Humanizing childbirth in Salvador, Brazil

Bodies, knowledges, and experiences in a *Centro de Parto Normal*

Aischa Schut

"Whenever and however you intend to give birth, your experience will impact your emotions, your mind, your body and your spirit for the rest of your life."
Ina May Gaskin

Picture on the cover by Melissa Jean, Australia

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B.Sc. Thesis

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Éramos uns poetas loucos, místicos
Éramos tudo o que não era são
Agora são com dados estatísticos
Os cientistas que nos dão razão.

- 'É fogo', Lenine

We were some mad, mystic poets
We were all that wasn't sane
Now, with statisic data
The scientists are the ones that give us reason

I have learned so much from God
That I can no longer call myself
a Christian, a Hindu, a Muslim, a Buddhist, a Jew.

The Truth has shared so much of itself with me
that I can no longer call myself
a man, a woman, an angel
or even pure soul.

Love has befriended me so completely
It has turned to ash and freed me
of every concept and image
my mind has ever known.

-Hafiz, translated by Daniel Ladinsky in the book 'The Gift: Poems by Hafiz the Great Sufi Master'

This Sufi wisdom is widely acknowledged within anthropology: the science of recognizing that and trying to understand how we make sense of our worlds through concepts and categories. One day, I hope to be able to understand that all the concepts and categories created by the human kind are fluid, transient and do not embody a single truth. This study is only an attempt to contribute to this understanding…

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Acknowledgements

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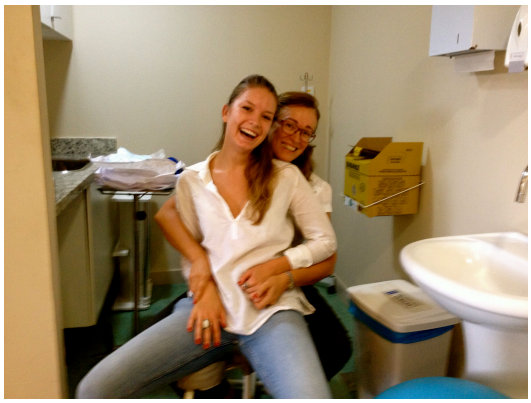
INTRODUCTION

My plans were to spend the summer of 2012 in Salvador as an intern working on social projects to prevent the sexual exploitation of children. Soon however, I started picking up many conversations about the *humanização do parto* ('humanization of childbirth'), on the streets and especially from Brazilian friends on online networks. It appeared to be a social movement, currently adopted by the government through the initiative called *Rede Cegonha* ('Stork Network'). It all sounded intriguing but very strange to me: after all, what could possibly be humanized about the birth of human beings?

Asking around, I learned about the size and strength of the movement, about common practices in Brazilian obstetrics. Countless stories of violent treatment during labor, shockingly high cesarean rates, numerous medical interventions being performed on a routine (without informed consent) and much, much more. I was shocked.

The aforementioned facts were an eye-opener, to me and many others. Unexpectedly, this shock generated an enchantment with the female body, with the spirituality of birth, and especially with the movement for *parto humanizado* ('humanized birth'): I started to read and ask around about their aims, the recent involvement of the Brazilian government, and listened to many women who impressed me with their beautiful stories, scientific evidences, and empowering accounts of natural and humanized childbirths. After this first 'baptism' in the humanization of childbirth, I decided to let go of the internship and dedicate myself to an exploratory research on this subject. I was fortunate to get to know some of the key actors in the movement in Salvador and the *Centro de Parto Normal* (CPN), the first 'Centre for Normal Birth' of the state Bahia implemented by the government.

The CPN attracted me. It was a well-delineated space and it seemed to be an embodiment of the humanization of birth. Its mission incorporated everything I had become enchanted with that period: providing the space and assistance for women to live a conscious, happy, and empowering natural birth. Inaugurated only one year ago, it had been assisting much less births than they imagined they would. When I asked its team members what they thought might be the causes, many mentioned 'myths'[i] going round about the CPN and Brazilian women living in a 'culture of cesareans' and in fear of pain. I imagined that these causes could not be the only ones, and became intrigued by all their underlying stories and by other issues involved in the decision-making process and experiences of



With Márcia on the 'cavalinho' (little horse, kind of birth stool), obstetrician and medical coordinator of the CPN. Picture taken by Eugenia Georges

childbirth: I had given birth to the subject of my bachelor research.

With this research I aim to contribute to a new and deeper understanding within the anthropology of childbirth by focusing on how social configurations and the production and exchange of knowledge about childbirth are of influence on the decisions women make regarding their delivery and, consequently, on their experiences of childbirth. Having heard such a variety of birth stories I am very interested in registering and understanding women's experiences of childbirth within this relatively new and 'other' setting of a *Centro de Parto Normal*. In addition, this understanding will be important for the further development and implementation of this governmental initiative, as the insights about its functioning may shed new light on its possibilities as well as contribute to overcoming experienced difficulties. With these aims in mind, I formulated the main research question: *How do women and the actors involved in their delivery construct, exchange and select knowledge about childbirth in the Centro de Parto Normal to make decisions related to childbirth, and how do these processes affect women's lived experiences of childbirth?*

To answer this question, I spent a period of almost three months conducting ethnographic fieldwork at the *Centro de Parto Normal*. In this research, childbirth is interpreted as a meaningful event to the women living it. Anthropological or ethnographic methods may be seen as most adequate for the researcher to live and understand the meanings of lived experiences. Following the key research method within anthropology, participant observation, I started and did not stop 'hanging out': walking around the centre, asking practical questions, getting to know the team, observing and writing down interactions and routines, lunching together, taking pictures, participating in the visits nurses guide for pregnant women, trying to have everybody get used to my presence and myself to my new daily reality. The past five years I have spoken Portuguese on a daily basis, which has made it possible to conduct the research in Portguese with negligible probability of misinterpretations.

Interviewing and listening to women in the waitingroom. Picture taken by author

When entering the CPN, the first thing you see is the waiting room. I spent a lot of my time there during the research period conducting short, semi-structured interviews (see appendix I) with 32 women who were waiting for their consult. In order to ensure their anonimity, every informant

mentioned in this research is named by a fictive name. Before touching upon their perspectives on natural birth and cesarean, I introduced myself, illustrated the aims of the research and asked them for their informed consent and guaranteed their anonymity in any publication. Sometimes they allowed me to accompany them during the consult. In this way, I got to know a lot about the ways different obstetricians interact with the pregnant women: how women express their bodily sensations, how they exchange knowledge about childbirth and which knowledges seem to 'count' more than others. The fact that it was an open room within the CPN, where other women were always listening and nurses and an obstetrician sometimes passed by, might have caused the women's answers to be limited and socially desired. Nevertheless, most women talked with such ease and enthusiasm about their perspectives that I think this did not cause their answer to be very biased. Also, this dynamic often turned into of *focus group*[ii] in which women started discussing and defending their perspectives on childbirth. This provided very valuable insights on decision-making processes and the construction of knowledge about childbirth. I collected phone numbers during these short interviews, which enabled me to keep track of some of the women by calling them once in a while and asking if they had already given birth and, if so, where, why, and how the experience had been. It was also in this space I proposed some women to organize a meeting together, a focus group, and talk more profoundly about their feelings, ideas, fears and doubts about childbirth. At the end, we had organized two of those focus groups. Semi-structured interviews (see appendix I) were held with 14 women who had delivered at the CPN that day or the day before. Always asking what their ideas were and had been about natural birth and cesarean, their passionate stories about the delivery provided great insights on fears of a different kind of treatment, of pain, and on the highly transformative character of their experience.

It soon became clear that it would only be desirable and possible to be present during deliveries if I could introduce myself to and be with a woman from the moment she arrived at the CPN, allowing me to create a bond of confidence and security from the beginning. Already in the first week of my fieldwork, I was gifted with the unforgettable experience of being present during a delivery. At the end of my fieldwork, the team often recognized me as one of the 'doulas'[iii] and I had assisted six enchanting births. I tried to be aware of the 'birth ecology' and 'participation structures' (Jordan, 1993:164,166), the presence and practices of obstetricians, nurses and auxiliaries, and of expressed feelings and interactions of the woman and the people present in the delivery room. However, these experiences did not become a fundamental part of my research, as for me they were so intense and emotional it was almost impossible to step back, observe, and not be

With Litza, for whom I have been a doula during her labor. Picture taken by author

completely absorbed by and supportive in the moment. Also, I was more interested in how the women experienced the delivery and what they would tell me about it afterwards. I can only be grateful for their openness and trust of welcoming me into this incredibly intimate, spiritual and beautiful moment.

During a home visit with Cris. Picture taken by author

Furthermore, I held semi-structured interviews (see appendix I) with one of the auxiliaries, five obstetric nurses, and six obstetricians about their work experiences, attitudes towards the women they attended, towards *parto humanizado*, and about their social configurations. I attended some of the meetings of the Fórum Perinatal (I will provide a description in the context) to get insights on the professional and political context of the CPN, held an interview with the main promotor of the *Rede Cegonha* in Bahia, and collected demographical data about the neighborhood in which the CPN is situated. Only close to the end of my fieldwork period I had built a relationship that allowed this kind of intimacy with three women and visited them in their homes. Their characteristics and the relationship these women had with the CPN were very diverse and therefore insightful into different motives they had to give birth naturally and, more specifically, in the CPN.

The theoretical framework of this research is based on a medical anthropological perspective. After having highlighted the key elements of this perspective, I continue with an exploration of the anthropology of the body and of the female reproductive body. This exploration is meant to provide a base for an interpretation of bodies, experiences and reproductive decisions as inherently socially constituted: one of the main arguments of this research. For a better understanding of this social constitutedness, I will set forth two important notions elaborated by Erica van der Sijpt (2011): 'social configurations' and 'reproductive navigation'. Subsequently, I enter the specific area of this research: childbirth. I will explore anthropological notions and developments within this area, mainly based on Robbie Davis-Floyd's notion of 'childbirth paradigms' (2001). Crucial for a better understanding of the construction, exchange and selection of knowledges about childbirth, Brigitte Jordan (1993) argues that 'authoritative knowledge' is the kind of knowledge that sustains a certain paradigm and devalues others. I will analyze this concept in further detail, connect it with the notion of socially constituted bodies and decisions, and reflect on their relevance for the context of this research.

The context is the next section of this thesis: I will provide broader insights on the Brazilian movement and history of the *humanização do parto* as well as a description of the emergence and characteristics of the CPN. Subsequently, three empirical chapters on social configurations,

socioeconomic constructions of pain and lived experiences in the CPN will cover the body of this research. In this body I will try to provide new understandings about the research data by connecting them to the theoretical framework and, little by little, try to answer the main research question. Finally, I reflect on the research and make an attempt to reach a coherent and elucidating conclusions, of which I want to emphasize their fluid and non-generalizable character.

THEORETICAL FRAMEWORK

Medical Anthropology

All human beings experience health, illness and death. Therefore, all cultures engage in practices focused on coping with, preventing, and healing illness and death. Medical Anthropology is seen as the sub-discipline of anthropology that tries to understand the causes of health and illness in society (Brown, 1998:1). Systems of healing and curing have been interpreted by medical anthropologists as socially and culturally constructed. As a result, 'medical anthropologists examine how the health of individuals, larger social formations, and the environment are affected by interrelationships between humans and other species; cultural norms and social institutions; micro and macro politics; and forces of globalization as each of these affects local worlds.'[iv]

While named as such onlyin the 1960s, the emergence of medical anthropology goes back to the beginning of the 20th century, when biological anthropologists studied human evolution and ecology and social or cultural anthropologists focused on traditional healing practices (Ember & Ember, 2004:4), the latter interpreting medicine as 'a cultural system of knowledge and practice' (Brown, 1998:6). After the Second World War, medical anthropology became internationally recognized through the incorporation of social and cultural aspects of health into international public health policy, incentivizing an applied orientation of medical anthropology. Near the end of the 20th century, a more theoretical approach gained importance as cross-cultural studies required theories for comparison. As a result hereof, biomedicine was increasingly seen as a cultural construction; and, as I will show in further detail, the medicalization of pregnancy and birth required a more theoretical approach (see Ember & Ember, 2004; Ginsburg & Rapp, 1991; Johnson & Sargent, 1990).

Anthropology of the Body

> *'To keep the body in good health is a duty, otherwise we shall not be able to keep our mind strong and clear'*
>
> - Buddha

The body, in all its forms, can be considered an essential element in understanding health and illness as it is often the medium through which both are expressed. Within the anthropology of the body, as well as my research it is important to distinguish between representations of the body and the experiencing body (Ember & Ember, 2004).

A long held representation of the body is that of a mere 'natural object', isolated from and unaffected by the world in which it resides. The idea of an isolated, individual body may be seen as a result of new ways of interpreting bodily events related to the Enlightenment[v] and Industrial Revolution. In this context, the French philosopher and mathematician Descartes interpreted the body as a kind of machine[vi], which acted and could be 'taken apart, studied, and repaired' (Davis-Floyd, 2002:2), while the mind remained unaffected.

In the late 1970s this representation of the body was increasingly seen as problematic by anthropologists (Lock, 1993). Especially influenced by Bourdieu's practice theory[vii] and Foucault's notion of biopolitics[viii], anthropologists came to see the body not only as a cultural construction (instead of representation) but also as a locus in which culture is produced. Bodily experiences were interpreted as fundamental elements of cultural production, which also stimulated an increased focus on the experiencing body and embodiment[ix].

Scheper-Hughes & Lock have responded to these developments in anthropology by arguing for a 'mindful body', unveiling the intimate relationship between the mind and the body. In their groundbreaking article, they propose the idea of people having and being multiple bodies. Criticizing the notion of an individual body as mentioned above, they note a 'missed identification between the individual and the social bodies, and a tendency to transform the social into the biological' (1987:10). This emphasis on the ('failing') biological generates a need for medical expertise and intervention, thereby contributing to the medicalization of the body. Therefore, they firstly argue for a 'social body': the body as an 'integrated aspect of self and social relations' (Van der Sijpt, 2010:1775). As a result hereof, the body consequentially becomes intrinsically socially constituted, resulting in an interpretation of health and illness as influenced not only by the mind and body but also by social relationships as well as political economy contexts.

