Gender, maternal health and the perinatal paradox[1]

Gênero, saúde materna e o paradoxo perinatal

Género, salud materna y la paradoja perinatal

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ABSTRACT

In the last 20 years there was an improvement in access to services and in almost all maternal health indicators in Brazil. Paradoxically, there is no evidence of improvement in maternal mortality. This paper aims to help to understand this paradox, by analyzing the typical models of care in childbirth in public (SUS) and private sectors; the proposals for change based on evidence and on women's rights; and the conflicts of interest and resistance to change. We review the gender biases in research and in programming, especially the overestimation of the benefits of technology, and the underestimation, or the denial, of adverse effects and discomforts of interventions. Beliefs based in sexual culture are often accepted as 'scientific' explanations of the body, sexuality and the birth physiology, and are reflected in the imposition of unnecessary risk and suffering, in practices that are harmful for genital integrity, and in the denial of the right to companions in delivery. This 'pessimization of birth' is instrumental to promote, comparatively, the model of routine section. Finally we describe how the use of gender as analytical category can contribute to promote rights and cultural changes, as in the case of companions in childbirth.

KEYWORDS: Gender. Sexual and reproductive health. Evidence-based care. Unified Healthcare System. Maternal health. Humanization.

RESUMO

Nos últimos 20 anos, houve uma melhoria de praticamente todos os indicadores da saúde materna no Brasil, assim como grande ampliação do acesso aos serviços de saúde. Paradoxalmente, não há qualquer evidência de melhoria na mortalidade materna. Este texto tem como objetivo trazer elementos para a compreensão deste paradoxo, através do exame dos modelos típicos de assistência ao parto, no SUS e no setor privado. Analisaremos as propostas de mudança para uma assistência mais baseada em evidências sobre a segurança destes modelos, sua relação com os direitos das mulheres, e com os conflitos de interesse e resistências à mudança dos modelos. Examinamos os pressupostos de gênero que modulam a assistência e os vieses de gênero na pesquisa neste campo, expressos na superestimação dos benefícios da tecnologia, e na subestimação ou na negação dos desconfortos e efeitos adversos das intervenções. Crenças da cultura sexual não raro são tidas como explicações 'científicas' sobre o corpo, a parturição e a sexualidade, e se refletem na imposição de sofrimentos e riscos desnecessários, nas intervenções danosas à integridade genital, e na negação do direito a acompanhantes. Esta 'pessimização do parto' é instrumental para favorecer, por comparação, o modelo da cesárea de rotina. Por fim, discutimos como o uso da categoria gênero pode contribuir para promover direitos e mudanças institucionais, como no caso dos acompanhantes no parto.

PALAVRAS-CHAVE: Gênero. Saúde sexual e reprodutiva. Cuidado baseado em evidências. Sistema Único de Saúde. Saúde materna. Humanização.

RESUMEN

En los últimos 20 años mejoraron prácticamente todos los indicadores de salud materna en el Brasil, así como hubo un amplio acceso a los servicios de salud.

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Paradoxalmente, no existe ninguna evidencia de mejora de la mortalidad materna. El objetivo de este texto es ofrecer elementos para comprender esta paradoja, a través de la evaluación de los modelos típicos de asistencia al parto, en el Sistema Único de Salud (SUS) y en el sector privado. Analizaremos las propuestas de cambio para una asistencia basada en evidencias sobre la seguridad de estos modelos, su relación con los derechos de las mujeres, y con los conflictos de interés y resistencias al cambio de los modelos. Examinamos los presupuestos de género que modulan la asistencia y los sesgos de género en la investigación en este campo, que se expresan en la sobrevalorización de los beneficios de la tecnología, y en la subvalorización o en la negación de los desconfortos y efectos adversos de las intervenciones. Creencias de la cultura sexual no raramente son consideradas como explicaciones 'científicas' sobre el cuerpo, la parturición y la sexualidad, y se reflejan en la imposición de sufrimientos y riesgos innecesarios, en las intervenciones dañinas a la integridad genital, y en la negación del derecho a acompañantes. Este 'pesimismo del parto' es instrumento para favorecer, por comparación, el modelo de la cesárea de rutina. Por fin, discutimos como el uso de la categoría género puede contribuir para promover derechos y cambios institucionales, como en el caso de los acompañantes en el parto.

