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Review Article

Disrespect and abuse in childbirth in Brazil: social activism, public policies and providers' training

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Abstract: *Brazil is a middle-income country with universal maternity care, mostly by doctors. The experience of normal birth often includes rigid routines, aggressive interventions, and abusive, disrespectful treatment. In Brazil, this has been referred to as dehumanised care and, more recently, as obstetric violence. Since the early 1990s, social movements (SM) have struggled to change practices, public policies and provider training. The aim of this paper is to describe and analyse the role of SM in promoting change in maternity care, and in provider training. In this integrative review using a gender-oriented approach, we searched the Scielo database and the Ministry of Health's (MofH) publications and edicts for institutional and research papers on SM initiatives addressing disrespect and abuse in the last 25 years (1993–2018) in Brazil, and their impact on public policies and training programmes. We analyse these groups of interrelated initiatives: (1) political actions of SM resulting in changes in public policies and legislation; (2) events organised by SM for diffusion of information to the public; (3) MofH policies to humanise childbirth with participation of SM; and (4) initiatives to change providers' training, including legal actions based on obstetric violence reports. To promote real change in maternity care, the progression of policies and enabling environment of laws, regulations, and broad dissemination of information, need to go hand in hand with changes in all health providers' training – including a solid base in ethics, gender and human rights.* DOI: 10.1080/09688080.2018.1502019

Keywords: Human rights, gender, evidence-based health care, maternity hospitals, medical education, sexism, disrespect and abuse

Introduction

Maternity care in Brazil

Brazil is a middle-income country with a universal healthcare system, where 98.4% of births occur in health institutions with the assistance of trained health professionals, 85% of them obstetricians.[1,2] In 2013, the maternal mortality rate was 69.0 deaths per 100,000 live births (stagnant, comparing to 70.9 in 2001) and the country did not manage to achieve the Millennium Development Goal related to maternal health.[3] There are more than 63 million women of reproductive age[2] and although there are programmes for contraception, mostly based on hormonal methods, over half of pregnancies are either unplanned or mistimed.[4] Abortion is illegal except for pregnancies that put the mother's life at risk or those that result from rape.[1] While virtually all women attend antenatal consultations, 61.8% of them have at least seven prenatal visits.[2] Little attention is given to information and educational groups to empower women to make informed choices regarding pregnancy and childbirth.[5]

The Birth in Brazil national survey in 2012 showed that "aggressive management"*[6] with excessive intervention was the norm, such as

Aggressive management is a "native" term used by some medical authors to refer to interventions in early labor (amniotomy, oxytocin augmentation, etc.) reportedly aimed to shorten labor and prevent dystocia.[6]

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high rates of episiotomy (53.5%) and uterine fundal pressure (36.1%), besides the fact that almost all women (91.7%) gave birth in the lithotomy position.[4] Cesarean-section is more frequent than vaginal birth: in 2015, the rate was 55.5% of all live births.[2] In birthing facilities across the country, oxytocin to induce or augment labour, frequently repeated vaginal exams, restriction of food and fluids, excessive manipulations of the cervix, amniotomy, and restriction to bed are frequent.[4] Lack of privacy and prohibition of companion of women's choice during labour and birth admission are common, despite the presence of a federal law that has guaranteed this right to women since 2005.[7] A national survey on gender relations in 2010 showed that around 25% of women in labour were submitted to threats and verbal violence,[8] with mixed-race or black women, women with lower education, and those who were attended by the public sector reporting more verbal, physical or psychological abuse.[8,9]

There are differences in the organisation of care between geographical regions, and in addition to the public, universal health system (sole source of care for 70% of the population), there is a private sector (Health Maintenance Organizations – HMOs), which is poorly regulated, where the excess of obstetric interventions is the norm and the C-section rate is around 86%.[4] Reflecting this reality, in training hospitals the model of childbirth care tends to be highly medicalised, with little sensitivity to psycho-social aspects of care and little adherence to evidence-based guidelines regarding women's privacy, bodily integrity and physical comfort. This model is still more evident in university training hospitals – the privileged locus of production and diffusion of training and scientific knowledge.[10]

The social movements to humanise childbirth care

In Brazil, social movements for change in childbirth began in the 1980s, galvanised by feminist groups, alternative health practitioners, health reform activists, public health officials, and others, that in 1993 formed the Network for the Humanization of Childbirth (ReHuNa). In its founding letter (1993), ReHuNa recognised the "circumstances of violence and constraint in which assistance is provided".[11,12] However, the organisation has deliberately declined to speak about confronting violence, favouring terms such as "humanizing childbirth" or "promoting women's human rights", to prevent the hostile reaction from providers that accompanies the use of the word violence.[11] In recent years, many other networks have been denouncing mistreatment and low quality of care,[13,14] and the popular media have presented the matter as a relevant social problem that must be addressed as a public health issue.[†] Social movements, dissident providers, academics and public policy officials have also created mutually influencing networks where sometimes the same individuals can move freely between different professional/social identities, helping to disseminate innovative concepts and initiatives.[11]

