternity care[1]. It recognises 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 supported by systematic reviews of scientific evidence (Bohren et al., 2017; Downe et al., 2018) and are echoed in recommendations from leading health institutions, such as England's National Institute for Health and Care Excellence (NICE), and comprehensive research, such as the *Birthplace in England* study (Birthplace Collaborative Group, 2011).

While the women-centred model of respectful maternity care informs the development of institutional practice and public policies around the world, service provision is far from adequate in many health systems, with huge variation between and within countries. In many high-income contexts, obstetric-led hospital-based care has become the standard model for healthy women with healthy babies, despite the evidence-base favouring care in a midwifery-led unit. In over-medicalised settings, such as private hospitals in the United States, the Dominican Republic, and Egypt (Boerma et al., 2018), women are at risk of a "cascade of interventions," in which one minor medical intervention, such as an induction of labour using synthetic oxytocin, can require further monitoring with a cardiotocograph (CTG), a move from midwifery-led to obstetrician-led care, and ultimately delivery by forceps or c-section (Jansen et al., 2013). In other health systems, such as rural regions of West and Central African countries, technological interventions are not accessible for women who need them, resulting in preventable deaths and illness (Cavallaro et al., 2013). Women may also be poorly treated by health professionals, particularly in societies where doctors are revered and their decisions rarely questioned (WHO, 2015; Manning & Schaaf, 2019)—this disrespect and abuse is often termed *obstetric violence* (Jardim & Modena, 2018). Although the term remains contested, activists use obstetric violence to refer to both the excessive or inappropriate use of clinical interventions, and the disrespectful treatment of women during pregnancy and childbirth.

The most alarming example of the overuse of interventions is caesarean sections. The global rate of c-section has almost doubled in the years between 2000 and 2018 and is now estimated to be the mode of delivery for 21.1% of births, despite the WHO's recommendation that rates above 10–15% are excessive (Boerma et al., 2018). 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 newborns include altered immune development, an increased likelihood of allergies, and reduced intestinal gut microbiome diversity (Sandall et al., 2018).

[1] This model emerged from social movements for midwifery and homebirth in the 1970s and 1980s in the United States and Canada. There is not one single definition of 'woman-centred care', but generally it requires health professionals to respond respectfully to a woman's unique needs, women to be well-informed and play a central role in planning and making decisions about their care, and creating a calm birth environment (Morgan 2015).

It is now a global health policy priority to *optimise* the use of c-sections and other interventions that may cause harm to women and their newborns. In this chapter, I focus on these efforts in Brazil, where maternal health care in both public and private hospitals is highly medicalised, and "aggressive management" with excessive intervention is the norm (Diniz et al., 2018). My research involved following the *movement for humanised care in childbirth*—a national social movement that formed in the early 1990s, whose members seek to reduce unnecessary clinical interventions and promote a "humanised" model of childbirth where women are respected and birth is normalised as far as possible (Davis-Floyd, 2018). I focussed on the movement's activities between 2015 and 2018 when it was starting to see measurable progress, with rates of c-section and episiotomy falling in São Paulo's public municipal and private hospitals. The movement's profile grew as national celebrities opted for normal births, and women from different areas of the country and different social classes sought alternatives to the highly medicalised norm.

Key actors in the movement—including academics, humanised health professionals, and women seeking obstetric services—have been involved in the development and implementation of policies to promote humanised birth, including the *Rede Corgonha* national policy plan in the public health system (*Sistema Único de Saúde* or SUS), and a large number of local-level programmes and interventions in specific municipalities and hospitals (Diniz et al., 2018). I followed three policy case studies: (1) *Parto Adequado,* a partnership between *Hospital Einstein* (the largest private hospital in Brazil), the Brazilian health regulatory authority, and the US-based *Institute for Health Care Improvement*, which sought to reduce the rate of c-sections in participating private hospitals by training health professionals in normal deliveries; (2) *Parto Seguro*, a policy implemented by the research institute CEJAM (*Centro de Estudos e Pesquisas "Dr. João Amorim"*) and the São Paulo Municipality health department, which implemented humanised protocols based on international best practice guidelines, including freedom of movement, non-medical analgesia, delayed cord clamping, and breast-feeding support; and (3) the *Volunteer Doula programme*, a pilot intervention to train and integrate volunteer doulas into municipal hospitals, providing women with continuous support during labour.