PALABRAS-CLAVE: género; salud sexual y reproductiva; cuidado basado en evidencias; SUS; salud materna; humanización.

Introduction

Are pregnancy and childbirth becoming safer?

In Brazil, the latest data on maternal mortality available at DATASUS indicate a ratio of 74.68 deaths per 100.000 live births (LB) in 2005[1], already including the estimated adjustment factor of 1.4, calculated in 2002 to correct the sub-notification of maternal deaths among the deaths of women of the reproductive age (10-49 years)[2].

Maternal death is a rare event, and even at places with high rates, its measurement can be hard and complex. And because the figures are small, it is not simple to detect improvement or worsening trends[3]. But if we ask ourselves "Are pregnancy and childbirth becoming safer for women in Brazil?" the answer would be, in spite of the methodology used, that there is no evidence of improvement.

In order to face the challenge of promoting safe maternity, the Brazilian government launched a National Pact for Reduction of Maternal and Neonatal Mortality in 2004, with the aim to reach the Millennium Development Goal 5, a reduction of 75% in maternal and neonatal mortality in 2015 in comparison with 1990. The pact integrates national strategies, including professional care during pregnancy, childbirth and post-abortion for all women; training of health professionals in Humanized Childbirth Practices and Based on Evidences Seminars in all states; guaranteed referral of medical care and hospital for high risk cases; right to rooming in for women and babies; and the right to a companion of her choice during labor and birth[4]. Unfortunately, these initiatives have not been enough to change the maternal mortality figures. A preliminary analysis of the 2004 to 2006 data was far from the predicted reduction of 15% in maternal deaths, and the expectations of reaching a 75% reduction in 2015 do not seem realistic with the current pace of change[5]. But why hasn't the investment on the increase of access to services had an impact on maternal mortality?

This text aims to present some elements to answer that question, reviewing the typical models of care in childbirth at Public Healthcare System (SUS) and in the private sector, the proposals of change directed to the adoption of a care which is more based on the respect to scientific evidence and women's rights, and the conflicts of interest and resistance to change. We review the gender biases in maternal health assistance and in research in this field, among them: the overestimation of the benefits of technology, and the underestimation, or the denial, of adverse effects and discomforts of interventions. And finally, we discuss an agenda aimed at the implementation of the change in care models, and the potential of initiatives such as campaigns for the right to a companion in delivery.

Perinatal paradox: More access and more technology, with inferior results.

Paradoxically, although we have no evidence of improvement of maternal mortality rates, in the last 20 years, almost all of the other

maternal and women health indicators have improved, just as the access to health services. Women have better nutrition, smoke less, have fewer children, with longer intervals between the childbirths, have more antenatal appointments, start antenatal checkups earlier, have better immunization, better testing for the diagnosis of infections and even a larger number of postpartum appointments[6,7].

According to the latest National Research on Demography and Health (PNDS, 2006)[6], the access to antenatal care can be considered universal. In the five years prior to the two studies (1996 and 2006), the percentage of women who did not go to a single appointment during her last pregnancy dropped from 14% to 1%, a reduction which occurred both in the urban and in the rural areas. The 2006 PNDS showed that 77% of the women had at least six antenatal appointments. The percentage of women who had 7 or more antenatal appointments in the country increased from 47%, in 1996, to 61% in 2006, a growth which was even more evident in the rural area[6].

Between 1996 and 2006, the coverage of hospital childbirth grew from 91% to 98%, and the coverage of childbirths assisted by qualified professionals (physician and/or nurse), increased from 87% to 98%. This growth was more evident in the rural area, where these percentages increased from 78% in 1996 to 96% in 2006 in regard to hospital births, and from 73% to 94% in regard to births assisted by a trained professional. This increase in the rural areas was accompanied by a 75% leap in the cesarean section rates (from 20% in 1996 to 35% in 2006), while in the urban areas this rate, already very high, had a smaller increase (from 42% to 46%). As a consequence, the national cesarean section rate increased from 36% to 44%[6], with a great weight of the reproductive *surgicalization process*[8] in the rural area.

