The role of Traditional and Alternative Healthcare Practitioners in building Reproductive Justice in Brazil and Beyond

Citation:

Melo, Matheus Barbosa, 2023. The Role of Traditional and Alternative Healthcare Practitioners in building Reproductive Justice in Brazil. Institute of Global Innovation (IGI) Working Papers, University of Birmingham.

Description:

Recent historic development and state of art: the use of tradicional medicine in the field of Sexual and Reproductive Health and the professional regulation of midwifes, doulas, “parteiras” (or similars).

Summary:

This pump-priming study, financed by the University of Birmingham (IGI), aims to develop a large-scale interdisciplinary research project on the regulation of traditional healing practices in the field of sexual and reproductive healthcare.
The preliminary research conducted by the PI Atina Krajewska and the Co-I, Calabria, revealed that during the COVID-19 pandemic traditional and complementary medicine (TCM) became particularly relevant in supporting healthcare systems across the world. In Brazil, Mexico, and Nicaragua, indigenous TCM practitioners shared knowledge of remedies historically used to treat respiratory diseases that partially mitigated the spread or effects of COVID-19 in their communities (UN 2022; Paudyal et al. 2022). In particular, Indigenous midwives redoubled their efforts to meet the growing demand for sexual and reproductive care delivered at home. The Office of the High Commissioner for Human Rights recognised traditional midwives as essential emergency personnel as early as at the start of the pandemic (OHCHR 2020). In 2022 the Colombian Constitutional Court found that the government has a duty to integrate indigenous midwifery, as a form of ancestral medicine, into the Social Security System (T-128/22). Other Latin American states have advanced similar policies (PHO 2021). And yet, significant challenges remain. According to the latest WHO Report on TCM (2019) lack of sufficient disaggregated research data, mechanisms to train and monitor TCM practitioners, and expertise within national health authorities as the main obstacles to good regulation and implementation of existing rules.
The project focuses on the role of the traditional midwives in building reproductive justice in societies experiencing intense pluralist tendencies and legal systems committed to legal pluralism. It focuses on Brazil, Colombia and Ghana as case studies. First, it aims to analyse the way in which different belief systems and worldviews are protected (and integrated) in different healthcare systems in accordance with human rights standards. Second, it aims to identify particularly regulatory and implementation challenges in this respect. The project aims to build collaborations between lawyers, anthropologists, and healthcare scientists.

Case study 1: Brazil

Researcher: Matheus Barbosa de Melo

1. Description of tradicional medicine/practices and professionals in the field of Sexual and Reproductive Health in each country

1.1 General aspects of the work of traditional midwives in Brazil

For centuries, childbirth assistance and delivery have been a private matter, carried out as a home setting with the support of midwives, "comadres", "aparadeiras" and "curiosas", who are individuals recognized within their communities and possess empirical knowledge passed down through generations via oral and symbolic transmission, typically within kinship relationships and a network of female connections (DE MENEZES et al., 2012, p. 6). Furthermore, Aires (2005, p. 4) defines traditional midwives as "women recognized by the community, where they practice their craft and provide assistance to the birthing mother and newborn, using technological resources that lack sophistication when compared to hospital births"[1]. According to the author, "knowledge of artifacts, techniques, and procedures is usually acquired through daily experiences and practices, and in some cases, through their own childbirth experience"[2] (AIRES, 2005, p. 4).

Additionally, Santos and Silva (2021, p. 4) highlight the connection to the "divine gift" as a central aspect of the profession, with practices predominantly found in rural or intraurban areas, particularly in the North and Northeast regions, where the highest rates of births attended by traditional midwives were concentrated (DE MENEZES et al., 2012, p. 26).

> In practice, traditional midwives have their own techniques that defy the logic of modern medicine, with a strong religious connection to the supernatural. Their knowledge stems from a symbolic logic that goes beyond modernity. For birthing mothers, midwives, and comadres who possess the knowledge of "catching babies," their primary role is seen as a social endeavor, linked to the divine gift, where they intervene minimally in the pregnant body and provide emotional support to the birthing mother (SANTOS; SILVA, 2021, p. 8)[3].

In this perspective, Tornquist (2005, p. 71) states that "most of the time, popular and/or rural midwives are deeply connected to popular religiosity, and childbirth is an event that is at once physical, familial, sexual, and religious"[4]. In a study applied to the work carried out by traditional midwives in a rural region of the state of Amazonas, some authors were able to identify the practice of midwifery as "part of the reciprocity regime that governs social relations among traditional

---

[1] Original: "as parteiras tradicionais são mulheres reconhecidas pela comunidade, onde atuam em seu ofício e prestam assistência à parturiente e ao recém-nascido, usando recursos tecnológicos sem qualquer sofisticação, se comparados ao parto hospitalar".

[2] Original: "o conhecimento dos artefatos, das técnicas e dos procedimentos é normalmente adquirido nas vivências e práticas cotidianas, e, em alguns casos, da experiência de seu próprio parto".

[3] Original: "Na prática, as parteiras tradicionais têm técnicas próprias que fogem à lógica da medicina moderna, tendo uma forte ligação religiosa com o sobrenatural. Seus saberes remontam a uma lógica simbólica que vai além da modernidade. Para as parturientes, as parteiras, comadres, conhecedoras do saber "pegar crianças", fazem antes de tudo um trabalho social, ligado ao dom divino intervindo pouco no corpo gravídico e dando a parturiente apoio emocional".

[4] Original: "na maioria das vezes, as parteiras populares e/ou camponesas estão profundamente ligadas à religiosidade popular e o parto é um evento, a um só tempo, corporal, familiar, sexual e religioso".

populations in the region"[5] (OLIVEIRA et al., 2020, p. 85). In this sense, they emphasize: "the gift of midwifery is accepted. The gift of 'catching babies' does not emanate from their psychic-cognitive individuality but is 'sent by God'. Thus, they are always attentive to their behaviours and divine teachings"[6] (OLIVEIRA et al., 2020, p. 85).

The learning of this craft generally occurs informally, through the transmission of knowledge by older women. According to Araújo and Lima (2010, p. 19), the learning process results from both observing lived experiences in everyday family life and the passing on of knowledge through ancestry or friendship relationships. However, they emphasize: "as these practices become routinized over time, they are transformed into sedimented knowledge, which is naturalized and activated as spontaneous knowledge"[7] (ARAÚJO; LIMA, 2010, p. 17). Afterwards, "each midwife follows a logic established according to their learning contexts, reproducing, without being automatic, what they have learned [and] developing their own techniques based on their practical experience"[8] (OLIVEIRA et al., 2020, p. 91).

In Brazil, until the 1930s, the medicalization of childbirth was not a prevalent concept in medical literature. The activity of the lay midwife prevailed, and rarely that of the "diplomaed" midwife (MOTT, 2002, p. 198). Within indigenous communities, there is not even an identification with the term "midwife", as the category would imply an official position rather than the act of assisting in childbirth (GUSMAN, et al., 2019, p. 2633). As Ferreira et al. (2013, p. 210) emphasize, quoting a Katukina shaman, "people started talking about midwives when they began studying the 'white man's laws'"[9]. However, in the early decades of the 20th century, childbirth started to be seen "as a medical event and potentially dangerous, leading to increasingly frequent interventions"[10] (MOTT, 2002, p. 203). Regarding the historical circumstances that favoured this situation, the authors state:

> With the advent of capitalism, there was a gradual development of modern and social medicine in Europe, which acquired a significant role due to the need for population control. This led to increased medical interest in reproduction and the incorporation of obstetrics into medicine in the 18th century. [...] In Brazil, this process began to have an impact in the early decades of the 19th century with the arrival of the Royal Family, the establishment of the Medical Schools in Bahia and Rio de Janeiro, the licensing of midwives, and the creation of childbirth courses. In this configuration, in addition to lay

[5] Original: "parte do regime de reciprocidade que rege as relações sociais entre as populações tradicionais na região".

[6] Original: "o dom de partejar é aceito. O dom de pegar criança não emanaria de sua individualidade psíquico-cognitiva, mas seria 'enviado por Deus'. Assim, estão sempre atentas aos seus comportamentos e aos ensinamentos divinos".

[7] Original: "à medida que tais práticas vão sendo rotinizadas temporalmente, elas vão sendo transformadas em saberes sedimentados, que são naturalizados e acionados como saberes espontâneos".

[8] Original: "cada parteira segue uma lógica estabelecida segundo seus contextos de aprendizagem, reproduzindo, sem ser de forma automática, o que aprenderam [e] desenvolvendo suas próprias técnicas a partir de sua experiência prática".

[9] Original: "o povo começou a falar em parteira quando começou a estudar as 'leis do branco'".

[10] Original: "como um evento médico e potencialmente perigoso, no qual eram preconizadas intervenções cada vez mais frequentes".

> midwives, doctors, examined midwives, diplomaed midwives [and later nurses] became part of the childbirth scenario[11] (DE MENEZES et al., 2012, p. 7).

According to Mott (2002, p. 207), referring to a research conducted by Dr. Edgard Braga, head of the Prenatal Service of the Inspectorate of Hygiene and Child Assistance in São Paulo in the 1930s, out of eighteen thousand records of pregnant women, a total of 85% of deliveries at that time were performed by lay midwives ("curiosas"); 10% were attended by diplomaed midwives, and only 5% took place in hospitals and maternity wards[12]. During that time, there was significant resistance from women and families regarding the involvement of doctors in women's healthcare and childbirth. On the other hand, midwives were more socially accepted figures as they were part of the realm of feminine values, understanding and sharing women's issues (DE MENEZES et al., 2012, p. 7).

The non-discrimination of women based on their social condition was an important attribute of midwives' professional identity: "ambition, the desire for profit, and abandoning a poor birthing woman to attend to a wealthy one was considered unworthy and condemned behaviours"[13] (MOTT, 2005, p. 129-130). However, "in the 1930s and 1940s, there was a considerable increase in the number of hospitals, healthcare facilities, and maternity wards, with both paid and free beds, as well as shelters for poor mothers"[14] (MOTT, 2002, p. 207). During this time, maternity care was becoming more accepted by the female public. "Childbirth began to be seen as a medical event and potentially dangerous [...] [and] obstetrics began to master new techniques that promised better chances of survival for both mother and child"[15] (MOTT, 2002, p. 203). In this context, De Menezes et al. (2012, p. 7) highlight the importance of instruments such as forceps for the acceptance of the medical profession and the recognition of obstetrics as a technical and intellectual discipline.

However, the shift towards hospital births meant "the realization of a process of male domination and the removal of women's agency in the sphere of childbirth"[16] (DE MENEZES et al., 2012, p. 8). Grounded in a discourse of hygiene and the technical and intellectual competence of men, a significant effort was made to delegitimize the work of women who possessed informal knowledge of healing, body care, and childbirth (DE MENEZES et al., 2012, p. 8). Mott (2002, p. 205) explains

---

[11] Original: "Com o advento do Capitalismo, houve um gradativo desenvolvimento da medicina moderna e social na Europa, que adquiriu um papel relevante devido à necessidade de controle das populações, levando ao aumento do interesse médico pela reprodução e acarretando a incorporação da obstetrícia à medicina, no século XVIII. [...] No Brasil, esse processo começou a repercutir nas primeiras décadas do século XIX, a partir da vinda da Família Real, da fundação das Faculdades de Medicina da Bahia e do Rio de Janeiro, do licenciamento de parteiras e da criação dos cursos de partos. Nessa configuração, além das parteiras leigas, os médicos, parteiras examinadas, parteiras diplomadas [e posteriormente as enfermeiras] passaram a compor o cenário do parto".

[12] Mott (2005, p. 119-120) explains that "with the advent of diplomaed midwives, some professionals began to promote their services by distributing advertising pamphlets on the streets. [...] Another way to advertise their services was by placing a sign on the door of their house, with their name and profession engraved on metal or another material. According to the author, "throughout the 19th century and the early decades of the 20th century, midwives worked as independent practitioners, offering their services. They attended to birthing women in their own residences, as well as in their own homes or maternity houses created by themselves. It was only by the end of the 19th century that advertisements seeking midwives could be found, as a consequence of the establishment of maternity wards and hospitals" (MOTT, 2005, p. 121, our translation).

[13] Original: "a ambição, o desejo de lucro e o abandono de uma parturiente pobre para atender uma rica eram comportamentos considerados indignos e condenados".

[14] Original: "nos anos 30 e 40, houve um aumento considerável no número de hospitais, casas de saúde e maternidades, com leitos pagantes e gratuitos, e de abrigos para mães pobres".

[15] Original: "O parto começava a ser visto como um evento médico e potencialmente perigoso [...] [e] a obstetrícia começava a dominar novas técnicas que prometiam maiores chances de sobrevivência para a mãe e para o filho".

[16] Original: "a efetivação de um processo de dominação masculina e a retirada da protagonismo da mulher na esfera do parto".

that from the 1940s onwards, the medical community widely recommended the systematic hospitalization of pregnant women, discouraging home births. According to the author,

> The old "comadres" – along with other practitioners in the city (healers, bloodletters, etc.) – became the target of a campaign to discredit them. Legal midwives began to face competition from an increasing number of other certified professionals, especially foreign women who were trained in their home countries, as well as Brazilian and foreign midwives who graduated from the midwifery course attached to the Faculty of Medicine in Rio de Janeiro, established in 1832. They also faced competition from doctors, who began to claim the practice of obstetrics for themselves. This process occurred later in the city of São Paulo, starting in the 1890s, due to the advancement of urbanization and economic development caused by coffee exports[17] (MOTT, 2005, p. 119).

In this context, "the hospitalization of childbirth began to be seen as an ideal to be achieved, an example to be followed. For the majority of doctors, it meant civilization"[18] (MOTT, 2002, p. 213). Therefore, there was progress in understanding childbirth as a public (institutional) event, laying the foundations for the adoption of the technocratic and interventionist American model, which still predominates today (DE MENEZES et al., 2012, p. 8). According to Santos and Silva (2021, p. 6-7), at this moment, when the desired modern standard became hospital childbirth, doctors, "mostly white men, sought to control the knowledge and practices related to the female body"[19], disregarding the feminist practice of solidarity, support networks, and nurturing, which were led by women in traditional childbirth.

However, there were frequent complaints about the lack of beds, poor care due to the precarious conditions of the facilities, and unnecessary surgical interventions (MOTT, 2002, p. 204). These problems were compounded by issues such as hostile treatment, indiscriminate use of medication, disregard for women's autonomy, lack of psychoemotional support, and inadequate physical structures that did not provide privacy, comfort, and family support (DE MENEZES et al., 2012, p. 4). In contrast, "the models of painless childbirth, non-violent childbirth, and active childbirth, combined with ideals and principles inspired by the countercultural movement, naturalism, the New Age, and ecofeminism [...] unfolded into the multifaceted movement for humanized childbirth and delivery"[20] (TEMPESTA; FRANÇA, 2021, p. 268). The movement was composed of middle-class women, doctors, nurses, midwives, and doulas, aiming to enhance the experiences of pregnancy and childbirth (TEMPESTA; FRANÇA, 2021, p. 268).