My findings provide a local-level analysis of what Storeng and Béhague (2014) identify as "evidence-based advocacy" (EBA) in their ethnography of the *Safe Motherhood Initiative* (SMI). EBA represents a shift in the tactics used by the SMI over the past 20 years, where actors now use quantitative scientific evidence instead of moral arguments to call for policy change in global maternal health (Storeng & Béhague, 2014). I found that members of the humanised birth movement strategically used the power and perceived objectivity of science and evidence-based medicine (EBM) to further their goals in a similar way to the SMI actors. Storeng and Béhague also identify ways in which some safe motherhood experts are resisting and modifying these authoritative paradigms, and "couching [their] ideological and moral convictions in the language of scientific evidence for the sake of political expediency" (2014, p. 274). My findings suggest that the humanised birth movement has employed this strategy from its beginnings in the 1990s (Irvine, 2021). Throughout this time, key members have explicitly framed their campaigns as

combining evidence-based and women's reproductive rights perspectives (Diniz & Chacham, 2004; Rattner et al., 2010). For instance, movement members would use the term "obstetric violence" to indicate that they saw the poor treatment of Brazilians as a violation of rights, in addition to describing the issue as a public health problem (the c-section "epidemic"), and references to systematic reviews that supported a humanised model (such as Sandall et al.'s 2016 systematic review of midwifery-led care). The decision of which strategy to use (or whether to use them all in the same speech, legal document, or social media post) depended on its perceived effectiveness and on who the audience was. This research is, therefore, also a contribution to what Ecks has called "evidence-based medical anthropology", where evidence use is performative, strategic, and "always used in relation to a particular audience" (2008, p. S85).

In the same way that some SMI actors expressed frustration with the "technocratic narrowing" of the policy agenda through prioritising particular forms of evidence (Storeng & Béhague, 2014), some members of the humanised birth movement were exasperated that pro-c-section doctors and the powerful medical lobby resisted the movement's activities and policy reforms, and firmly rejected the scientific support for humanised birth and moral claims that their actions constituted obstetric violence. In response, some members of the movement also used other tactics to raise public awareness about these issues and to stimulate private sector demand for humanised services. I discuss this alternative strategy and briefly reflect on its implications for the accessibility of natural/normal birth care.

Methods

My methodological approach is informed by Wright and Reinhold's approach of *studying through* policy (2011). This method enables researchers to "follow a process of contestation as it tracks back and forth across different sites in a policy field and over time" (Wright & Reinhold, 2011, p. 88). 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).

From October 2015 to February 2018, I made several trips to São Paulo, for a total of 12 months of fieldwork. Upon arrival, I constructed a map of the policy community at the local level in central São Paulo, as well as key figures in the national movement I met at conferences in São Paulo and the capital Brasília, and who were vocal on social media. The movement can be 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. The movement is composed of peripheral groups and individuals working towards a common cause (humanising childbirth in Brazil), who 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).

I chose research sites to conduct observation based on their association with the movement. These included: five municipal public hospitals implementing humanised policy programmes; three humanised birth clinics that ran regular antenatal classes; a private hospital; state health council meetings; health conferences and campaigning events. I observed clinical training sessions for *Parto Adequado* and the integration of volunteer doulas into the hospital wards. The ethical approval I obtained from the public hospital administrations permitted me to conduct participant observation on the obstetric wards, but not to conduct formal interviews, which seemed appropriate given that women there were either in labour or had recently given birth. I was, however, able to informally discuss their experiences of care to document how they perceived existing services and new policy interventions.

I conducted in-depth semi-structured interviews (n45) and shorter informal interviews during participant observation (n4) with: women who were pregnant or had recently given birth in the public or private sector (n8), doulas and trainee doulas (n15), midwives (n10), obstetricians (n5), senators and politicians (n4), academic researchers (n4), and the policy programme leads (n3) at CEJAM, Hospital Einstein and the São Paulo municipal health department. I conducted two focus groups—one with a group of trainee doulas from the private sector, another with trainee doulas from the volunteer doula programme. The majority of my interviewees explicitly identified as being part of the humanised birth movement and would refer to themselves or their style of healthcare provision as *humanizada,* as opposed to the *cesarista* (pro-caesarean) doctors.

I recruited participants by identifying key members of the movement at academic conferences, at the municipal government health department, and at Hospital Einstein. I used snowball sampling to meet other stakeholders, most of whom were humanised health professionals. I asked key contacts to post on relevant social media groups about my research, asking if any mothers or women who were currently pregnant if they would be interested in participating. 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 controlled for this by asking interviewees to reflect on the negative aspects of the movement and its relevance for different population groups. My attempts to interview *cesarista* doctors were unsuccessful, as despite the objective position set out in my research questions it was likely they assumed I was involved with the movement and that they would face criticism (studies of the c-section epidemic and/or the movement have, for the most part, painted obstetricians in a negative light—see McCallum & dos Reis, 2008; Diniz et al., 2018; Lansky et al., 2019).