These movements understand that Brazil's highly medicalised model of care is designed to meet providers' and institutions' needs, rather than women's bio-psychosocial needs.[7] In having a vaginal birth according to this model, a woman's experience is undermined and made more negative than it could be, as she faces preventable suffering such as the iatrogenic pain resulting from unnecessary interventions, the loneliness of being deprived of a companion, and the emotional indifference of providers; these feelings of sorrow and helplessness confirm the idea of childbirth and motherhood as sacrifice and agony.[11,15–18] Many women accept C-sections, even when unnecessary and unwanted, because vaginal birth, in a typical health service, can be lived as a threatening experience, physically and emotionally.[7,19] Although abuse can happen in any phase of childbirth, empirical research indicates that it is more strongly associated with going into labour (because of its aggressive management – augmentation of contractions with oxytocin, liberal use of episiotomy, fundal pressure and others).[9] C-section is seen by many women as a shortcut to escape from labour and to preserve their dignity, and a way to defend themselves from abuse and disrespect.[7,9] In the last ten years, the term "obstetric violence" has been used to refer to such violations, inspired by the Venezuelan and other Latin American countries' laws that define it as a form of violence against women.[5,20] This change in rhetoric was brought about by new women's groups and legal professionals that joined these networks.[11]

[†]Magazines, newspapers and TV shows have substantially portrayed the problem, as can be seen, for example, in http://apublica.org/2013/03/na-hora-de-fazer-nao-gritou/ and http://justificando.cartacapital.com.br/2017/07/26/mercantilizacao-da-saude-e-violencia-obstetrica/.

Gender and policies to promote respectful maternal care: the challenge of providers' training

Although in the last decades there has been major progress internationally in the understanding of birth physiology, evidence-based and respectful care, with progressive guidelines for change such as the WHO recommendations,[21] medical knowledge and training is highly influenced by gendered concepts that reinforce misogynistic ideas of women's bodies needing correction and control.[11,16] Some of Brazil's most important obstetrical textbooks and medical authorities have reinforced the idea that vaginal birth is unacceptably painful for the mother and risky for the baby, as well as a threat to women's pelvic continence and sexual attractiveness.[15,19] C-section is thus presented as a superior alternative, liberating doctors and women from their unpredictable, primitive and distasteful physiology.[19–22] Health professionals usually declare that women share these views and request a C-section before or during labour; however, studies do not corroborate this statement.[23] Besides that, 46.6% of women who desire a C-section cite the fear of pain as a reason,[23] which is understandable, considering the aggressiveness of management and the iatrogenic, additional pain of unnecessary interventions.[4] On the other hand, in a system with so many problems, typical health professionals, especially obstetricians, argue that they are themselves the victims, considering the health system's deficiencies, birthing facilities' lack of appropriate infrastructure, women's demands upon them, and low payment, as forms of violence against them.[‡]

Since the 1990s, the movement for change addressed how providers' training, especially medical training, resists following the recommendations for innovation in practice to adopt respectful, rights-based, evidence-based approaches to maternity care.[11] There is a semantic dispute around the terms used (humanisation of childbirth, obstetric violence, disrespect and abuse in childbirth, etc.), which can facilitate or hinder the dialogue between different stakeholders, and new alliances that need to be formed between social movements and policy makers in order to promote and mainstream change in practice and in training. In this context, the aim of this paper is to describe and analyse the role of social movements in influencing and mainstreaming innovative, respectful, evidence-based public policies for maternity care and providers' training in Brazil over the last 25 years.

Methodology

This research adopted a mixed study design that included: an integrative review[24] about public policies, social movements and teaching in obstetrics for medical students; search on the Ministry of Health databases; search on the internet; testimony of key-informants; and case studies.

The guiding question of the review was: "what is the impact of social movements (for the humanization of childbirth, on abuse and disrespect) on the implementation of change in public policies in maternal care, including those policies for health providers' training, in Brazil?" We searched the literature in the Scielo (Scientific Electronic Library Online) database,[§] to identify studies related to the topic, without temporal or language limitation. The search included three components: (1) social movements in the women's reproductive health field, combined descriptors "social movements" or "social participation" with "health" and "women"; (2) public policies, combining "policy" or "health policy" or "public policy" with "childbirth", "tocology", "childbirth care", "obstetrics", "obstetric violence", "humanization" or "humanized childbirth"; (3) professional training, combining "training" or "professional training" or "teaching" with "childbirth", "tocology", "childbirth care", "obstetrics", "obstetric violence" or "humanized childbirth". This strategy identified 358 studies, 325 after excluding duplicate studies. We excluded 308 studies, since they were not related to childbirth or abortion care or were not original research. Hence, 17 studies were selected for deeper analyses and were read by two independent researchers. After critical analyses, five studies were considered for analyses,[20,25–28] and a further three studies[7,29,30] were added after handsearching the included studies' references and consulting experts. These papers were analysed using a gender perspective and organised chronologically, and thematically regarding their contribution to the changes identified. A gender perspective is

[‡] http://www.sggo.com.br/sggo/download.php?c=305 and http://portal.cfm.org.br/index.php?option=com_content&view=article&id=26869:2017-04-20-14-19-15&catid=46.

[§] http://www.scielo.br

one that distinguishes between biological and social factors while examining how they interact, taking into account how inequality affects health experiences. It further provides guidance for identifying the appropriate responses by the healthcare system and public policy.[31] This information was the basis for additional searches of governmental databases and web searches on governmental and non-governmental initiatives to confront the problem of obstetric violence; results were then mapped by initiative.

Hence, a thorough search of the Ministry of Health (MofH) edicts and publications was made to identify all federal initiatives in the field of humanisation of childbirth and reduction of excessive interventions, adopting the last twenty-five years as a timeframe, based on a previous publication.[32] This timeframe took into consideration that the public health care system underwent major development from 1990 and that the first public initiatives regarding humanising childbirth care were published in 1998.

Some of the authors have followed these developments since the 1990s, either the governmental actions, initiatives stemming from social movements and academic groups,[11] and including initiatives have not been published elsewhere. Therefore they were considered key informants who could report on these actions, and their contributions were taken into account to explain the historical context and to structure the timeline.