---

[17] Original: "As antigas comadres – assim como os demais práticos que atuavam na cidade (curandeiros, sangradores etc.) – passaram a ser alvo de uma campanha de descrédito. As parteiras legais começaram a sofrer a concorrência de um número crescente de outros profissionais diplomadas, sobretudo estrangeiras, formadas por escolas dos países de origem e de parteiras brasileiras e estrangeiras formadas pelo curso de partos anexo à Faculdade de Medicina do Rio de Janeiro, criado em 1832, bem como dos médicos, que passam a defender para si o exercício da obstetrícia. Este processo ocorreu mais tarde na cidade de São Paulo, a partir da década de 1890, devido ao avanço do processo de urbanização e desenvolvimento econômico ocasionado pela exportação do café".

[18] Original: "a hospitalização do parto passava a ser vista como um ideal a ser atingido, um exemplo a ser seguido. Significava, para a maioria dos médicos, sinônimo de civilização".

[19] Original: "em grande maioria homens brancos, buscam pelo controle sobre as práticas dos saberes sobre o corpo feminino".

[20] Original: "os modelos do parto sem dor, do parto sem violência e do parto ativo, combinados a ideais e princípios inspirados no movimento da contracultura, no naturalismo, na Nova Era e no ecofeminismo [...] se desdobraram no multifacetado movimento de humanização do parto e nascimento".

Furthermore, it is worth noting that the practice of midwifery and childbirth assistance remained present in various regions of the country. For example, Galvão et al. (2019, p. 36) report that "until the 1970s, there were no hospitals in Cabula, [...] the culture of childbirth and delivery was still preserved, with its characteristics of a family event, carried out at home under the care of midwives and traditional caregivers"[21]. Additionally, due to multiple problems in maternity care within hospitals, as mentioned, since the mid-1980s, the World Health Organization (WHO) has taken a critical stance toward the excessive medicalization of childbirth, which has led to the trivialization of caesarean section practices (TORNQUIST, 2005, p. 65).

Moreover, the hospitalization of childbirth did not solve the problem of high maternal mortality rates, which reached significant numbers in Brazil in the late 20th century. According to Fleischer (2005, p. 5), data from three international organizations – WHO, United Nations Population Fund (UNFPA), and United Nations Children's Fund (UNICEF) – indicated that in Brazil, there were 260 maternal deaths per 100,000 births, while in Europe and the United States, the rate was 6 to 11 deaths per 100,000 births. Equally significant are the data regarding the number of caesarean sections: although the WHO suggested that an acceptable margin for this practice was up to 15% of births, the average in the Brazilian context reached a total of 38% of cases, reaching up to 90% in some private hospitals (FLEISCHER, 2005, p. 3). In this regard, the author emphasizes that

> There is a "culture of caesarean section", a major surgical intervention that is often prioritized over its necessity. Among other negative consequences, there is the risk of "puerperal infection, three times higher risk of maternal mortality and morbidity, increased risks of prematurity and neonatal mortality, more difficult recovery for the mother, longer separation period between mother and baby with delayed initiation of breastfeeding, and increased costs for the healthcare system" (Hotimsky et al., 2002, p. 1)[22] (FLEISCHER, 2005, p. 3-4).

In view of this, various initiatives sought to reclaim the value of traditional methods of childbirth assistance. Examples of these initiatives include the efforts of professionals responsible for the training of traditional midwives in the state of Tocantins in the 1980s, and the I International Meeting of Forest Midwives held in Macapá, the capital of Amapá, from July 18th to 21st, 1998 (PINTO, 2002, p. 445). Within the institutional sphere, the Comprehensive Women's Health Care Program (PAISM) launched in 1984 is noteworthy. Among its directives, it included "the adoption of measures aimed at improving the quality of home births performed by traditional midwives through training, supervision, provision of birthing materials, and establishment of referral mechanisms"[23] (GUSMAN et al., 2015, p. 367). Additionally, in the year 2000, the Ministry of Health launched the "Working with Traditional Midwives Program" (PTPT) with the goal of reducing maternal and

---

[21] Original: "até a década de 1970, não existiam hospitais no Cabula, [...] a cultura do parto e nascimento ainda era preservada, com suas características de evento familiar, doméstico sob cuidados de parteiras e cuidadoras tradicionais".

[22] Original: "Há uma "cultura da cesárea", intervenção cirúrgica de grande porte que se sobrepõe, em muito, à sua conveniência: entre outras conseqüências negativas, estão o risco de "infecção puerperal, três vezes mais risco de mortalidade e morbidade materna, aumento dos riscos de prematuridade e mortalidade neonatal, recuperação mais difícil da mãe, maior período de separação entre mãe/bebê com retardo do início da amamentação e elevação de gastos para o sistema de saúde" (Hotimsky et al., 2002, p. 1)".

[23] Original: "a adoção de medidas visando à melhoria da qualidade do parto domiciliar realizado pelas parteiras tradicionais, através do treinamento, supervisão, fornecimento de material de parto e estabelecimento de mecanismos de referência".

perinatal mortality rates and improving care during pregnancy, childbirth, abortion, postpartum, and for newborns (ARAÚJO; LIMA, 2010, p. 11).

Despite the stigma and extensive campaign to discredit them, midwives persisted in operating in the gaps and loopholes of hygiene and modernization, preserving a status of "almost" sanctity in peasant and popular contexts (TORNQUIST, 2005, p. 62-63). According to Araújo and Lima (2010, p. 20-21), the social position of midwives is ambiguous, oscillating between a position of subordination [to doctors and nurses] and a position of prestige among pregnant women and the local population, where they perform an important role in maintaining the values and knowledge of the community in which they are embedded. Additionally, Barroso (2009, p. 10-11) states:

> In fact, the social legitimacy of the midwifery profession lies within the popular core of rural and riverside areas, where they are culturally identified, share experiences, and engage in vibrant, enduring, and effective social relationships. They are women who are homemakers, fishermen, farmers, elderly, and poor, yet they possess a distinct popular knowledge in modern times. (...) In light of this account, being a midwife means producing a particular mode of assistance through their profession. It entails dedication and selflessness. This act of giving leads to an increase in their personal power within the community that relies on their services, while simultaneously gaining social legitimacy. This legitimacy is expressed in the production of knowledge, in the spaces where they reproduce their practices, that is, within the boundaries of their field of operation involving the community and their relationship with nature.

As Oliveira et al. (2020, p. 84-85) point out, "the daily life of these women is marked by their common tasks in rural life: working in the fields, making flour, preparing food, doing laundry and dishes, caring for small animals, and medicinal plants"[24]. Nevertheless, they are always ready to assist people who seek them out, whether during pregnancy, childbirth, or the postpartum period, as they play a significant role in managing pregnancy risks and diagnosing the appropriate type of delivery. Addressing the context of rural communities in the Amazonas, the mentioned author states that "in the month preceding the due date for delivery, women consult the midwives to find out if they can have a normal delivery or if they will need a caesarean section. It is the midwife who must finally 'make the decision whether it will be a normal delivery or not'"[25] (OLIVEIRA et al., 2020, p. 94).

Although the demand for their services has significantly decreased in recent times due to the so-called "medicalization of childbirth", in remote regions far from health centres and hospitals, these women continue to play a vital role in providing care to pregnant women. In this context, they perform various activities even after the birth of the child, depending on geographical needs and the recognition they receive from the community (OLIVEIRA et al., 2020, p. 94). Discussing the context of midwives and "experienced" women in rural villages in the Tocantins region of Pará, Pinto emphasizes:

> They are mothers, wives, grandmothers, godmothers, and aunts who have learned from their ancestors to perform tasks both in the natural world, carrying out various forms of

[24] Original: "o cotidiano dessas mulheres é marcado por seus afazeres comuns da vida rural: trabalho em roça, fabricação de farinha, preparação da comida, lavagem de roupas e vasilhas, cuidado de pequenos animais, de plantas medicinais".

[25] Original: "no mês que antecede a data prevista para o parto, as mulheres consultam as parteiras para saber se poderão ter parto normal ou se precisarão de cesárea. É a parteira que deve, finalmente, 'dar a decisão se é para ter normal ou não'".

> work, and in the supernatural realm, performing blessings, reciting prayers, and invoking enchantments to obtain help during childbirth and heal the ailments of their people. Even today, the presence of these women in rural villages is indispensable. Among their communities, they are seen as doctors, nurses, pharmacists capable of providing relief, through ointments, baths, herbal teas, and prayers, for the pains and ailments of the population who have no other resource[26] (PINTO, 2002, p. 441).

Although the dichotomy between tradition/modernity, which subordinates local knowledge to a universal biomedical order, structures official discourses (FERREIRA, 2013, p. 207), it can be said that in recent decades the discourse valuing traditional midwives has undergone changes, recognizing their true importance (GUSMAN et al., 2015, p. 367). However, there are still several challenges for the practice of this profession, such as lack of remuneration for their services; disrespectful treatment from the healthcare sector; disregard for empirical knowledge by trained midwives, nurses, and doctors (ARAÚJO; LIMA, 2010, p. 20); difficulties in mobility; lack of basic resources; and adverse circumstances inherent to the profession, such as sleep and hunger, as they often spend days or even weeks at the birthing woman's house (PINTO, 2002, p. 443).

Nevertheless, Aires (2005, p. 6) emphasizes that both the mother and the baby benefit from the care provided by midwives, as the support extends beyond the moment of birth. “In fact, it is common for midwives to inquire about the lives of the babies even after they have grown up [...]. Some children, now adults, maintain a friendship relationship with them, calling them grandmother or even mother”[27] (AIRES, 2005, p. 6). Furthermore, De Menezes et al. (2012, p. 30) highlight freedom as a key element of home birth, where women have freedom in their food choices, movements, positions, behaviours, and expressions, enjoying the freedom to socialize with privacy and comfort. In their words, they summarize: “the woman is considered an active subject and protagonist of the birth”[28] (DE MENEZES et al., 2012, p. 23).

In summary, it can be said that “the act of midwifery as a feminist practice has the power to value the profession of midwifery, as well as the feminine knowledge surrounding this process, being a rescue and a form of resistance to domination and subjugation”[29] (SANTOS; SILVA, 2021, p. 8). In contrast to the reality of institutional violence and dehumanized practices in various Brazilian maternity wards and obstetric centres, the work of traditional midwives, marked by their own techniques that diverge from modern medicine, has a strong religious connection to the supernatural and presents practical consonances with the principles of humanizing childbirth. It has a symbolic logic that goes beyond modernity (SANTOS; SILVA, 2021, p. 9; DE MENEZES et al., 2012, p. 23).

Finally, it is worth noting that although midwifery is predominantly seen as a practice carried out by women, there are some accounts of male involvement in childbirth assistance, as mentioned

---

[26] Original: “Elas são mães, esposas, avós, comadres, madrinhas e tias, que aprenderam com suas antepassadas a desempenhar afazeres tanto no mundo natural, executando as mais diversificadas formas de trabalho, como no plano sobrenatural, benzendo, recitando rezas e invocando encantarias, para obter ajuda na hora do parto e curar os males do seu povo. Ainda hoje, a presença dessas mulheres nos povoados rurais é indispensável. Entre os seus, são vistas como médicas, enfermeiras, farmacêuticas, capazes de fazer aliviar, com ungüentos, banhos, chás de ervas e rezas, as dores e os males da população que não conta com outro recurso”.

[27] Original: “Tanto é assim, que é comum as parteiras procurarem saber da vida dos bebês depois de adultos [...]. Algumas crianças, agora já adultas, mantém com elas uma relação de amizade, chamam-nas de avó, ou até de mãe”.

[28] Original: “a mulher é considerada sujeito ativo e protagonista do parto”.

[29] Original: “o ato de partejar como prática feminista tem o poder de valorização do ofício de partejar, bem como, dos saberes femininos em torno desse processo, sendo um resgate e uma forma de resistência ao domínio e a condição de submissão”.

by Pinto (2002, p. 446-227), according to which: “through the memories of the elderly in Tocantins, stories of men, mainly in the Umarizal village, were reconstructed, who, besides having the gift of blessing and healing, are also remembered as midwives”[30]. According to the author, “the men considered 'half-midwives' [...] were blessers, prayer reciters, experienced or healers. However, they only assisted in childbirth if they had a midwife assistant”[31] (PINTO, 2002, p. 446-227).

1.2 The issue of delivery and birth assistance in the indigenous context

Differing from what has been presented so far, there are multiple interpretations of the practice of midwifery within different indigenous cultures. Therefore, we will present data from some of these cultures, noting that they may not necessarily apply to the experiences of other ethnic groups (and often to different villages within these ethnic groups, which, although part of the same sociocultural context, have different ways of “approaching” the issue of childbirth and delivery assistance). In some cultures, for example, the person attending the birth is not even identified as a “midwife”, as this is “modern” concept that has been internalized through the exchange of experiences with doctors and indigenous health agents (GUSMAN, 2019).

The following analysis is primarily based on anthropological research with an ethnographic approach conducted with indigenous women from the Upper Rio Negro (AZEVEDO, 2009) and the Munduruku ethnicity in the Amazonas (DIAS-SCOPEL et al., 2017); the Krahô ethnicity in Tocantins (GUSMAN, 2019); midwives and/or shamans and indigenous health agents in the Upper Juruá region in Acre (FERREIRA, 2013), who provide services to the Kaigang ethnicity in Santa Catarina (GIRARDI; LÓPEZ, 2020); Xukuru do Ororubá (ARAÚJO et al., 2020) and Pankararu (TENDERINI, 2020) in Pernambuco; Xukuru-Kariri in Alagoas (DA ROCHA; MOREIRA, 2022), and the Karipuna and Galibi-Marworno ethnicities in the Uaçá River valley, Oiapoque, Amapá (TASSINARI, 2021).

Firstly, it is important to note that in most cases, the events that occur during women's reproductive period are part of a broader relationship with the sociocultural and environmental context in which the woman is situated. The cosmologies of her people play a fundamental role and are determinants in ensuring the woman's health and the healthy development of the unborn child. According to Dias-Scopel et al. (2017, p. 195), “what is at stake is an understanding of the body that does not separate, *a priori*, the cosmological and social from the biological”[32]. As an illustration, we cite an excerpt from the ethnographic study conducted by the authors with indigenous people of the Munduruku ethnicity:

> For the Munduruku, these events constitute stages of a process marked by liminal moments in which the individuals involved strive to avoid misfortunes and illnesses and to maintain the well-being of the baby and parents in the face of the dangers of coexistence between humans and animals. Notions of health and well-being, from a Munduruku perspective, encompass the relationships of proximity and distance with other beings that

[30] Original: “através das lembranças de velhos e velhas do Tocantins, [foram reconstituídas] histórias de homens, principalmente no povoado de Umarizal, que, além de possuírem o dom de benzer e curar, também são lembrados como parteiros”.

[31] Original: “os homens considerados ‘meio parteiros’ [...] eram benzedores, rezadores, experientes ou curadores. Porém, somente partejavam se tivessem uma parteira auxiliar”.

[32] Original: “o que está em foco é uma compreensão de corpo que não separa, *a priori*, o cosmológico e o social do biológico”.

inhabit the cosmos. In this perspective, the body, territory, and environment are elements that are interconnected in self-care practices for health[33].

In the same vein, Azevedo (2009, p. 471) reports that, in the experience of indigenous communities in the Upper Rio Negro, "a khumbo baby is considered to be formed by the blood of the woman who generates its blood and flesh, and the sperm that forms its bones and a type of soul connected to the cycle of rebirth and the sacred mountains, to which all the deceased return"[34]. Moreover, it is important to note that in various cultures, childbirth blood is remembered as something dangerous: "contact with another person's kaprô (blood) causes illness and makes the skin turn yellow"[35] (GUSMAN et al., 2019, p. 2634); "menstrual, childbirth, and postpartum bleeding constitute a threat to the community, as blood has the ability to attract evil spirits"[36] (DIAS-SCOPEL et al., 2017, p. 192).