I developed a standard 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, political and social rights, and supporting laws in achieving this, and what they thought of specific programmes (Irvine, 2021). I used *NVivo* qualitative data analysis software to organise and code

interview transcripts to compare interviews through connected themes. I coded my paper fieldnotes thematically and referred back to these to triangulate my data.

Being non-Brazilian 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 inside the policy community (Walt et al., 2008). I found that having some clinical experience as a trainee midwife in the UK made people feel comfortable discussing their experiences of delivering and receiving obstetric care. I personally support the normalisation of birth, whilst also recognising the need for life-saving interventions where necessary. To account for my positionality, I would remain impartial in interviews until explicitly asked about my own opinion. Many people 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.

The Intervention Epidemic in Brazil

There is strong evidence to support the humanised birth movement's claims that the excessive use of procedures in Brazil is driven by political, economic, and convenience factors rather than genuine clinical need. 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, and a lack of practice by clinicians of difficult vaginal deliveries (Irvine, 2021).

Throughout the 1970s and 1980s, Brazilian maternal health care became increasingly medicalised, at the same time as services were privatised and deregulated, particularly in the rapidly industrialising cities. Private obstetricians promoted c-sections as a "safe, painless, modern, and ideal form of birth" (de Mello e Souza 1994, p. 358). Over this period, Brazil's c-section rate soared, with many private hospitals in the wealthy south-eastern states delivering 80–95% of babies operatively (Leal et al., 2012). Rates of c-section in the private sector remain between 80–90%, and around 30–40% in public sector hospitals (Secretaria Municipal da Saúde, 2015). Research into c-section rates (Alonso et al., 2017) and private insurance coverage (in Paim et al., 2011) suggests that around 75% of the population deliver in SUS facilities. These excessive rates are referred to as the "caesarean epidemic" in national (Ferey & Pelegri, 2018) and international media (Associated Press, 2015), as well as by Brazilian politicians and in leading academic journals (Barros et al., 2018).

Monetary reward for physicians is a key driver of high c-section rates. In an attempt to lower the rate of c-section, government policy dictates that doctors are paid less per procedure for a c-section than a normal birth. They can, however, still earn more overall by carrying out c-sections by performing multiple operations per day. Elective c-sections can also more easily be performed during normal working hours, meaning doctors do not have to work nightshifts, on weekends or 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. Elective c-sections are thus preferable and more convenient for many doctors, being easier to plan than normal birth (de Bessa, 2006).

Because of the high rates of c-section in teaching hospitals and the use of out-of-date training manuals (Hotimsky, 2008), few doctors have the opportunity to practice complex vaginal deliveries such as breech position, making them less inclined to perform one. Obstetricians are also expected to be proactive and "hands-on" in a delivery, and to treat any problem that does emerge aggressively—which normally means exhausting all options for intervention. Doctors who do not intervene in a normal birth with a poor outcome risk being sued, meaning that very few will attempt vaginal delivery with intermittent monitoring (the suggested approach in a woman-centred model for low-risk pregnancies). C-section is, therefore, the preferred mode of delivery for many doctors, despite the risk of serious adverse effects for the woman and newborn (Souza et al., 2010).

A key factor driving patient demand for c-section is the poor quality of care offered during normal birth, especially in the public sector. While c-section rates are far lower in the SUS, care is still highly interventionist, and clinical procedures such as the shaving of pubic hair, induction of labour using synthetic oxytocin, continuous monitoring with a CTG, and episiotomy (a surgical cut at the opening of the vagina) are routinely practiced (Leal et al., 2014). For instance, 56.1% of low-risk women undergo episiotomy in Brazil across the public and private sectors (Leal et al., 2014), despite the lack of clinical evidence to support its routine use (Jiang et al., 2017). Some SUS hospitals are infamous for institutionalised maltreatment of women, particularly women of colour and low economic status (Diniz et al., 2018). There are reports of inappropriate or disrespectful behaviour towards women by medical staff, most often in the form of verbal bullying and coercion into unnecessary treatment. Anaesthesia is rarely used in public sector births, despite the frequent use of oxytocin to induce and augment labour, which increases the intensity of contractions. Because of this, many women closely associate vaginal deliveries with pain and suffering. Those that can will avoid this risk by paying for an elective c-section in the private sector (McCallum & dos Reis, 2008; Béhague, 2002). Women in the public sector have also negotiated with clinicians to access the kind of care they prefer and avoid pain. In Bahia, women persuaded doctors to use medicalised interventions, such as foetal monitoring, because they knew this was more likely to clinically justify a c-section delivery (Béhague et al., 2002). Women seeking care are therefore not merely passive patients or consumers of care, but themselves deploy strategies in order to access particular services and interventions.