Scheper-Hughes and Lock also identify a 'body politic', which they define as 'the regulation, surveillance, and control of bodies' (1987:7) and consider to be in line with Foucault's notion of biopolitics. They note that the body politic of a society regulates and controls bodies when the social order is perceived to be threatened, or in order to produce a politically and culturally 'correct' body: the body a society 'needs'. It could be said that this notion represents the body as a passive receptor of cultural inscription. Instead, however, it helps to uncover the intimate relationship between bodies and power relations through which the body can be seen as an active participant in cultural production. The social body and body politic are strongly connected as social relations are often imbued with power relations and may become a form of regulation and control. This connection will be elaborated further on, when I explore the notion of authoritative knowledge in social interaction and about childbirth.

This research is based on the assumption of pregnant women having and being an intrinsically socially constituted body. It is thus assumed that social and cultural representations of and social interaction about the body are essential to understanding the ways in which they are experienced. More importantly, when considering the physicality of pregnancy and childbirth, bodily experiences in itself may differ from these representations and interactions and thereby challenge and transform them.

Anthropology of the female, reproductive body

The notion of body politic has been an important element for the emergence of the anthropology of women's health and bodies and of reproduction. On the one hand this emergence has been influenced by upcoming women's movements, which analyzed women's reproductive experiences as 'sources of power as well as subordination' (Ginsburg & Rapp, 1991:312). Feminist perspectives emerging in the 1970s started questioning issues such as male dominance in different areas of human life; the medicalization of the female body and (patriarchal) power relations in Western biomedicine; and the essentialization of women as reproducers through which women's health has often been equated with reproductive health (Brown, 1998, Inhorn, 2006, Ginsburg & Rapp, 1991, Johnson & Sargent, 1990). In terms of the Cartesian body-mind dualism, it has been argued that the male body came to be seen as 'the prototype of the properly functioning body-machine' (Davis-Floyd, 2001:2). As a result, the female body has been regarded as deviating from this prototype and therefore as dysfunctional, defective and 'in need of constant manipulation by man'[x] (ibid.), reproducing power differences in gender relations and medicalizing the female body.

On the other hand, as a result of a more general paradigmatic in anthropology to social constructedness (Van Hollen, 1994 & Ginsburg & Rapp, 1991), reproduction was interpreted as a social construct but also as a *locus* of cultural production. In the past thirty years, these perspectives have been of significant influence on medical anthropological studies that have documented 'health concerns from women's own perspectives' (Inhorn, 2006:346), highlighting the interplay between representations and experiences.

This study has to be situated within these developments, and therefore aims to contribute to an understanding of the female, reproductive body not only as socially constructed and imbued with power relations (a representation), but also as intrinsically socially and physically constituted. In the next section I will try to elucidate this aim.

Social configurations & reproductive navigation

I adopt the notion that every individual is intrinsically embedded in and constituted by its social surroundings. Looking at fertility matters, 'where interrelations between bodies are *sine qua non*' (Van der Sijpt, 2011:22) and through the talks I have had with pregnant women in Brazil, I became aware of the fact that looking at human beings as free and rational individual bodies results in a too narrow of an understanding of women's experiences when pregnant and during delivery.

In her research on pregnancy interruption in Cameroon, Erica van der Sijpt provides us with some very useful insights into understanding the social constitution of pregnant bodies, as well as women's decisions and experiences related to reproduction. First of all, she argues that an individualist approach tends to 'ignore the mutual implication of women's reproductive agency with social others and structural factors' and 'overlooks other social relations – and their power dynamics – often implicated in reproductive decision-making' (2011:17). She argues that women's 'social configurations'[xi] intersect and therefore mutually influence their reproductive navigation. Because of the many specific conditions involved in these social configurations a woman's reproductive navigation turns out to be 'highly contingent' (ibid.:21).

In addition, she claims that the focus on the sociality of pregnant bodies and reproductive decisions draws attention to the physicality of pregnancy. If the focus would be merely on women's decision-making, one runs the risk of adopting a 'mere mentalist representation of the choices and actions surrounding reproductive happenings' (ibid.:23), when, in fact, the body *itself* is an active and often unpredictable actor in this process. In light hereof, Van der Sijpt concludes that 'the body does not only enable or constrain women's [reproductive] navigation, but it needs to be navigated itself as well' (ibid.:211).

Even though a pregnant body might be socially constituted, the bodily navigation as mentioned above sheds light on why it is also very important to be aware of a woman's individuality in reproduction: 'it is this very individuality and privacy that offers pregnant women a secret space for decision-making – even if these decisions are never 'free choices' but informed social interests and horizons.' (ibid.:208).

It is with these notions of the sociality, physicality, ánd individuality of pregnant bodies in mind that I want to look at the decisions women make and experiences they have related to childbirth. Next, I will display a general overview of different conceptualizations of childbirth present within anthropology. This, in order to sketch a more conceptual background in which pregnant women reside and that may be of influence on their reproductive decisions and experiences.

Anthropology of childbirth

'It was industrialization that created the fear women today have for birth, not birth itself'

- Robbie Davis-Floyd

The anthropology of childbirth should be situated within a broader context of the anthropology of reproduction as mentioned earlier. In light hereof, childbirth, which forms a fundamental aspect of reproduction, came under the microscope of anthropology. When referring to the anthropology of childbirth it is impossible not to mention Brigitte Jordan, also know as 'midwife to the anthropology of birth' (Hahn in Davis-Floyd & Sargent, 1997:3). She was the first to conduct a cross-cultural study of birth systems, arguing for a 'fruitful accommodation' (Jordan, [1978] 1993:136) of biomedical and indigenous birth systems. Hereby, she presented the birth practices as observed in four different cultures as reflections of underlying cultural patterns. The interpretation of birth practices as reflections of a static culture has been criticized for the ignoring of the variety of practices *within* a birth system, in which dominant perspectives on childbirth are not only reproduced in different ways, but also contested and transformed (Van Hollen, 1994).

In 1993, affected by the paradigmatic shift in anthropology, Jordan adjusted this interpretation by developing the notion of 'authoritative knowledge', recognizing power relations and a variety of hegemonic perspectives *within* a birth system. Davis-Floyd added to this by focusing on the 'processes by which ideologies related to birth are constructed' (Van Hollen, 1994:504). She does not only recognize a variety in representations of childbirth within a given culture, but also of experiences of childbirth which provide a great potential for internalization, contestation and transformation of authoritative knowledge. Studying these representations and experiences of childbirth in America (1992), she distinguishes three paradigms of childbirth. Even though these paradigms are socially constructed and fluid (which makes it impossible to provide for a fixed definition), some key characteristics can be identified. First of all, she mentions the technocratic paradigm, in which 'successes are founded in science, effected by technology, and carried out through large institutions governed by patriarchal ideologies in a profit-driven economic context' (2001:1). Technology reigns supreme and obstetric practices are 'routinely performed not because they make scientific sense but because they make cultural sense' (ibid.). It 'entails a pathologizing of the "normal" by placing birth under the domain of the professional doctor' (Van Hollen, 2003:12).

Second, and perhaps most important within the context of this research, is the humanistic paradigm. As a reaction to the technocratic paradigm, it aims to humanize technomedicine[xii]. First of all it is founded in Evidence-Based Medicine (EBM)[xiii]. EBM in birth care redefines pregnancy, childbirth: the female body as capable of giving birth, most often without the need for interventions;

birth as a physiological process necessary for the transition to the extra-uterine life and as a highly personal, sexual and familiar event (Diniz, 2005), recognizing its social construction and importance of social configurations in this event. The second approach underlying the humanistic paradigm lies in the understanding of human rights in the context of a nonviolent delivery assistance guided by women's experiences and desires. In this sense, the right to be correctly (based on evidences) informed about the procedures, physical processes and consequences and possible positions during childbirth and the right to decide about them are fundamental in the ethics of the humanization of childbirth.

Finally, Davis-Floyd identifies the holistic paradigm. Holism in health care can be characterized by the 'inclusion of mind, body, emotions, spirit, and environment of the patient in the healing process' (Davis-Floyd, 2011:12). Body and mind are believed to be in continuous connection and integration, which places the ultimate authority and responsibility for health on the individual; care, therefore, is individualized; life is seen as a continuous process in which birth and death are only two steps; there is a focus on healing from the inside out in which, for example, intuition is an important element.

Authoritative knowledge in childbirth

Jordan developed the notion of authoritative knowledge (AK) to better understand the ways in which 'decision-making power' (1993 [1978]:151) in the context of childbirth is legitimized. Therefore, she understands childbirth as an event in which certain power relations are produced and reproduced. Here, the central observation is that 'for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others' (ibid.:152). In addition, related to the social constitution of childbirth, she states that 'AK is an interactionally grounded notion' (ibid.:154).

Acknowledging the work of Van Hollen (1994), my criticism here is that the interactional character of AK in the United States as Jordan describes it, seems to recognize women's participation in the production of this knowledge only in the sense that they affirm and reproduce it. In Jordan's argument there seems to be no acknowledgement of possible challenge or transformation. She does propose this transformation by arguing for a 'mutual accommodation' of the biomedical and indigenous birth systems, but does not seem to recognize that contestations and transformations of AK happen *within* any given birth system. The data I collected during this research affirm this.

Nevertheless, the notion of AK provides us with a useful theoretical lens through which decisions women make and experiences they have related to childbirth can be analysed. The process by which AK is created and maintained, and hierarchical social structures are generated is also known as 'misrecognition' (Bourdieu & Passeron in ibid.:153): A certain knowledge system (in this case a

paradigm of childbirth) comes to be perceived as natural and legitimate instead of socially constructed and relative, independent of its 'correctness'. As a result, non-authoritative knowledge systems are devalued.

It could be stated that authoritative knowledge is a fundamental characteristic of a woman's social configurations and thus of their reproductive navigation. Her social configurations are situated within and affected by a context in which certain birth knowledges and practices are authoritative, influencing her reproductive navigation in certain ways. This is not to say that, as Jordan puts it, women merely affirm and reproduce certain knowledges and power relations within a dominant paradigm of childbirth. As is the case with many Brazilian women, women's experiences and desires might not resemble certain representations or knowledges within a paradigm and might therefore transform them or contribute to the creation of a new paradigm. I will explore the lived reality of Brazil's childbirth paradigms and dynamics of the upcoming and devaluation of paradigms in the empirical chapters.

Focus of this research: childbirth decisions & experiences

Women make decisions about childbirth and, therefore, are agents while embedded in a social, cultural, political and economic contexts that might or might not adopt a positive attitude towards these decisions. Thus, the agency these women seem to 'have' 'is, in reality, 'something that is always interactively negotiated' (Ortner, 2006:151).

An assumption I make in this research is that a woman, when deciding on issues related to childbirth, interactively makes a unique selection of the knowledges that are present within her social configurations and of those that may be considered intuitive and bodily. The knowledges themselves, as much as the way in which she selects them, are in turn influenced by the context she is situated in. I argue that this selection is an important element of a woman's agency, either as 'a form of power' (such as empowerment, resistance to the dominant childbirth paradigm, Ortner, 2006:151) or as a 'form of intention and desire' (ibid., such as in the pursuit of giving birth in the first place, having a satisfactory experience of birth), and often some of both.

This selection largely and indirectly determines how a woman experiences her delivery. Having heard many stories of women who have suffered immensely during and after delivery, and knowing that these experiences in turn highly influence other women's decisions about childbirth, I do not doubt the importance of this experience. Therefore, the importance of the individual, physical body and its experiences should not be dismissed by its inherent social constitution. As Lock (1993:136)

already said: 'The question of the body requires more than reconciling theory with practice. It brings with it the difficulty of people both having and being bodies'. Reproductive navigation is 'not only possible or constrained because *others* and *individuals* act, but also because *bodies* act' (Van der Sijpt, 2011:211). In other words, while the idea of 'knowledge selection' might sound as a process in which women are free and rational agents, this selection and resulting decisions about childbirth are influenced not only by their social configurations, but also by their own (often unpredictable) bodily experiences. The body 'both *directs* and *demands* navigations' (ibid.).

In this research, I focus not only on *why* women make particular choices about childbirth, but I go beyond this question by also trying to understand *how* women frame and justify these decisions within their social worlds. I believe that the notions of social configurations and authoritative knowledge as described above can prove to be very useful in understanding these processes.

Finally, it is necessary to be reflexive about my own positionality within the research. The social view of the body I adopt is rooted within the humanistic paradigm, which provides the context for the research. In light hereof, it is important to note that I will be studying a paradigm of which I am, in many senses, a great proponent and have tried to remain critical about truth claims within this paradigm.

CONTEXT

Centro de Parto Normal: an embodiment of the humanization of childbirth

The concept of the CPN in Salvador can be seen as an embodiment of the aims for birth care as promoted by humanized paradigm of childbirth. To get a better idea why and of what is understood by a CPN, I display some fragments from the Practical Handbook for the Implementation of the *Rede Cegonha* (Ministry of Health, 2012:12,27):

> *The CPNs are units of labor and birth care, that realize a humanized and quality assistance, exclusively for normal births without complications, and privilege the privacy, dignity and autonomy of the woman to give birth in a more cozy and comfortable ambiance and [where she can] count on the presence of a companion of her choice.*
>
> *These units are managed by (obstetric) nurses and must always be organized in order to promote access, bonding and humanized assistance to labor and birth.*
>
> *The CPNs must be linked to a maternity or hospital of reference for pregnancy, labor, birth and postpartum of high risk. The units should offer conditions of stay, alimentation and monitoring by the reference team, with special efforts to maintain the autonomy of the woman and open visits, as this is fundamental to maintaining the mode of co-management for the decisions of the CPN and a humanized ambience.*

Further on in the handbook, EBM and human rights are mentioned as essential to the concept of the *Casa de Parto*[xiv]. These, together with above mentioned notions of choice, autonomy and continuous support are the key elements of the humanization paradigm.

In between paradigms

The *Rede Cegonha* and the recent creation of the CPN in Salvador and elsewhere in Brazil may be seen as revolutionary steps in Brazilian obstetrics and as a long demanded incorporation of voices from civil society into governmental initiatives. In many ways, the dominant birth paradigm in Brazil's public health care (called *SUS: Sistema Único de Saúde*) could be said to represent the technocratic paradigm as described by Davis-Floyd. Diniz (2010) explains that in addition to unnecessary physical and emotional suffering, this form of birth assistance involves the use of a technology known to be harmful. Medical interventions and (elective) cesareans have become widespread and routine, which

has resulted in a 'perinatal paradox': while technology is often framed as the 'savior' of a physiological event such as birth, it is precisely what has prevented Brasil to reduce maternal and perinatal mortality.