Understanding the reality of cultural differences related to indigenous communities, the Indigenous Health Subsystem was created in 1999 as a result of changes in the Brazilian public health system that had been taking place since the 1980s. Consequently, in 2002, the National Policy on Healthcare for Indigenous Peoples (PNASPI) was instituted, seeking to reconcile the differentiated rights constitutionally guaranteed to indigenous peoples with the Organic Health Law. However, it was only in 2004 that, through the development of the National Policy for Comprehensive Women's Health Care (PNAISM), guided by the principles of comprehensiveness, equity, and universality that constitute the Unified Health System (SUS), gender, race, ethnicity, and generational perspectives began to be considered (ARAÚJO et al., 2020, p. 198).

Despite the late emergence of government policies, historical data indicate that the state's relationship with assistance practices led by indigenous women already had a place in the second half of the 20th century. In the Xucuru-Kariri context in Palmeira dos Índios (AL), a work plan promoted by Dutch nuns already envisioned a prenatal care project for pregnant indigenous women, which subsequently led to the training of traditional midwives for curative and hygiene activities during childbirth (DA ROCHA; MOREIRA, 2022, p. 96-97). In this context, Da Rocha and Moreira (2002, p. 97) transcribe the testimony of a midwife who reports that when she interned at the hospital, she already mastered the art of midwifery, learned from her grandmother:

> When a person is born with a gift, it's already with them! In the villages, in indigenous tribes, it's always like that, it's always like that. If there's someone in my family who has the intuition to be a midwife, then another one will come in the family. My mother is getting old and tired, she can't do it anymore... Before she can't do anything, someone will appear who will do it. If it's a healer, someone who knows prayers, who makes herbal remedies and such, someone

[33] Original: "Para os Munduruku, esses eventos configuram etapas de um processo marcado por momentos liminares em que os atores envolvidos se esforçam para evitar infortúnios e doenças, e para manter o bem-estar do bebê e dos pais frente aos perigos da coexistência entre *gentes* e *bichos*. As noções de saúde e bem-estar, desde uma perspectiva Munduruku, englobam as relações de aproximação e afastamento com os demais seres que habitam o cosmo. Nessa perspectiva, corpo, território e ambiente constituem elementos que se articulam nas práticas de autoatenção à saúde" (itálico original).

[34] Original: "um nenê khumbo é considerado como formado pelo sangue da mulher que gera seu sangue e sua carne, e o esperma que forma os ossos e um tipo de alma ligado ao ciclo do renascimento e às montanhas sagradas, para as quais todos os mortos voltam".

[35] Original: "o contato com o kaprô (sangue) de outra pessoa faz adoecer e torna a pele amarelada".

[36] Original: "o sangramento menstrual, do parto e do período pós-parto constitui uma ameaça à coletividade, na medida em que o sangue tem a capacidade de atrair espíritos maus".

> from the family will come. It was my grandmother, my mother's mother. We used a lot of prayers, did a lot of rituals during the delivery. At the beginning, when the pains started, we would place a prayer around the neck, make a cross on the belly with the remedies. All these things were what we used, there were no doctors, my child! And it was the things we used that worked[37].

Traditional midwives, often members of indigenous communities, play a crucial role in preserving the rituals, customs, and traditions related to pregnancy, childbirth, and postpartum care. As Girardi and López (2020, p. 213) explain, "the knowledge passed down by indigenous women regarding care during the pregnancy and postpartum period spans generations and evolves, it is a dynamic process"[38]. Such knowledge is acquired within the family, as stated in a testimony transcribed by the authors: "The first delivery I attended was my sister's, with the help of my mother when I was around fifteen years old"[39] (GIRARDI; LOPEZ, 2020, p. 212).

In this context, Tassinari (2021, p. 112-113) points out that, within the Karipuna or Galibi-Marworno ethnic groups, the presence of older women from the family in their daily activities of assisting pregnant women "is such a common occurrence that it does not deserve special attention"[40]. In her words, "every Karipuna or Galibi-Marworno woman masters the knowledge related to the mother's body and is ready to assist in childbirth, if necessary, as they have already attended several deliveries of their aunts, sisters, or neighbors"[41] (TASSINARI, 2021, p. 112). However, the author emphasizes that not only the generational transmission of knowledge is important but also learning through experience and new partnerships, where there is a circulation of these techniques and knowledge, forming a network of learning, exchanges, and mutual support (TASSINARI, 2021, p. 114).

Among the practices used by traditional midwives in indigenous communities of the mentioned ethnic groups, one notable practice is "puxação", which "refers to a technique to 'put the

---

[37] Original: "Quando a pessoa nasce com um dom, ai já vem com ele! Nas aldeias, nas tribos indígenas sempre tem assim, sempre é assim, se tem uma pessoa da minha família que ela tem essa intuição dela ser parteira, depois vai vir um na família, minha mãe vai ficando velha e vai cansando, não vai podendo mais fazer... Antes dela não puder fazer nada vai aparecer uma que vai fazer. Se for um curador de ramo, de reza, de fazer garrafada, essas coisas, vai vir um da família. (Foi) a minha avó, a mãe da minha mãe. Se usava muita oração, fazia muita simpatia na hora de fazer aquele parto, no começo, começava a sentir as dores, colocava uma oração no pescoço, fazia um encruzamento na barriga com os remédios, tudo isso era coisa que usava, não tinha doutor meu filho! E era as coisas que usava e funcionava".

[38] Original: "os conhecimentos passados pelas mulheres indígenas sobre os cuidados no período gravídico-puerperal perpassam gerações e vão se renovando, são processos dinâmicos".

[39] Original: "o primeiro parto que eu fiz, foi da minha irmã, com a ajuda de minha mãe, eu tinha uns quinze anos".

[40] Original: "é algo tão corriqueiro que não merecesse destaque".

[41] Original: "toda mulher Karipuna ou Galibi-Marworno domina os conhecimentos relacionados à mãe do corpo e está pronta a partejar, se for necessário, na medida em que já acompanhou vários partos de suas tias, irmãs ou vizinhas".

mother's body in place'[42], restoring the person's health and balance"[43], meaning it is a massage technique or body procedures aimed at restoring balance and health (TASSINARI, 2021, p. 108). This technique is considered essential for preparing for a smooth delivery, as it contributes to the proper positioning of the fetus during birth. However, Tassinari (2021, p. 117) reveals that with the increasing influence of indigenous women adopting biomedical practices, such practices have been met with suspicion and discouraged, along with other aspects of their sociocultural context, viewed with scepticism by doctors and nurses.

In addition to this, other practices are common among traditional midwives in the indigenous context. In the Pankararu indigenous women's community, Tenderini (2020, p. 51) mentions guidance on proper and healthy nutrition and the use of home remedies such as teas, syrups, concoctions, and "sitz baths for the woman's recovery"[44]. Similarly, the use of herbal remedies, concoctions, and teas was a common practice among Xucuru-Kariri midwives (DA ROCHA; MOREIRA, 2022, p. 100). The same applies to the Munduruku culture, where older women in the family, who possessed knowledge and experience in midwifery, would cleanse the woman and prepare teas and prayers to manage any complications (DIAS-SCOPEL, et al., 2017, p. 197). Finally, within the Karipuna or Galibi-Marworno ethnic groups, "the strength of the foetus is recognized as an important element for its birth, and some teas and massages aim to 'encourage the baby to be born'"[45] (TASSINARI, 2021, p. 118).

According to Tassinari (2021, p. 119):

> The midwives visit the postpartum woman for eight days, during which they prepare baths and teas for her and the newborn. For the baby, they prepare a bath with purple cotton leaves and take care of their umbilical cord. The postpartum woman's sitz bath is called "bẽ" and is made with "travosas" barks: barks of andiroba, ucuúba, verônica, cashew, mango, anani, capitiú. (...) It is said that the bath is very effective for internal and external healing of the vaginal area[46].

The preparation of teas is a constant in the experiences of traditional midwives working in indigenous contexts, even used to increase contractions (TASSINARI, 2021, p. 118; TENDERINI, 2020, p. 22). The experience of midwives is valued, particularly for the support, care, respect, affection, and

---

[42] According to Dias-Scopel et al. (2017, p. 197-198), "pulling the mother of the body is an activity that plays a central role in self-attention practices during childbirth, especially in women's health, impacting the rest of their lives. The mother of the body is part of the female body. It is a vital force that has materiality in the female womb but should not be confused with the uterus or ovaries. Pulling the mother of the body involves manipulating the woman's abdomen with hands, intending to place it in its proper position just below the navel. It is a common practice whenever a woman, whether pregnant or not, feels unwell. It is said that her displacement within the female body can cause illness and death. This fact weighs upon childbirth practices, which is why, immediately after the expulsion of the placenta, an older and experienced woman should reposition the mother of the body through a series of massages on the labouring woman's abdomen".

[43] Original: "se refere a uma técnica para 'colocar a mãe do corpo no lugar', restabelecendo a saúde e equilíbrio da pessoa".

[44] Original: "banho de assento para a mulher ficar boa".

[45] Original: "a força do feto é reconhecida como elemento importante para seu nascimento e alguns chás e massagens têm o intuito de "animar o bebê para nascer".

[46] Original: "As parteiras visitam a puérpera durante oito dias, quando preparam banhos e chás para ela e para o recém-nascido. Para o bebê, preparam um banho com folhas do algodão roxo e cuidam do seu cordão umbilical. O banho de assento da puérpera é chamado de *bẽ*, feito com "cascas travosas": cascas de andiroba, ucuúba, verônica, caju, manga, anani, capitiú. (...) Dizem que o banho é muito eficaz para a cicatrização interna e externa da região vaginal".

love they provide to the birthing woman (TENDERINI, 2020, p. 55). However, the use of biomedicine is increasingly integrated with traditional knowledge, primarily due to the action of indigenous healthcare teams in these territories. Araújo et al. (2020, p. 200) point out that "Xukuru do Ororubá women regularly use both biomedicine and indigenous medicine simultaneously"[47]. According to the authors, "indigenous women under 30 know less and almost no longer use culturally acquired ways/ care"[48] (ARAÚJO et al., 2020, p. 200-201).

Considering this situation, Gusman et al. (2019, p. 2633) emphasize that using the rationality of the dominant medical model to align indigenous knowledge and practices with the categories practiced and recognized by biomedicine can lead to subordination and devaluation of certain indigenous knowledge and its practitioners. In this context, Tassinari (2021, p. 116-117) highlights the feeling of resentment among traditional midwives regarding how their knowledge is treated in meetings organized by the government, as some practices are discouraged due to mistrust of their hygiene notions. According to the author,

> It is necessary to point out that the overvalorization of biomedical knowledge, the simplified translation of local concepts into biomedical terms, the mistrust of the knowledge held by elder women and their notions of hygiene, and the insecurity instilled in young apprentices have strongly threatened the maintenance of the halevã practice (TASSINARI, 2021, p. 118).

In addition to impacting the culture of indigenous communities, the interaction with healthcare professionals aligned with biomedicine has led to a reorganization of care provided to pregnant women and parturients, redefining roles and interfering with the relationships established among family members and relatives involved in the process of bringing forth a new indigenous person (FERREIRA, 2013, p. 211). For example, the case of the Kaxinawá ethnic group, located in the upper Juruá region in Acre, is noteworthy, as after contact with health agents who provided training in the region, "other individuals with practical experience in assisting with childbirth were no longer authorized to provide assistance"[49] (FERREIRA, 2013, p. 211).

In this context, Gusman et al. (2019, p. 2633) emphasize "the need to propose culturally sensitive intervention models, agreed upon with the community members for whom the intervention is intended, and based on a deeper understanding of cultural relations and codes"[50]. Similarly, Araújo et al. (2020, p. 195) argue that "to achieve understanding between traditional indigenous culture and Western culture, healthcare teams must expand their knowledge beyond biomedicine and seek to understand transcultural care"[51].

---

[47] Original: "as mulheres Xukuru do Ororubá fazem uso regular da biomedicina e da medicina indígena, simultaneamente".

[48] Original: "mulheres indígenas com menos de 30 anos conhecem menos, e já quase não utilizam os modos/ cuidados culturalmente apreendidos".

[49] Original: "outras pessoas com experiência prática em 'pegar menino' foram desautorizadas a prestar assistência".

[50] Original: "a necessidade de se propor modelos de intervenção culturalmente sensíveis, pactuados com os membros da comunidade a quem se destina a intervenção e pautados no conhecimento mais aprofundado das relações e dos códigos culturais".

[51] Original: "para chegar ao entendimento entre a cultura tradicional indígena e a cultura ocidental, as equipes de saúde devem ampliar sua bagagem de conhecimentos para além da biomedicina, e buscar a compreensão do cuidado transcultural".

1.3 The practice of "doulagem" in the world of childbirth care

The scenario of obstetric violence and practices considered "unnecessary, risky, and excessively interventionist"[52] (TORNQUIST, 2002, p. 484), associated with the emergence of the medicalization of childbirth, led to a national movement in Brazil advocating for the rescue of humanization elements and the use of integrative and complementary practices (ICPs) in childbirth and maternity care (SILVA et al., 2016, p. 110). It is precisely in this context that the figure of the "doula" emerges, linked to the use of Traditional Medicine (TM) and Complementary and Alternative Medicine (CAM) (SILVA et al., 2016, p. 110), which proposes a series of less invasive procedures as an alternative to medicalization (FLEISCHER, 2005, p. 4).

According to Sampaio et al. (2018, p. 105), the presence of doulas in public hospitals began in 1997 with the pioneering initiative of the Sofia Feldman Hospital in Belo Horizonte, Minas Gerais, through the "Volunteer Doula" project. The experience spread to other Brazilian maternity hospitals until it was included in the National Policy of Obstetric and Neonatal Care. However, it was only in 2013 that doulas were recognized as a professional occupation in the Brazilian Classification of Occupations, updated by the Ministry of Labor and Employment (MTE). Nevertheless, the profession still lacks specific professional regulation, and there is a bill currently under consideration in the Federal Chamber of Deputies seeking to regulate the practice.

In this regard, the Brazilian Classification of Occupations (CBO) classifies doulas as professionals who work in health and social services, mostly as freelancers, and who apply the following techniques:

> They apply manipulative, energetic, and vibrational therapeutic procedures for the treatment of psycho-neuro-functional, musculoskeletal, and energetic disorders. They treat foot pathologies and deformities using perforating-cutting instruments, topical medications, and orthoses. They evaluate physiological, systemic, energetic, and vibrational dysfunctions through methods from Oriental and conventional medicines. They recommend their patients/clients to practice exercises and use floral essences and herbal remedies with the aim of restoring energetic, physiological, and psycho-organic balance.

In doctrinal terms, we find a series of definitions or complementary characteristics that identify and professionally situate the meaning of working as a doula. According to Silva et al. (2012, p. 2792), a doula is "a woman who provides physical, emotional, social, and spiritual support, also providing guidance to labouring women during labour, childbirth, and postpartum"[53]. Additionally, Fleischer (2005, p. 4) adds that "the doula transforms an inappropriate place into an appropriate one. [...] They proclaim that childbirth should return to being a matter for women and not for doctors, hospitals, and technology"[54].