On top of this, Brazilian women face substantial legal, financial, and practical challenges to accessing alternative types of care, such as midwifery-led care or homebirth services. Only 16.2% of vaginal births are carried out by a nurse or nurse-midwife, with the rest performed by doctors (Gama et al., 2016). The University of São Paulo began the first direct-entry midwifery (*obstetriz*) degree in 2005, but graduates have faced obstacles to entering the workforce. The conservative medical lobby has blocked midwives' appointments to public hospitals. The Brazilian Nursing Council has resisted licensing and regulating midwives (Gualda

et al., 2013). Private hospitals have refused doulas entry for questioning the overuse of clinical interventions. These competing professional interests create barriers to the employment of health professionals adequately trained in women-centred and evidence-based care (Gualda et al., 2013).

Further, contracting a team of humanised health professionals is costly. From my interviews, I gathered that in São Paulo hiring a humanised doctor and obstetric nurse for their services in a hospital costs between US$1600 and US$2400, a team of midwives for a homebirth around US$2000, and a doula US$350–US$500 for either home or hospital birth. These are considerable expenses given that the average monthly salary is around US$1000 (IBGE, 2019). Some women seek humanised care at normal birth centres, most of which are free at the point of use, but this can mean travelling a considerable distance, as there are few in existence. At the time of my fieldwork, there was only one freestanding normal birth centre in operation in São Paulo city. Across the country, some public hospitals have been refurbished with normal birth centres under the *Rede Cergonha* policy, but not all hospitals are participating in these programmes. So far, seven out of eighteen municipal hospitals in São Paulo have brought in humanised protocols and retrained obstetricians and obstetric nurses under the *Parto Seguro* programme. Four municipal hospitals are trialling the volunteer doula programme.

These financial barriers to accessing humanised birth services reinforce the existing unequal distribution of obstetric care. Poorer women using SUS hospitals are more likely to experience poor quality care or obstetric violence unless they live close to one of the hospitals participating in *Parto Seguro* or another humanised policy programme. In contrast, upper-class women can opt for an elective c-section with a private obstetrician and also have the option of contracting their own humanised birth team at home, or delivering at a private hospital that permits humanised births.

The Movement for Humanised Care in Childbirth

The movements' diverse members are united by their goal to normalise vaginal delivery for low-risk births and to humanise care more broadly. "Non-expert" members include pregnant woman and mothers who have sought out a humanised birth. "Expert" members include academics, politicians in regional government health departments, and humanised health professionals—doctors, midwives, nurses, anddoulas who practice according to this model (Diniz, 2005; Diniz et al., 2018). The movement is active across the country, with many different permutations (see Béhague, 2002; McCallum & Dos Reis, 2008). Members are predominantly upper- and middle-class women, educated, *branca* (of European descent), and carry "cultural capital", understood as the capacity to critically challenge certain social regulations (Carneiro, 2015).

Diniz (2005), who has studied the movement extensively, describes how it grew slowly over the 1970s and 1980s, when dissident health professionals were inspired

by indigenous childbirth practices and the global feminist movement. From the late 1990s the humanised birth community met several times a year at conferences and communicated via email, and more recently, social media platforms (Irvine, 2021). Important milestones included the first humanised public maternity hospital in Rio de Janeiro in 1994; the creation of prizes for humanised maternity wards, based on adherence to WHO recommendations for promoting normal birth; and the introduction of freestanding normal birth centres. The movement has played a central role in influencing public policy and some members have worked closely with the government to develop humanised policy interventions and guidelines (see Diniz et al., 2018 for a comprehensive list of these).

Strategies for Humanising Policy and Practice

Movement members transitioned between personal and professional spheres, employing different strategies as they moved between sites and spoke with a range of audiences. Different factions within the movement prioritised particular activities for influencing policy over others. Some members—mostly academics working at universities and in national and local government departments—directed their attention towards using research to inform public policies, campaigning and lobbying for the rights of women to have access to humanised services in SUS hospitals, and sharing information about humanised birth with women in poorer areas of the city through outreach programmes. Within this group, actors tended to support their arguments either with scientific evidence and/or rights-based arguments grounded in national and international law.

Obstetric Violence

Obstetric violence was commonly discussed among movement members—and it was one of the primary reasons that women sought humanised care or became involved with the movement. One woman, a nurse, described its long-term impact: "I suffered obstetric violence from an obstetric nurse…in 35 years I haven't been able to forget…It's the same for all of us [women]. During labour, we are abused". Women 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". Until recently, the term "obstetric violence" was present in formal policy documents, including in a memo written in 2014 by the São Paulo State Ministry of Health which defined it as: "the appropriation of women's bodies and reproductive processes by health professionals through dehumanised

treatment, drug abuse and pathologisation of natural processes" (Ministério Público do Estado de São Paulo, 2014, p. 1).