Cesarean sections, when correctly indicated, be them an emergency or elective, are an essential component of the obstetric care and must be duly available so as to decrease neonatal and maternal mortality rates. A percentage between 5% and 15% of total births seem to achieve the best results as to the health of women and babies, since a lower rate than 1% or higher than 15% seem to do more harm than good, the so called cesarean section paradox[9]. Large observational studies on cesarean section show that a higher rate is associated with an increase of maternal and newborn morbidity and mortality[10]. In Brazil, the use of cesarean section is poorly-regulated in the public services and unregulated in the private sector, where it reached 80,8% of all births in 2006[6]. In 2008, a number of initiatives were launched by the Ministry of Health and directed to the private sector, by the Agência Nacional de Saúde Suplementar[11] (ANS) and by the Associação Brasileira de Medicina de Grupo[12]. The various campaigns point out the potential negative impact to babies of the cesarean section for non-medical indications, mainly the epidemic of preterm births.

The term "perinatal paradox" is attributed to Rosemblatt[13] (1989), in his text "The Perinatal paradox: doing more and accomplishing less". At that time, the author showed how the quick expansion of intensive care for babies more and more premature – sometimes with serious sequels - received much more attention and resources than the prevention of prematurity, aimed at poor pregnant women. At that time, after a decreasing trend, both the prematurity and the low weight at birth started to increase again in the United States, a trend continuous until today. Twenty years ago, this author affirmed that the first step to analyze this paradox would be to "understand the factors which prompt professionals to adopt a style of clinical practice that does not necessarily meet the best interest of the individuals nor the society's". One of the main factors would be the intensive use of technology on the low-risk population, "prompting inappropriate interventions and causing iatrogenic harm".

Though frequently referred only to babies, this paradox "around childbirth" also applies to maternal health. The acknowledgment of this paradox is very uncomfortable because, as professionals, we consider that if these procedures are carried out by specialists, they must be correct, and we tend to self-deception so much so that we don't even see the most evident harms[14].

The perinatal paradox and the worst of two worlds: The problem of lack of care and the problem of excess of interventions

Having a qualified professional caring for childbirth is essential, but in the case of Brazil it has not been enough, due to the frequent

lack of adherence to evidence-based protocols concerning the management of high-risk pregnancies. A study showed that in the city of São Paulo, less than 10% of the women who died from eclampsia (in hospitals and attended by doctors) were treated with magnesium sulphate, the cheapest and most effective treatment[15], recommended by the Ministry of Health. In Brazil, we can have the worst of two worlds in care in childbirth: falling ill and dying by lack of appropriate technology, and falling ill and dying by excess of inappropriate technology.

Various authors analyzed the potential harms to mothers and babies associated with the inappropriate usage of technology in the perinatal period in Brazil. In Pelotas, the results of three cohorts (1982, 1993 e 2004) show that the proportion of premature births increased substantially, from 6,3% in 1982 to 14,7% in 2004. According to the authors, it was not possible to explain this increase through changes in maternal characteristics, since the mothers in 2004 had better health indicators than those from the previous cohorts[16]. The study shows that there was a significant increase in interruptions of preterm pregnancy, be it by cesarean section or by induction. The rate of cesarean sections increased from 28% in 1982 to 45% in 2004, and the rate of induced childbirth from 2,5% in 1982 to 11,1% in 2004. According to the authors, the increase in preterm births may be due partially to the growing number of interruptions, but there must be other causes, since this increase was also observed among children who were born by non-induced vaginal births. They consider other causes may be involved, such as infections and stress, especially among poorer women[16].

In practice, it is not easy to tell which births are "induced" and which ones are "augmented". Since the definition of the onset of labor is very inaccurate[17], it is possible that other hospital interventions such as amniotomy (rupture of membranes) are carried out on women who are not on labor yet, but have some cervical dilation and contractions (Braxton-Hicks), still in a preterm pregnancy. Such procedures lead to a "precipitate labor", followed by the use of oxytocin not to *induce* labor – but to *augment it,* since the amniotomy makes the labor inevitable in a certain number of hours, be the woman effectively in labor or not[18] .

The outcome of preterm babies or babies who are small for gestational age are better if they are born by spontaneous birth than from induced birth[19]. Even the so-called full term births (37 to 41 weeks), the prognosis is significantly unfavorable the earliest the interruption. Clark et al (2009), compared the outcome of elective births (induction or cesarean section, scheduled), in 27 American hospitals, and showed that 4,6% of babies born by elective births with 39 weeks or more, and 17,8% of babies born between 37 and 38 weeks ($p<0.001$)[20] needed intensive care admission. The cohort of elective cesarean sections between 37 and 39 weeks in 19 centers followed by Tita et al. (2009) shows that the rates of respiratory complications, mechanical ventilation, neonatal sepsis, hypoglycemia and intensive care admission increase gradually and significantly the more premature the labor is, even among the so-called "full term" births"[21].