Furthermore, we used two case studies that oriented legal action and reinforced the need to include gender issues and human rights on providers' training: (1) the report to the Office of the Public Prosecutor of São Paulo, from a woman having had two episiotomies in a training hospital,[20] and (2) the report of the Office of the Public Prosecutor of the Federal District, concerning the denunciation of a medical student who witnessed obstetric violence in a teaching hospital.[33]

Results

Table 1 presents the political initiatives of social movements, many of them successful in triggering related policies, both for the public and private sectors, or laws.

The first initiatives sought the support of the Brazilian Association of Public Health Congresses, where many activists were affiliated. Since these petitions were signed by a large number of participants from these congresses (1997 and 1998) and approved in the final plenary, the Brazilian Association of Public Health (ABRASCO) endorsed them and forwarded them to the Ministry of Health as their own. These were the start for some edicts, from 1998 through 2000 that introduced some demands of the social movement: care assisted by obstetric nurses; acknowledgement of services with good practices (Galba de Araújo Award), and the Program for Humanization of Prenatal and Birth Care, that was intended to guarantee quality in antenatal care (a minimum of six visits, exams, vaccines, postnatal visit and group orientation), as well as guaranteeing a hospital bed available for admission.

The first federal law regarding humanisation of childbirth, Law n° 11,108/2005 – guaranteeing a companion during labour, birth and in the post-natal period – was also an initiative of the social movement.

Since the 1990s, the Brazilian Network for the Humanization of Childbirth (ReHuNa) has been the leading organisation of activists. In 2006, women users of the private sector organised themselves in a network (*Parto do Princípio – Mulheres em Rede pela Maternidade Ativa*) to work against excessive C-sections and for the right to a vaginal birth in the private sector. The C-section rate for the private sector was 85% at that time. Since then, other organisations have been founded all over the country, focused on local and regional action, apart from Artemis (founded in 2013), an organisation with lawyers that helps women nationally to prosecute and defend themselves in processes linked to violence in obstetric care.

The private sector

Particularly resistant to any regulation, the private sector had a C-section rate above 80% in 2007. The women's network *Parto do Princípio,* through the Public Prosecutor, has focused efforts on the excess of C-sections and the poor treatment of women who searched for a normal birth experience in this sector. As a result, the ANS, an agency that regulates the private sector, launched in 2015 the *Parto Adequado*** (Adequate Birth), a pilot project including 35 hospitals. Participation in this programme is encouraged but voluntary, and involves innovations to include nurse-midwives for normal births and more woman-friendly protocols. An evaluation in November 2016 showed that these hospitals had performed about 10,000 fewer

**http://www.ans.gov.br/gestao-em-saude/projeto-parto-adequado

Table 1. Political initiatives of the social movements, Brazil, 1993–2018

Year	Organisation	Action	Effect
1997 + 1998	ReHuNa[a]	Petitions endorsed by 315 participants of the 5th Brazilian Congress of Public Health (1997) and by 285 participants of the 4th Brazilian Congress of Epidemiology (1998) demanding a public policy on humanisation of childbirth (1997) and training of professionals on humanisation of care (1998). The Brazilian Association of Public Health endorsed them and presented these demands to MofH	Creation in 1998 of the *Galba de Araúdo Award*, the first accreditation to promote humanised, woman-friendly, evidence-based maternal care; In 1998 the MofH published an edict acknowledging payment for births attended by obstetric nurses; In 1999, the MofH started courses of specialisation in Obstetric Nursing, contracting federal universities; In 2000, the MofH launched the Program for Humanization of Prenatal and Birth Care
1998–1999	ReHuNa	Alliance with state representative of São Paulo State	São Paulo State Law 10,241 that guarantees patients' rights, among them a companion during prenatal care and birth
2002	ReHuNa	Alliance with state representative of Santa Catarina State	Santa Catarina State Law N° 12,133/2002 that guarantees companions to women during labour and birth
2003	ReHuNa	That Santa Catarina State representative was elected to the Senate and proposed the same law project	Federal Law N° 11,108/2005, guaranteeing a companion during labour, birth and in the postpartum period. Other states also edited their laws during this period
2006	*Parto do Princípio*	Demand in the Public Prosecutor Office against the excess of C-sections in Brazil. There were public audiences in 2007, 2014 and 2015	Normative Resolution N° 368/2015 of the Regulatory Agency of the Supplementary Sector (ANS), defining: women with health insurance should receive their prenatal care records; their birth record should have a partograph; and hospitals and obstetricians in the private sector should publicise their C-section rates. In 2016 ANS launched the programme ***Adequate Birth***, designed to reduce C-section rates in the private sector
2010	*Parto do Princípio*	Denounced to Public Prosecutor violation of Federal Law N° 11,108/05	In some States, maternity hospitals had to commit to complying with the law
2011	*Parto do Princípio*	Participated in municipal, state and national women's policy conferences	Four motions related to childbirth assistance approved, one for eradication of institutional violence in obstetric care
2012	*Parto do Princípio*	Prepared a dossier on obstetric violence presented to the Joint Parliamentary Committee of Inquiry on violence against women	Denunciations and claims were included in the Joint Committee's final report, to contribute to governmental actions addressing violence against women

(*Continued*)