Obstetric violence was a central theme of public academic events with high-profile speakers from academia and government. For example, a conference held at The University of São Paulo's Faculty of Public Health was entitled "Best practices to counter obstetric violence". At this event, Professor Simone Diniz (who is frequently cited in this chapter) spoke about the evidence of the effect of obstetric violence on physical and mental health indicators, and the State Secretary for Health gave a plenary session which detailed the "gold standards and best practices" to reduce obstetric violence. The title and content of these talks very literally brought together the discourses of obstetric violence and scientific evidence.

The idea of the right to quality humanised care and freedom from violence also came up frequently in interviews. In her discussion of the Volunteer Doula Programme, a leading academic who ran advocacy groups argued: "if health is a right, and not a product—doulas improve outcomes for babies and women, so a doula should be a right in the SUS". Similarly, one of the few working midwives described the movement as a "battle for rights", another explained that women had "the right to a homebirth" and another still stated that a woman has "the right to a professional companion of her choice". These activists' claims were supported with references to clinical evidence that supported the interventions referred to—for instance, the doula who insisted women have a right to homebirth went on to talk about how "studies confirm it".

However, the changing political environment influenced which strategies activists were using. Two senior politicians explained that they had worked with the movement to create a progressive course for the volunteer doula training programme, "about elements of humanised birth, feminism, and principally to combat obstetric violence". But when the conservative mayor of São Paulo, João Doria, came into office in January 2017, "the feeling of the course changed completely…the content of the course has been tamed…they said you cannot teach obstetric violence in a doula course". Obstetric violence was clearly politically controversial and had to be removed from the volunteer doula training programme in order for it to run during the Doria administration. The term recently has been revoked and disallowed in policy by the Ministry of Health under President Jair Bolsonaro, to the ire of the humanised birth movement (Cancian, 2019). The Brazilian Medical Association argued that the term is too judgemental and attributes the poor quality of care solely to doctors. In the eyes of most humanised birth activists, this was an accurate attribution. When movement members met this kind of resistance from the medical establishment and politicians, they would turn to the authority of scientific evidence to bolster their claims.

Using Evidence in Humanised Policy Design

The movement worked to bring in evidence-based policy-making (EBPM) to national decision-making. In 2011, CONITEC (the National Committee for Health Technology Incorporation) was established to make recommendations for the use of medicines and procedures in the SUS based on the best available scientific evidence. According to a midwifery professor involved in the movement, CONITEC is directly modelled on similar health technology assessment (HTA) initiatives from other countries, such as NICE and the Belgian Health Care Knowledge Centre. A public consultation process brought in several thousand professionals and members of the public (many of whom were members of the movement) to advise CONITEC on the creation of best practice guidelines for c-section and normal birth.

Clinical evidence-based guidelines were a tool the movement used to negotiate. They informed the overarching goals and the design of specific policy programmes, including the installation of normal birth centres under *Rede Cergonha* and local level initiatives, such as *Parto Seguro*. These were the result of key figures championing humanisation within the Municipal Health Secretariat or the support of research institutes and private hospitals (Diniz et al., 2018). For instance, both the *Parto Seguro* and *Parto Adequado* programmes created normal birth facilities in hospital wards and implemented humanised birth protocols in São Paulo that 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 stated aim was to "ensure high quality humanised obstetric and neonatal care based on scientific evidence" (CEJAM, 2019, no page). Its director repeatedly stressed the importance of clinical evidence and internationally recognised models of care that had been incorporated into its programme 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". She makes a clear distinction between the "biomedical model", which is not supported by internationally recognised assessment metrics, and the "humanised model", which is.

The volunteer doula policy authors frequently referred to scientific research on the benefits of non-clinical emotional support during labour (such as Bohren et al., 2017) that was disseminated in online humanised birth groups by a group of doulas in Rio (Núcleo Carioca de Doulas, 2012). Volunteer doulas received training on how to apply this evidence in their practice—for example, their manual sets out the equipment and techniques doulas can use for non-clinical analgesia (Kozhimanni et al., 2013). One of the authors explained: "Trials, scientific evidence—I think this is aligned [with the policy's aims]. The scientific point of view is something that helps our actions". Another doula who was involved in lobbying for the professionalisation of doulas explained: "Science says that a trained companion…is the sole intervention with the most significant impact on outcomes…Fewer c-sections, less use of anaesthesia, pain killers, medications". She describes doula care as an

"intervention" with clear outcomes for maternal health, taking up the scientific language typically used to convey the results of clinical trials.