In Brazil's private health care, elective cesareans are legitimized for their 'prevention' of the suffering often associated with the experience of and treatment during a vaginal delivery and, therefore, as a symbol of social and economic status. Yet, an overview of the health situation of mothers and children in Brazil shows the abuse of hospital and cesarean delivery in the country: the majority (89%) of births is assisted by doctors (only in the North and Northeast there is a larger presence of midwives). Almost half (47%) of these births was by cesarean section, with these surgeries accounting for 35% of births in the SUS and 80% in the private sector[xv].

Many studies have explained the 'epidemic of cesarean' in Brazil either by focusing on women's cultural preferences for abdominal birth or on obstetrician's self interest (MacCallum, 2005). However, as has been shown by others (Hopkins 2000 & Potter, 2001) and will be shown in this research, many women prefer a vaginal delivery when asked directly. Underlying processes of knowledge exchange and factors such as social configurations are therefore important not only to understand the high rates of cesareans in Brazil, but also the ways in which women decide to give birth 'normally'[xvi] in an environment such as the *Centro de Parto Normal*.

Despite of these high rates of 'high tech' births, Diniz (2005) tells us how various professionals in Brazil who have been inspired by practices of traditional midwives and indigenous communities already formulated a discourse with elements of *parto humanizado* (humanized childbirth) since the 1970s. In the 1980s distinct groups began to mobilize throughout the country, proposing changes in obstetric practices and promoting natural childbirth[xvii].

The past three years have proven fertile for developments surrounding the humanization of birth. First of all, the government has adopted many of the goals the social movement for humanization has been promoting by launching the *Rede Cegonha* program in 2011. Evidence based medicine and human rights in childbirth are two of the main elements in its proposals[xviii], besides emphasizing 'low risk' births as physiological, non-medical events. The program mainly promotes and finances the reorganization of and improvement of access to antenatal care; humanized practices in birth care; guarantee of a companion during birth; guarantee of a bed in the hospital upon arrival; acces to and improvement of family planning in public health care. Although the home is often interpreted as the most humanized place to give birth[xix] and, for 'low risk' births,

Rede Cegonha logo

has shown to be a safer place than the hospital (De Jonge et al., 2013), it does not appear in the proposals of the *Rede Cegonha*. It is here that the *Centros de Parto Normal* step into this scenario.

The initiative of *Centros de Parto Normal* has raised contention among different groups of the Brazilian society. Nationally, the Federal Council of Medicine and its regional representations are leading actors against the initiative. In 2012, two proposed resolutions[xx] of the CREMERJ[xxi] promoted a ban on the participation of physicians in delivery and perinatal care outside the hospital. This is in addition to the prohibition of 'unauthorized' professionals such as doulas and midwives in hospital environments.

During a demonstration in Salvador, june 2012. Banner says: 'Birth at home is just as safe as in the hospital and much safer than a cesarean without necessity'. Picture taken by author

However, several groups in civil society, health professionals and women's movements are in favour of the *Centro de Parto Normal*. In recent years and particularly in 2012, these groups have organized various meetings, protests and conferences in different cities of the country to express their discontent, combat the institutionalization of these proposals and promote home birth and the humanization of the Brazilian birth assistance. Also, on the 31st of January the Ministry of Labor has recognized 'doula' as an official occupation.

In between paradigms in Salvador

The estimated population of the Metropolitan Region of Salvador is 2.6 million people. The city is the capital of the state Bahia in the Northeast of Brazil and its public obstetric care consists of five maternity wards and two general hospitals (Aquino, Menezes, et al., 2012). Health insurance often appears as an indicator of socio-economic class, which in Salvador (frequently named as the 'most black' city of Brazil) goes hand in hand with race/color[xxii] (MacCallum, 2005). As is shown in the overview of rates per maternity in appendix II, the rates in Salvador do not differ significantly from the national average rates of cesareans and vaginal births.

The *Rede Cegonha* is being implemented in the city; the *Fórum Perinatal*[xxiii] has been set up to discuss and implement humanized practices in the maternities of Salvador; and *Roda Viva* has also started, a weekly open circle with the purpose of providing and exchanging information and experiences about natural and home births.

The *Centro de Parto Normal* in Salvador

The CPN in Salvador is a philanthropic institution and is part of a large Spiritist centre[xxiv]. It is located in a neighborhood on the outskirts of the city and mainly populated by black citizens and users of the *SUS*. Almost all women I interviewed lived in the district of the CPN, three of all women were users of private health care, one obtained an undergraduate degree. The majority of the women were Catholic and Evangelic, four did not have a religion, and three were Spiritists. The women were aged between fifteen and fourty, of which half were becoming mothers for the first time.

The CPN from the side. On the ground floor, 6 'p.p.p' rooms with varanda. Upstairs, offices and a memorial. Picture taken by author

In 2011, the *Rede Cegonha* and the Spiritist centre agreed to turn the CPN into the first CPN of supported by the program: it financed the medical equipment and the inauguration of the centre became the official launch of the *Rede Cegonha* in Bahia.

When entering the CPN[1], you first arrive at the reception and the waiting room: clean, white floors and walls, light green furniture and a painting of Joana D'Angêlica[xxv] on the wall. After having measured your blood pressure and checked your weight, the obstetrician calls you into the admission room for your consult. A small corridor and a glass door leads you into the next area: a spacious and light common room with a large lunch table and garden-view on the right, and on the left you find the 6 'p.p.p.'[xxvi] rooms. Close to the entrance an ambulance is parked, for the exclusive use of the CPN and the eventual transference of a laboring woman to the maternity of reference[2]. The CPN offers obstetric and antenatal consults, however the latter are most of the time realized by the medical post in the Spiritist centre.

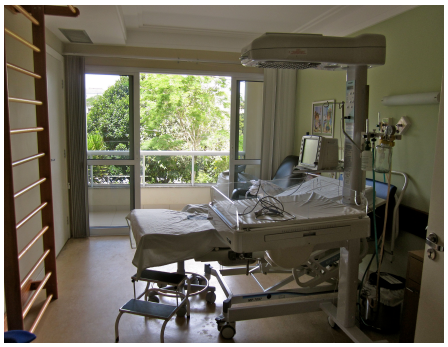
The admission room. Picture taken by author

[1] For a detailed map of the centre, see appendix III
[2] For the indicators of transference, medical interventions and birth outcomes in the centre, see appendix IV

Before being admitted, it is verified if your antenatal profile fits in within the admission criteria of the centre. These criteria have been subject of discussion as some professionals and women think they cause too many women to be rejected to give birth there and as it is argued some are not based on the latest evidence. This is an example of the tension between paradigms also occurring within the CPN on which I will elaborate later on.

The common room. Picture taken by author

The medical team consists of auxiliaries, obstetric nurses and obstetricians, currently all women. Every day, one obstetrician, one or two obstetric nurses and two auxiliaries are present for a *plantão* (duty) of twelve hours. A pediatrician also spends a few hours in the centre every day to check up and dismiss or transfer the newborn babies. Doulas have been occupying more space in the centre, but have worked with irregularity. As I will show in the empirical chapters, the professionals are also subject to transformation and contestation within the CPN, as they have often been trained in the common, technocratic paradigm of childbirth.



One of the 'p.p.p.' rooms. On the left there is a small sink-unit; then you see a reck to hold on to and relieve pain during labor; a door to the bathroom; varanda; companions chair, bed that can be set up in such a way that women can give birth in an upright position; pre-heated cradle that is only present shortly before and after the birth of a baby. Picture taken by the author

The CPN is positioned in between paradigms, and it is a place where civil society forces and government initiatives meet. This has caused the centre to be under continuous pressure from society and government, of which some professionals expressed that they felt like 'everybody is just waiting for something to go wrong[3].' Even while the centre and most professionals are highly convinced of the 'correctness' of their practices, doubt and insecurity are difficult to suppress when challenging such a deeprooted paradigm.

[3] *Estão todos esperando algo dar errado*

EVERY BIRTH IS UNIQUE

Influence of social configurations on reproductive navigation and birth experience

Arriving in the favela[4] Litza lives in, she guides me the way through the narrow streets where open doors and windows of unfinished brick houses reveal flashes of daily realities of hard work, little space and privacy, loud televisions and sound systems, and often many children to take care of. A steep hill leads to her small house, where her two other children welcome us excitedly. A domestic worker[5] and her husband also live there, but he is rarely at home working as a mototaxista to make ends meet, meeting up with friends or 'doing things that I'm not worried about anymore'[6]. Coming from a city in the countryside of Bahia, the 34-year old Litza moved to Salvador a year ago. Until then, she worked in sanitary services for civil construction companies and selling drinks on the street, however the majority of the family income has come from her husband. Her seven year old daughter and 4 year old son go to a public school in the afternoon, while her husband works and she takes care of the house.

As we sit together on the couch with the other kids and while breastfeeding her newborn girl, she says: 'So, what do you want to know, do your interview querida[7]'. It has been a week since we first met and since she allowed me to be present during the beautiful birth of her little daughter. I ask her if she can tell more about how she arrived at the centre and what have been her previous birth experiences[8]. 'Well, I always wanted to give birth normally because I think it is the natural way of life. They have always told me the recuperation of a cesarean takes much longer and hurts more, and I really hate pain. I think women who want a cesarean are afraid of the pain, of the treatment, and think they will lose the esthetics of their intimate region. I don't have this fear, and if anything I can pay for a kit[9] to get it all nice and beautiful again, haha! I planned to go to the maternity of reference, but found out it had started a strike. I didn't want to go to the maternity I had delivered before, because they treated me without respect and I only hear stories on TV about women and babies dying there. Binho[10] said: 'Don't worry, Preta[11], I will find you a decent place to have your child!' He started asking to pregnant women he met on the street and some told him that at the centre 'it's good'[12]. He went there to have a look and liked it: I trusted him. Later on, I heard that they only did normal births, and you have to have all your exams done. I only discovered my pregnancy with six months and because my husband was sick I only got to do two ultrasounds. With my first child I almost wasn't able to do any exam, she was born like someone would be at the end of the world. The second was more 'taken care of'[13]. I have had high blood pressure so it would be a childbirth of risk and they wouldn't accept me at the centre. So before going there, I drank about a liter of erva cidreira tea (lemongrass) to lower it. When I started feeling contractions, I waited some more so that they couldn't reject me anymore at the centre and did what a woman does at home: wash the dishes, I called to my neighbor to come and paint my nails, do my hair... But we didn't even have time to finish because my water already broke and we went to the centre. It was such a beautiful moment, I felt so supported. That is why the pain was much more bearable than with the other children. At the hospital nobody really cares about what you're feeling, you are 'abandoned'[14] and the doctors are so hostile towards us, saying things like: 'when you were doing it you liked it, why are you screaming now?'[15]. They are not there because of love for the profession. I was sad Binho didn't want to be at the birth, because I think that if he'd seen me giving birth to his child our relationship would be stronger, you know? He would give more value to what a woman passes through to give birth to a child. But after the birth, when I looked around me and saw that tranquility and the private room I felt so good, it looked like a was in luxury spa! It would be so important if there were more places like these. Every pregnancy, every birth, every pain, and every sensation when you see your child be born is unique, right?'

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[4] 'Slum'. For interesting accounts of life and motherhood in other Brazilian slums, see Perlman (2010) and Scheper-Hughes (1992).

[5] *Empregada domestica*

[6] *Fazendo coisas que já não me preocupem mais*

[7] 'Sweetheart'

[8] Litza's story as I present it here is a collection of pieces of the interview I held with her. I have selected elements that are of importance for this research, however I believe this selection did not cause the text to become sensitive for misinterpretation, as the elements are really the ones she emphasized as well.

[9] As Litza explained to me, a plastic surgery 'package' including tubal ligation, abdominoplasty and vaginoplasty

[10] Her husband, abbreviation for *Fábio/Fabinho*

[11] Female conjugation of 'black' (black woman), in this case it is a loving nickname

[12] *É bom*

[13] *Cuidado*

[14] *Largada*

[15] *Na hora de fazer você gostou, porque está gritando agora?*

Litza's story has been one of the first that gave me insights into the great amount of social configurations involved in the decision for a natural birth, birth location and in the resulting birth experience. It also affirms the sociality of a pregnant body by showing how social configurations can be of decisive influence in a woman's reproductive navigation. In this chapter, I will analyze this sociality of pregnant bodies by exploring the social configurations present in Litza's story and complementing them with examples other women have given me.

Healthcare seeking behaviour and socioeconomic status

One of the first social configurations that come up in Litza's story is healthcare seeking behaviour. She explains that her preference for natural birth comes from the idea that 'the natural way of life' is how she thinks it should be. In this sense, her healthcare seeking behaviour is not medicalised and any medical intervention (including cesarean) would appear as negatively intervening in the natural. This behaviour also shows in the fact that she did very little antenatal exams, with her first child as well. Other women have shown this kind of behaviour by telling me that they were afraid of 'cutting' and injections. Cris (25) also told me: 'the way it came in is the way it should come out. Because a caesarean is something forced, isn't it?'[16]. Yet other women have often mentioned the same argument for natural birth in relation to religious notions of the natural, like Angêlica (35): 'God meant you to have the baby, didn't he?'[17], Vera (40): 'it's a marvelous moment that God gave to us'[18], and Cris as well: 'God's nature, we can't not opt for the things God meant to, you understand?'[19]Litza also shows how agency in healthcare seeking behaviour can be of great importance in achieving the desired delivery: she knew about her high blood pressure and the lack of sufficient exams to give birth at the CPN, so she drank lemongrass tea and arrived in an advanced stadium of labor.

Lana is one of the higher educated (undergraduate) women that have been active in the movement for the humanization of birth and gave birth in the CPN. Even though she knows about the evidences in favor of home birth, she did not feel comfortable to give birth in her home nor had the financial conditions to pay for home birth assistance. She told me how natural childbirth became the most 'sophisticated' preference for her, as she transformed by informing herself and getting informed, mainly by a friend-doula, about evidences in favor of natural childbirth and against interventions during labor. Being a client of private healthcare, and living in a social environment in which most people are, she explains that 'the people talk: 'oh, poor woman, she had to give birth normally at a public hospital.' They hardly know I went after the SUS, it was my choice and it was much

[16] *Da forma que entrou é a forma que tem que sair. Porque a cesariana é algo forçado, né?*
[17] *Deus lhe deu você ter o bebê, né?*
[18] *É um momento maravilhoso que Deus deu pra gente*
[19] *A natureza de deus. a gente não pode não optar pelas coisas que Deus deixou, entendeu?*

better than any hospital I could pay!'[20] While Béhague et al. (2000:4) have shown that 'women with a more medicalised approach to birthing had more cesarean sections'[xxvii], these examples show that a different approach can also influence birth experience.