In this sense, authors report that "the work of doulas demonstrates the emergence of a new type of organization of knowledge and practices about childbirth, delineating another area of

[52] Original: "desnecessárias, geradoras de risco e excessivamente intervencionistas".

[53] Original: "a mulher que dá suporte físico, emocional, social e espiritual, fornecendo também orientações às parturientes durante o trabalho de parto, parto e pós-parto".

[54] Original: "a doula transforma um lugar não adequado em um lugar adequado. (...) Elas proclamam que o parto deve voltar a ser uma coisa das mulheres e não da seara de médicos, hospitais e tecnologia".

knowledge and professional practice committed to women's needs"[55] (Silva et al., 2016, p. 110). According to Tempesta (2018, p. 43-44):

> Doulas act to promote a childbirth experience perceived as respectful, satisfying, beautiful, in which medical resources are employed only in case of "real" necessity, and with the woman's express consent. Thus, for childbirth to be considered successful, the labouring woman must be respected in her entirety as the protagonist of the event; she must receive all relevant information in understandable language and be fully embraced by those present; her unique physiological and psychological rhythms must be respected; pain must be addressed in the manner she deems appropriate at the moment it manifests; skin-to-skin contact with the baby should be encouraged; non-pharmacological methods should be applied for discomfort and pain relief; and the bond with significant people to her should be protected in the birthing scene[56].

In their research, Silva et al. (2012, p. 2789) identify six types of support provided by doulas, which are: i) physical, including breathing techniques, positioning, walking, hot or cold compresses, and body movements; ii) social, concerning respect for the family and the multidisciplinary team, where the doula promotes a calm environment focused on the labouring woman's interests; iii) emotional, as one of the main functions of the doula is to reduce fear and anxiety and provide encouragement, maintaining physical and visual contact with the labouring woman through sincere and transparent conversations; iv) informational, as the doula provides guidance on obstetric interventions, proper positioning, clarifies technical terms, and answers questions, providing information to family members and the multidisciplinary team; v) support for the labouring woman's decision-making, and vi) alternative and complementary practices.

In this last type of support, techniques aligned with the idea of childbirth humanization are found, such as: accepting comfortable positions chosen by the labouring woman; providing comforting massages; performing pain relief techniques; teaching body movement with props (ball, birthing stool, Ling's ladder); promoting tenderness; physical and mental relaxation; using herbal teas, homeopathy, music therapy, colour therapy, hydrotherapy, meditation, prayers, and blessings (Silva et al., 2012, p. 2789). As an illustration, we present the "intentionally open and incomplete" table by Tempesta (2018, p. 46-47), which describes a series of practices used by childbirth humanization activists in contrast to those found in the biomedical model:

Biomedical Model	**Humanized Model (Respectful)**

[55] Original: "no trabalho das doulas evidencia-se a emergência de um novo tipo de organização dos saberes e práticas sobre o parto, demarcando outra área de saber e de prática profissional comprometida com as necessidades das mulheres".

[56] Original: "As doulas atuam no sentido de favorecer uma experiência de parto percebida como respeitosa, satisfatória, bonita, na qual os recursos médicos sejam empregados somente em caso de necessidade "real", e com o consentimento expresso da mulher. Assim, para que o parto seja considerado bem-sucedido, a parturiente deve ser respeitada em sua integralidade, enquanto protagonista do evento; ela deve receber todas as informações relevantes em linguagem compreensível e deve ser plenamente acolhida pelos presentes; seus ritmos fisiológicos e psicológicos únicos devem ser respeitados; a dor deve ser enfrentada da maneira que lhe convier no momento de sua manifestação; o contato pele a pele com o bebê deve ser estimulado; métodos não-farmacológicos devem ser aplicados para alívio do desconforto e das dores; e o laço com as pessoas significativas para ela deve ser resguardado na cena do parto".

Risk as a variable to be analysed before and during the event	Risk as part of life
Medical team's protagonism, rigid hierarchy, distinct responsibilities	Woman's protagonism, birthing as a symmetrical relationship, shared responsibility
Specialized information as the professional's monopoly	Shared and discussed specialized information with the woman
Impersonality	Empathy, connection
Physical contact mediated by instruments	Skin-to-skin contact
Ideal of complete asepsis	Acceptance of contact with bodily substances (blood, amniotic fluid, sweat, feces)
Pain as an emotion to be fought against or neutralized	Pain as an emotion to be embraced
Institution or healthcare professionals imposing schedules, measures, and standards	Respect for the woman's physiological and psychological rhythms, her decisions, and desires
Generalizing and objectifying practices towards individuals	Individualized practices that respect the woman's subjectivity
Viewing a person as having a problem (illness, deviation, imperfection, etc.) to be solved or a flaw to be corrected, normalized	Viewing a person with a microcosm of relationships to be embraced
Ideal of a motionless, generic body susceptible to manipulation	Ideal of a liberated body invested with unique emotions, desires, and sensations
Result (a healthy baby) matters more than the process (labour)	Result and process are equally important
Fragmented and mechanical approach to childbirth and birth	Holistic/organic approach to childbirth and birth
Hard technology	Soft technology
...	...

It can be said that “the ideal guiding the work of doulas is natural childbirth, centred on the woman, minimally surrounded by doctors and technology”[57] (FLEISCHER, 2005, p. 6). In the case of the need for a caesarean section, doulas strive to implement humanized procedures to minimize the need for medical intervention. In this sense, Fleischer (2005, p. 7, original italics) explains that “to humanize [...] *each* doula offers a specific approach for *each* moment of each woman's childbirth, instead of subjecting all women to the same 'routine procedures'”[58].

Symbolically, one could say that the doula is “halfway between the close family members of the birthing woman”[59] (TEMPESTA, 2018, p. 49-50), which, however, also has negative effects. Due to the lack of regulation regarding the specific role that doulas should play in the medical-hospital

[57] Original: “o ideal que norteia o trabalho das doulas é o parto natural, centrado na mulher, minimamente cercado de médicos e tecnologia”.

[58] Original: “humanizar (...) é *cada* doula oferecer uma abordagem específica para *cada* momento do parto de cada mulher, ao invés de submeter todas as mulheres à mesma ‘rotina de procedimentos’”.

[59] Original: “a meio caminho entre os familiares próximos da parturiente”.

environment, they are sometimes seen as “companions” of the birthing woman rather than as members of the medical team. This factor is often severely criticized in specialized doctrine, as hospitals typically only accept one companion during childbirth, usually the husband. From this perspective, APOIAR[60] suggests that the entry of the doula into the hospital should be presented and negotiated by the pregnant woman with the obstetrician, so that, with their authorization, they are not required to justify their presence to the hospital's administrative authorities and can equally enjoy the same sense of “authority” as the medical team (FLEISCHER, 2005, p. 10).

The contact between the doula and the birthing woman can occur either beforehand or only at the hospital. However, it is essential that this contact takes place before labour to establish a “bond” between the doula and the woman (FLEISCHER, 2005, p. 9). At this moment, they should negotiate and establish a “birth plan”, which is “a document with all the steps that the medical team and the birthing woman intend - ideally - to follow during childbirth”[61] (FLEISCHER, 2005, p. 9). Furthermore, studies point to the importance of establishing a written contract or agreement between the parties, stipulating, among other things, the amount to be paid in exchange for their services. However, this is a controversial issue that generates disagreement among professionals, as “some doulas have expressed some discomfort in introducing a contract into a relationship that prioritizes 'affection, love, dialogue, support, friendship'”[62] (FLEISCHER, 2005, p. 8-9).

In addition to this, Fleischer (2005, p. 8) highlights another point that sparks discussions among professionals:

> During the training, the instructors emphasized that it is preferable, but not necessary, for the doula to have personal experience with pregnancy, childbirth, and motherhood. The important thing is that if she is a mother, her childbirth experience has been positive. If she is not yet a mother, her experience of being born has been positive. If either of these cases has been negative, the doula needs to "work through" it before providing any assistance to pregnant women. This means undergoing some form of therapy and, above all, not confusing her own experience with that of the birthing woman. In her work, the doula needs to maintain a "rational" perspective and not become overwhelmed by the problems faced by the birthing woman. In fact, during the training, they emphasized that "any professional who knows themselves well tends to work better”. "Self-awareness" is highly valued in this field[63].

In practice, there are several prerequisites for becoming a doula, including: availability of time; being healthy and physically capable; having someone to take care of their own children if necessary; having the support of their partner and family regarding the practice of the activity;

---

[60] APOIAR is a non-governmental organisation created in 2001 to train and give visibility to the work of doulas.

[61] Original: “um documento com todas as etapas que a equipe médica e a parturiente pretendem – idealmente – cumprir durante o parto”.

[62] Original: “algumas doulas têm manifestado certo constrangimento em introduzir um contrato em uma relação que prioriza ‘afeto, amor, diálogo, apoio, amizade’”.

[63] Original: “Durante o curso, as instrutoras asseguraram que é preferível, mas não necessário, que a doula tenha experiência própria com gravidez, parto e maternidade. O importante é que, se for mãe, a experiência de parto tenha sido positiva. Se não for mãe ainda, que a experiência de nascer tenha sido positiva. Se qualquer um dos casos tenha sido negativo, a doula precisa “se resolver” antes de prestar qualquer assistência a gestantes. Isto quer dizer fazer algum tipo de terapia e, sobretudo, não confundir sua experiência com a da parturiente. No trabalho, a doula precisa ser a ponta “racional” e não se desesperar com os problemas enfrentados pela parturiente. Inclusive, lembraram no curso que “qualquer profissional que se conhece bem tende a trabalhar melhor”. O “autoconhecimento” é muito valorizado neste meio”.

having another doula to cover emergencies; having undergone training and having a reliable means of transportation (FLEISCHER, 2005, p. 8). Tempesta and França (2021, p. 281) explain that "in training courses, the transmission of knowledge about feminine identity and reproductive powers occurs in a personalized and initiatory manner"[64]. According to the authors, this learning experience combines knowledge obtained from personal experiences, "traditional" and "alternative" practices, and information provided by evidence-based medicine (TEMPESTA; FRANÇA, 2021, p. 281).

However, Fleischer (2005, p. 5), citing Tornquist (2002, p. 487), points out that "despite criticizing scientific language, these doulas also use it"[65]. However, they adopt biomedical language "so that their proposals are heard"[66], as a way of seeking scientific legitimacy for the profession. By practicing their approaches focused on the humanization of childbirth, "the doulas would be simultaneously destabilizing the supremacy of certain hegemonic concepts and images and proposing the formulation of other meanings, another type of technology, and other 'authoritative knowledge'"[67] (TEMPESTA, 2018, p. 57).

Finally, Tempesta (2018, p. 38) highlights a wide diversity of doula styles, ranging from more traditionalist approaches (such as "doulas in the tradition", who work with traditional midwives) to more technicist approaches that resemble obstetric nursing, with a common mixture of techniques and conceptions from different epistemological frameworks. Despite this multiplicity of ways of practicing the profession, the expected outcome in all cases is the empowerment of the pregnant-mother woman, "who feels secure in experiencing childbirth her own way, facing the challenges of the postpartum period, and making 'conscious' decisions regarding her own health and the baby's health"[68] (TEMPESTA, 2018, p. 52-53). "Even without institutional ties, doulas fill a gap in maternity wards and homes and benefit the pregnant woman, the family, and the institution"[69] (SILVA, et al., 2012, p. 2791).

2. Law and Jurisprudence

2.1 Brazil

It is possible to identify in Brazilian legislation some laws that deal with the activity of traditional midwives. For example, we can mention Decree N. 20.931, dated January 11, 1932, which "regulates and oversees the practice of medicine, dentistry, veterinary medicine, and the professions of pharmacist, midwife, and nurse in Brazil, and establishes penalties". The regulation stated that "midwives and nurses specialized in obstetrics should limit themselves to the essential care of labouring women and newborns in normal cases, and in any abnormality, they should request the presence of a physician [...]" (Article 36). Similarly, it held midwives responsible for accidents

[64] Original: "nos cursos de formação, a transmissão de conhecimentos sobre a identidade feminina e seus poderes reprodutivos se dá de forma personalizada e iniciática".

[65] Original: "apesar de criticarem a linguagem científica, estas doulas também a utilizam".

[66] Original: "para que suas propostas sejam ouvidas".

[67] Original: "as doulas estariam simultaneamente desestabilizando a supremacia de certos conceitos e imagens hegemônicos e propondo a formulação de outros sentidos, outro tipo de tecnologia e outros 'conhecimentos autoritativos'".

[68] Original: "que se sente segura para viver a experiência do parto à sua maneira, para enfrentar os desafios do puerpério e para tomar decisões "conscientes" em relação a sua própria saúde e à saúde do bebê".

[69] Original: "As doulas, mesmo sem vínculo institucional, suprem uma lacuna de profissionais nas maternidades e domicílios e beneficiam a mulher grávida, a família e a instituição".

attributable to their lack of skill in their interventions, imposing certain restrictions on the practice of the profession, such as:

> Article 37. The following activities are prohibited for midwives: a) Providing medical assistance to women and children outside the childbirth period or performing any surgical intervention; b) Taking in labouring women and pregnant women for treatment at their own residence or in an establishment under their immediate or indirect direction; c) Operating a clinic for examinations and wound care; d) Prescribing medications, except in urgent cases where it is necessary to prevent or combat severe accidents that endanger the life of the labouring woman, fetus, or newborn[70].

Therefore, Decree-Law N. 8.778, dated January 22, 1946, came into effect, aiming to regulate the qualification exams for nursing aides and "practical midwives". The decree stated that professionals with more than two years of effective nursing experience in a hospital setting could undergo qualification exams to obtain the certificates of "practical nurse" and "practical midwife" (Article 1). It also specified that the certificates granted the right to serve as attendants to patients in hospitals, maternity wards, clinics, and outpatient facilities in the state where they were issued (Article 13).

Later, Law N. 3.640, dated October 10, 1959, extended the terms of Decree-Law N. 8.778, dated January 22, 1946, for a period of five years. However, it exempted practical nurses and midwives with more than 20 years of professional experience from the qualification exams mentioned in Article 1 of the decree. Subsequently, Law N. 7.498, dated June 25, 1986, was enacted to regulate the nursing profession. The law recognized midwives as professionals in the field (Article 2) and classified midwives as either (i) holders of the certificate provided for in Article 1 of Decree-Law N. 8.778, dated January 22, 1946, subject to the provisions of Law N. 3.640, dated October 10, 1959, or (ii) holders of a diploma or certificate in Midwifery, or its equivalent, awarded by a foreign school or course in accordance with the laws of the country, registered as a Midwife certificate through cultural exchange or revalidated in Brazil within two years after the publication of that law.

However, there has never been specific regulation of the profession in the Brazilian context. At the federal level, legislative initiatives began with Bill N. 2.354, dated October 22, 2003, proposed by then-Deputy Janete Capiberibe (PSB/AP). The bill aimed to recognize the profession and stipulated that the practice of traditional midwifery, whenever possible, would be carried out under medical supervision or under the supervision of a nursing professional when conducted in healthcare units (Article 2, §1). However, the bill required obtaining a certificate of completion of a traditional midwifery training course issued by the Ministry of Health or the State Health Secretariat as a prerequisite for practicing the profession (Article 3, II).