Several interviewees explicitly linked research done by health professionals linked to humanised/natural birth movements around the world with the growth of EBM, with one humanised doctor explaining that "Cochrane, and the evidence movement, arose with the humanised birth movement…The first research was done by midwives, because of the demand for midwife-led birth". In Brazil, the stubbornly high maternal mortality ratio (MMR) has been an important tool for the movement, precisely because epidemiologists have found an association between Brazil's poor performance and the excessive use of clinical interventions (Barros et al., 2018). One humanised doctor explained that "the government evaluated [the MMR]…in neighbourhoods with lots of c-sections…c-section can lead to preventable deaths, due to haemorrhage, infection. So this led to their focus on reducing the c-section rate and unnecessary interventions".

Some of the evidence being used in advocacy was generated by Brazilian public health and midwifery researchers who were involved with the movement (Diniz & Chacham, 2004; Rattner et al., 2010; Niy & Delage, 2015; Diniz et al., 2018). One doula explained that many women who had opted for humanised birth were part of a particular educated, middle-class social group who also "produced scientific evidence", through their professional roles as academics, adding to the pool of knowledge about humanised birth. Senior politicians (such as 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*, *Rede Cergonha,* and *Parto Adequado* by name (Occhi et al., 2018).

Contesting Evidence, Overcoming *Cesaristas*

Non-expert members of the movement accessed and shared clinical evidence through social media and personal networks to disseminate information and attract new members. The movement's frequent citation of scientific papers and best practice guidelines meant that women who sought out humanised care, but were not clinically trained, were nonetheless familiar with and confident using scientific terminology. A midwife explained:

> …women already know how to translate this information. What is a meta-analysis, what a study with *x* amount of participants means…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. One mother also explained:

> Evidence has power, because it's not me just thinking it's the best. Studies have shown that those are the best policies. Those have the better outcome for health, for results, so we need to use that. Because that information is being shared…that is what's driving the change.

Mothers and pregnant women involved in the movement had taken to using evidence to promote its messages among friends. One middle-class mother who had opted for humanised birth with a doula explained that she would share WHO recommendations with people: "I bought a book just about c-sections. I would bring the book with me and would tell my friends who are pregnant". Others explained key "inspirations" they had from friends who had homebirths or "very natural birth stories", who had introduced them to the movement, and shown them key materials, such as the *Rebirth of Birth* documentary.

Links to research article summaries, open access articles, and Cochrane reviews were regularly posted on Facebook and in humanised birth WhatsApp groups, framed by comments encouraging people to read them and a liberal scattering of emojis. One woman who had a humanised birth in a public hospital explained that Facebook was a tool for the movement: "you have information exchange, you report on your [birth] experience, and let people know if you had a doctor who claimed to be humanised but turned out not to be". The membership of these online groups ranged from around 10,000 to 200,000. Even though they had initially only been accessible to wealthier women, this was changing with the proliferation of cheap smartphones. According to one influential member of the movement, social media was important in building bridges to reach poorer women in the *periferia*. These women, most of whom used SUS services, were not as familiar with EBM terminology as middle-class members of the movement—but were certainly aware of the positive stories passed on from friends and relatives about certain humanised protocols that had been introduced, such as the use of birthing pools and being able to move around freely.

Doulas in particular prided themselves on being up-to-date with the latest international evidence. In a doula training course at one of the private humanised birth centres, every technique was taught alongside the evidence that supported it, including the "emotional work", such as reassuring touch and creating a relaxed birth environment. A Cochrane review on the benefits of continuous support during childbirth was regularly referred to (Bohren et al., 2017). One doula also described the success of an informative booklet she had helped produce and distribute in the public sector—"It has all the information…[about] women's rights, birth positions, nutrition".

Access to scientific knowledge about pregnancy and birth gave non-clinical professionals and their clients greater power in encounters with resistant doctors, however, the movement's members experienced varying degrees of success in confronting *cesarista* doctors. One doula 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".

Humanised obstetricians, midwives, and doulas claimed *cesarista* doctors were aware of evidence-based guidelines, but that they often refuted them on personal or political grounds:

> There are lots of doctors who unfortunately think that this evidence is not reliable, that its manipulated…The oldest ones, the professors, defend caesarean…It's difficult for someone to change, who has practiced in a certain way for their whole life…

> 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.

One doula told me she had shown multiple doctors best practice guidelines only for them to shrug her off and say "Brazilian women are different—this doesn't apply here". Another told me of the countless instances a doctor had performed 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). Scientific evidence was effective up until a point: when *cesarista* doctors were powerful enough to refute it.