However, some women have been ambiguous about their preferences in birth care. Although almost all women preferred natural birth, they often mentioned their fear about having heard the CPN does not 'cut'[21] or 'put serum'[22]: two interventions that are very often realized routinely in public hospitals, while the CPN strives to realize them 'only' when there is evidence-based necessity. The team told me that they were having a hard time demystifying these interventions and at times even had to explain that they did not avoid them to economize materials. It soon became clear that not only profound feelings of fear for the unknown but also for mistreatment have led women to say that they are not sure if they will be capable of giving birth (at all, without interventions or without a cesarean) and that 'the doctor knows'[23]. Here, we see that professionals can be influential on the birth experience by either stimulating or discouraging interventions and exchanging evidence-based knowledge about them. Medical interventions then become meaningful practices because the doctor figure is attributed a high social and status decision-making power and a lack of interventions is interpreted as medical negligence based on socioeconomic status. Edna (31) had an even stronger opinion about socioeconomic-based treatment, as she said that 'there is no difference between cesarean or natural, they treat who is from the SUS worse anyway'[24]. Later on, I will explore how notions of suffering and pain are also related to these practices.

What is interesting to see that, in Litza's case and those of all but two of the women I interviewed, this fear of discrimination does not seem to apply a cesarean. She mentions her hate for pain, arguing that she has heard that the recuperation is much more painful than the pains of a natural birth. This notion of pain contradicts what she and many women indicated as the reason for *other* women to prefer a cesarean: fear of pain. As notions of pain, principally related to socioeconomic questions, have been very present in women's discourses on childbirth, I decided to dedicate the next chapter to the aforementioned issue.

I hope to have shown that a woman's healthcare seeking behaviour and socioeconomic status may affect her preference of birth, birth location and the birth experience. I argue that this birth experience is more than a fundamental event for a woman's physical and emotional well-being. Birth stories are shared with other women and remembered during a next pregnancy as I will explore in the next section. In light hereof, every birth experience contributes to reaffirming authoritative knowledge or to creating new knowledges that have a great potential to challenge the existing.

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[20] *O povo fala: 'ó, coitadinha, teve que parir normal no hospital do SUS'. Mal sabe que eu fui atrás do SUS, foi a minha escolha e foi muito melhor do que qualquer hospital que pudesse pagar!*
[21] *Corta*: episiotomy.
[22] *Bota soro*: induce or increase labor with synthetic oxytocins
[23] *O médico sabe*
[24] *Não tem diferença cesárea ou natural, quem é do SUS tratam pior mesmo*

Previous experiences, heard stories

In her account, Litza says how her husband asks other women on the streets for advice on a birth location. During my research, I noticed how hearsay on the street and during meetings with family and friends also shapes a woman's social configurations. It often constituted a large part of what women (in particular primipari[25]) held as authoritative knowledge in childbirth and was highly influential in the decision making process about childbirth and even on birth experience. The majority of the women I spoke with got to know the CPN through indications of friends, family member, colleagues, neighbors, etc. Often, such an indication was enough to go there and start antenatal consults, and in some cases women only went there when labor had started. Socioeconomic issues also played a role in the hearsay, as the indications were often based on the physical structure and treatment of the CPN like 'there it is a maternity of the first world!'[26] (Carla's (22) mother), Litza's account about feeling in a 'luxury spa', and 'here they treat you as if you were one of them'[27] (Felícia, 16).

However, hearsay also often contributed to fear about natural childbirth and the CPN. I have been overwhelmed with horrifying accounts of verbal and physical violence[28], solitude, and lack of space and hygiene when admitted into the hospital for delivery. Nadja (23) told me: 'If I would tell all the stories you hear in a maternity I could write a book. If you get attached to this you will panic and really want a cesarean'[29] It also appeared that this traumatizing hearsay and mistreatment are not limited to public hospitals. I will include this story and some other stories women have told me of in appendix VI, as I think they are indispensible to understand the their gravity and profound impact on women's healthcare seeking behaviour and their birth experiences. Lana mentions how the fact that she lives in a context where most people are private health care users influenced her vision on natural birth: 'I just heard that nobody did it (normal birth) and I didn't know that it was because the doctors fooled the people and didn't empower them. I really thought it was something absurd. Because if nobody does it? Then something must be wrong, right? I really thought that there were only a few warriors. Will I be? I didn't think so.'[30] The fact that Lana empowered herself by hearing stories and studying clearly shows the sociality of pregnant bodies. On the other hand, however, it also shows that 'the inherently social domain of reproduction is often an individual affair' (Van der Sijpt, 2011:

[25] Women pregnant for the first time
[26] *Aí é maternidade do primeiro mundo!*
[27] *Aqui eles te tratam como se fosse parte deles*
[28] Also referred to as obstetric violence. In 2010, Perseu Abramo Foundation's conducted the research *Mulheres Brasileiras e Gênero nos Espaços Público e Privado* (Brazilian women and gender in public and private spaces). It consists of 2.365 interviews held among women above the age of 15, from the five macroregions of the country, and covering rural and urban areas and uncovered shocking statistics of the violence women often have to endure with antenatal and birth care. For some of the main results on obstetric violence, see appendix V.
[29] *Se eu contasse todas as histórias que ouve na maternidade eu poderia escrever um livro. Se você se apegar a isso você entra em pânico, quer ter cesárea mesmo*
[30] *Só ouvi que tipo ninguém fazia e não sabia que era por conta que os médicos enganavam as pessoas e tal e que as pessoas não se empoderavam. Eu achava que realmente era absurdo. Porque se ninguém fazia? Então, alguma coisa tinha né? Achava realmente, poucas são as bravas guerreiras. Será que eu sou? Achava que não.*

208). In between this strong pro-cesarean social context, her individuality shows in the studying of a different birth paradigm and thus provides a secret place for decision-making.

Another medium for spreading birth stories and negatively impacting the CPN has proven to be television. The past year, the maternity of reference for transfers from the CPN has been in the news with a few terrible stories about perinatal and maternal deaths. For some women, these stories and the fact that this maternity will be the only possible location for transfer in case of necessity during labor have proven to be factors that instill fear and resistance to give birth at the CPN.

Logically, these stories arise from previous birth experiences women have and become meaningful by being shared and compared with other: a fourth social configuration. Women who have given birth before ('multipari') have told me to remember and consider these experiences during their current pregnancy, and they might be decisive in their healthcare seeking behaviour and experience of this delivery. Litza, for example, mentions how she was asked why she was screaming now when she liked it when making the baby, how she felt abandoned and hostility from the professionals during her labor in the hospital and really preferred not to go to that maternity again. Ana Luisa (30) told me that she had noticed during the delivery of her first child that the more you 'scream' and be 'scandalous'[31], the more the professionals mistreat you. Therefore, she was already prepared to stay 'quiet' and be an 'educated woman'[32]. This might actually influence the treatment she will receive, but it will undoubtedly influence the labor process and birth experience as well[xxviii]. Not surprisingly, many women reacted giggly, relieved, but also uncomfortable when they heard that at the CPN you can and are sometimes encouraged to scream (however without emphasis on pain, but on vocalizing bodily sensations) during the delivery.

These stories and experiences have shown to be essential elements in what a woman envisions as authoritative knowledge about childbirth. The resulting knowledges are exchanged and consequently selected by women according to their social configurations and in the pursuit of what they would find a satisfactory birth experience. I will also elaborate on this navigation in the next sections.

Gender and aesthetics

A focus on 'women's fears of the physiological consequences of vaginal delivery and their desire to keep their sexual performance intact' (Béhague et al., 2002:1) has been criticized for ignoring underlying socioeconomic processes that might result in apparently irrational preferences or decisions

[31] *Grita* and e*scandalosa*
[32] *Quieta* and be a *mulher educada*

surrounding childbirth. Even though I agree with this (and, with this research, try to shift the focus to these processes), gender related discourses about motherhood, womanhood, and aesthetics were present in the interviews I held with women in the CPN. In their research about ideal feminine embodiment and childbirth choices among childless women and new mothers, Malacrida and Boulton have also shown how 'birthing choices are reflective of tensions embedded in normative femininity; conflicting ideas relating to purity, dignity, and the messiness of birth; and contradictions about women's bodies as heteronormative sites of pleasure and sexuality on one hand and of asexual, selfless sources of maternal nurturance on the other' (2012:748). Therefore, I think they should not be dismissed as social configurations influencing a woman's birth preferences and experiences.

First of all, only 3 of the 32 women I interviewed expressed anxiety about having their vagina end up 'totally unstructured' or 'open'[33]. When asked, the other 29 women did recognize that *other* women might prefer a cesarean because of aesthetic reasons, but that they thought it was 'nonsense' or that 'it would go back to its place'[34]. For them, these notions of femininity do not constitute authoritative knowledge. However, women were sometimes ambiguous about this as well. In her story, Litza also says that she is not afraid to 'lose' the aesthetics of her intimate region, but does mention the possibility of a *kit*. Five of the women who didn't consider aesthetics as a reason for preferring a caesarean told me they did not want the father to be present during the delivery because they did not want him to see them 'dirty' or 'screaming'[35]. Nevertheless, aesthetics did not seem to be a decisive factor for preferring a caesarean.

Interestingly, for ten women the father's presence during the natural birth served another important purpose. To quote Litza: 'I think that if he'd seen me giving birth to his child our relationship would be stronger, you know? He would give more value to what a woman passes through to give birth to a child.' This relational factor was often mentioned in relation to pain; even some of the professionals encouraged women to take along the fathers so that they could 'bite his arm and that he will feel some of the pain as well'. Nevertheless, many women also expressed their wish for the father to be present because he would see their strength. Some of the women who gave birth at the CPN with the presence of the father indeed told me how the experience had been positive as he was now completely in love with her, constantly calling her his 'warrior'[36]. Also, Maria (29) said that she wanted the father to be there because she thinks that 'men who watch have more responsability'[37].

Besides these notions of esthetics and stakes in marital relationships, social configurations such as

[33] T*oda desestruturada* or *aberta*
[34] *Besteira* and *voltar para o lugar*
[35] *Suja* or *gritando*
[36] *Guerreira*
[37] *Homem assistindo tem mais responsabilidade*

ideas about motherhood and womanhood emerged as influential on birth preferences and experiences. We saw that Ana Luisa mentioned she had prepared herself to be an 'educated woman', which, in this sense, would mean not to scream and maybe ignore her intuitive impulses and bodily sensations. Litza said, along with other women I heard in the CPN, that before going to the CPN she wanted to have her hair and nails done. These ideas of how a woman should act and look when giving birth seem to come from patriarchal notions about 'clean' and 'decent' women. Even though this might be true in some sense, Ana Luisa already mentions why it is important to recognize the underlying socioeconomic issues with these practices: these apparently oppressing patriarchal practices of 'being an educated woman' and looking 'decent' become meaningful and a painful reflection on these practices exactly because women actively use them to enable the navigation towards a hopefully positive childbirth experience.

However, many other women did not share these ideas and this leads me to a final social configuration that appeared of influence on birth preferences and experiences: ideas of what it means to be a 'good' mother. Lúcia (25) told me that 'who did a caesarean doesn't know how to love her child'[38], and that some women just do not have the 'courage'[39] you need to give birth to a child. Here, we see how natural birth may be interpreted as a fundamental process for 'good' motherhood and might therefore be decisive in a woman's birth preference and experience (especially when we imagine how someone like Lúcia would feel like if she ended up having a caesarean). Malacrida and Boulton have mentioned that these ideas can also arise from notions related to selflessness and pain. In the next chapter I will further explore the different notions of pain that have passed by in the interviews and conversations I held.

[38] *Quem fez cesárea não sabe amar seu filho*
[39] *Coragem*

BODY PAIN & SOUL PAIN, GOOD PAIN & SAD PAIN

Socio-economic constructions of pain

'Pain and sadness are the best teachers until we learn to grow through love and pleasure. Closing up is the best surviving strategy until we learn to enjoy life through opening and shifting of our own perception settings... Options are many... and suffering is optional, too.'
Elena Tonetti-Vladimirova[xxix]

When I knock on one of the delivery rooms, I find Sara, the coordinator of nursery, talking to a couple that had given birth the day before. Sara is squatted next to the woman, who is breastfeeding her newborn baby in a chair. They hold each other's hand, look into each other's eyes and a tear runs down from both of their eyes. Sara tells me to join and explains: 'this woman had her first baby some years ago in the maternity of reference, where I was working at the time. They participated in the birth preparation course I gave and I had told them about their rights to good and respectful treatment, and especially about the right to have your partner accompany and support you during birth. She just told me that her experience had been very disappointing and painful: the doctors didn't let her husband accompany her, she felt abandoned, and the pains only got worse with these feelings of solitude and helplessness. I feel so guilty that the promise I made wasn't kept, because I know that we can support the 'body pain, but 'soul pain'[40] is much more difficult to bear.' The father then tells me: 'after that experience I didn't want to have children anymore, because I didn't want my wife to suffer like that again. However, now that she gave birth here and I have seen how birth can also be, with so little pain and so much loving support, she can have ten children if she wants to, haha!'

I found Sara's way to describe different kinds of pain, body pain and soul pain, very touching and useful to imagine how bodily sensations such as pain can be attributed different meanings, and especially, how they may be directly connected to and influenced by social and emotional experiences. Tornquist (2003:423) argues the same by saying that *'we know that pain, like illnesses, aren't solely universal manifestation of organic processes, but symbolic constructions that vary according to socio-cultural contexts and the subjectivity of the 'sick'* (author's translation). Obviously, pregnant women are nothing close to being sick, but during my research it has become very clear that experiences of pain are related to socio-cultural symbolic constructions and therefore exist in great variety.

In their study in a Brazilian public maternity, Béhague et al. noticed that 'many of the factors influencing maternal behaviours, such as fear of pain, are meaningful precisely because they are understood to differ by socioeconomic status and to be embedded in discriminating practices' (2002:4). In this sense, 'soul pain' is a strong socioeconomic construction related to birth care. It becomes clear that the strong bodily sensations during birth, which are often said to be physiological ('real') pains but can sometimes be interpreted and experienced differently, gain meaning and become 'soul pains' in relation to others. The fact that these sensations are so often experienced as pain can be directly connected to the treatment and support women receive during labor[41], just as

[40] *Dor do corpo* and *dor da alma*
[41] See Hodnett et al., 2011.