The bill was ultimately archived in the Chamber of Deputies. Subsequently, Bill N. 7.531, dated October 31, 2006, authored by Deputy Henrique Afonso (PT/AC), was introduced with similar wording. Additionally, the bill imposed certain restrictions on the practice of the profession, such as prohibiting services outside the prenatal, childbirth, or postpartum periods, performing surgical

[70] Original: "Art. 37. É vedado às parteiras: a) prestar assistência médica a mulheres e crianças fora do período do parto, ou realizar qualquer intervenção cirúrgica; b) recolher as parturientes e gestantes para tratamento em sua residência ou em estabelecimento sob sua direção imediata ou mediata; c) manter consultório para exames e prática de curativos; d) prescrever medicações, salvo a que for urgentemente reclamada pela necessidade de evitar ou combater acidentes graves que comprometam a vida da parturiente, do feto ou recem-nascido".

interventions, taking pregnant women to their residences for treatment, maintaining a clinic, and prescribing medications[71] (Article 3). The bill also required the same certificate of completion of a traditional midwifery training course and added the Municipal Health Secretariat among the institutions authorized to offer the course (Article 4, II).

Therefore, Deputy Janete Capiberibe (PSB/AP) proposed the new Bill N. 2.145, dated October 2, 2007, which also sought to regulate the profession of traditional midwives. Like the previous bill, this one established that the practice of the traditional midwife profession was subject to the successful completion of a basic qualification course for traditional midwives (Article 3, I). Additionally, the bill required that the traditional midwife reside in the neighbourhood of the community where they operate (Article 3, §3). Furthermore, the bill proposed, once again, the integration of the midwife into the Unified Health System (SUS), as well as the establishment of a remuneration equivalent to 01 (one) minimum wage (Article 5).

The second bill was appended to the first one, so both were processed together, going through several committees. However, in the end, both bills were archived. Therefore, a new bill was proposed with the same objective. Bill N. 912, dated February 19, 2019, presented by then Deputy Camilo Capiberibe (PSB/AP), with the same wording as the one previously presented by Deputy Janete Capiberibe (PSB/AP), is still under consideration by the Chamber of Deputies. During the process, a substitute for the bill was approved, aiming to ensure the possibility of autonomous practice in areas where there is no public health service or the capacity to meet the demand for healthcare services.

According to the text of the substitute bill:

> Article 3: The performance of Traditional Midwives' functions is guaranteed exceptionally and without prejudice to the need for subsequent implementation of medical-hospital care in places where there is a lack of public health service or where it does not meet the demand for obstetric medical services[72].

Among its benefits, the substitute bill removes the obligation for traditional midwives to complete a basic qualification course provided by the government. Furthermore, it establishes that "the permanent educational actions referred to in this article shall preferably be carried out through participatory methodology, respecting the values, beliefs, and ways of seeing the world of all participants" (Article 4, sole paragraph). However, it imposes on the Unified Health System (SUS) the possibility – rather than the obligation – of providing traditional midwives with the necessary resources for their activities, including remuneration (Article 5)[73]. Its latest development was the approval of the substitute bill in the Labor Committee of the Chamber of Deputies, which occurred on June 14, 2023.

Simultaneously, Bill No. 955 of 2022 is being processed in the Federal Senate, presented by Senator Mecias de Jesus (REPUBLICANOS/RR), which addresses the practice of the traditional

---

[71] However, the text of the bill provided for an exception, namely, in cases of urgency to avoid serious accidents capable of endangering the life of the mother, the foetus or the newborn (Article 3, V).

[72] Original: "Art. 3º Fica garantido o desempenho das funções das Parteiras Tradicionais, de modo excepcional e sem prejuízo da necessidade de implantação superveniente de atendimento médico-hospitalar, nos locais onde há ausência de atendimento de saúde pública ou este não supra a demanda dos serviços médicos de obstetrícia".

[73] Article 5: The Unified Health System (SUS) may provide traditional midwives with the necessary resources for the exercise of their activities, ensuring periodic replenishment, and may establish any remuneration, in accordance with regulations.

midwife profession. The bill presents the same contours as the one presented by Deputy Janete Capiberibe (PSB/AP) in 2007, requiring, for the practice of the profession, the successful completion of a qualification course for traditional midwife training (Article 3, II). However, it adds a provision stating that "those who, at the date of publication of this Law, have been engaging in traditional midwife activities for more than five years, as provided in Article 2, shall be exempt from the requirement referred to in item II of the main provision"[74] (Article 3, §1).

At the state level, there have been some legislative experiences related to the practice of the traditional midwife profession or the recognition of the importance of humanizing childbirth. Examples include:

i) Law N. 2.834, dated December 30, 2013, of the state of Acre (AC), which instituted the "midwife grant" in the amount of R$ 250.00 (two hundred and fifty Brazilian Reais).
ii) Law N. 5.312, dated November 18, 2020, which authorized the practice of midwives, whenever requested by the parturient, within the public and private networks of the state of Amazonas (AM).
iii) Law N. 11.650, dated February 3, 2022, of the state of Maranhão (MA), which established guidelines for the recognition and training of traditional midwives.
iv) Law N. 23.175, dated December 21, 2018, of the state of Minas Gerais (MG), which, although not specifically addressing traditional midwives, ensures women the right to receive humanized care during prenatal, childbirth, postpartum, and abortion situations.
v) Law N. 20.596, dated October 4, 2019, of the state of Goiás (GO), which instituted the State Policy for Quality Care for Pregnant Women in the State of Goiás, which included in its text, as principles, "obstetric humanization" (Article 3, III) and "preference for the use of less invasive and more natural methods".

Regarding the work of doulas, the process for the regulation of the profession is more advanced. On March 16, 2022, the Federal Senate approved Bill N. 3.946/2021, proposed by Senator Mailza Gomes (PP/AC). In its text, the bill defines a doula as "a professional who provides physical, informational, and emotional support to individuals during their pregnancy, childbirth, and postpartum cycle, aiming for the best progression of this process and the well-being of the pregnant woman, parturient, and postpartum woman"[75] (Article 2). Furthermore, it establishes two requirements for the practice of the profession by "new" doulas, meaning those who have not been practicing the profession for more than five years. Let's see:

> Article 3: The practice of the doula profession is guaranteed to: I - holders of official high school diplomas and professional training at the medium level - doula technical course; II - holders of official high school diplomas and professional training at the medium level - doula technical course, issued by foreign institutions and validated in Brazil, in accordance with current legislation; III - those who, as of the date of

[74] Original: "Aquela que, na data de publicação desta Lei, exerça há mais de cinco anos atividades próprias de parteira tradicional, na forma do art. 2º, fica dispensada do requisito a que se refere o inciso II do caput".

[75] Original: "a profissional que oferece apoio físico, informacional e emocional à pessoa durante o seu ciclo gravídico-puerperal e, especialmente, durante o parto, visando à melhor evolução desse processo e ao bem-estar da gestante, parturiente e puérpera".

> publication of this Law, have been provenly practicing the doula profession for more than five years[76].

Furthermore, the approved project establishes that doula support is part of the multidisciplinary care provided to individuals during the pregnancy cycle (Article 5), and that "the doula will be integrated into the primary care health teams" (Article 6, §4), which represents a significant contribution in addressing one of the main concerns of professionals, namely the lack of recognition by medical teams and hospital institutions. Similarly, it overcomes the obstacle of the presence of a companion by stating that "the presence of a doula does not exclude the presence of a freely chosen companion for the pregnant person" (Article 6, §1). However, it does not address issues such as remuneration and/or affiliation with the SUS, consolidating the profession as predominantly private and autonomous, not even linked to the hospital[77].

After approval, the project moved to the Chamber of Deputies, where it is being processed alongside Bill N. 8.363/2017, authored by Deputy Erika Kokay (PT-DF). The latter, more specific bill, addresses the registration of doulas in official professional organizations (Article 6); the tools of the trade for doulas (Article 7); prohibits certain procedures (Article 9); and imposes sanctions for non-compliance (Article 10). Furthermore, it also states that "the doula is freely chosen by the pregnant person, and their role is independent of the presence of a companion, as already established by Law N. 11.108/2005, with doula support being part of the multidisciplinary care provided to individuals during the pregnancy and postpartum cycle"[78].

Due to the advanced stage of Senate Bill N. 3.946/2021, authored by Senator Mailza Gomes (PP/AC), which has already been approved in one of the legislative houses, there is a forecast for a faster process. However, the project still needs to be analysed in various committees of the Chamber of Deputies and is currently awaiting the rapporteur's opinion in the Committee on the Defence of Women's Rights (CMULHER). Moreover, the project is being processed as a priority due to being a Senate-initiated bill, in accordance with Article 151, II, of the Internal Regulations of the Chamber of Deputies.

At the state level, several state legislative assemblies in the country have already made progress in analyzing the topic, including:

i) Law N. 3.657, dated November 9, 2015, of the state of Roraima (RR), which regulates the presence of doulas during labour, childbirth, and immediate postpartum in maternity wards, birth centres, and similar healthcare establishments.
ii) Law N. 16.869, dated January 15, 2016, of the state of Santa Catarina (SC), which establishes the presence of doulas throughout the entire labour, childbirth, and immediate postpartum period, and establishes other provisions.

---

[76] Original: "Art. 3º O exercício da profissão de doula é assegurado: I – aos portadores de diplomas de ensino médio oficial e de formação profissional em nível médio – curso técnico em doulagem; II – aos portadores de diplomas de ensino médio oficial e de formação profissional em nível médio – curso técnico em doulagem, expedido por instituições estrangeiras e revalidado no Brasil, de acordo com a legislação vigente; III – aos que, à data da publicação desta Lei, vinham exercendo, comprovadamente, há mais de cinco anos, a profissão de doula".

[77] According to Article 6 §3 of the project "the presence of the doula in the health facility, at the request of the pregnant person, does not imply obligations on the part of the facility, such as remuneration or employment relationship".

[78] Original: "a Doula é de livre escolha da pessoa grávida e sua atuação independe da presença de acompanhante conforme já instituído pela Lei nº 11.108/2005, sendo a doulagem parte da atenção multidisciplinar à pessoa no ciclo gravídico puerperal".

iii) Law N. 15.880, dated August 17, 2016, amended by Law No. 18.135, dated December 30, 2022, of the state of Pernambuco (PE), which guarantees the right to the presence of doulas during labour, childbirth, and immediate postpartum in public and private hospitals, maternity wards, birth centres, and similar healthcare establishments.

iv) Law N. 3.169, dated October 13, 2016, of the state of Acre (AC), which established a program for humanization of childbirth and delivery in all healthcare establishments, ensuring the right to the presence of a doula in addition to a companion (Article 3, XII).

v) Law N. 6.305, dated December 26, 2017, of the state of Rio de Janeiro (RJ), which allows the presence of doulas in healthcare establishments during the pregnancy and postpartum cycle.

vi) Law N. 20,072, dated May 9, 2018, of the state of Goiás (GO), which established the presence of doulas throughout the entire labour, childbirth, and immediate postpartum period. The law was amended by Law N. 21.078, dated September 8, 2021, which recognized the work of doulas as an essential activity during the Covid-19 pandemic.

vii) Law N. 8.129, dated August 7, 2019, of the state of Alagoas (AL), which guarantees the right to the presence of doulas during labour, childbirth, and immediate postpartum.

viii) Law N. 10.611, dated October 18, 2019, of the state of Rio Grande do Norte (RN), which regulates the right to the presence of doulas in maternity wards, birth centres, and similar healthcare establishments of the public and private networks in the state during labour, childbirth, and immediate postpartum of women.

ix) Law N. 7.750, dated March 14, 2022, of the state of Piauí (PI), which establishes humanized, anti-racist, and non-transphobic assistance, setting measures regarding women's right to have a doula during childbirth, in the pre-labour, postpartum, and abortion situations, as well as to express themselves through their individual birth plan, and institutes mechanisms to prevent obstetric violence.

x) Law N. 21.053, dated May 23, 2022, of the state of Paraná (PR), which regulates the presence of doulas during labour, childbirth, and immediate postpartum upon the request of the labouring woman.

Within the jurisprudence of the Brazilian Federal Supreme Court (Supremo Tribunal Federal - STF), there are only two decisions related to the practice of traditional midwifery, both within the context of Direct Action of Unconstitutionality (Ação Direta de Inconstitucionalidade - ADI) N. 4.726 - AP, under the rapporteurship of Justice Marco Aurélio Mello. The action, filed by the Governor of the State of Amapá (AP), challenged State Law N. 1.598, dated December 28, 2011, which established the "Income for Better Living" program within the direct administration of the state executive branch. This law provided for the payment of half the value of the minimum wage to families living in poverty and extreme poverty. In its text, it established that traditional midwives would be entitled to the benefit if they met certain requirements, including: a) being actively engaged in their activities; b) being recognized by the community; c) being active in the movement through associations; d) providing evidence of attending deliveries through witnesses; and e) having a monthly per capita income of up to 25% (twenty-five percent) of the prevailing minimum wage (Article 9).

As can be seen, the action did not specifically address the exercise of the profession of traditional midwifery. On the merits, the justices deemed the reference to the minimum wage contained in the governing norm of the welfare benefit constitutional, establishing a unitary value at the date of issuance of said law, while prohibiting future linkage as an indexing mechanism. Furthermore, they declared the unconstitutionality, among other things, of Article 9, item "e" mentioned above, stating that references to the minimum wage should be understood as indicative of the prevailing value at the date of publication of the norm, with no future linkage (STF - ADI: 4726 AC

– ACRE 9940468-16.2012.1.00.0000, Rapporteur: MARCO AURÉLIO, Judgment Date: 11/11/2020, Full Court, Publication Date: 30/11/2020).

Furthermore, when searching for the term “parteiras” (midwives) on the STF's jurisprudence search engine, only four mentions were found, one of which was due to the presence of the word in a party's surname. On the other hand, when performing the same search on the JusBrasil website, 25 results were found. By cross-referencing this data, we can provide below the most relevant decisions related to the exercise of the professional activity of midwifery:

- The decision rendered by the Court on January 1, 1970, 53 years ago, under the rapporteurship of then Justice Gonçalves de Oliveira, in which the heading states that “only individuals of the female sex can practice this profession, can enroll in public qualification exams to obtain the certificate, the reference diploma”, solidifying the constitutionality of Articles 1, 7, 12, and 13 of Decree-Law N. 8.778 of 1946 (STF - RMS: 9963 PR - PARANÁ, Rapporteur: Justice GONÇALVES DE OLIVEIRA, Judgment Date: 01/01/1970, FULL COURT, Publication Date: DJ 17-12-1963 PP-04448 EMENT VOL-00566-02 PP-00702);
- The decision rendered by the rapporteur, Justice Edson Fachin, within the scope of the Internal Appeal in Extraordinary Appeal with Appeal (ARE) 1069126 PE - 0061462-67.1996.8.17.0480, in which the State of Pernambuco questioned its liability in relation to a delivery performed by a midwife on duty, without the presence of an obstetrician or any other doctor at the hospital, resulting in a normal delivery the next morning, followed by the death of the parturient shortly thereafter due to eclampsia and internal haemorrhage resulting from an interine rupture. On this occasion, the Justice denied the appeal's continuation due to the need for re-examination of evidence. Nonetheless, it emphasized that “the State's objective liability to compensate, stemming from the causal link between the administrative act and the damage caused to the individual, does not require subjective elements (intent and negligence)”, as well as that “neither the State nor the Casa de Saúde Bom Jesus and Dr. Sônia Lemos Costa produced satisfactory and sufficient evidence that the victim's death did not result from incompetence, imprudence, or negligence, thus establishing the responsibility of all parties and the duty to compensate the damages suffered by the plaintiffs" (STF - AgR ARE: 1069126 PE - PERNAMBUCO 0061462-67.1996.8.17.0480, Rapporteur: Justice EDSON FACHIN, Judgment Date: 12/18/2017, Second Panel, Publication Date: DJe-021 06-02-2018);
- The decision in the Cautious Measure in ADI No. 7,222 - DF, reported by Justice Luís Roberto Barroso and judged on September 19, 2022, which dealt with the constitutionality of Law No. 14,434/2022, which amended Law No. 7,498/1986 to establish the national minimum wage for nurses, nursing technicians, nursing assistants, and midwives. In this case, the STF decided to temporarily suspend the effects of Law No. 14,434/2022, considering that such a matter could generate a financial and budgetary impact on States and Municipalities and risks to their solvency; on employment in the sector, given the plausible allegations of mass layoffs brought to the records; and on the provision of healthcare services, due to the alleged risk of hospital closures and reduction in the number of nurses and technicians (STF - ADI: 7222 DF – FEDERAL DISTRICT, Rapporteur: ROBERTO BARROSO, Judgment Date: 09/19/2022, Full Court, Publication Date: ELECTRONIC PROCESS DJe-236 DIVULGED 11-21-2022 PUBLISHED 11-22-2022).