Interviewees in 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. Doctors were known to have considerable political influence over policy-making and implementation and to fight aggressively for their professional interests over those of patients and other health professionals. One midwife 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".

CONITEC should arguably have become a centrally important institution in determining evidence-based policy guidelines for Brazil—as NICE has in the UK. But, according to movement activists, from the outset it was given limited political power, and health professionals and hospital management teams resistant to change often ignore its recommendations.

Some of my interviewees seemed unsure about the future direction for humanised birth policy in an increasingly conservative national policy environment. When I asked government officials in the São Paulo health secretariat what actions they would take to continue the movement's progress, they often replied that all they could do was to continue producing evidence and developing "technocratic" answers to policy problems.

Marketing Beautiful Births

One subgroup of the movement was deeply disillusioned with trying to change public policy with appeals to evidence and women's rights. These members tended to work as doulas or doctors in private humanised birth centres and sought to influence hospital practice and public opinion by inducing a rise in demand for humanised

birth, believing that private services would necessarily adapt. São Paulo was a consumer society, they argued, and, therefore, the way to change hospital policy and practice was to stimulate demand for humanised services among paying clients. These activists essentially marketed humanised birth as a "lifestyle product" to paying clients, primarily on social media, through humanised birth websites, and at private humanised birth centres as well as on posters and flyers displayed at organic supermarkets and yoga centres in São Paulo's bohemian neighbourhoods. Clients—normally wealthy and influential women—would then request humanised services from private obstetricians and hospitals, and as a result, hospital administration would modify hospital regulations. The humanised health professionals who engaged in this strategy claimed it was highly effective:

> 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.

> the hospitals are going to start changing, once the pregnant women, the clients, start complaining, more than if we go and try to change policy.

Private sector doulas and midwives spoke about their own role in increasing the demand for humanised birth:

> I believe in creating an attractive product…One day our society will evolve so that it doesn't function anymore in this product mentality. But at the moment it works like this. Creating desires. Working with image.

These activists clearly describe birth as a commodity that could be marketed in an attractive way to women. The implication of this is that women can pay to achieve their desired outcome in childbirth. In some instances, this has the negative effect of women feeling disappointed or even as though they have failed if they do end up genuinely requiring clinical intervention—something I observed in postnatal groups in São Paulo, and which Rossiter (2017) discusses in her work on the ecstatic birth movement in the United States.

These movement members were still aware of the evidence-base and would inform women about best practice guidelines, as well as their rights during childbirth—but they suggested that for the particular audience they were targeting (women who were attracted to alternative health and lifestyle practices and wanted or could afford private care) the positive experience of humanised birth was as, if not more important than the scientific evidence supporting it. Further, some attested that behaviour change among *cesaristas* would only occur through financial incentivisation.

Women who had opted for private humanised services spread awareness about and generated further demand through sharing their own experiences online, particularly "birth reports" posted online on Facebook or Vimeo, and widely distributed. The majority of the women I met at private humanised birth clinics captured their births in this way and said it helped to change opinions about what birth could (and in their opinion should) be like.

Interviewees described specific ways in which marketing humanised birth had proven to be effective. Humanised doulas and midwives working in the private sector confirmed there had been a steady rise in demand for their services, with a sharper increase from 2010 onwards. According to the managers of two of the private humanised birth centres, they had gone from running one or two doula training courses each year to one every month, each with a cohort of 20 doulas, the majority of whom were able to find steady employment. Some humanised obstetricians attributed specific policy changes in certain 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. One humanised doctor told me about the changes in private hospitals: "Ten years ago, rupturing membranes to induce labour was considered absurd in these hospitals. This has changed a lot…In 2006 [Hospital], São Luis opened the first *sala de parto* [normal birth room]". She explained that two of São Paulo's largest private hospitals implemented these humanised protocols because women "who inform themselves don't want another kind of assistance".

I observed some minor tensions between the different factions of the movement, for instance, some members focussing on public policy expressed frustration that more activists did not attend public hearings and campaign for the rights of all women to access humanised services (rather than just those who could pay). But for the most part, relations were amicable and many members worked collaboratively on research projects and campaigning efforts.

Discussion

Brazilian authors have studied the humanised birth movement over the course of its history (Tornquist, 2004; Diniz, 2005; Rattner, 2009; Carneiro, 2015; Diniz et al., 2018 among others) and provide a comprehensive review of the public policies and private sector initiatives the movement has helped shape and deliver. To contribute to this literature, I have focussed on *how* the movement has changed policy and practice, critically analysing what I see as specific strategies its members employ. I have discussed several of these in this chapter: the use of the term obstetric violence and rights-based arguments; the strategic use of scientific evidence in developing specific policy programmes and lending authority in clinical encounters; and the marketing of humanised birth as a desirable product to increase demand among wealthier women.