Litza mentions: 'we feel pain, and because we are alone it seems like the pain is stronger, and there are women that don't know, don't know how to breathe, don't know how to behave to receive that pain in a good way'.[42]

Discriminating practices during natural birth as mentioned before have been characteristic for Brazil's public health care[43] and, with the medicalization of the female body, 'high' technology such as medical interventions and cesareans have come to be associated with high quality care. These are two powerful mechanisms of socioeconomic 'pain construction' that have come to sustain eachother. As I mentioned before, a characteristic of the humanized paradigm in Brazil and of CPN's birth care has sometimes been interpreted as an example of mistreatment: the absence of pharmacological pain relief (such as an epidural) and the use of 'only' non-pharmacological methods of pain relief such as massage, space to move and find different positions to be comfortable in, the presence of a loved one, aromatherapy, warm water showers. Tânia's (28) preference is very expressive in this context: 'I will not ignore that if I had money I would'nt give birth normally. It's not better, for what I've heard. But to not suffer that much. Then it would only be scheduling [a cesarean], going there, and you're done. Here [CPN], no, you have to wait, feel the pains.'[44].

Here, I would briefly like to comment on another characteristic of birth that, in Brazil, has often been related to public health care and, implicitly, to poverty: waiting. Waiting hours (and, thus, 'suffer') for your doctors consult is no excession and the fact that natural birth is about a lot of patience and waiting has also had a negative effect on birth preferences in this sense. The experience of waiting as suffering is also reinterpreted in the humanistic paradigm through the notion of 'continuous support', for example by a doula. In light hereof, it becomes clear that, as Van der Sijpt (2011) has mentioned, a pregnant body also demands navigation as continuous support is often desired during the intense physical sensations of birth. In the CPN, many women told me that what they found essential in birth assistance was patience and attention: these bodily needs will direct health seeking behavior in the sense that try to give birth in a place in which this kind of support seems most likely to be given.

However, as Litza mentioned before, many women I spoke with in the CPN preferred a natural birth for different reasons also related to pain: a cesarean is much more painful afterwards and the recuperation takes much longer than with natural birth. Many women did recognize fear of pain as a reason for *other* women to prefer a cesarean. Selma, one of the obstetricians, mentioned that most women who come to the CPN already know that the chance to have a natural birth is much higher

[42] *A gente sente dor, e porque a gente tá sozinha parece que a dor é maior, e tem mulher que não sabe, não sabe respirar, não sabe como se comportar pra receber aquela dor de uma forma boa*

[43] However not limited to public health care. See appendix VI for a heard story about the treatment during a birth in a private hospital.

[44] *Não vou negar que se tivesse dinheiro não ia parir normal não. Melhor não é, pelo que ouvi. Mas pra não sofrer tanto. Aí seria só marcar, ir lá, e pronto. Aqui não, tem que esperar, sentir as dores*

than a cesarean. In this sense, it might be said that the women who would prefer a cesarean nevertheless frame natural birth as something less painful than a cesarean, maintaining a socioeconomic status in without the presence of suffering. However, this would mean that these women actually see natural birth as something to be avoided when possible, while the majority of the women I talked to preferred a natural birth even if they would be given the choice between both.

Another social construction of pain that came up from the social configurations women mentioned, was its power to generate respect and admiration from the father and have a positive influence on their relationship. During some of the circles organized for women to get to know the CPN and their practices, obstetric nurses have sometimes encouraged, even though in a joking way, to take along the fathers for the birth so that the women could bite his arm and also feel some pain. This kind of knowledge exchange addresses the relational aspect of pain as some women mentioned, however it does not contribute to a different interpretation of this bodily sensation and a vision of the father's presence as providing support that could alleviate these sensations during the birth of *their* child. I argue that this might be done through a more holistic approach, in which a caregiver should try to understand *why* a woman would focus so much on gaining respect from the father.

In their research among North American women, Malacrida and Boulton (2012) have also noted that enduring pain during a natural childbirth is sometimes normatively considered as 'the "proper" means of accomplishing the rite of passage to motherhood. Some women in the CPN confirmed this vision, such as Vera : 'They say that being a mother is to have [your baby] normal, feel the pain, right'[45]. Interestingly, it is therefore not 'only' natural birth, but the pain for them inherent in the event that opens the doors to 'true' motherhood. One of my informants, Cris, related this construction of pain to religion: 'the nature of God, what did God say? The woman will suffer during birth, wasn't it like this? The pain of birth would be our punishment.'[46].

For Lana, after studying and talking (that is, exchanging knowledges) a lot about the medical evidences and risks about natural childbirth and interventions, concluded that a natural birth without anesthesia would be the best and most healthy option for her as well as for her child. She was able to frame the pain in a different way because of this conviction: 'for example, we are used to a pain from an accident, a disease. Or a cut, that is a sad pain. It's a pain with which you are losing something, or you are feeling that pain because of a bad thing. And the pain of birth is a pain for a good thing,

[45] *Dizem que ser mãe mesmo é ter normal, sentir a dor, né*
[46] *A natureza de deus, deus disse o que? A mulher sofrerá no parto, não foi isso? A dor do parto seria o nosso castigo*

understand. It's different, nobody will ever be able to explain, but it's different. When I do a depilation I can't take it! I'm the weakest person for pain. So, what kind of pain is it? '[47].

Again it becomes clear that a birthing body demands navigation, in this case to be able to experience birth in a gentle and pleasant way. During labor, there are intense and universal physical processes happening that can generate intense physical sensations: indeed, the body acts. Lana shows that it may therefore be important to enter the holistic paradigm a little more and, besides awareness of and continuous support with social configurations, create awareness of the influence of the mind on the acting body. Going back to the theory, it could also be said that more awareness of 'being' a body and a 'mindful' body can be useful in handling physical sensations of birth. As Luisa, one of CPN's obstetric nurses once said to a woman in labor: 'the pains cannot be stronger than you are: they *are* you.'

[47] *Porque é uma dor que, tipo a gente ta acostumada com a dor de um acidente, uma doença. Ou um corte, é uma dor triste. É uma dor que você ta perdendo alguma coisa, que você ta sentindo aquela dor por uma coisa ruim. E a dor do parto não, é uma dor que é para uma coisa boa, entendeu. É diferente, ninguém nunca vai conseguir explicar, mas é diferente. Eu vou fazer uma depilação e não agüento! Então, que dor é essa? Eu sou a pessoa mais frouxa do mundo para dor*

LIVED EXPERIENCE: MEDIUM FOR TRANSFORMATION

Women into mothers, technocracy into humanity

> *'The doctor called me to go to the home of one of his clients whose labor had started. He was my supervisor during my obstetric training and said he would arrive a little bit late. When I arrived there, I noticed the woman was close to giving birth. I didn't finish my training yet, so I didn't know what to do. So I sat on my hands, didn't do anything and the baby was born before the doctor arrived. It was so beautiful, because when the head was crowning, I saw it going back and forth, stretching the vagina and the woman naturally stopped pushing when it hurt too much. It was then that I saw for the first time that a woman can really give birth without episiotomy, without any intervention. I was lucky to have seen that so early in my training.'* Márcia, obstetrician

This beautiful excerpt is from the interview that was actually held by Eugenia Georges; she generously allowed me to use the interview for my research. In this chapter, I would like to start off with the lived experiences of the CPN's professionals, especially because they are of influence on the care the women receive.

Professional experiences

First of all, it is important to note that the majority of the professionals working at the CPN also work in one, sometimes two other private or public hospitals where routine practices are often very different than in the CPN. They have been selected by the coordinators for having expressed themselves in favor of natural and humanized birth and put effort in practicing in accordance to that. A minority of the professionals is active in the humanization movement in the sense that they make a point of being updated about all the medical evidences on cesareans, interventions and natural births, attend meetings of the Forum Perinatal, participate in demonstrations and otherwise.

In the interview, Márcia said very cleary she was 'lucky' to have experienced such a positive, natural birth so early in her training. In her research on American obstetric training, Davis-Floyd has noted how this training is often an 'initiatory rite of passage through which nascent obstetricians are socialized into the technological model of birth' (1987:288). Also in Brazil, obstetric practices have long been (and often still are) based on tradition: they have become recognized as 'necessary' or routine because they have 'always' done it like that[xxx]. In light hereof, it could be said that the training you received as an obstetrician becomes a social configuration that highly influences the way you practice and experience childbirth. In appendix VI I provide an account of my visit in the maternity where the federal university's students are being trained to share brief thoughts on this initiation rite. When you are trained in this context or paradigm, and thus have little or no contact with evidence based obstetrics, lived experience can be crucial for one's perception of natural birth. One recent

development in favor of these lived experiences of natural birth is the fact that a two-year practical internship is now part of the training in obstetric nursery at the federal university (of which the CPN is one of the locations).

Observing and interviewing the professionals in the CPN, it has become clear that the experience of 'succesful' natural births in itself, sometimes only once, may indeed be sufficient to more or less radically transform one's attitude towards birth. For example, Roberta (obstetrician) told me: 'in the beginning it was difficult not to do episiotomy. Until a short time ago I was obliged to do it, it was difficult to be obliged not to do it. I still think that some cases really need it, but yesterday for example there were three births, two of them didn't even need stitches. I thought this was beautiful, because it gives something in return, right?'[48]

Another social configuration that influences most professionals' way of caring is mentioned by Cecilia MacCallum (2005). She argues that doctors are subject to the effects of accumulated experiences in different institutions (private and public) (235,225). The impositions of their day-to-day routines, the very experience of attending births at the different hospitals and, more recently at the CPN, is bound to shape health professionals' feelings about 'normal birth'. Many professionals mentioned that, working in the CPN, they came to appreciate normal birth, and sometimes 'even' natural birth as they see more and more women giving birth 'well', without necessity for anaesthetics, an episiotomy or oxytocins, and that they have tried to adopt a similar posture in other working environments. Mônica, obstetrician, told me: 'Here it's fantastic, isn't it, such an innovative proposal. I say that we are the ones that learn most in here. Every birth is an experience, totally different, every woman is different. What I like most is working in a team. There is no hierarchy, it's all mixed. The obstetric nurses are great, I learn a lot from them. I think that is how it should be and I try to put this in practice in my practice and the other maternities I work.'[49]

Earlier, we have seen that the knowledge exchange between a professional and a birthing woman can be of great influence on a woman's lived experience of birth, whether it is in a positive or negative sense. Here I hope to have shown that the professionals' social configurations influence not only their lived experience of birth as much as those of the women they attend. I argue that the CPN provides a space in which natural birth can be reinterpreted and experienced in a positive way, thereby transforming the social configurations of the professionals. As the professionals take these experiences with them to other working environments, I argue that they contribute to the devaluation of the technocratic, authoritative paradigm of chidbirth.

[48] *No início foi difícil não fazer episiotomia. Até pouco tempo atrás era obrigada a fazer, foi difícil ser obrigada a não fazer. Eu acho que tem casos que realmente precisa, mas ontem por exemplo teve três partos, e duas nem precisaram de sutura. Achei lindo isso, porque dá um retorno, né.*

[49] *Aqui é fantástico né, a proposta uma coisa inovadora assim. Aqui eu falo que aqui quem aprende mais é a gente. Todo parto é uma experiência, totalmente diferente, cada mulher é diferente. O que gosto mais é trabalhar em equipe. Não tem hierarquia, é tudo misturado. As enfermeiras obstetras são ótimas, aprendo muito com elas. Acho que tem que ser assim e estou tentando levar isso no meu consultório e nas outras maternidades que trabalho.*

Women's experiences

Here, I would first like to come back to the individuality of reproductive affairs such as birth experience. The individual character of birth was first showed to me by Nara (36), who told me that she had come to the CPN to 'overcome the trauma of her first delivery'[50]. I found her reason for coming to the CPN very significant to understand that a birth experience can go beyond fear and traumatizing experiences or stories: it can be an individual, empowering experience in *itself*.

At the same time, Nara shows that birth is a social event in which the location and assisting professionals influence the way she experiences (and overcomes a trauma) of birth. Many other women also mentioned the sociality of their birth experience: here I will provide some accounts of birth experiences in the CPN as I think they will be most expressive.

> 'It was so strange, there were four people in the room I had never seen before in my life and suddenly they were so important, so caring, loving, strong, pacient… Without them and this humanized work I wouldn't have the pride to talk about the most important moment of my life. I didn't imagine myself abandoned in a room with various pregnant women screaming, every one suffering and I also suffering, without any comfort, without people to help me, without my husband by my side, all this pain would multiply without a doubt! People get impressed when I talk about my delivery, that I gave birth with my husband giving me a massage with oil, seated at a 'little horse' (*cavalinho*), at the ball to ease the contractions under warm water, with a suite only for me, aromatizing candles, drinking a little orange juice.'
>
> *- Anonymous account at the CPN's social network page [authorized for publication]*

> 'Within all the qualities of the team, I want to highlight the humanized and extremely professional reception. Yet I highlight the naturality with which the given 'assistance' occurred, that is, in such a humanized way, transmitting confidence and calmth so that the greatest pain in the world became turned into a small and bearable pain in the hands of these two 'angels'. The care, fondness and happiness in 'contributing' to another being coming to the world in a natural way turns the dedication of these professionals into something extremely commendable. The options were various, we chose the way in which we wanted to give birth, the most natural way possible! *Viva* to the SUS!'
>
> *- Anonymous account at the CPN's social network page [authorized for publication]*

> 'Never in my life did I think I would give birth with a doula at my side to support me, teach me how to breath, all this facilitates because the pain I felt with the others, with my daughter I didn't feel. The comfort we have after the baby is born, everything they do with the baby they do with us closeby, watching… We feel more comfortable like this, because [there are] so many stories we see about children being stolen from the mother in the maternity. When we have the opportunity to live, to experiences all that… With the patience that the people from the SUS don't have it remains an experience for us, it's so much better.'
>
> *- Litza*

[50] *Superar o trauma do meu primeiro parto*

These accounts show how a woman's experience of birth may transform her ideas about birth care and of her right to good and humanized care during the event that transforms her into a mother. From the women I have spoken with in the CPN I have not heard unsatisfied stories about their experiences of birth. Lana has told me that the obstetrician who was assisting her, did propose some interventions she did not agree with. Nevertheless, she felt empowered by being able to ask the obstetrician why she wanted to do that, to wait a little more and thus navigate the delivery according to her physical and emotional sensations. Many women I spoke to after their delivery at the CPN mentioned that they 'really did not have anything to complain[51]', 'still didn't believe this [the CPN] exists[52]', and that 'here it's different[53]'.