Table 1. Continued

Year	Organisation	Action	Effect
2013	Activists + *Casa da Borboleta*	After prohibiting women breastfeeding in public sites in the city of São Paulo, they organised a *mamaço*, a collective action of women breastfeeding in public sites. Alliance with state and municipal legislators	São Paulo city Municipal Law N° 16,161/2015 and São Paulo state Law N° 16,047/2015, that proposes a fine for establishments that hinder breastfeeding
2014	Artemis Women's Network	Alliance with Federal Representative: organised a seminar in the Federal House of Representatives, "Faces of Violence against Women" and proposed Law Project N° 7,633, that guarantees humanised care in childbirth and defines obstetric violence	The project is still under discussion
2014	ReHuNa + ADDF[b]	Alliance with Federal District Representative: law project guaranteeing humanised care, doulas, companions, and defining obstetric violence	Became Federal District Law 5,534/2015
2014	*Parto do Princípio*	In Pará state, training on obstetric violence for women's rights NGOs, Human Rights Defense Center's prosecutors, Order of Attorneys of Brazil section and health professionals	Sensitisation of diverse actors on obstetric violence and violence against women; legal actions were taken against hospitals that did not respect the legislation regarding companionship
Since 2014	Activists, mostly doulas	Alliances with local and state politicians proposing laws that guarantee doulas during labour and birth	There are about 60 state and municipal laws guaranteeing doula care for childbearing women
Since 2014	*Parto do Princípio*	Was elected to participate in the National Council of Women's Rights	Sensitisation on obstetric violence and change in the Call 180 – Women's Hotline for Gender-based Violence, to receive reports on obstetric violence, mainly in childbirth and abortion care

[a]ReHuNa: The Brazilian Network for the Humanization of Childbirth.
[b]ADDF: Doulas Association of the Federal District.

surgeries. ANS then launched the second phase, now reaching 150 hospitals.[5]

In Brazilian legislation, there are specific mechanisms that can be instigated when violations are identified. In the last decade, with the increased visibility of women's rights in health care institutions, initiatives by women's movements led to the organisation of Public Audiences at the Public Prosecutor's office (there were audiences in most states, not shown in Table 1), to confront several issues linked to the poor care women received in childbirth, including obstetric violence, the abuse of interventions, and "mandatory" or "universal" C-sections in the private sector.[11,20] At these hearings, social movements argued that the persistence of uncritical teaching in training services of painful and unnecessary interventions reflects teaching values that attribute predominance to health professionals (mostly white, upper-middle-class students), while violating women's (mostly black and low income) rights. For example, in practice, it was taught to future providers that patients have no right to informed choice or refusal, and that the training needs of the trainees are more important than the autonomy or the bodily integrity of the women in labour.[20]

Violence in health institutions and social movements against gender-based violence

In São Paulo, these hearings happened at the same time as the organisation of a network of students

and female professors to fight against sexual violence within the university, tackling the impunity of the aggressors and the re-victimisation of those who denounce it. The problem of violence within the university was taken to a public audience in the state House of Representatives, and important media coverage led to a legislative enquiry on all forms of violence in the Universities of São Paulo State, leading the Public Prosecutor to impose regulatory actions upon the Universities to stop gender-based violence – including those committed during medical training.[34]

Women's movements have been responsible also for spreading information, which has gained media attention, about evidence-based practices, humanisation of childbirth as a women's human rights issue and related topics since the early 1990s, as is shown in Table 2. The International Conferences on Humanization of Childbirth connected the international and national movements, contributing to wider dissemination of information about humanised childbirth care, and the formation of the Latin American and Caribbean Network for the Humanization of Childbirth (Relacahupan) in 2000.

These social movement activities succeeded in making the expression "humanized childbirth" accessible to the general public, contributing to the emergence of other NGOs, bloggers, Facebook groups, film-makers and humanised childbirth care consumers. The emergence of international meetings like Siaparto – a yearly symposium that brings together about 1,500 participants, with national and international speakers at the forefront of physiological, women-friendly care in childbirth – helped disseminate this agenda to mainstream providers. The crowdfunding campaign for the documentary "Birth reborn" (2013) surpassed its target in three weeks (the deadline was three months), and was exhibited in movie theatres for 22 weeks, with record audiences.[35] As the movement grows, it spreads the concepts of humanised childbirth as a woman's right, leading to more public policies and social activism, such as the film shot by activists and accessible online: *Violência obstétrica – a voz das brasileiras* (*Obstetric Violence – the Voice of Brazilian Women)*.

Although there were sparse previous federal initiatives for change, such as the Baby Friendly Hospital Initiative (1991), it was from 1998 on that the MofH began to launch edicts to influence the way childbirth care was being provided, as is shown in Table 3. A turning point occurred in 2000, with the above-mentioned Program of Humanization of Prenatal and Birth Care proposing a major restructuring of the care system, besides providing funding for such a structure. Another turning point was the launching of the Stork Network in 2011, a convergence of all previous policies that intends to change countrywide the interventionist and non-evidence-based model of care to a woman-friendly multi-professional (including midwives and nurses) humanised approach that adopts evidence-based and respectful practices, besides organising the health care network to make sure all hospital beds are available for all women in labour. This programme also received a considerable amount of funding, together with a decision to invest in birth centres under obstetric nurses' care and management.

Another development was the publication of the guidelines for normal birth and C-section. With the participation of all the stakeholders – government, professional societies, scientific societies, women's organisation representatives and other partners – these guidelines had an elaboration team and every development was discussed with the stakeholders. Guidelines on C-section issued in 2015 were intended to prevent abuses[36] and the guidelines on normal birth in 2016,[37] clearly included a woman-friendly, respectful care approach.

The Brazilian Ministry of Health has invested in more in-service training and campaigns for health providers in this period, as shown in Table 4. The training of obstetric nurses is meant to change the model of care. The Seminars on Humanized and Evidence-Based Obstetric and Neonatal Care, held in the period 2004–2006, were a huge effort that involved 457 health services, state and municipal administrations and 1857 health professionals. However, an analysis of the later C-section rates of these hospitals, by state, showed a stable or upward trend, questioning the effectiveness of such training.[38] The campaigns in the media, since their duration is limited, had almost no effect. The Advance Life Support in Obstetrics (ALSO) training managed to influence the maternal mortality ratio, but not C-section rates. Since 2009, the MofH has invested more in changes to the model of care, including the organisation of the Stork Network, to guarantee hospital beds and reduce the shortage of maternity beds.