In addition to the risks of speeding up the end of pregnancy, in Brazil little attention has been given to the iatrogenic potential of drug use in labor, specially oxytocin, used routinely and frequently indiscriminately[17]. The liberal use of oxytocin for conduction of labor was the target of an alert recently, when in 2008 it was included in the short list of the 12 drugs whose use is most associated with serious medical errors[22]. Oxytocin is the drug most frequently associated to adverse perinatal results, and it is involved in half of the litigations against gyneco-obstetricians in the north-American case[23]. Recommendations published proposed the selective use of the drug, in low dosage and well-controlled protocols, *prevention* of the need of its use, and the use of non-pharmacological resources to speed up the labor[26].

In Brazil, several studies and initiatives reflect a concern with the iatrogenic potential of the assistance models. In Rio de Janeiro, a research coordinated by Maria do Carmo Leal between 1996 e 2006[24], shows that also in Rio, in spite of improvement of some indicators of living conditions and access to obstetrical health services, there has been an increase in prematurity and in low birth weight.

In Belo Horizonte the seminar "Brazilian Perinatal Paradox: changing paradigms for the reduction of maternal and neonatal mortality" was organized in 2008"[25]. The seminar enlarged

the debate about the relations between high rates of unnecessary cesarean sections and growing and elevated rates of prematurity, evaluated the indiscriminate practice of procedures with no scientific evidence used routinely in childbirth care, and discussed how to tackle these problems on services daily.

Many SUS services have strived to improve the attendance offered to women, some with excellent results. This process has been facilitated by the Ministry of Health initiatives, such as the Labor and Birth Humanization Program and the Galba de Araújo Award, among others[18]. In spite of that, the typical model of care for childbirth in many SUS services, in addition to being unsafe and having little support of scientific evidence, is often marked by an authoritative professional-user relation, which includes discriminatory, inhuman or degrading forms of treatment[26,27,28,29].

Models of care in childbirth and gender biases

Childbirth and its care are complex phenomenons and their study is also an area of interest of the social sciences, given the permeability of practices in local cultures and their large geographical variability, even in industrialized countries. Among the dimensions involved in the cultural formatting of care in childbirth practices, are the sexual culture of that society, its hierarchies and values of gender, race, social class, generation, among others[30].

We understand the concept of gender as a category which, socially, corresponds to the anatomical and physiological sex of the biological sciences[31]. Gender is the socially constructed sex, or, as Rubin defines[32], the set of arrangements by which a society transforms biological sexuality *(and reproduction)* into products of human activity, and in which these transformed human needs are satisfied.

The terms "gender bias" and "gender blindness" are used to highlight the way research and practice in a field of knowledge can fail to value fundamental aspects of its study objects, seeing only those which confirm the dominant paradigm. The epistemological aim is to remove the elements which "blind", turn invisible or bias the knowledge production, so that better descriptions of reality are produced[33]. The term gender bias in epidemiological research is used more frequently to define systematic errors related to gender-dependent social constructs. As a result of the gender insensibility, the outline and analysis of researches may create biases dependent on "engendered" interpretation. The term is more well-known in comparative researches between men and women – such as the difference in diagnosis and treatment of diseases, but its applications in epidemiological research are wide and capable of expanding the explicative models[34].

In the case of care in childbirth, gender blindness lead researchers and professionals to accept sexual culture beliefs about the female body, related to this "socially constructed sex", as scientific and objective explanations about the body and sexuality[30]. One of the expressions of this bias is the belief that the female body is essentially defective, unpredictable and potentially dangerous, therefore it needs correction and protection, expressed in interventions. Such belief leads to the *overestimation of the benefits of technology, and the underestimation, or even invisibility (blindness), as to the adverse effects of the interventions*. An example of this 'gender blindness' is the history of episiotomy, the incision of muscles, erectile tissues, nerves and blood vessels of the vulva and vagina, instituted in the beginning of the 20th century, with the intention of widening the birth canal. For decades, hundreds of millions of women had their vulvas and vaginas cut supposedly to prevent serious genital lesions on the mother and to prevent harms to the baby.