The way birth is experienced, while influenced by involved others, is a highly individual and private affair. Besides often mentioning that they did feel strong and long pains, all of the women I spoke with told me they would certainly recommend it to others. As almost all of the women come here through an indication from a friend, family member, or neighbour, I argue that these positive, individual experiences can create new authoritative knowledges about childbirth, transform women's social configurations related to childbirth, and devalue the current authoritative paradigm of childbirth. In contrast to Jordan's (1993) narrative stated earlier, this also shows that contestations and transformations of authoritative knowledge do happen *within* any given birth system. Lived experiences, from the professionals as much as from the women, thereby create the base of a kind of social movement that expands and can transform social configurations related to childbirth in the community.

[51] *Realmente não tenho o que reclamar*
[52] *Ainda não acredito que isso existe*
[53] *Aqui é diferente*

CONCLUSION

'To change the world, we must first change the way we are born'

-Michel Odent

In such a short research period, I have not been able to provide for detailed accounts of decision-making processes about and birth experiences of different women in the CPN as I would have liked to. However, I did get many different impressions of the issues involved in decisions and experiences related to birth, which have provided important insights to partially answer my main research question: *How do women and the actors involved in their delivery construct, exchange and select knowledge about childbirth in the Centro de Parto Normal to make decisions related to childbirth, and how do these processes affect women's lived experiences of childbirth?*

First of all, I have shown that decisions about childbirth in the CPN are intercontingent. The women I spoke with (and we all) are no free, purely rational beings that make their decisions in a vacuum unaffected by social configurations and bodily sensations, but rather interactively negotiate their agency in birth affairs. This intercontigency has shown in the variety of social configurations that influence women's decisions in reproductive affairs. In the CPN and Brazil more generally, it has become clear that socioeconomic status is a social configuration that especially affects women's decisions and experiences of childbirth. Of course, the social configurations mentioned in this research are only a few of the endless elements influencing a woman's preferences for and experiences of childbirth and a demonstration of the uniqueness of every birth. Therefore, I highly encourage more research on social configurations involved in childbirth decisions and experiences. My informants showed me that authoritative knowledge is a fundamental characteristic of a woman's social configurations and thus of her reproductive navigation. Her social configurations are situated within and affected by a context in which certain birth knowledges and practices are authoritative, influencing her reproductive navigation in certain ways. This is not to say that, as Jordan puts it, women merely affirm and reproduce certain knowledges or power relations within a dominant paradigm of childbirth and do not have agency in their search for the most satisfying birth. Pregnancy and childbirth, while being highly socially constituted, are also very individual and private events that are only felt by a woman herself. While it might be 'interactively negotiated' (Ortner, 2006:151), it is precisely this individuality that gives space to a woman's agency. In line with this, I argue that the concept of authoritative knowledge should be broadened from something that is solely imposed onto a pregnant woman, to something that is inherent in and often challenged by her social configurations, decisions about and experiences of childbirth, providing a fertile ground for the decision-making processes surrounding birth of other women.

Second, through their influence on childbirth decisions and their presence during the delivery, social configurations also affect birth experiences in the CPN. To respect and provide support for these influences, it has become clear that it is of great importance that a woman has the liberty to choose where she wants to give birth, how she wants to move, and who she wants to be present. If the woman desires so, continuous support and attention is needed so that these social configurations do not influence the birth in a negative way and maybe even contribute to a positively transforming experience.

Thirdly, in this research I argue that it is in this lived experience, women's as much as professionals', which embodies a great and beautiful potential for the humanization of childbirth. For some -such as for Lana and some of the professionals in the CPN-, information and intellectual knowledge about evidences on childbirth precedes the experiences and bodily knowledges, for others it happens the opposite way or at the same time, as has been my case. Both are created and exchanged through negotiation between the involved subjects and their social configurations and they need spaces that allow and support their realization. The CPN is such a unique space, as the professionals are on the one hand expected to stimulate normal births as much as possible whereas on the other hand the barrier to indicate cesarean is higher than in regular maternity.

Thus, I have shown that experience can be a great generator of transformation. Spaces for natural and humanized birth experiences such as the CPN become part of a humanized rite of passage: for women, that into a respectful, gentle motherhood, and for the professionals into the humanized world of childbirth, maybe even generating new visions on life. Slowly, positive experiences of normal childbirth are accumulated and spread around the community, the city, and the country. They can, to a certain extent, undermine the traumatizing birth experiences and interpretations of a natural delivery as destined for 'the poor' or as 'romanticized naturalism' (MacCallum, 2005) shared between friends, family and strangers on the streets.

Fourthly, in my research project I argue that in Brazil the humanistic paradigm of childbirth can be seen as a collection of authoritative knowledges in a country in which the main (technocratic) paradigm of childbirth (still) consists of a different collection of authoritative knowledges[xxxi]. The humanistic paradigm in Brazil has long belonged to the domain of social movements. Recently however, the social movements promoting the humanization of birth in Brazil started to have their aims concretized in a broader sense through initiatives in national health policy such as *Centros de Parto Normal*.

McCallum has mentioned that 'what some read as women's 'cultural' inclination towards abdominal birth may simply be compliance, born in the absence of both a coherent, culturally appropriate critique of existing practices and knowledge about vaginal delivery.' Therefore, the situation of obstetric knowledge systems in Brazil is passing through a unique moment: while the

humanistic paradigm has long been devaluated as non-authoritative (and, implicitly, as 'backward, ignorant, naïve troublemaker', Jordan, 1993:152), it is now very slowly being constructed as the 'true'[xxxii] knowledge system of childbirth. However, the technocratic paradigm continues to occupy a dominant position and therefore it could be stated that a non-authoritative knowledge system is challenging and devaluating the still authoritative knowledge system of childbirth in Brazil, a process contrary of the one Jordan described.

Lastly, we have seen that social configurations are of profound impact on women's birth decisions and experiences and these experiences are, in turn, of profound impact on other women's decisions and experiences. An important social configuration has also proven to be the relationship and resulting exchange of knowledge between a caregiver and a pregnant woman. In this sense, I want to emphasize the importance of caregivers creating a space in which these social configurations can be made explicit, where they as much as the woman they attend can be aware of and respect her desires for childbirth, and where patience and informed decisions create a relationship of confidence and trust between both[xxxiii]. It is by this awareness of for a woman's inherent sociality that one can respect support her individuality and that of the birth of her child.

During my research project I have created a great passion and conviction for the right of every woman to give birth in the most healthy, respectful and peaceful way and, in a way, had become an active member of the humanization movement. In this sense, I have to be reflexive about the objectivity of the results of this research. Here, I would like to quote my dear friend and acitivist-anthropologist Anne, who beautifully states: 'I believe that activism and anthropology can walk hand in hand. Research and personal involvement can be intertwined and reinforce each other. For me, the power of anthropological research does not reside in objectivity, but in providing insights into complex subjects by analysing them in a context-sensitive way and tell the human stories behind them.' I hope that the insights provided in this research contribute to a better understanding of the lived reality of the Centro de Parto Normal in Salvador. I also hope this understanding contributes to the ongoing improvement of the birth care provided in the centre, as much as to a broader recognition of the importance of humanized birth care.

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APPENDICES

Appendix I: Topiclists

With women in the waiting room

- Age
- Residence
- Youth, family life
- Education
- Job
- Religion
- Previous deliveries, experiences
- Current living situation
- Did you desire a child? If so, why?
- Feelings about the pregnancy
- Ideas/plans for the delivery
- How did you get to know the CPN?
- Why did you come to the CPN?
- How long have you been coming here, what consults have you had?
- How do you feel about a natural/humanized birth?
- Fears

With women who recently gave birth at the CPN

- Name
- Age
- Previous birth experiences
- Residence
- Religion
- Father?
- Delivery(ies) of mother
- Prenatal, information passed about the CPN
- How did you hear about the CPN?
- Previous visits
- Stories about the CPN on the street
- Preference, why normal birth
- Opinion of friends and family
- Dream or ideal of delivery
- Companion? Who? Why?
- How was your experience? Treatment?
- Would you recommend it to other women? Why?
- Why do you think women wouldn't deliver here?

With the team

- Age
- Residence

- Religion
- Family situation, children
- Other jobs
- Education
- Experiences with birth during education
- Decision to work at the CPN
- Training at Sofia Feldman?
- If so, what did you think about it? Did it change something?
- What is your position in the CPN now?
- Are you satisfied with that?

Open interview topics
With the team

- Interaction and cooperation within the team
- Is there something you would like to change about your job?
- Description of the women that visit and deliver in the CPN
- Identification with them, imagination of their social context
- Why do you think they come to the CPN for their delivery?
- What risks are related to the delivery
- What would you tell a woman about giving birth in the CPN
- Have you had negative experiences with delivery in the CPN
- Feelings about/dealing with the protocol
- Activities with the staff? Meetings? Workshops?
- Changes over the year?
- What are the involved actors: opinion about them?

Appendix II: Vaginal birth/cesarean rates in Salvador's private and public hospitals

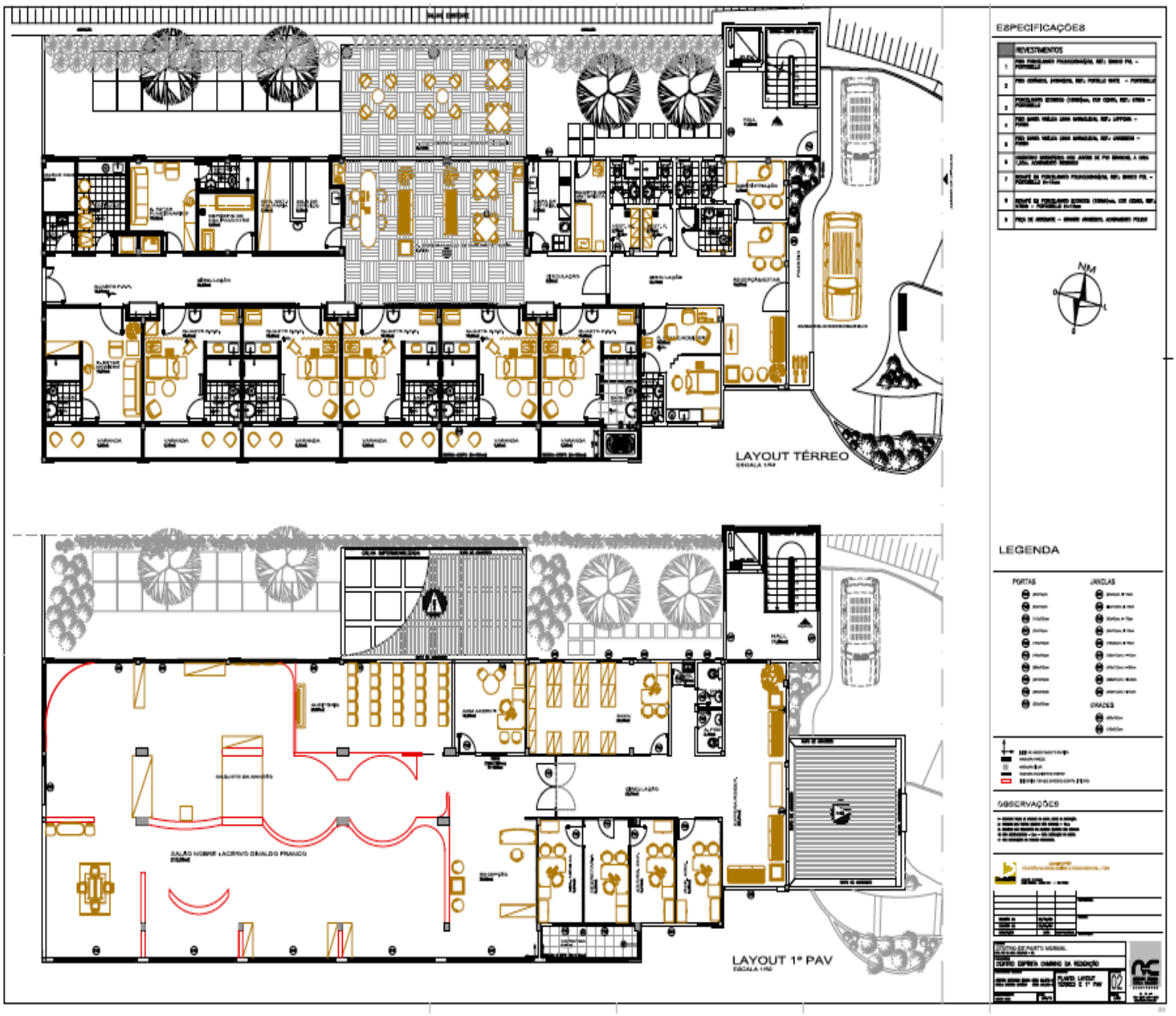
Tipo de parto segundo estabelecimento hospitalar. Salvador, Bahia, 2012

	TIPO DE PARTO[1]						TOTAL	
	VAGINAL		CESÁRIO		SEM INFORMAÇÃO			
	N	%	N	%	N	%	N	%
PUBLICOS								
MATERNIDADE PROF. JOSÉ MARIA DE MAGALHÃES NETO	5.757	61,7	3.555	38,1	17	0,2	9.239	100,0
IPERBA-INSTITUTO DE PERINATOLOGIA DA BAHIA	2.755	64,4	1.505	35,2	21	0,5	4.281	100,0
MATERNIDADE TSYLLA BALBINO	2.369	65,9	1.191	33,1	36	1,0	3.596	100,0
MATERNIDADE ALBERT SABIN	2.215	64,1	1.237	35,8	1	-	3.453	100,0
MATERNIDADE CLIMÉRIO DE OLIVEIRA	1.900	56,5	1.453	43,2	11	0,3	3.364	100,0
HISPITAL GERAL ROBERTO SANTOS	1.245	44,5	1.552	55,5	1	-	2.798	100,0
HOSPITAL JOÃO BATISTA CARIBÉ	544	90,8	53	8,8	2	0,3	599	100,0
HOSPITAL DA SAGRADA FAMÍLIA[2]	2.265	38,0	3.649	61,5	17	0,3	5.931	100,0
UNIDADE MISTA DR. JOSÉ CARNEIRO DE CAMPOS	353	99,4	2	0,6	-	-	355	100,0
HOSPITAL GERAL DO ESTADO	1	50,0	1	50,0	-	-	2	100,0
UNIDADE DE EMERGENCIA DE SAO MARCOS	1		100,0		-	-	-	-
DISTRITO SANITÁRIO SUBÚRBIO FERROVIÁRIO	1	100,0	-	-	-	-	1	100,0
PRIVADOS								
HOSPITAL SANTO AMARO	131	4,4	2864	95,5	3	0,1	2.998	100,0
HOSPITAL PORTUGUÊS	197	7,4	2460	92,4	5	0,2	2.662	100,0
HOSPITAL ALIANÇA	140	6,5	2003	93,0	10	0,5	2.153	100,0
HOSPITAL TERESA DE LISIEUX	173	17,8	766	78,7	34	3,5	973	100,0
HOSPITAL ESPANHOL	139	14,3	831	85,6	1	0,1	971	100,0
HOSPITAL PROF. JORGE VALENYE	132	10,2	795	85,5	3	0,3	930	100,0
HOSPITAL NAVAL DE SALVADOR	7	11,7	53	88,3	-	-	60	100,0
HOSPITAL GERAL DO EXÉRCITO	1	2,8	33	91,7	2	5,6	36	100,0
SAMES	1	4,3	22	95,7	-	-	23	100,0
CLINICA SR. DO BONFIM SAGRADA FAMILIA	-	-	1	100,0	-	-	1	100,0
HOSPITAL SALVADOR	-	-	1	100,0	-	-	1	100,0
HOSPITAL SÃO RAFAEL	1	100,0	-	-	-	-	1	100,0
TOTAL	20.328	45,7	24.027	54,0	164	0,4	44.519	100,0

FONTE: SESAB/SUVISA/DIS/SINASC
(1) Situação na base de dados em 08/04/2013
(2) Hospital privado, conveniado ao SUS

Obs: 'Unidade mista José Carneiro de Campos' is the health unit of Mansão do Caminho, referring to the CPN. Here it proves we should look at these data with care, as two cesareans appear for the CPN and other data might also be inadequate and partial.