Making disrespect and abuse visible in providers' training

The importance of these initiatives was highlighted when, in a public audience about obstetric

Table 2. Meetings organised by social movements for diffusion of information, Brazil, 1993–2018

Year	Organisation	Event
Since 1992	*Instituto de Ioga e Terapias Aurora*	Empowering women to fight the system and find alternatives; Yearly Meetings on Conscious Pregnancy and Natural Birth – Rio de Janeiro
1996, 1999	GENP[a]/ ReHuNa	I and II Seminars on Childbirth in São Paulo State; biannual bulletins on evidence-based childbirth practices
1997	*Grupo Curumim*	Seminar, Campaign "Humanized birth, think about it!"
1999	GENP + ReHuNa	Campaign for the companion of choice during labour and birth
2000, 2005, 2010, 2016	ReHuNa and partners	International Conferences on Humanisation of Childbirth: I – Fortaleza; II – Rio de Janeiro; III and IV – Federal District
2002, 2004	State University of Rio de Janeiro and partners	I and II Congresses on Ecological Childbirth – Rio de Janeiro Meeting of doulas and companionship movements
2003	ReHuNa	Campaign to abolish routine episiotomy, with policy makers and training institutions
Since 2009	*Parto do Princípio* and partners	Yearly exhibition of photos of normal births during International Week for Respecting Childbirth, coordinated with European Network of Childbirth Associations (ENCA)
2011 to 2014	ReHuNa	2 Seminars on Humanised Care, several Workshops on Soft Technologies for Birth (doulas, ambience and companion), in the Federal District and nationally
2012	Group of bloggers	Connected via social media, filmed the documentary "Obstetric Violence – the voice of Brazilian Women". Launched on November 25th for the "16 days of activism to end violence against women". Best film award in the *Fazendo Gênero* Congress on Gender in 2013. Raised awareness on this issue
2013	Activists	Filmed the documentary "Birth reborn", a harsh critique of Brazilian obstetric care, was exhibited for several months at cinemas, reaching an audience that would not be sensitised by the movement otherwise
2013	Artemis	Elaborated folder explaining the meaning of Obstetric Violence
2014	*Parto do Princípio*	Publication of two booklets (on obstetric violence and episiotomy), used in awareness-raising activities with health professionals, activists and women
Since 2014	Activists	Yearly Siaparto – International Symposium on Childbirth Care, foremost specialists on evidence-based, rights-based childbirth care, including both normalcy and complications
Since 2014	Artemis	Courses for Public Defenders, health professionals and women about Obstetric Violence. Distribution of material that explains what obstetric violence is about

(*Continued*)

Table 2. Continued

Year	Organisation	Event
Since 2015	Santa Catarina State House of representatives	Yearly National Congresses on Humanisation of Childbirth, to contribute to elaboration of laws
2017	Unicef + ReHuNa	Campaign *Quem espera, Espera!*[b] ("One who is expecting should be patient"), to reduce iatrogenic pre-term births

[a]Study Group on Childbirth (Grupo de Estudos sobre Nascimento e Parto).
[b]http://www.quemesperaespera.org.br/.

violence in 2014, a black undergraduate student presented a very disturbing testimony: in a university hospital, she received two episiotomies at birth, one on either side of her vulva. She reported hearing a preceptor say to two students: ***you cut at the right and the other at the left side***, so that both would have the opportunity to train to cut and suture in her vagina.[20] In this case, as in other settings, students were expected to perform a certain number of procedures to complete their training, regardless of clinical indication, so this double episiotomy was supposed to "optimize" the training opportunity. This case was a turning point, establishing accountability mechanisms by the Public Prosecutor in São Paulo for cases of obstetric violence.[20]

After that, in the Federal District, a medical student denounced anonymously to the Public Prosecutor his observance of obstetric violence in teaching hospitals. The report of the Public Prosecutor defined actions to be taken by the hospital, the Federal District Health Secretariat and the School of Medicine, to include obstetric violence in the formal curriculum.[33]

The recognition that training services are resistant to change, and their importance in training future health care providers, to incorporate both evidence-based as well as rights-based maternal care, led to the MofH launching of the programme *Apice – ON* (Obstetric and Neonatal Upgrading and Innovation in Care and Teaching), in August 2017. Involving 96 teaching hospitals in Brazil, its main objective is to qualify processes of care, management and education regarding childbirth and abortion in hospitals with teaching activities, adopting a model of evidence-based practices, with humanisation, safety and underlining explicitly the importance of guaranteeing women's rights.[††]

[††]http://portaldeboaspraticas.iff.fiocruz.br/apice/.

Discussion

The shift from a technocratic and interventionist model of care to a humanistic one is arduous and slow. In Brazil, since the 1990s, the social movement has had an important role in triggering the first changes and was successful in seeking the partnership of the MofH, since the spread of evidence-based and humanised care requires public policies to become nationally available. There were quite a few initiatives, some more successful, such as the Stork Network, and some less, such as the Seminars on 'Humanized and Evidence Based Obstetric and Neonatal Care' that had almost no effect. However, if we consider the need to build up knowledge that influences attitudes and practices, they were necessary in that period. The process of change is very complex and one of the main resistances comes from the academic sphere. The existence since 2017 of an explicit public policy in the form of the Apice-ON programme, which aims at changing the model in teaching and university hospitals, in our opinion distinguishes Brazil from other settings, and holds much promise.