In the 80's, the first discussions about the scientific basis of safety and effectiveness of childbirth procedures began. This critical movement inside medicine appears in the perinatal health field[35] and is influenced by the international women's movement[36]. Organized consumers in the 70's and 80's questioned the use of these practices, claimed childbirth was a part of the female sexual experience, and demanded the participation of women in the definition of research priorities. One of these claims was the systematic registration by the health services of interventions, many of which denounced as irrational and violent, to make possible their evaluation, and a main focus was episiotomy. Episiotomy could barely be

"seen", because up to 1981, when the movement claimed it, it was not even registered[37].

Since the supposition was that the female body was wrong and should be corrected, there were no researches about *if* episiotomy should or shouldn't be performed. Reviews identified many well-outlined clinical trials about episiotomy, although not one questioned if it was worth-while performing it[36]. Only in the middle of the 80's clinical trials about risks and benefits emerge, recommending the *abolition* of its routine use[16].

Recommendations about this and other interventions were widely publicized in the middle of the 90's, and in many countries the use of episiotomy dropped continuously, having been used only in minor situations – one of its main indications is a rigid perineum, consequence of a prior episiotomy. More recently, editorials in magazines specialized in gynecology and obstetrics have been published inclusively in Brazil, clamoring the professionals to abandon the routine use of episiotomy, and its teaching[38,39].

The first Brazilian population-based data about episiotomy, the 2006 PNDS, show that among women who had vaginal childbirths at SUS, 70,3% underwent the procedure, and among primiparous women, this percentage reached 84,8%[6]. In Brazil, until today the data about episiotomy is not available in the public health database (DATASUS).

Models of care in childbirth and conflicts of interest

> *"There is no doubt that, even when unnecessary or even when it represents a greater risk to the mother or to the newborn, an elective cesarean section has a much lower risk to the obstetrician." (Editorial, Revista Brasileira de Ginecologia e Obstetrícia"*[40]

The contrast between evidences on the safety and effectiveness and care practices in Brazil is illustrative to the understanding of the role of conflicts of interest and institutional conveniences in the definition of how care is structured. The private sector in Brazil adopted the organizational model of the "routine cesarean section", substituting the unpredictability of the full term childbirth for a taylorist planning of great efficiency and profitability, creating a cultural fact: if it is done by specialists, it must be safe. Thus, if a professional, dissident of the model, has any complications in a vaginal birth, he or she will be much more vulnerable and be isolated by his or her peers or be prosecuted by the patient, as stated in the above mentioned editorial.

According to Maia[41], in the technocratic model of Brazilian care, for women of the public and the private sector "there are just two alternatives of delivery: a traumatic vaginal birth, due to the excess of unnecessary interventions, or a cesarean section", which is "a sign of social differentiation and 'modernity' ". The author demonstrates that the incitement of the dispute for the model of care in childbirth, with official promotion of the humanized model, occurs at the same time in which pressures from the governments are intensified to regulate the private health care and in which promotion and health prevention actions are strengthened. Such *timing* would not be mere coincidence, because it would be impossible to question the model of care in childbirth without questioning the health care logics in Brazil[41].

The consolidation of a public-private health care results from a dualism in financing, at the same time it generates a dualism in care. When the more qualified workers, as well as the economic elite, were equalized to all Brazilians by SUS, new forms of differentiation were created – and the way of birth was one of them. If the medicalization of childbirth is a reality to almost all Brazilian women, women from different social classes were subjected to different forms of medicalization and inappropriate care, reflecting the hegemony of corporate interests over the interests of the population health and the lack of regulation of practices[41].

Gender and childbirth pessimization: The naturalization of iatrogenic suffering and harm

The other nuclear component in the cultural formatting of models of parturient care in Brazil, interconnected with the conflicts of interest above described, is the sexual and reproductive culture[12]. These dimensions are

associated with the acknowledgment – or non-acknowledgement – by health services, of women's rights to their sexual expression (evidenced by pregnancy), to bodily integrity, to their personhood, to autonomy and to non-discrimination[18].

Countless studies show that discriminatory and inhuman attitudes in care in childbirth, including at SUS, are frequent[25-29]. Studies about women's perspectives show that many times they describe labor as overwhelmed with fear, loneliness and pain, in institutions that delegitimize sexuality and reproduction of women considered subaltern, such as black, single and low-income women, and stigmatize maternity in adolescence[26]. Verbal abuse aimed at the sexual humiliation of the kind "you liked it when you did it", are a constant in the studies and are part of the professionals informal learning about how to discipline the patients, demoralizing their suffering and discrediting occasional calls for help[25-28].