Appendix III: Map CPN



Above: ground floor, entrance on the right side. When entering, you find the reception on the right, waiting room on the left. Then, a small corridor with the admission room on the left, dressing room and toilets on the right; doors; kitchen, common room and patio/garden on the right; p.p.p. rooms on the left; after the common room, on the right: supplies; rest room for medical team; sanitizing room.

Appendix IV: Indicators CPN 01/01/2012 – 30/11/2012[54]

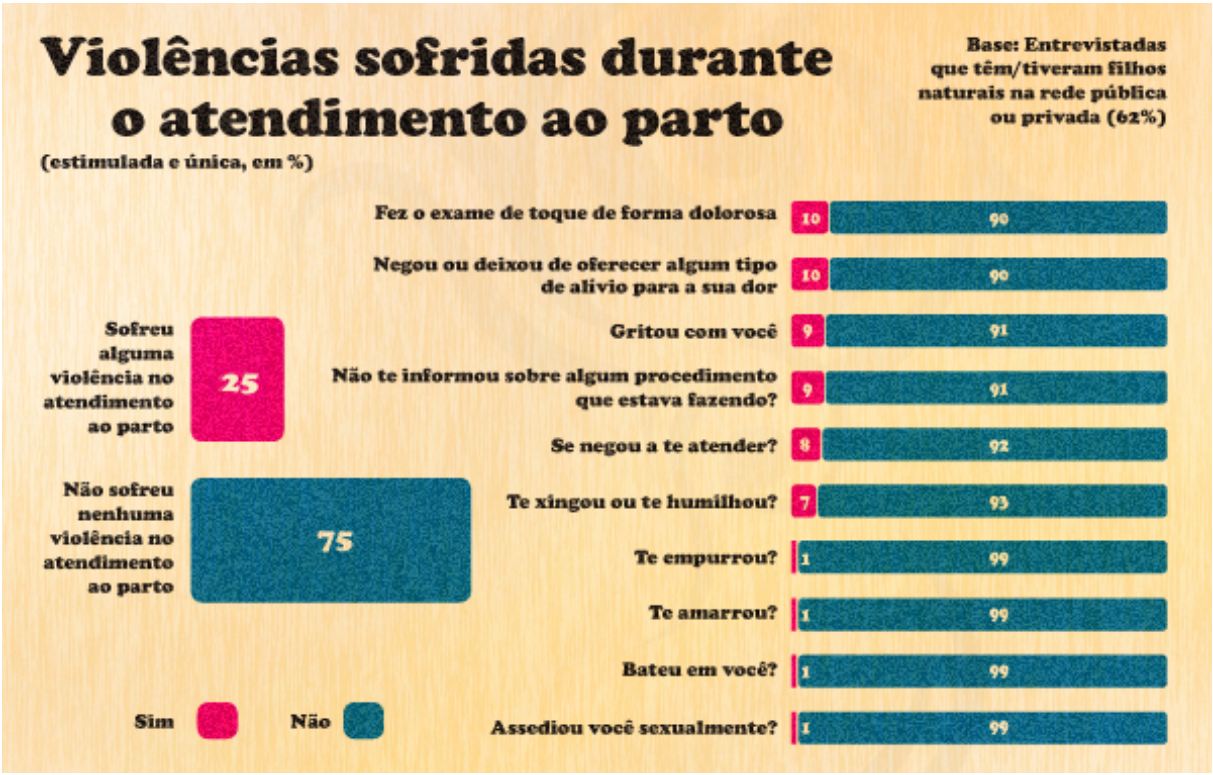
1ª Centro de Parto Normal da Rede Cegonha no Brasil Atividades ano de 2012 de 01 de janeiro a 30 de novembro

• 348 partos	
• Parturientes primíparas internadas	47%
• Partos em posição não supina	99%
• Presença do acompanhante	99 %
• Episiotomia	6 %
• APGAR igual ou menor que 7 no 5º`	0,8%
• Corte de cordão pelo acompanhante	59%
• Contato pele a pele	100%
• Aleitamento 1ª hora	87%
• Parto assistido pela enfermeira	60%
• Transferência da parturiente	9%
• Transferência Rn	4%
• 1 ª Consulta puerperal e do Recém nascido	100%
• Implantação do serviço de doulas	

- *348 births*
- *Primiparous women: 47%*
- *Births in non-supine position: 99%*
- *Presence of companion: 99%*
- *Episiotomy: 6%*
- *APGAR equal or less than 7 at the 5th minute: 0,8%*
- *Umbilical cord cut by companion: 59%*
- *Skin-to-skin contact: 100%*
- *Breastfeeding during first hour after birth: 87%*
- *Birth assisted by nurse: 60%*
- *Transference of the mother: 9%*
- *Transference of the newborn: 4%*
- *1st post-partum and newborn consult: 100%*
- *Implantation of doula services*

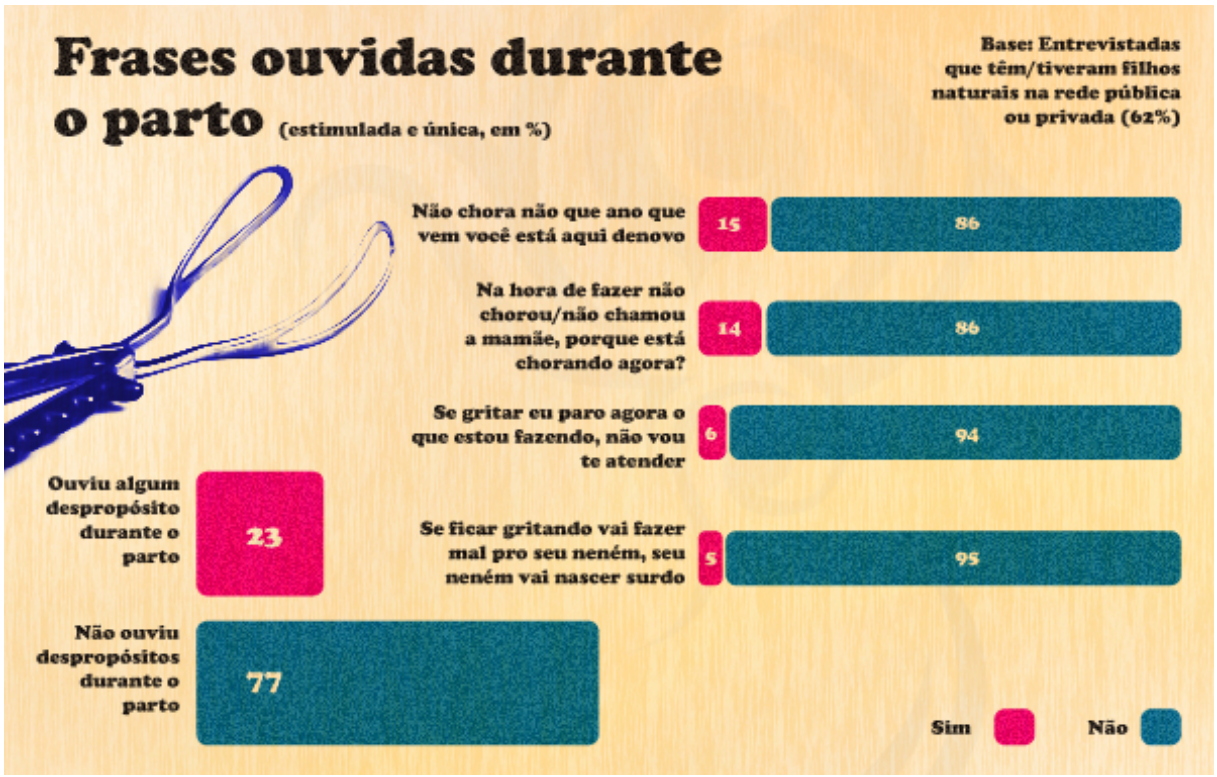
[54] Provided to me by the centre

Appendix V: Results from the Perseu Abramo research on obstetric violence[55]



Suffered violences during the birth assistance
Suffered some kind of violence during birth assistance: 25 %
Suffered no violence during birth assistance: 75%
Did a dilation check in painful way: 10%
Denied or did not offer some kind of pain relief: 10%
Yelled at you: 9%
Did not inform you about a procedure he/she was doing: 9%
Denied assistance: 8%
Cursed or humiliated you: 7%
Pushed you: 1%
Tied you down: 1%
Hit you: 1%
Sexually beset you: 1%

[55] Images obtained from http://www.apublica.org/2013/03/na-hora-de-fazer-nao-gritou/



Heard phrases during birth

Heard some kind of impertinence during birth: 23%
Did not hear impertinences during birth: 77%
'Don't cry because next year you will be here again': 15%
'When you were doing it you didn't cry/call for your mother, why are you crying now?': 14%
'If you scream I will stop what I am doing now, I will not assist you': 6%
'If you continue screaming it will be bad for your baby, he will be born deaf': 5%

Appendix VI: Heard stories and previous experiences

Lana's heard stories

'I don't know if you already heard this story, but there is a girl, Maria Andrade. She had a VBAC[56] at home. She had her cesarean in a private hospital. She was telling that the female doctor arrived and she said to her she wanted a natural birth. Her husband couldn't come in, she couldn't drink water, walk, the doctor arrived and said: 'You? Will have a natural childbirth? Haha!' She resisted, resisted, resisted, stayed there alone, hungry, thirsty, because it took a long time. She layed down during labor, and contraction like this hurts a lot more. The violence with her was such, that they took her bed and said: 'You want to have a natural birth? Wait and you'll see how it is.' There was a labor room in which a woman was giving birth. The woman was giving birth with oxytocins, when the contraction hurts a lot more and screamed, and the baby was born dead. She watched the birth of a dead fetus! She was in labor! They did this to her. At the end she said: 'for the sake of God, take me to a cesarean!' Is she wrong? Was she weak? No! She should have asked for a cesarean before, poor woman, because the suffering they had her pass through was absurd.'

Não sei se você já ouviu dessa história, mas tem uma menina, Maria Andrade. Ela teve uma VBAC em casa. A cesárea dela teve no hospital Sagrada Família, que é particular. Ela tava contando que a medica chegava ela dizia que queria parto normal. O marido não podia entrar, não deixavam beber água, andar, a medica chegava e falou: 'você? Vai ter normal? Haha!' Ela resitiu, resistiu, resistiu, ficou lá sozinha, com fome, com sede porque demorou muito. Trabalho de parto deitada, que contração deitada dói muito mais. A violência com ela foi tanta, eles pegaram a maca dela e falaram: 'você quer ter normal? Peraí que você vai ver agora como é normal'. Aí tinha a sala de parto, tinha uma mulher parindo. Eles botaram a maca em frente para ela poder assistir a mulher parir. E a mulher tava parindo com ocitocina, que a contração dói muito mais e aberrava e tal, e o neném nasceu morto. Ela assistiu um parto de um feto morto! Ela tava em trabalho de parto! Fizeram isso com ela. No final ela disse, pelo amor de deus, me leva para uma cesárea! Ta errada? Foi fraca? Não! Devia ter pedido a cesárea antes, coitada, porque o sofrimento que fizeram ela passar foi absurdo.

'And sometimes even in a private hospital, many women in the maternity ward. Then the doctor: 'everybody open you legs to receive an internal exam (litt. 'touch')!' Imagine! I have already heard this. You are there, vulnarable, and sometimes there even is a group of students learning. Then there are 3 people 'touching' one woman. And the touch is a painful thing, invasive, it shouldn't be done for nothing.'

E às vezes até em hospital particular, várias na enfermaria. Aí o medico: 'todo mundo abre a perna para receber toque!' Imagine! Já ouvi relatos disso.. Você ta lá, vulnerável, as vezes ainda tem turma para aprender fazer toque. Aí tem 3 pessoas para fazer toque em uma mulher. E o toque é uma coisa dolorida, invasiva, não deve ser feito para nada.

'I was treated so much better, my daughter was treated better, imagine: I can pay milions to give birth at a private hospital, but when she is in the nursery they will pass a cane through the anus of my daughter! I will be being to have my daughter be raped right after being born. How beautiful, isn't it? I didn't want that.'

Eu fui muito melhor tratada, minha filha foi muito melhor tratada, imagine: eu posso pagar milhões para parir em um hospital particular, mas quando tiver no berçário eles vão passar um cano no anus da minha filha! Eu vou estar pagando para minha filha estar estuprada recém-nascida. Que lindo né? Eu não queria.

[56] Vaginal Birth After Cesarean

Taís' previous experience (29, third child)

'With my other daughter I suffered a lot in another maternity. I didn't have any rights, they humiliated me, screamed and thew the hospital at me. I was feeling a lot of urge to push and the doctor told me: 'If you push and tear it's your problem because I'm getting ready to leave.' I cried. They almost treated me like a dog.'