"Humanization" and the prevention of mistreatment

Included in the agenda for change proposed by ReHuNa and other social movement campaigns in the 1990s, and in their participation in governmental initiatives, were: the inclusion in the care teams of midwives and nurses in charge of normal births; the right to companions at birth; freedom of position during labour and delivery; the right to eat and drink if desired, non-pharmacological pain relief methods for all (and pharmacological if necessary); the end of verbal abuse; preserving women's bodily integrity by preventing invasive interventions (episiotomy, forceps, C-sections); waiting for term deliveries; skin-to-skin contact

Table 3. Ministry of Health policies related to humanisation of childbirth, Brazil, 1993–2018

Year	Policy/Edicts[a]	Content
1995	Safe Motherhood Program	Partnership with PAHO, UNICEF and Febrasgo to reduce aggressive management of labour and birth
1998	2815	Authorises payment of delivery care by obstetric nurse in Universal Health System (SUS) to reduce aggressive management of labour and birth
1998	2816	Defines limit of 40% C-section rate for reimbursement to hospitals (progressive reduction till 30% in 2000) in SUS
1998	2883	Institutes Prize Professor Galba de Araujo for public maternities with good practices, one for each region; acknowledgement for humanised, evidence-based obstetric and neonatal care
1998	3016	Institutes programme to organise state references for high-risk pregnancies in SUS, reducing aggressive management
1998	3477	Creates high-risk pregnancy programme in SUS
1999	985	Creates Birth Centers programme in SUS to reduce aggressive management. Updated in 2013 and 2015
2000	466	Creates Pact for the Reduction of C-section Rate in SUS
2000	569, 570, 571, 572	Creates Program for Humanization of Prenatal Care and Childbirth (PHPN) in SUS: perspective of citizenship, rights to prenatal and hospital childbirth care, financial incentives to municipal health secretariats to provide care, support to purchase equipment, adequacy of ambience, organisation of call centres for referrals and other structural developments
2005	1067	Institutes National Policy for Obstetric and Neonatal Care
2009		Program to Reduce Infant and Maternal Mortalities in the Legal Amazon and the Northeast in SUS. Program to Qualify Maternities
2011	1459	Institutes the Stork Network in SUS, a programme to induce change in the models of care and management of health services and health systems. Emphasis on birth centres and obstetric nurses delivering care. Created committees of specialists, of social mobilisation, of campaign for normal birth to support the MofH action. Created **Perinatal Forums**, a monthly meeting with managers, providers, social movements representatives in the states and capitals to discuss and support the local policies and actions
2014–2017	Vaginal birth and C-section guidelines	Based in the NICE protocols and using Adapt methodology, guidelines were elaborated with the participation of experts, professional corporations and social movements
2018	Careful birth	Programme launched on March 8th, similar to the *Adequate Birth* program of ANS

[a]Numbers refer to edicts of that year.

Table 4. Campaigns, seminars and training organised by the Ministry of Health, Brazil, 1993–2018

Year	Partners	Event
1999	Federal Universities	Specialisation in Obstetric Nursing for Nurses (previously, only MDs were supposed to be authorised to assist births
Since 2000	Programme "Working with traditional midwives"	Includes publications and training of traditional midwives
2002	University of Campinas	Seminar "C-section: evaluation and proposal for action"
2004–2006	National and international organisations	30 Seminars "Humanized and Evidence Based Obstetric and Neonatal Care". All states and FD
2003–2005	Doulas program	Training of community voluntary doulas in 10 states
2006 + 2008	Campaigns in the media	2006: to publicise law about companion of choice at birth. 2008: about normal birth
Since 2009	ALSO	Training on Advanced Life Support in Obstetrics in several states, to reduce inappropriate clinical management
Since 2009	Hospital Sofia Feldman	Training of health managers and health professionals on new model of care and of management. Visit to model collaborative centre
Since 2013	Federal Universities	Specialisation in Obstetric Nursing, Residences in Obstetric Nursing, Upgrading for obstetric nurses out of practice
Since 2017	Federal University of Minas Gerais	Project *Apice ON* – Upgrading and Innovation in Teaching and Care – Obstetrics and Neonatology. 96 Teaching Hospitals

after birth; and others. This agenda precedes and overlaps with the initiatives addressing disrespect and abuse that emerged in recent years, and was catalysed by the intense dialogue among social movements, providers, researchers and policy-makers. In the first period, instead of denouncing violence, it was believed that it was more effective for change to be constructive, borrowing the authority of the scientific discourse of evidence-based maternal care.

It was more strategic to say, for instance, that "the systematic review showed several improvements in maternal and neonatal outcomes for those having companions" than that "depriving women of their companions was cruel, harmful and a violation of their dignity and human rights". Many systematic reviews, organised as the "World Health Organization recommendations" in 1996, were extensively used to orient training programmes and to support changes in practice, policy and legislation. After over 20 years, the innovative "2018 WHO recommendations: intrapartum care for a positive childbirth experience"[39] holds promise in terms of using international guidelines to inspire change, now openly focusing on women's rights to a positive experience in childbirth – not only to surviving childbirth.