Another expression of this discriminatory bias is the denial to the right of a companion of the woman's choice during labor and childbirth. Although guaranteed by law at some states since the past decade and nationally since 2005, this right is still denied to the majority of women. PNDS data[6] shows that only 16,2% of women exercised this right, being 34,6% of women in the private sector, and only 9,5% at SUS.

As a complex cultural phenomenon, it is difficult to define what would be a "physiological" or "spontaneous" birth, since the interpretation of physiology and normality are cultural constructs themselves[29]. The possibility itself of a woman having informed choices about her care may make a great difference in the interpretation she makes about the 'normality' of her experience[42]. However if we use the definition proposed in 2008 about what would be a normal or physiological birth (initiated spontaneously, conducted spontaneously, and which ends spontaneously – without drugs or surgeries)[43], it is a rare phenomenon in Brazil. In Brazil, in addition to a spontaneous birth be perceived as riskier to the babies by the professionals, it is also considered as riskier to the mother herself, being associated with irreversible sexual harms. Professionals perform interventions on the vagina, such as episiotomy (which is at least a 2nd degree laceration) and forceps, which increase the risks of serious genital harms[16], and when these harms occur, they blame the *childbirth itself* for the harms[13]. This way, the iatrogenic harm is turned invisible and it is re-described as a "natural" childbirth harm, associated with the physiological process and not with the interventions. The routine use of episiotomy and forceps in primiparous women is still taught at important Medicine Schools, in spite of all scientific evidence about its unsuitability, and without women having any chance of making informed choices[29].

In terms of model of care, the preferred 'bodily correction' for white and higher-income women is the cesarean section: "if childbirth is a negative event, we should prevent it". It is defended by professionals as a superior and more modern alternative in terms of maternal comfort (supposedly avoids childbirth pain), protection against sexual harms (supposedly avoids the baby's passage through the perineum, episiotomy, forceps), and against the potential harms of vaginal birth for the baby. In order to make this model feasible, the surgery must be scheduled *before* the woman enters labor. Among the minority of women who had vaginal birth in the private sector, it generally includes procedures such as induction or speeding up with oxytocin (procedure which generally helps overcoming the limit of pain tolerance), episiotomy, and frequently forceps in primiparous women. All these procedures are painful – however almost always, women have peridural anesthesia at their disposal in the private sector, which makes physical suffering easier to bear for both the woman and the provider[44].

Whereas among women who are poorer and more dependant on SUS, the correctional model presupposes that "if childbirth is a negative event and we are not authorized to prevent it, let's at least shorten its duration". The resources to its speeding up include the routine use of oxytocin, early membrane rupture, and episiotomy[18]. Other resources used are manual membrane sweep, manual reduction of the cervix, and Kristeller maneuver (fundal pressure), but there is rarely any record of these procedures. Because these procedures increase pain, having or not having access to effective anesthesia may make a huge difference in the quality of the childbirth experience, to

the parturient woman, to the baby and to the professionals who assist them[24]. To make things worse, women are generally kept immobilized in uncomfortable positions during the expulsive period, without privacy, and subjected to potentially harmful instructions of directed pushing ("push!"), and not rarely they are threatened with adverse results should they not obey. The care for the physical and emotional well-being of women in labor, which should be "one of priorities of care and considered at each intervention"[17], is a slightly visible theme, mainly at SUS.

Although more effective and safer as analgesia, the peridural has important adverse effects, such as a relative inability to move, and a greater risk of prolonged births, surgical interventions, use of oxytocics, and cesarean section, in addition to having a baby less alert for breastfeeding[17]. It is important to p*revent* painful procedures and promote the use of non-pharmacological alternatives for pain management (presence of companions, massage, baths, freedom of movement and of position, among others) at SUS.