Com minha outra filha sofri muito em uma outra maternidade. Não tive direitos, me humilharam, gritaram, jogaram a roupa do hospital em cima de mim. Eu estava sentindo muita vontade de fazer força e a médica me falou: 'se você fizer força e lacerar é problema seu que estou me arrumando para sair.' Chorei. Me trataram quase como cachorro.

Erica's previous experience (18, first child)

'We were waiting in antother maternity. Next to me there was a woman with contractions and pain, screaming. The doctor told her: 'what is this? All scandalous! Are you going to give birth like this? It will be natural, you know? Are you thinking it will be a cesarean? Only with an insurance, here nothing like that!' To me he said: 'and you, like to be 'fingerprinted' (get an internal exam)? Well, it is not your time yet!'

A gente estava esperando em uma outra maternidade. Do meu lado estava uma mulher com contrações e dor, gritando. O médico falou para ela: 'O que é isso? Toda escandalosa! Vai parir assim? Vai ser normal, viu? Tá achando que vai ser cesárea, é? Aí só pelo convênio, aqui nada disso.' Para mim ele disse: 'E você, gosta de levar dedada, é? Pois você não tá na hora ainda!'

Litza's heard stories

'These days it is what has happened most.. Problems with women that will give birth, 15 days ago we saw about 2 cases on television of death histories. The woman died because she arrived in a public maternity while feeling pain, they gave her a medicine and sent her back home saying that it wasn't the time yet. Then the baby died inside the belly and they had to do a cesarean to take out the fead fetus, during this 'joke' the woman also died.. There was a case in a maternity, which is considered the model of Salvador, that a woman arrived to give birth, an adolescente, and in the hall the child fell on the ground and the mother died, you understand? So it's a case of violence.'

Ultimamente é o que mais tem acontecido é... problema com mulheres que vão ganhar neném, de 15 dias pra cá a gente já teve na televisão uns dois, dois... mais de dois casos com histórico de morte. A mulher morreu porque chegou na maternidade sentindo dor, deram um remédio e mandaram ela pra casa dizendo que não tava na hora. Acabou que a neném morreu dentro da barriga e aí precisaram fazer uma cesárea na mulher pra retirar o feto morto, nessa brincadeira a mulher também morreu... Teve um caso na maternidade que...(que a minha queixa?)... é considerada a maternidade modelo da cidade de Salvador que é Professor José Maria de Magalhães Neto, que a mulher chegou pra parir, uma adolescente chegou pra parir, no pátio mesmo a... no hall do hospital a criança caiu no chão e a mãe morreu... entendeu? Então é caso de violência.

My own experience at a university maternity (excerpt from fieldnotes)

'*Depressive. Green paint falling of the walls everywhere, old floor, waiting room with space for five people but fifteen people (and pregnant bellies) waiting. Nurseries with 10 beds on one room. People talk loud, noise, sound of water flowing, narrow beds, new mothers looking at me and their babies with a helpless and lonely expression. Admission hall with five extremely narrow beds, only seperated by green plastic*

curtains allowing every move and word to be heard by everyone present. Three tiny delivery rooms. One of their doors is wide open, leaving through oppressed sounds of pain and showing five student-obstetricians looking in the direction of where the woman must be. Huge operation lights directed at her vagina, all other women in labor can hear and feel everything that is happening in there. Everything is unpersonal, doctors walk around without smiles on their faces, a horrible energy to give birth in. I can truly imagine any woman would try to avoid this.'

NOTES

[i] The three main 'myths' that they mentioned were that the CPN would not use *soro* (ocitocyns to intensify contractions and speeden up labor) or anesthesia, nor that they would give a *corte*, a 'cut' (episiotomy).

[ii] 'Focus groups represent a specific set of group interviews that particularly emphasize the interactive patterns among group members and how they come to generate mutual understandings and ideas. […] Focus groups are an excellent way to collect data on group norms and find out what is (and is not) expressed in a group context. […] Focus groups mau also be used when the communication and construction of certain knowledge is the main interest of the research. Focus groups show us in situ how people determine and/or change their point of view in terms of sources, arguments and evidence.' (Boeije, 2010:64)

[iii] 'According to DONA International, a doula is a professional who is trained in childbirth and provides continuous support to a mother before, during, and just after birth (postpartum douluas are not covered in this article). Doula comes from a Greek word that means "a woman who serves" or "handmaiden."' http://evidencebasedbirth.com/the-evidence-for-doulas/

[iv] http://www.medanthro.net/definition.html

[v] This period has been described as entailing a shift 'from viewing reproductive processes, such as childbirth, which could be facilitated through some degree of human intervention but which ultimately lay beyond human control, to viewing childbirth as something which can and should be improved upon through the application of new, scientific practices base don the study of the *laws* of nature.' (Van Hollen, 1994:13)

[vi] Even present in our course in anthropology: the mechanical display of the body as 'being on' and 'in the participant observation mode' (KOAT class 2, Geert Mommersteeg) during fieldwork, disregards the fact that social relations as much as unpredictable bodily action highly influence the way in which researchers conduct fieldwork.

[vii] In short, it could be said that Bourdieu's practice theory is 'centralized on *habitus*, unconscious behavior that is constructed and limited by an individual's previous experiences, or as Bourdieu defines it, "spontaneity without consciousness or will". In direct contrast to structuralism, practice theory believes social structures to be set forth and defined by the actions of the people, in particular *habitus*. He theorizes that, to an extent, structures also influence one's *habitus*, but only in regards to social 'norms' that have already been set forth by society. In this respect, *habitus* and institutionalization coexist in self-perpetuating cycles.' (http://anthrotheory.pbworks.com/w/page/29532696/Practice%20Theory). Later on, Ortner adds that practice theory suggests restoring 'the actor to the social process without losing sight of the larger structures that constrain (but also enable) social action' (2006:3).

[viii] Summarized, 'Biopolitics refers to how politics and government policy directly impact biological aspects of health in people's lives. Drawing from Michel Foucault, biopolitics can be understand as examining ways in which the state controls people through political power. Largely involving analysis of state power, biopolitics explores policy impacts on biological health and questions how the state governs individuals and influences their biological frameworks. A biopolitical analysis of health may also examine the political economy of health to consider how structural inequality impacts health' (http://medanth.wikispaces.com/Biopolitical).

[ix] 'Embodiment is the process in which people literally incorporate biologically, the social and material world in which we live. From a medical anthropology perspective, the concept of embodiment focuses on how social influences impact the physical body' (http://medanth.wikispaces.com/Embodiment).

[x] Emily Martin shows us how 'medical metaphors' have been used to contribute to the image of the woman as a reproducer. Notions of the female body as a 'factory', her uterus as a 'machine', the baby as the 'product', and the doctor not only as a mechanic, but 'perhaps more like a factory supervisor or even an owner' (2001 [1987]:57).

[xi] Such as her social position within kinship relationships and the broader community she lives in; the particularities of the sexual or marital relationship with the man that might become the father of her child; and a woman's personal reproductive trajectory (Van der Sijpt, 2011:203). She adds that these social configurations are not only made up out of local contexts, but also out of broader ongoing transformations – such as developments in medical technologies, state policies (in the case of Brazil such as those influenced by the 'new' humanistic paradigm of childbirth) and global economic trends (ibid.:21) .

[xii] 'That is, to make it more relational, partnership-oriented, individually responsive, and compassionate' (Davis-Floyd, 2001:6).

[xiii] Created by the European Committee in 1979 with the aim of studying interventions to reduce perinatal and maternal morbidity and mortality in the continent.

[xiv] A study that is often cited by people in the movement is the systematic review published by the Cochrane Library, 'Midwife-led versus other models of care for childbearing women' (Hatem et al. , 2008). This is a compilation of 12 randomized trials involving 12,276 women attended by midwives. The results show that these women had lower odds of hospitalization during pregnancy, receiving regional analgesia, conduct of episiotomy, having instrumental delivery, and were more likely to have spontaneous vaginal delivery, to experience a sense of control during childbirth, being attended by the same midwife and begin breastfeeding immediately. The study also found a lower risk of fetal loss before 24 weeks and shorter duration of neonatal hospitalization. The recommendation of the reviewers is that women should have the choice of models of care promoted by midwives and women should be encouraged to request this option.

[xv] These percentages from 2007 are notably higher than the maximum of 15% recommended by the World Health Organization (WHO) and exceeding the figures registered in any other country in the world. Almost half (46%) of all cesarean was scheduled in advance according to the mothers interviewed in the National Demographic and Health Survey 2006, a national survey with a representative sample of women (Victora, Aquino et al., 2011).

[xvi] In Brazil, *parto normal* (normal birth) is the most common term for vaginal birth. This is not to be confused with *parto natural* (natural birth), often understood (if not feared) as birth without interventions.

[xvii] Some milestones should be underlined. In 1985, a conference by the PAHO and WHO on appropriate technology in childbirth held in northeastern Brazil resulted in the drafting of the Letter of Fortaleza. Recommendations in this letter still constitute the main assumptions of the *parto humanizado* as framed by activists and, recently, by governmental initiatives. In 1993 the Rehuna-Network (*Rede pela Humanização do Parto e do Nascimento*) was founded for the Humanization of Childbirth, consisting of a variety of health professionals and feminist movements, which since its inception has contributed to disseminate proposals favorable to humanized birth (Diniz, 2010).

[xviii] http://portal.saude.gov.br/portal/saude/gestor/visualizar_texto.cfm?idtxt=37082.

[xix] WHO's Safe Motherhood: 'the best place for a woman to give birth is where she feels most secure.' This is a statement often adopted by humanization activists and often related to the home. However, this does not appear in *Rede Cegonha* program. Secondly, for many women the home simply is not the place in which see feels most secure.

[xx] Resolutions nº 265 and nº 266 by the CREMERJ.

[xxi] Conselho Regional de Medicina do Rio de Janeiro (Regional Counsel of Medicine of Rio de Janeiro)

[xxii] *Raça/cor* ('race/color') is a very common category found on all kinds of forms to be filled in by women for antenatal consults, admission in hospitals, etc.

[xxiii] Excerpt from an interview with Manoel, main promotor of the Rede Cegonha in Bahia: '*The Forum is made up of state representatives, maternity staff, primary care network, sanitary districts, the technical areas of the Municipal Health Secretariat of Salvador (SMS) and State Secretariat of Health of Bahia (SESAB), universities, the Public Ministry of Bahia of the class councils. Attending their monthly meetings are representatives of social movements, the state committees of Maternal and Perinatal Mortality, and residents and undergraduates in healthcare courses. Its purpose is to open spaces for the discussion of work processes, subject recognition, institutional analysis, service articulation, a more shared management. In 2010 the Rede Cegonha entered, which resulted in a larger institutionalization of this space and humanized assistance to become more debated. The proposal has become to adopt a new management method, work according to real demands, involve everyone into the responsibility of good practices, recognize insufficiencies, and implement humanized practices. The management still is very vertical, centralized, and hospitals function like isolated isles. In 2012 the Colegiado de Maternidades became the Fórum Perinatal. The proposal is to involve social movements in the meetings, however this is not being implemented yet.*'

[xxiv] 'Spiritists do not have what is commonly referred to as a church, temple, shrine, etc. In fact, Spiritism is not actually a religion per se, i.e. in the traditional sense, since there exists no hierarchical structure of authority or dogmatic practices. The place where Spiritists gather is referred to as a Spiritist Center. There, they collaborate, with one another and with spiritual benefactors, in the study, practice, and dissemination of Spiritism. Spiritist Centers operate independently, though some are affiliated with larger associations or federations that bring various Centers together for events and special initiatives related to the dissemination of Spiritism. The Centers are often (though not always) named after a historical pioneer of Spiritism, a mentoring Spirit, or sometimes a charitable quality, etc. Centers are often run by a board of directors, but these are elected positions. Such positions, as well as those involving the other work that goes on in managing the Center and organizing and running its activities are non-paid positions. The people who work in a Spiritist center and fulfill those roles do so as volunteers. A Spiritist center is more than just a place to study. It is places to pray, learn, grow, collaborate, and work for the benefit of others. It is often said that a Spiritist center is a home, a school, and a hospital, all in one. In addition to the legal and corporeal aspects of its existence, a Spiritist Centre is also believed by its members to have an informal and incorporeal level of existence in the spirit world which comprises its patron and a series of protector spirits (which may be shared by other centres in the world).' http://www.explorespiritism.com/SpiritistCenter.htm Interestingly, Eugenia Georges told me that in their research so far, she and Robbie Davis-Floyd have noticed that 40% of the obstetricians adopting a humanized view of childbirth were Spiritists. More research on the subject is needed to explore this relationship.

[xxv] In 2008, the spiritual leader of the centre received a spiritual insight that incentivized the construction of the CPN. Joana D'Angelica appeared to him and told him that, besides the daycare, primary school, secondary school and elderly homes, the Mansão do Caminho *faltava um lugar para nascer* (was missing a place to be born). After mobilizing the current director of the CPN and at that time dedicated practitioner and volunteer within the centre, an architect was contracted to construct the CPN within the norms of the Ministry of Health, large donations were received to facilitate the construction, and in 2010 meetings were organized with the Bahian Secretary of Health (SESAB) to articulate its involvement.

[xxvi] *Pré-parto, parto, pós-parto*: pre-natal, delivery and post-partum

[xxvii] From a sample of 80 women. In addition, they mention that 'despite economic constraints, women with more decision making and power in the home were more able to implement such medicalised behaviours' and 'women with more socioeconomic power at home also tended to have a cesarean section' (ibid.). These are very interesting notions, unfortunately they were not possible to investigate in this research.

[xxviii] Jordan refers to this process as 'misrecognition of her own interests' (1993:160).

[xxix] See www.birthintobeing.com

[xxx] Melania Amorim in her lecture during the course on 'Humanized assistance to labor and birth', organized by the Spiritist Centre on the fifth and sixth of october in 2012.

[xxxi] A situation of 'parallel knowledge systems' (Jordan, 1993:152).

[xxxii] If we remember the claims of correctness in knowledge systems as described by Jordan (1993) as well as by Davis-Floyd (2001), the humanistic paradigm also engages in truth-claims when it refers to Evidence Based Medicine and human rights. Nevertheless, we have to stay aware of the fact that women's desires and experiences might not 'fit' into this paradigm and therefore challenge and transform it.

[xxxiii] I have seen that it requires a lot of strength and passion to put this kind of assistance in practice in Brazil. In light hereof, Daniela Leal has mentioned 'the transformative potential of support groups for professionals in the delivery assistance, which could translate into opportunities for strengthening, exchange of experience, health promotion and psychoeducation' (2012:10).