Women's rights violations in training settings

It is intriguing that training hospitals can be the most resistant to these innovations. One of the possible explanations is that, traditionally, training services used to trade-off the assistance they provide, for having access to women's bodies (basically those poor, black and public-system dependent), to supply the training needs of their students and residents. This tradition comes from the times before the universal right to health (1988), when the poor were not entitled to any form of care, relying solely on philanthropic and religious services, and persisted after the creation of the Universal Health System (SUS), particularly for women

belonging to the most vulnerable groups, such as black and with low income.[20]

In the Public Hearings about women's rights in childbirth in recent years, reviewing the care usually provided and disseminated in teaching programmes, social movements suggested that these rights were violated when there was: an excessive ("liberal") use of non-evidence-based, potentially harmful procedures without considering adverse effects on mothers and babies; as well as the interventions performed without the patient's authorisation (and even regardless of oral or written refusal of the intervention); for the purpose of training surgical techniques, such as "didactic" episiotomies and forceps, such as the double episiotomy reported above.[20] Although we have robust evidence since the 1990s that the routine practice of episiotomy results in more harm than benefit, "the majority of obstetricians, even those responsible for medical education, cannot abandon it, since it was taught them in the university benches and they got used to it".[40] According to Vilela,[10] based on the Stork Network Ombudsman Research, episiotomy was more frequently used in university hospitals. These hearings and the cases ignited a change in reporting of interventions used in training services, with the creation of new accountability mechanisms to prevent abuses.[20]

Gender violence in medical training – the hidden curriculum

The hidden curriculum consists of a set of informal influences and experiences that comprise the cultural, organisational, ritual, emotional and professional dimensions that can shape students, and the establishment of their professional values.[25]

In the last decades, medical schools have been urged to include humanities, ethics, human rights and patient-centred care in the syllabus, and the guidelines launched by the Ministry of Education in 2014 are clear in stating: "Art. 29. The structure of the Medical Graduation Course should: […] III – include ethical and humanistic dimensions, developing, in the student, attitudes and values oriented towards active multicultural citizenship and human rights".[41] However, the few studies published about this goal have shown that despite the inclusion of some new disciplines, the "humanization" content is still rather theoretical and undervalued,[42] and lacks integration in hospital practice, where doctors still perform in such a disrespectful way that many students fail to find a good example to follow.[43] It is also shown that gynaecologists are more resistant to integrate this content than other specialists.[42,43] Fortunately, the new importance given to ethics and to the quality of the patient-doctor relationship is spreading in medical schools around the country, with training focusing more on empathy, ethics and humanisation.[44]

Gynaecology and obstetrics are medical specialties that historically consolidated medical control and subordination of women's bodies and sexuality.[15,45] Studies about medical training in Brazil and Latin America[26,46] show the use of violence as a "pedagogical tool". Castro[46] shows how an authoritarian medical habitus is built and consolidated during training, based upon the hierarchical system of the profession, gender inequality, and the use of punishments, public humiliations, submission and coercion. Those practices are part of a hidden curriculum, underlying the formal one.[46] De-humanisation as part of undergraduate medical training is also highlighted by Hotimsky,[26] not just in the student-professor interaction, but in the teaching of care practices, especially in the gynecology/obstetrics field.

According to Hotimsky,[26] the value given in medical undergraduate training to technical/scientific knowledge and the devaluation of care in gynecology and obstetrics, result in a trivialisation of patients' pain and suffering. This process includes the use of technical language and jargon aimed at peers and excluding women from the conversation; clinical interventions based on moral judgements and gender stereotypes; and use of obsolete interventions, regardless of recommendations for their discontinuation. When taken as an object for medical intervention, women have their subjective experience and autonomy annulled by the reproduction of gender-based violence that appears as "necessary intervention", "good practice", or even harmless humour, making violence invisible in the daily hospital practice.[47]

The resistance to change is also related to the expectation of maintaining a social structure marked by race and income inequalities. In Brazil, only 58.5% of the population between 18 and 24 years old go to college. While among whites this proportion is 71.4%, for blacks it is only 45.5%.[48] Although there is a discussion about the need for racial and social quotas in public educational institutions, the main universities of the country resist establishing such affirmative policies. Hence, every year many white students get their degree, trained

in teaching hospitals that care for public sector users that are, as a majority, non-white women coming from the more disadvantaged social layers.

This use of violence as a pedagogical tool is also enacted in the relationship with patients, teaching them "how to behave". In this logic, women should comply during labour by obeying and submitting themselves to the medical commands, since doctors are considered the real protagonists, based on their technical and moral authority.[47] Going into labour and having a vaginal birth is associated with greater chances of reporting abuse; this may help to explain why women in the public sector report more violence, as in the private sector the most frequent experience is a pre-labour, elective C-section.[9]

The growing visibility of the movement against "obstetric violence" (whether using these terms, "disrespect and abuse" or the initiatives to promote "humanization", "adequate birth", "safe birth" or others) has led to the recognition of the need to change health providers' training, and the understanding that to achieve the technical dimensions – safe, effective, evidence-based care – the component of women's rights in health care is inseparable. The WHO statement "Prevention and Elimination of Abuse, Neglect and Ill-Treatment during Childbirth in Health Facilities"[49] and other documents from official health agencies consolidate this international recognition, as well as the creation of the International Mother-baby-friendly Birthing Facility Initiative[50] by the WHO and other institutions, reinforcing its importance as a global problem, and the need for interventions for its control and prevention.

Conclusions and recommendations

There is a synergy of social movements and MofH initiatives pushing towards more respectful and evidence-based maternal care in Brazil. Slowly, but consistently, new alternatives are arising for women seeking a more comprehensive, humanised and safe childbirth. However, university hospitals are among the most resistant locus for the needed change, in spite of their importance to form new generations of professionals capable of uniting ethical and scientifically-based care. This is paradoxical because the common understanding would be that change needs to start through training, and medical schools should be more advanced in terms of scientific knowledge and best practices. However, the inertia within big institutions, the difficulty of integrating and translating into practice human rights and gender perspectives in medical care, the ownership and control of knowledge and practice around labour by doctors, and even the widespread and hidden gender-based violence within universities (against female students, other professionals and, in some degree, professors too) make progress more difficult in the very places that should be the first to innovate and promote needed changes.