In Brazil, many times the debate about the quality of care falls into the polarization between cesarean section and normal childbirth. With the available evidence, nobody can defend that the cesarean section without medical indication does not have inferior maternal and neonatal outcomes when compared to a physiological birth. On the other hand, when compared to a vaginal birth full of unnecessary, painful and potentially harmful interventions, it may seem like a comparable alternative. According to Klein et al[45], this comparison is not acceptable and neither scientifically honest. Groups of organized consumers believe that to make the overuse of cesarean sections acceptable, it is fundamental to keep vaginal birth the most painful and harmful possible, if need be denying scientific evidences which the medical practice should supposedly adopt. The demand for cesarean section, in Brazil, would essentially be a demand for dignity, since the model of the typical "normal" birth is interventionist and traumatic[41]. It is a "choice between the bad and the worse", between two forms of victimization. Quoting a consumer, "if you have to cut anything, it is better to cut above, because below is a more noble area".[44]

Equity, gender, evidences and rights: an agenda

In Brazil we had great advances in the maternal health field, among them the universalisation of access to antenatal and childbirth care. There is indeed an "inverse equity" in certain aspects and regions, such as studies that show that SUS pregnant women have better routine tests, more HIV and syphilis testing, lower cesarean section rates and higher rates of rooming-in, compared to the private sector.[1] However inequalities remain and the quality of care is limited by the scarce attention to evidences about safety and comfort of procedures in the assistance, and by the permanence of a discriminatory, punitive and correctional culture directed towards women.

With such a scenario, it is necessary to use several languages to facilitate the dialogue between the sectors that can make a difference in the change of care practices. Among them, policy makers, social control of SUS, researchers (of social sciences, epidemiology, clinical research), and social movements.

One of the biggest challenges of perinatal health research is to give balanced weight to potential benefits as well as potential harms of birth interventions, both to the ones related to soft technology as well as to the ones related to hard technology, in research and program outlines, in order to understand its impact on mothers' and babies' outcomes.

The current SUS information system on interventions render invisible many important details which can make a difference in the health outcome of mothers and babies, such as the indiscriminate use of oxytocin in birth induction and speeding up, invasive maneuvers such as membrane sweep, and Kristeller maneuver. If the aim of care is to preserve the bodily integrity whenever possible, the registration of episiotomy and perineal outcomes must be monitored and assessed at the service level. The consumers' perspective about care is a key issue both for research and social control of services.

Research about how to implement changes in health practices must become equally a priority, since we have much more evidence of what is effective and safe than of how to make

change happen[9,47].

In addition to well-trained professionals and well-equipped services to treat complications, we need to develop innovative interventions, which use simple technology and which are applicable to all levels of care in rural and urban areas[47].

An example are "normal birth centers", wheather intrahospital, alongside or independent, with qualified midwives or obstetrics nurses, experienced in primary care and with efficient reference systems. Another promising example is the presence of a companion of the woman's choice, and the support of a doula (experienced companion) during and after birth. There is solid evidence that a companion during labor is a powerful tool to promote better neonatal and maternal results, among them a better maternal satisfaction with the birth process, shorter labors, lower rates of surgical births, lower rates of demand for analgesics, lower rates of Apgar under 7 in the first 5 minutes, and much more[48]. The potential of a birth companion to prevent maternal morbidity and mortality must be explored as it becomes a reality at SUS because, when women have a companion, they tend to be treated better[47]. Informal accounts show that in cases of *near miss* (women with serious complications who survived), the companion had a key role in early acknowledging the rapid deterioration of the woman's health after birth.

For SUS, the comparative studies of these models with traditional services are urgent, in order to create the so called "local evidence", as well as in order to offer a cultural experience and an environment for the development of more democratic relations between the services and the users and their families. These changes would make normal birth more comfortable, acceptable and safe, possibly by decreasing the number of interventions and the demand for cesarean section.

Since 2005, the "Companion Law" (No.11.108) has been approved by the President Lula da Silva. We urgently need to invest resources for the promotion and monitoring of this legislation execution, and disseminate the information to women about their rights, as part of the antenatal routine. It is about time that we develop policies of inclusion of fathers (when they exist and if they and their partner wish so) in the antenatal and postpartum care, as other countries have done, as a way of deconstructing the gender bias which presupposes women as the only baby caretakers[49]. The Brazilian civil society, specially networks for birth humanization and the feminist movement, may play a key role to ensure these rights are respected at SUS. It is inacceptable that a Brazilian citizen is born having his or her and his or her mother's rights disrespected. This law can help empower women to demand what they need from SUS, and it may be a powerful tool for change, integrating the evidence-based and rights-based approaches that we need.

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