When conducting the same search (using the keyword “parteiras”) on the website of the Superior Court of Justice (STJ), no related judgments were found. However, 14 monocratic decisions were found, most of which were related to the civil liability of doctors. On the JusBrasil platform, a total of 66 results were found. The discrepancy in the number of results is likely due to the fact that the second search engine presents any decision that mentions the selected word, even if it is in the reasoning or in a case that does not relate to the searched object.

In this context, it is worth noting that most decisions in the mentioned court are about the civil liability of doctors and/or hospitals. It should be emphasized that these references are usually indirect, used as a consequence of the inclusion of the term “parteira” (midwife) in laws such as Law N. 7.498, dated June 25, 1986, which mentions the regulation of the professions of “enfermeiro” (nurse), “técnico de enfermagem” (nursing technician), "auxiliar" (nursing assistant), and “parteira” (midwife), and Decree N. 20.931, dated January 11, 1932, which “regulates and oversees the practice of medicine, dentistry, veterinary medicine, and the professions of pharmacist, midwife, and nurse in Brazil, and establishes penalties”. Similarly, other decisions mention case laws that contain the term in their content appearing in the search results.

However, the fact remains that the lack of regulation of the profession through federal law makes it impossible to discuss the topic in the STJ. The STJ's responsibilities include judging, in Special Appeals, cases decided by state courts that contradict a federal treaty or law or deny their effectiveness; judging the validity of a local government act contested in relation to federal law or giving a different interpretation to federal law than that attributed to it by another court. Thus, after a detailed analysis of the STJ decisions that mention the term “parteira”, no relevant results were found for the purposes of this research[79].

Regarding doulas, 03 (three) results were found on the STF website and 8 (eight) results on the JusBrasil portal. The most relevant decision was made in the context of RE 1183725 – SC, judged on February 4, 2019, which aimed to question the constitutionality of Law N. 16.869/2016 and Decree N. 1.305/2017, both from the state of Santa Catarina (SC), which regulate the presence of doulas during labour and postpartum. The state Court of Justice had decided that "the obligation to accept 'doulas' by healthcare institutions, when requested by parturients, does not constitute the regulation of a profession, nor does it violate the principles of free enterprise and private property." In terms of the merits, the STF concluded that the plaintiffs in the case did not demonstrate the general significance of the matter, which is why the court did not specifically deliberate on the issue of professional regulation (STF - RE: 1183725 SC - SANTA CATARINA 4023746-87.2017.8.24.0000, Rapporteur: Min. ROSA WEBER, Judgment Date: 02/04/2019, Publication Date: DJe-039 02/26/2019).

Within the scope of the STJ, no judgments were found on the subject, only monocratic decisions, totalling 10 (ten) on the court's website. On the JusBrasil platform, 14 (fourteen) results were found, and in both cases, the decisions were exclusively related to a party named “Doulas”. Therefore, it can be inferred that like the search for judgments related to “parteiras” (midwives), the absence of a federal law regulating the profession hinders the filing of claims related to the practice of the profession within the jurisdiction of the STJ.

2.2 International

[79] Despite this conclusion, we highlight the decision in the Interlocutory Appeal in Special Appeal No. 359,680 - AC (2013/0185739-5), judged on April 17, 2015. The reporting Justice Ricardo Villas-Boas examined the request for the continuation of the appeal, which discussed the hospital's liability for providing a midwife and a nurse, instead of a doctor, to administer medication to induce the expulsion of a stillborn fetus. On that occasion, the Justice affirmed that the Second Section of the Court understands that "there is no objective liability of the hospital for occurrences within its premises if there is no link between the institution and the doctor responsible for the patient." Furthermore, it was emphasized that there is no failure in the provision of the service solely because it was performed by a midwife (STJ - AREsp: 359680 AC 2013/0185739-5, Rapporteur: Justice RICARDO VILLAS BÔAS CUEVA, Publication Date: DJ 04/29/2015).

In the year 2000, the United Nations, with the support of 191 nations, established the "Millennium Development Goals" (MDGs), which included the promotion of women's autonomy (goal #3), the reduction of infant mortality (goal #4), and the improvement of maternal health (goal #5). According to the ODM Brazil website, infant mortality is concentrated in the first months of life, specifically in the early neonatal period (0 to 6 days) and late neonatal period (7 to 27 days), with improving maternal health being the goal that Brazil faces the greatest difficulty in achieving (BRAZIL, n.d.).

> The country has made progress but has not yet achieved the goal of reducing maternal mortality by three-quarters between 1990 and 2015. According to estimates from the Health Surveillance Department of the Ministry of Health, the maternal mortality ratio was 141 per 100,000 live births in 1990 and declined to 68 per 100,000 live births in 2010. Between January and September 2011, maternal mortality decreased by 21%. There were 1,038 deaths due to complications during pregnancy and childbirth, compared to 1,317 in the same period in 2010. The goal is to reach 35 deaths per 100,000 live births by 2015 (BRAZIL, n.d.).

In this context, in 2014, the United Nations Population Fund (UNFPA) emphasized the need for greater **investment in the education** of midwives and other professionals with obstetric skills, which have a positive cost-benefit ratio, "to accelerate efforts in improving maternal health and achieving MDG 5"[80] (UNFPA, 2014). With this in mind, it reaffirmed the joint commitment to supporting midwives and other skilled birth attendants worldwide, with the aim of ensuring that every pregnancy is safe and that universal access to sexual and reproductive health services becomes a reality for everyone.

The measure follows the guidelines of the World Health Organization (WHO), which since the second half of the 20th century has developed campaigns aimed at the recognition and more effective participation of midwives in national healthcare systems. Examples of these guidelines are: i) the Declaration of Alma-Ata (1978), which states that primary care, at the local and referral level, should include professionals such as midwives and traditional birth attendants; ii) the Joint Statement by WHO, UNICEF, UNFPA, and the World Bank on Reducing Maternal Mortality, which urged states to take measures to strengthen the obstetric skills of healthcare professionals, including midwives (WHO, 1999, p. 32); iii) the Munich Declaration (2000), which called for the development of global strategies for human resources planning to ensure an adequate number of adequately trained nurses and midwives (WHO, 2017), and iv) WHO Resolution WHA 64.7 ("Strengthening Nursing and Midwifery"), adopted at the 64th World Health Assembly on May 24, 2011, which reaffirmed the commitment to developing policies aimed at strengthening the work of midwives.

Furthermore, the organization frequently develops guidelines and recommendations that directly or indirectly relate to the work of midwives. One of the most relevant documents is "Care in Normal Birth: a practical guide" (WHO, 1996), which provides universal guidelines for routine care of women during uncomplicated labour and childbirth. Among other things, the document emphasizes that:

> In many developing countries the midwife is considered the key person in the provision of maternity care (Mati 1994, Chintu and Susu 1994). However, that is not the case in all: some face a shortage of midwives. Especially in Latin America, schools of midwifery

[80] Original: "para acelerar os esforços na melhoria da saúde materna e para o alcance do ODM 5".

> have been closed down, on the assumption that physicians would cover the tasks. In some countries the number of midwives is declining, and those that are present are maldistributed: the majority work in hospitals in towns, and not in the rural areas where 80% of the population lives and consequently most of the problems lie (Kwast and Bentley 1991, Kwast 1995b). It is recommended that more midwives be trained, and that consideration be given to the location of the training schools so that they are easily accessible to women and men from rural areas who are thus more likely to stay in the community they come from. The training should be such that midwives can meet the needs of the communities they are going to serve. They should be able to identify complications which require referral, but if referral to a higher level of care is difficult they should be able to perform life saving interventions (OMS, 1996, p. 7).

In this line, more recently, in 2023, the Regional Task Force for the Reduction of Maternal Mortality, composed of various organizations[81] - including the WHO - launched the campaign "Zero Maternal Deaths" with the aim of "engaging countries in Latin America and the Caribbean to take measures to accelerate the reduction of maternal mortality, which increased by 15% between 2016 and 2020"[82] (UNFPA, 2023). In their joint statement, the group highlights several issues that have influenced the increase in maternal mortality, including the lack of access to skilled personnel, including professional midwives (RTF, 2023).

Furthermore, it is important to emphasize that, like the WHO, other global organizations provide guidelines and relevant documents that guide the practice of midwives, such as the International Confederation of Midwives (ICM), which "works closely with all UN agencies in advocating for Safe Motherhood, in the strategies for primary health care for families worldwide, and in defining and preparing midwives" (MPPR, n.d.). Among its main achievements, the following can be mentioned: "Essential Competencies for Midwifery Practice", "Code of Ethics for Midwives", "Guidelines for Home Birth Care", and "International Standards for Midwifery Education".

In this field, the work carried out by the International Federation of Obstetrics and Gynaecology (FIGO) is also noteworthy. Although not exclusively dedicated to midwives, FIGO develops guidelines and standards that cover a wide range of topics related to maternal health, including collaboration with midwives. Examples include the "FIGO Guidelines for Obstetric and Neonatal Emergency Care," which emphasize the importance of collaboration between obstetricians, gynaecologists, and midwives; the "FIGO Guidelines for Women's Sexual and Reproductive Health," which focus on promoting women's sexual and reproductive health, including aspects related to the role of midwives; and the "FIGO Quality Standards for Maternal and Neonatal Health Services", which establish criteria and indicators for assessing service quality.

In the realm of international legislation, norms related to the protection of women and children are more commonly found. For example, the "International Covenant on Economic, Social and Cultural Rights" (1966) states that "the States Parties to the present Covenant shall take steps to achieve the full realization of this right, including measures for the reduction of stillbirths and infant mortality and for the healthy development of the child" (Article 12); the "Convention on the Rights of the Child" (1989) prescribes in Article 24 that "States Parties shall pursue full implementation of this

---

[81] Pan American Health Organization/World Health Organization, United Nations Population Fund, United Nations Children's Fund, World Bank, Inter-American Development Bank, United States Agency for International Development, International Confederation of Midwives, Latin American Federation of Obstetrics and Gynaecology Societies, Management Sciences for Health, MOMENTUM Country Global and Leadership, and Fòs Feminista.

[82] Original: "engajar os países da América Latina e do Caribe a tomar medidas para acelerar a redução da mortalidade materna, cujo índice aumentou 15% entre 2016 e 2020".

right and, in particular, shall take appropriate measures to: reduce infant mortality; [...] [and] ensure appropriate prenatal and postnatal healthcare for mothers". Furthermore, the "Convention on the Elimination of All Forms of Discrimination against Women" (1979) also affirms that:

> Article 12.
> 1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
> 2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Regarding international jurisprudence, three decisions of the Inter-American Court of Human Rights (IACHR) related to obstetric violence have been found - Cases I.V. vs. Bolivia (2016), concerning an unauthorized surgery that deprived the victim of the right to conceive; Manuela y otros vs. El Salvador (2021), regarding an improper medical treatment that resulted in the victim's death; and Britez Arce vs. Argentina (2022), concerning an induced childbirth that also led to the victim's death. However, none of them make reference to the work of traditional midwives or doulas, although they provide relevant contributions, especially by recognizing that subjecting women to situations that can be categorized as "obstetric violence" constitutes a violation of Article 7 of the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (Belém do Pará Convention).

On the other hand, in the European Court of Human Rights (ECHR), we can highlight the case of Dubská and Krejzová v. the Czech Republic (2014), where the victim appealed to the court for a violation of her right to privacy (Article 8 of the European Convention on Human Rights[83]) due to being denied home assistance from a midwife by the health insurance plan. In the specific case, the court argued that there is no European consensus on the matter, which is why the authorities did not exceed the wide margin of appreciation granted to them and did not disturb the fair balance that must be established between the conflicting interests. However, in a dissenting opinion, Judge Lemmens pointed out:

> The contested legislation has a "serious impact on the freedom of choice of the applicants, who were required, if they wished to give birth at home, to do so without the assistance of a midwife and, therefore, with the attendant risks that this posed to themselves and to the newborns, or to give birth at a hospital." While only relatively few mothers might prefer to give birth at home, I have no reason to doubt that for these women, this is a very important matter of personal choice. To some extent, this is also confirmed in the 2010 observations on the Czech Republic, adopted by the Committee on the Elimination of Discrimination against Women. That Committee took up the

[83] ARTICLE 8. Right to respect for private and family life 1. Everyone has the right to respect for his private and family life, his home and his correspondence. 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

> issue and recommended that the State "consider taking steps to make midwife-assisted childbirth outside hospitals a safe and affordable option for women" (see § 37 of the observations, quoted in paragraph 56 of the judgment). [...] Having considered all of the above, I conclude that it has not been demonstrated that the current situation in the Czech Republic strikes a fair balance between the competing interests at stake. Therefore, I find that there has been a violation of Article 8 of the Convention (ECHR, 2014).

Furthermore, no relevant decisions related to the topic were found within the African Court of Human Rights. Similarly, no jurisprudence regarding doulas or midwives could be located within the International Court of Justice. Despite this, it is worth noting that this topic is frequently mentioned in the discourse of the Permanent Forum on Indigenous Issues of the United Nations Economic and Social Council (ECOSOC). For instance, it was included in the recommendations made after its third, fifth, and ninth sessions, where it urged UNFPA, WHO, UNICEF, regional health organizations, and governments to incorporate cultural perspectives into the scope of health policies, reproductive health programs, and services. In this regard, the work of midwives should be reassessed and expanded (UN, 2008, p. 4). Along the same lines, the forum expressed its stance in the recommendations made after the 17th session on April 24, 2018, stating:

> Despite this critical role, community-regulated indigenous midwifery is often undermined and actively criminalized, to the detriment of indigenous peoples' health. To close the gap between indigenous and non-indigenous health outcomes, the practice of indigenous midwifery must be supported by state health policy and integration. Indigenous peoples' right to self-determination extends to their reproductive health, and states should put an end to the criminalization of indigenous midwives and make the necessary legislative and regulatory amendments to legitimize indigenous midwives who are recognized by their communities as health - care providers. States should also support the education of new traditional indigenous midwives via multiple routes of education, including apprenticeships and the oral transmission of knowledge (UN, 2018, p. 4).