Innovative actions are needed to make visible, prevent and confront violence against women in health-care institutions, in the public and private sectors, and in the training of health providers. This agenda needs a joint action that will bring together governmental agencies, professional boards, civil society, universities and other teaching institutions to:

- End gender-based violence within the university and other training institutions;
- Teach and support research on the protection and promotion of the rights of women and of patients, including the right to autonomy and informed choice in the formal curriculum;
- Teach evidence-based childbirth care, prevent unnecessary interventions, including promotion of women's genital integrity; promote research on related implementation strategies.
- Include midwives, nurses and doulas and other professionals in the healthcare team, teaching the importance of collaborative teamwork, and providing fair opportunities for their training; promote research on team-based care.
- End the unregulated use, without explicit medical indications, of the bodies of patients as teaching material; encourage research on related accountability strategies.
- Promote transparency and accountability to regulate the overuse and misuse of technology by publicising information on rates of interventions during childbirth care, incorporate protocols and clinical audits, and models of quality, safety, respect and accountability in provider training; develop research on new indicators and disseminate results to the public.
- Promote collaborative research for implementing respectful maternity care, including the mapping of research gaps to set a research agenda.

To promote real change towards respectful maternity care, the progression of policies that ensure an enabling environment of laws, regulations, and broad dissemination of information,

need to go hand in hand with changes in all health providers' education and training – including a solid base in ethics, gender and human rights. Many of these recommendations are included in the *Apice-ON* programme, launched by the MofH in August 2017. Hopefully, its impact will soon be seen, improving the way childbirth care is provided all over the country. Changing a society's misogynist culture, that permeates health services, takes a long time, but the emergence of several initiatives nationally and internationally reflects a global and consistent effort to make visible and overcome the mistreatment of women in childbirth.

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Résumé

Le Brésil est un pays à revenu intermédiaire où les services de maternité sont universels, assurés principalement par des médecins. L'expérience d'une naissance normale inclut souvent des routines rigides, des interventions agressives et un traitement irrespectueux et abusif. Au Brésil, ces pratiques ont été qualifiées de soins déshumanisés et, plus récemment, de violences obstétricales. Depuis le début des années 90, des mouvements sociaux se sont efforcés de changer ces pratiques, les politiques publiques et la formation des prestataires. Le but de cet article est de décrire et d'analyser le rôle des mouvements sociaux dans la promotion des changements des soins de maternité et de la formation des prestataires. Dans cet examen intégrateur utilisant une approche axée sur le genre, nous avons cherché dans la base de données Scielo ainsi que dans les publications et les décrets du Ministère de la santé des articles institutionnels et de recherche sur les initiatives des mouvements sociaux s'attaquant au manque de respect et à la maltraitance ces 25 dernières années (1993–2018) au Brésil, et leur impact sur les politiques publiques et les programmes de formation. Nous avons analysé les groupes d'initiatives liées suivants : (1) activités politiques des mouvements sociaux aboutissant à des changements des politiques publiques et de la législation ; (2) événements organisés par les mouvements sociaux pour la diffusion de l'information au public ; (3) politiques du Ministère de la santé pour humaniser l'accouchement, avec la participation des mouvements sociaux ; et (4) initiatives pour modifier la formation des prestataires, y compris les activités juridiques fondées sur les notifications de violence obstétricale. Pour promouvoir des changements véritables dans les soins de maternité, la progression des politiques et d'un environnement propice aux lois, les règlements et une vaste diffusion de l'information doivent aller de pair avec des changements dans la formation de tous les prestataires de santé, notamment une base solide sur l'éthique, le genre et les droits humains.

Resumen

Brasil es un país de medianos ingresos con acceso universal a la atención materna, la cual es brindada principalmente por médicos. La experiencia de un parto normal a menudo implica rutinas rígidas, intervenciones agresivas, maltrato y falta de respeto. En Brasil esto ha sido tachado de atención deshumanizada y, más recientemente, de violencia obstétrica. Desde principios de la década de los noventa, los movimientos sociales (MM. SS.) han luchado por cambiar las prácticas, las políticas públicas y la formación de los prestadores de servicios. El objetivo de este artículo es describir y analizar el papel que desempeñan los MM. SS. en promover cambios en la atención materna y en la formación de los prestadores de servicios. En esta revisión integrativa, utilizando un enfoque orientado al género, realizamos una búsqueda en la base de datos de Scielo y en las publicaciones y edictos del Ministerio de Salud, de trabajos institucionales y de investigación sobre iniciativas de MM. SS. que abordan la falta de respeto y el maltrato en los últimos 25 años (de 1993 a 2018) en Brasil, y su impacto en las políticas públicas y en los programas de formación. Analizamos estos grupos de iniciativas interrelacionadas: (1) acciones políticas de los MM. SS. que produjeron cambios en las políticas públicas y en la legislación; (2) eventos organizados por MM. SS. para difundir información al público; (3) políticas del Ministerio de Salud para humanizar el parto con la participación de MM. SS.; y (4) iniciativas para cambiar la formación de los prestadores de servicios, entre ellas acciones legislativas basadas en informes de violencia obstétrica. Para promover verdaderos cambios en la atención materna, la progresión de políticas y un ambiente facilitador de leyes, reglamentos y amplia difusión de información, deben ir de la mano con cambios en la formación de todos los prestadores de servicios de salud, lo cual implica una base sólida de ética, género y derechos humanos.