In their study of EBA, Storeng and Béhague (2014) explain how at the global level, maternal health agencies and researchers responded to the global growth of EBM and EBPM by removing moral arguments from the policy-making process—though more recently, some actors have resisted this trend and strategically obfuscate ideological debates and subjective values as scientific and objective. 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).

Using the term "obstetric violence" in official policy documentation has been central to this activism, and indicates its legitimacy at high levels of government. Movement members also positioned themselves in alignment with global best practice guidelines, bolstering their cause. At public talks, on social media, and in conversation, the movement clearly distinguished the humanised model of care (scientifically proven, safe, best for women) against pro c-section doctors and hospitals. The terminology of EBM and EBPM was used by many non-clinical professionals, including doulas and women, giving them greater power to negotiate in clinical settings. This finding has been reported by others studying the humanised birth movement, for instance, Tornquist (2004) showed that movement members had publicly accused doctors of being ignorant about international evidence when they tried to block the opening of normal birth centres. This behaviour was also observed by McCullum and dos Reis when a senior medic in their study insisted that the WHO recommendations on oxytocin did not apply to public maternity hospitals in Brazil (2008). Scientific evidence was, therefore, not advancing overmedicalisation of childbirth but instead supporting the optimal use of medical technology in childbirth. This is in direct contrast to authors who have written of their concerns that EBM supported and even extended an excessively empirical and clinical approach to complex global health problems (Adams, 2013) and obstetric care (Wendland, 2007).

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. Brazilian evidence-based institutions such as CONITEC have thus far failed to build a national culture of support for EBM, as seen in other countries such as the UK and Belgium. This led to some members of the movement arguing that behaviour change would only occur among *cesaristas* through a rise in demand for private humanised birth services as an alternative "product" to elective c-section. Anecdotal evidence suggests that these strategies have been reasonably effective in increasing demand for humanised birth (measured, for instance, by the growing number of job opportunities for doulas and midwives in the private sector, the greater number of private hospitals allowing humanised obstetricians to deliver on their wards and growing membership of humanised birth groups online). This strategy seemed to have increased the number of wealthy women accessing humanised birth. It could be seen as what others have described as the "commodification of" or "consumerism in" childbirth, motherhood, and midwifery-led care (Taylor et al., 2004; Davis-Floyd, 2004; Macdonald, 2006). At the same time, there is a risk that investing time in selling the notion of beautiful births diverts attention away from the core principles of equity and justice espoused in the humanised birth movement, and in broader efforts towards universal health coverage. Some in the movement have voiced concerns that poorer and disadvantaged women will continue to face financial barriers to accessing high-quality care during childbirth and the risk of obstetric violence. This concern was somewhat alleviated by a trend I observed among the recently trained doulas I interviewed, almost all of whom expressed their desire to address inequalities of access and to provide their services at an affordable cost, or for free, for women from the poorer

periferia of the city. This does not, however, address the more fundamental issue of tackling embedded and systematic differences between the SUS and private hospitals.

With the election of the right-wing President Jair Bolsonaro in October 2018, much of the progress made by the humanised birth movement is now under threat. As part of a broader movement to restrict women's rights and cut funding for social services, members of Bolsonaro's government are passing increasingly conservative legislation. In 2019, a São Paulo state deputy allied with Bolsonaro was accused by movement members of colluding with the CFM after a video circulated in which she promised to represent their interests in government—supporting the widely held beliefs that *cesarista* doctors are politically powerful. The Ministry of Health has recently attempted to remove the term "obstetric violence" from legislation and prevent policymakers from referring to it. This is in contrast to the global health arena where there is widespread expert consensus that best practice is normalised, woman-centred, respectful care where possible, and policymakers are beginning to return to moral and rights-based approaches *with support from* the evidence base. My fieldwork ended in the run up to the 2018 election in Brazil, but the shift towards populist conservatism and the widespread public frustration with "politics as usual" was already visible. These events confirm the necessity for those working in global maternal health to consider contextually specific factors that facilitate or hinder the implementation of evidence-based guidelines. This chapter adds to the ethnographic literature that shows that evidence itself is not necessarily enough to support change.

If the global c-section epidemic and the widespread disrespectful treatment of women around childbirth are to be adequately addressed, the barriers to implementing policies focussed on improving the quality of care must be understood. In São Paulo, we have seen how the political power and social authority of doctors allow for the complete rejection of scientific evidence and the gravity of widespread obstetric violence. Looking at the strategies of local movements like the humanised birth movement might aid future efforts to normalise birth.

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