Finally, it is worth mentioning the judgment T-128-22 of the Constitutional Court of Colombia, which urged the Ministry of Health and Social Protection to initiate and complete all necessary initiatives to enable the integration of midwives into the General System of Social Security in Health, requiring the Congress of the Republic to legislate on this matter. In this decision, the Colombian Constitutional Court held that obstetrics constitutes ancestral knowledge and a cultural expression of indigenous communities, and as such, it should be preserved (COLOMBIA, 2022). Therefore, this is a paradigmatic decision with the potential to influence judicial decisions and public policies worldwide.

3. Public Policies

3.1 Public policies on childbirth care in Brazil

According to data from the Ministry of Health, several initiatives have been developed in the country related to the valorization of traditional midwives, including the following: the training and supervision of traditional midwives by the Foundation for Special Public Health Services (FSESP)

since 1943 in the Amazon region and the states of Minas Gerais, Espírito Santo (Vale do Rio Doce), Northeast, and Midwest; the Programa de Parteiras Leigas (Program for Lay Midwives) in Pernambuco in 1964; the Primary Health Care Program (Paps) starting in 1975 in Ceará; the Comprehensive Women's Health Assistance Program adopted by the Ministry of Health in 1984, which included measures to improve the quality of home births conducted by traditional midwives among its guidelines; the development of the document "Guidelines for the Role of the Traditional Midwife" in 1985; and the National Program for Traditional Midwives developed by the National Health Foundation in partnership with other entities in 1995 (BRAZIL, 2012, pp. 22-23).

To reduce maternal and neonatal morbidity and mortality rates in Brazil, in March 2000, the Brazilian Ministry of Health created the "Working with Traditional Midwives Program", which aimed primarily to raise awareness among health managers and professionals about the role of traditional midwives as partners in community health care. Based on this, the program proposed the development of actions to value, support, qualify, and coordinate the work of midwives within the Unified Health System (SUS), recognizing and valuing traditional knowledge as important elements for health production, new knowledge, and technologies (BRAZIL, 2012, p. 11). In "Parto e Nascimento Domiciliar Assistidos por Parteiras Tradicionais: o Programa Trabalhando com Parteiras Tradicionais e experiências exemplares" (2012), the Ministry of Health lists the objectives of the program as follows (BRAZIL, 2012, p. 23):

- Recognize, value, and reclaim the work of traditional midwives in the care of women and newborns during home births.
- Coordinate home births assisted by traditional midwives with the Unified Health System (SUS), ensuring the necessary material conditions, logistical support, and referral network for the safe and high-quality practice of such births.
- Guarantee the sexual and reproductive rights of rural, riverine, forest-dwelling populations, as well as those residing in hard-to-reach areas, and populations of traditional quilombola and indigenous communities.
- Improve access to healthcare actions and services for populations facing social exclusion and geographical isolation, as well as populations with ethnic and cultural specificities.
- Enhance the quality and humanization of care during home births.

As a result, the Working with Traditional Midwives Program facilitated the integration of traditional midwives' knowledge with biomedical knowledge. This was one of the strategies through which the Brazilian government aimed to reduce maternal mortality rates to less than one-third of the values found in the 1990s (GUSMAN et al., 2015, p. 365). However, Menezes et al. (2012, p. 34-35) states that despite good intentions, the program did not address the issue of access to healthcare services, "continuing a logic of cost reduction under the discourse of valuing traditional midwives"[84]. According to the author, there is a strong "romantization" of midwives, who become "anachronistic symbols 'of a past we do not intend to return to', but resonate in resistance to the medicalization of childbirth, the commodification of health, and the fragmentation of human beings"[85] (DE MENEZES et al., 2012, p. 10).

[84] Original: "dando continuidade a uma lógica de diminuição de custos, sob um discurso de valorização das parteiras tradicionais".

[85] Original: "símbolos anacrônicos 'de um passado ao qual não se pretende retornar', mas que ecoam na resistência à medicalização do parto, à mercantilização da saúde e à fragmentação do ser humano".

Furthermore, in the same year, the "Program for Humanization in Prenatal Care and Birth" (PHPN) was established (Portaria/GM N. 569, June 1, 2000, by the Ministry of Health), with the following priorities: i) focusing efforts on reducing the high rates of maternal, perinatal, and neonatal morbidity and mortality in the country; ii) adopting measures to improve access, coverage, and quality of prenatal care, childbirth, postpartum, and neonatal care; and iii) expanding the actions already taken by the Ministry of Health in the field of maternity care, such as investments in state networks for high-risk pregnancies, increased funding for specific procedures, and other initiatives like the Safe Maternity, the Traditional Midwife Training Project, as well as allocating resources for training and capacity-building of professionals directly involved in this area of care, and investing in the hospital units within these networks (BRASIL, 2002, p. 5). The program aimed to ensure the improvement of access, coverage, and quality of prenatal care, childbirth, and postpartum care for pregnant women and newborns.

Rattner (2009, p. 760) also highlights the partnership with the NGO Grupo Curumim Gestação e Parto for the training of traditional midwives, as well as the agreement with the Sofia Feldman Hospital, which established the Community Doula Program in 1997 (HORTA, 2008, p. 20).

> The Community Doula Project at HSF is pioneering in Brazil. It brought the possibility of incorporating another strategy in the process of humanizing childbirth and delivery. Based on the assumption that the presence and work of a doula have a qualitative impact on care, we can consider it a new tool that enriches the “toolbox” of care technologies. It is a tool with a differentiated technology, referred to by Merhy (2005) as “soft technology”, a relational technology that occurs in action (in care), in the encounter between subjectivities. It is a practice that goes beyond structured technological knowledge, allowing for a significant degree of freedom in choosing the way of providing care. Thus, the community and voluntary doula opens up new directions for the institution in terms of the model of care for childbirth and delivery (HORTA, 2008, p. 22).

Similarly, the Municipal Decree N. 20,652, dated September 22, 2004, from the municipality of Recife in the state of Pernambuco (PE), created the “Voluntary Community Doula Program”. The program aimed at humanizing the assistance during labour, childbirth, and the breastfeeding period in the municipal public maternity hospitals. Furthermore, the regulation stipulated that the municipal Health Department would be responsible for promoting a training course and regularly providing theoretical and practical enhancement courses for doulas in collaboration with healthcare professionals.

In 2004, the Ministry of Health, in partnership with other organizations, launched the "Pact for the Reduction of Maternal and Neonatal Mortality" with the objective of coordinating social actors engaged in improving the quality of life for women and children. Among its strategies was the inclusion of working with traditional midwives in the Unified Health System (SUS). Additionally, between 2004 and 2006, several “Seminars on Humanized Obstetric and Neonatal Care Based on Scientific Evidence” were held, and in 2006, the “Plan for the Reduction of Unnecessary Caesarean Sections” was launched. In this context, the "Children of the Forest Plan" stands out, developed by the Child Health and Breastfeeding Technical Area (DAPES/SAS/MS) in partnership with the Federal University of Maranhão and the Brazilian Society of Paediatrics. Between 2009 and 2010, the plan provided training for midwives in the Northern Region on neonatal resuscitation and initial care for newborns (BRASIL, 2012, p. 35-36).

Another noteworthy initiative was the creation of Normal Birth Centers (CPN) (or Birth Houses in Brazil) by the Ministry of Health (Ordinance MS/GM N. 985, August 5, 1999), which defined the criteria for implementing birth houses. This endeavour provides woman-centred care and emphasizes the importance of women's choices. Additionally, it considers the significance of regional and cultural specificities in accessing healthcare services, allowing the involvement of traditional midwives in these institutions. Thus, birth houses can be found, at least, in the states of São Paulo, Minas Gerais, and Rio de Janeiro (BRASIL, **2012**, p. 38). According to the Ministry of Health, the country has the equivalent of 39 normal birth centres that operate in the public healthcare network. There are a total of 161 beds, not counting private birth houses (data from 2021) (REVISTA CRESCER, 2021).

Furthermore, various experiences can be found within the states, some financed by the government and others by private institutions, which does not diminish their relevance in any way. Among them, the following initiatives serve as examples (BRASIL, 2012, p. 49-56):

Acre	The "Reproductive Health Project in the Alto Juruá Extractive Reserve", funded by the MacArthur Foundation, which trained and strengthened the organizational process of traditional midwives in the reserve.
Acre	The "Born in the Forest Program", promoted by the State Health Department of Acre in partnership with UNICEF, which trained midwives and distributed kits among the professionals.
Amapá	The project "Rescue and Valorization of Traditional Midwives in the State of Amapá", by the Government of Amapá, which provided various trainings for traditional midwives and strengthened their self-esteem and organizational process.
Pará	The project "Model of Humanized Obstetric Care, Aiming at the Control of Maternal and Perinatal Morbidity and Mortality", in the municipality of Melgaço, financed mostly by UNICEF, in partnership with public sector entities, which trained midwives and distributed kits among the professionals.
Goiás	The "Health and Rights Project for the Kalunga People and their Women", funded by the MacArthur Foundation, which conducted trainings for traditional midwives and community health agents, providing kits.
Pernambuco	The "State Traditional Midwives Program of Pernambuco", by the State Health Department of Pernambuco, which carries out, among other actions, the registration and socioeconomic survey of midwives; a process of continuous education with traditional midwives; raising awareness among municipal managers to include traditional midwives in primary care; providing a kit of basic materials for midwives who have undergone training.
São Paulo	The "Indigenous Midwife Guarani and Tupi-Guarani Project in the State of São Paulo", developed by the State Health Department of São Paulo in partnership with the National Health Foundation (Funasa) and the Projeto Rondon Foundation, which sought to rescue the actions carried out by the indigenous midwife; provide a permanent space for exchanging experiences among them; and identify possible mechanisms to encourage indigenous communities themselves to revive midwifery work.

Amazonas	The partnership between the Mamirauá Civil Society, the Ministry of Health, and various entities for the training of healthcare workers, including traditional midwives, for qualified and humanized sexual and reproductive health care for the populations of the Mamirauá and Amanã Sustainable Development Reserves.
Minas Gerais	The work of the State Health Department of Minas Gerais, in partnership with the Ministry of Health and other entities, which resulted in trainings for traditional midwives and indigenous midwives of the Maxakali ethnicity.
Paraíba	The work of the State Health Department of Paraíba, in partnership with the Ministry of Health and other entities, which carried out several trainings for traditional midwives and healthcare professionals, including quilombola midwives from the Caiana dos Crioulos community and indigenous midwives of the Potiguara ethnicity, with the distribution of midwife kits.
Various states	The partnership between the Women's Health Technical Area (ATSM) of the Ministry of Health and Funasa, through its Indigenous Health Department (DSAI), which resulted in workshops on indigenous women's health care and the promotion of trainings for midwives from various ethnicities.

In June 2011, the Brazilian government established the Rede Cegonha (Stork Network) within the SUS, aiming to organize the management of the system for the consolidation of networks of maternal and childcare in health regions. In this regard, it proposed the development of action plans and the qualification of care points, establishing goals and providing incentives based on their fulfilment. In its formulation, it included measures related to the work of traditional midwives, obstetric nurses, and doulas, promoting natural childbirth, and ultimately discouraging unnecessary and non-indicated surgical procedures. The objective was to promote a "change in the model of obstetric care, with the dehospitalization of childbirth and the delivery of routine risk"[86] (BRAZIL, 2012, p. 390-391).

That being said, we can see that the encouragement of midwives' practice remains present in government policies, albeit to a limited and insignificant extent. As an example, we can observe that the National Health Plan 2016-2019 established a goal to create spaces for dialogue and training involving a total of one hundred midwives from quilombola communities. This initiative included the distribution of 100 kits to traditional midwives and the organization of two seminars with the participation of managers, healthcare professionals, and community leaders (BRAZIL, 2016, p. 77-78). On the other hand, the National Health Plan 2020-2023 did not establish any goals related to the work of midwives but indicated that "prenatal care should be based on intercultural dialogue, [...] promoting the convergence between indigenous and biomedical models and the exchange of knowledge among healthcare professionals, midwives, and other indigenous caregivers"[87] (BRAZIL, 2021, p. 100).

[86] Original: "mudança do modelo de atenção obstétrica, com a desospitalização do parto e nascimento de risco habitual".

[87] Original: "a atenção ao pré-natal deve estar baseada no diálogo intercultural, [...] estimulando a aproximação entre os modelos indígenas e biomédico e a troca de saberes entre os profissionais de saúde, parteiras e outros cuidadores indígenas".

It is worth noting that concerning assistance during childbirth and the delivery of indigenous women, the 2016 "Qualification Program for Indigenous Health Agents and Indigenous Sanitation Agents" states that "prenatal care, when carried out by a team that includes midwives and health agents, contributes to reducing cases of maternal death, low birth weight, and infant diseases in the first days of life"[88] (BRAZIL, 2016b, p. 41). Therefore, it establishes that it is the role of health agents to work in partnership with local specialists such as midwives, shamans, herbalists, and healers when monitoring pregnant women (BRAZIL, 2016b, p. 65). Furthermore, it emphasizes that "the work of the Multidisciplinary Indigenous Health Team (EMSI) in assisting women in labour should be done together with traditional midwives, whenever possible, throughout the process of labor, childbirth, and postpartum"[89] (BRAZIL, 2016b, p. 79).

4. Relevant Institutions

4.1 Brazil

Currently, the Ministry of Health in Brazil is the main agency responsible for developing strategies to strengthen the work of doulas and midwives. It collaborates with state health departments and other organizations and agencies, as mentioned above, to implement guidelines for humanizing childbirth and delivery, in line with the recommendations of the World Health Organization (WHO). However, several other institutional and social organizations are involved in recognizing and valuing the work of traditional midwives. Among them, the following can be highlighted (BRAZIL, 2012, p. 41-42):

- Curumim, Gestação e Parto Group (PE)
- Center for Humanization of Therapeutic Practices (CHPT), São Pio X Hospital, Ceres (GO)
- Mamirauá Civil Society and Mamirauá Sustainable Development Institute (IDSM) (AM)
- Amazon Women's Articulated Movement (Mama/AC)
- Acrean Network of Men and Women (AC)
- Indigenous Council of Roraima (CIR/RR)
- Sofia Feldman Hospital (MG)
- State University of Montes Claros (Unimontes/MG)
- Malunga Black Women's Group (GO)
- Miriti Center for Women's Assistance - Gender and Development (Cemam/ Cametá/PA)
- Institute of Development, Environmental Education, and Solidarity (Ideas/ Baião/PA)
- Altamira Women's Movement and Transamazonica and Xingu Region (PA)
- National Network of Traditional Midwives (RNPT)
- Pastoral Youth of Janaúba/MG, among others.

[88] Original: "o pré-natal, quando realizado em equipe, incluindo as parteiras e agentes de saúde, contribui para a diminuição dos casos de morte materna, de crianças que nascem com baixo peso e de crianças que adoecem nos primeiros dias de vida".

[89] Original: "o trabalho da Equipe Multidisciplinar de Saúde Indígena (EMSI) no acompanhamento de mulheres em trabalho de parto deve ser feito junto com as parteiras tradicionais, quando houver, em todo o trabalho de parto, parto e puerpério".

In addition to these, we can highlight the work of the Brazilian Association of Obstetric Nurses and Obstetricians (ABENFO), which represents obstetric nursing professionals in Brazil, including midwives; the Network for Humanization of Childbirth and Delivery (ReHuNa), which supports the role of midwives and advocates for improved obstetric care, aiming to respect women's rights and promote evidence-based practices; Casa Angela - Urban Midwives in São Paulo, which provides prenatal, childbirth, and postpartum care to low-income women; and the National Feminist Network for Health, Sexual Rights, and Reproductive Rights, which advocates for women's reproductive rights and values the participation of midwives in childbirth assistance.

Finally, there is an increasingly frequent organization of various associations of traditional midwives, such as:

- Association of Traditional Midwives of the State of Amazonas - Algodão Roxo (AM)
- Association of Traditional Midwives of Maranhão (MA)
- Association of Traditional Midwives of Melgaço (PA)
- Association of Traditional Midwives of Jenipapo de Minas (MG)
- Central Association of Traditional Midwives of Macapá (AP)
- Association of Traditional Midwives of Laranjal do Jari (AP)
- Association of Traditional Midwives of Marajó Island (PA)
- Association of Traditional and Hospital Midwives of Jaboatão dos Guararapes (PE)
- Associations of Traditional Midwives of Caruaru (PE)
- Association of Traditional Midwives of the Maria Esperança Forest in Marechal Thaumaturgo (AC)

Regarding the work of doulas, there are several organizations and collectives that advocate in this field, among which we can highlight the work carried out by the National Federation of Doulas in Brazil (Fenadoulas Brasil), which has various affiliated associations, such as: the Association of Doulas of the State of São Paulo (Adosp); the Association of Doulas of the State of Rio de Janeiro (ADOULASRJ); the Association of Doulas of Paraíba (ADPB); the Association of Doulas of Alagoas (ADOAL); the Association of Doulas of the State of Rio Grande do Sul (ADOSUL); the Association of Doulas of Santa Catarina (Adosc), the Association of Doulas of the State of Mato Grosso (AdoMaTo), among others.

4.2 International

As previously mentioned, there are institutions of great relevance to the work carried out by midwives: the World Health Organization (WHO), the International Confederation of Midwives (ICM), and the International Federation of Gynaecology and Obstetrics (FIGO), which develop norms and guidelines related to the profession. In addition to these, the cause is supported by the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the Partnership for Maternal, Newborn & Child Health (PMNCH), and the project “The Florence Network”, which brings together 51 universities from 22 countries to promote annual meetings focused on international cooperation in education, scientific research, and the development of professionals working in nursing and obstetrics.

5. Literature review

During the investigation, a significant amount of academic literature was found regarding the work of doulas, midwives, and the humanization of childbirth, particularly in the fields of Anthropology, Sociology, and Health Sciences. However, it was not possible to locate relevant academic literature in the field of Law, which demonstrates the pertinence and relevance of the present research. Furthermore, works were found in the form of academic articles, as well as undergraduate, master's, and doctoral research[90]. In this regard, we will highlight some of the main contributions identified in the table below:

Autor(a)	Instituição	Título	Área	Nível	Ano
Carmen Susana Tornquist	Federal University of Santa Catarina	Birth and Power: the movement for the humanization of childbirth in Brazil	Social Anthropology	Doctoral Degree	2004
Soraya Resende Fleischer	Federal University of Rio Grande do Sul	Midwives, Baby Bumps, and Worries: an ethnography of unofficial obstetric care in the city of Melgaço, Pará	Social Anthropology	Doctoral Degree	2007
Júlia Cristina Amaral Horta	Federal University of Minas Gerais	The Community Doula: a reinvented experience	Medicine	Master's Degree	2008
Luciane Ouriques Ferreira	Federal University of Santa Catarina	Between Official Discourses and Indigenous Voices on Pregnancy and Childbirth in Alto Juruá: the emergence of indigenous traditional medicine in the context of public policy	Social Anthropology	Doctoral Degree	2010
Patricia Carvalho Rosa	University of Brasília	"To let grow and exist": on the production of Kaingang bodies and people	Social Anthropology	Master's Degree	2011
Rosamaria Giatti Carneiro	State University of Campinas	Birth Scenes and Body Politics: an ethnography of women's practices of humanized childbirth	Social Sciences	Doctoral Degree	2011

[90] Due to the short timeframe for the preparation of this report, which is less than a period of 3 (three) months, the researcher prioritized the reading of academic articles and government documents. Nevertheless, the researcher has kept a record of the academic works mentioned in the table in a personal file for future reference.

Daniel Scopel	Federal University of Santa Catarina	An Ethnography on the Plurality of Healthcare Models among the Munduruku Indians in the Indigenous Land Kwatá laranjal, Borba, Amazonas: practices of self-care, shamanism, and biomedicine	Social Anthropology	Doctoral Degree	2013
Andrea Cadena Giberti	University of São Paulo	Being Born, Enchanting, and Care – an ethnography of the Birth Process among the Pankararu of Pernambuco	Public Health	Master's Degree	2013
Ticiana Osvald Ramos	University of Brasília	Autonomous Birth Houses in the Brazilian Context: conflicts and meanings surrounding the humanization of births and deliveries	Sociology	Doctoral Degree	2013
Raquel Paiva Dias Scopel	Federal University of Santa Catarina	The Cosmopolitics of Pregnancy, Childbirth, and Postpartum: practices of self-care and the process of medicalization among the Munduruku Indians	Social Anthropology	Doctoral Degree	2014
Antonio Rodrigues Ferreira Junior	State University of Campinas	Invisible Professionalization: Training and Work of Doulas in Brazil	Medicine	Doctoral Degree	2015
Raquel Simas	Federal University Fluminense	Doulas and the Movement for the Humanization of Childbirth – Power, Gender, and the Rhetoric of Emotional Control	Anthropology	Master's Degree	2016
Luciana Guimarães Santos	Federal University of Amazonas	"The Art of Midwifery": From traditional midwives to the medicalization of childbirth in the Amazonas (1970-2000)	History	Master's Degree	2016
Christine Raniel Gusman	Federal University of São Paulo	Indigenous Midwives and the Objects of Midwifery: appropriation, uses, meanings, and significance	Medicine	Doctoral Degree	2017
Diana de Oliveira Bezerra	Federal University of Pernambuco	Childbirth Assistance in Indigenous Women from Pernambuco, 2008 to 2015	Collective Health	Master's Degree	2017

Iraci de Carvalho Barroso	Federal University of Ceará	"Training" Traditional Midwives in Amapá: tensions between the incorporation of medical knowledge and cultural resistance in the practice of midwifery	Sociology	Doctoral Degree	2017
Mariana de Oliveira Portella	Federal University of Pernambuco	Science and Custom in Childbirth Assistance	Sociology	Doctoral Degree	2017
Sandra Cavalcanti Silva	Oswaldo Cruz Foundation	Traditional Midwives: Attention to Pregnancy and Childbirth in an Amazonian rural community in the municipality of Itacoatiara – Amazonas	Public Health	Master's Degree	2017
Taciane Melo de Sousa	Oswaldo Cruz Foundation	The care offered by traditional midwives: networks of knowledge, care, and integrality in the attention to pregnancy, childbirth, and the postpartum period	Public Health	Master's Degree	2018
Francielli Girardi	University of Vale dos Sinos	Care itineraries and healthcare practices of Kaingang women during the pregnancy-postpartum period in the Kondá Village/SC	Collective Health	Doctoral Degree	2019
Mary Lucia Souto Galvão	University of the State of Bahia	Education, Health, and Memory: narratives and knowledge of traditional midwives in the Cabula territory	Education	Doctoral Degree	2020
Juliana Floriano Toledo Watson	University of Brasília	Births and Midwifery in the History of Cavalcante-GO: epistemicide, childbirth monoculture, and reproductive justice	Bioethics	Doctoral Degree	2022

The research, being preliminary, is not exhaustive but illustrative of the wide diversity of investigations carried out in the field of traditional methods of childbirth and delivery assistance in Brazil. Furthermore, it is worth noting that some of these investigations appeared more frequently in the analyzed articles, such as those by Fleischer (2007), Ferreira (2010), Gusman (2017), Scopel (2014), and Tornquist (2004). Nevertheless, it was not possible to identify with certainty what the

fundamental references discussing the topic would be, as references to the authors are diffuse and focused on exemplifying childbirth and delivery assistance in other locations[91].

6. References

AIRES, Maria Juracy. The right to the art of midwifery. **Revista da Faculdade de Direito UFPR**, v. 43, p. 61-80, 2005.

ARAUJO, Maria Rafaela Amorim de et al. Sexual and reproductive health in the Xukuru do Ororubá ethnic group: tell women to move forward. **Saúde em Debate**, v. 44, p. 193-204, 2020.

AZEVEDO, Marta. Reproductive health and indigenous women of the Upper Rio Negro. **CADERNO CRH**, v. 22, n. 57, p. 463-477, 2009.

BRAZIL. Ministry of Health. Department of Health Surveillance. Department of Health Situation Analysis. **Health Brazil 2011:** an analysis of the health situation and the surveillance of women's health. Brasília: Ministry of Health, 2012b.

BRAZIL. Ministry of Health. Department of Labor and Health Education Management. Department of Education Management in Health. **Qualification Program for Indigenous Health Agents (AIS) and Indigenous Sanitation Agents (AISAN)**. Brasília: Ministry of Health, 2016b.

BRAZIL. Ministry of Health. Department of Health Care. **Homebirths and domiciliary births assisted by traditional midwives:** the Working with Traditional Midwives Program and exemplary experiences. Brasília: Ministry of Health, 2012.

BRAZIL. **Brazil and the MDGs**. n/d. Available at: http://www.odmbrasil.gov.br/o-brasil-e-os-odm. Accessed on: June 15, 2023.

BRAZIL. **National Health Plan PNS 2016-2019**. 1st ed. Brasília: Ministry of Health, 2016.

BRAZIL. **National Health Plan 2020-2023**. 2nd ed. Brasília: Ministry of Health, 2021.

BARROSO, Iraci de Carvalho. The knowledge of traditional midwives and the practice of homebirth in rural areas. **Revista Eletrônica de Humanidades do Curso de Ciências Sociais da UNIFAP**, v. 2, n. 2, 2009.

COLOMBIA. **Sentencia T-128/22**. Available at: https://www.corteconstitucional.gov.co/relatoria/2022/T-128-22.htm. Accessed on: June 15, 2023.

[91] The only author who, in the researcher's perception, deviates from this rule is the historian Maria Lucia Mott, who makes a significant contribution to the history of childbirth assistance in Brazil, being regularly cited by several of the researched authors.

CRESCER. **Casa de Parto no Brasil:** o que são e como funcionam esses espaços do nascer. Available at: https://revistacrescer.globo.com/Gravidez/noticia/2021/01/casas-de-parto-no-brasil-o-que-sao-e-como-funcionam-esses-espacos-de-nascer.html. Accessed on: June 2, 2023.

DA ROCHA, Adauto Santos; MOREIRA, Vânia Maria Losada. "QUANDO A PESSOA NASCE COM UM DOM, AÍ JÁ VEM COM ELE!": Dona Salete and the midwifery profession among the Xukuru-Kariri. **Revista de Estudos Indigenas de Alagoas-Campiô**, v. 1, n. 1, p. 89-102, 2022.

DE MENEZES, Paula Fernanda Almeida; PORTELLA, Sandra Dutra Cabral; BISPO, Tânia Christiane Ferreira. The situation of homebirth in Brazil. **Revista Enfermagem Contemporânea**, v. 1, n. 1, 2012.

DIAS-SCOPEL, Raquel Paiva; SCOPEL, Daniel; LANGDON, Esther Jean. Pregnancy, childbirth, and postpartum among the Munduruku of Amazonas: conflicts and articulations between the hegemonic medical model and indigenous practices of self-care. **Ilha**, v. 19, n. 1, p. 183-216, 2017.

DO SOCORRO ARAÚJO, Maria; DA ROCHA LIMA, Janirza C. Midwives in Pernambuco: tradition and memory. **Cadernos de Estudos Sociais**, v. 25, n. 1, 2010.

ECHR (European Court of Human Rights**). Case of Dubská and Krejzová V. The Czech Republic**. Former Fifth Section, 11 December 2014. Available at: https://hudoc.echr.coe.int/fre#{%22itemid%22:[%22001-148632%22]}. Accessed on: June 15, 2023.

FERREIRA, Luciane Ouriques. The emergence of traditional indigenous medicine in the field of public policies. **História, ciências, saúde-Manguinhos**, v. 20, p. 203-219, 2013.

FERREIRA, Luciane Ouriques. The participatory development of the indigenous traditional medicine area, Vigisus II/Funasa Project. **Saúde e Sociedade**, v. 21, p. 265-277, 2012.

FLEISCHER, Soraya. Doulas as "affective buffers": Ethnographic notes on a new birth companion. **Ciências Sociais Unisinos**, v. 41, n. 1, p. 1-12, 2005.

GALVÃO, Mary Lúcia Souto et al. Memories of traditional knowledge in the former Quilombo Cabula (Salvador-Bahia): Journeys through birth narratives. **Revista Encantar**, v. 1, n. 1, p. 28-43, 2019.

GIRARDI, Francielli; LÓPEZ, Laura Cecília. "And when the fruit ripens, it falls": care during pregnancy and childbirth among the Kaigang from the perspective of a midwife. In: Schweickardt, J. C.; SILVA E SOUSA, M. J.; NASCIMENTO, A. C. S.; GOMES, M. D. M.; MORAES, T. S. (Org.). **Traditional Midwives: shared knowledge, practices, and healthcare**. 1st ed. Porto Alegre: Rede UNIDA Publisher, 2020.

GTR (Regional Working Group for Maternal Mortality Reduction). **Joint Declaration on the Reduction of Maternal Morbidity and Mortality**. Available at: https://brazil.unfpa.org/sites/default/files/pub-pdf/cmm_-_declaracion_pt_1.pdf. Accessed on: June 16, 2023.

GUSMAN, Christine Ranier et al. Inclusion of traditional midwives in the Unified Health System in Brazil: reflecting on challenges. **Revista Panamericana de Salud Pública**, v. 37, n. 4-5, p. 365-370, 2015.

GUSMAN, Christine Ranier; RODRIGUES, Douglas Antônio; VILLELA, Wilza Vieira. Paradoxes of the traditional midwives program in the context of Krahô women. **Ciencia & Saúde Coletiva**, v. 24, p. 2627-2636, 2019.

MOTT, Maria Lúcia. Maternity care: from home to hospital (1830-1960). Projeto História: **Revista do Programa de Estudos Pós-Graduados de História**, v. 25, 2002.

MOTT, Maria Lucia. Midwives: the other side of the profession. **Revista Gênero**, v. 6, n. 1, p. 117-140, 2005.

MPPR (Public Prosecutor's Office of Paraná). **Essential Competencies for Basic Obstetric Practice**. N/d. Available at: https://saude.mppr.mp.br/arquivos/File/kit_atencao_perinatal/manuais/competencias_obstetricia_2005.pdf. Accessed on: June 12, 2023.

OLIVEIRA, Rônisson de Souza de; PERALTA, Nelissa; SOUSA, Marília de Jesus Silva. Traditional midwives and the medicalization of childbirth in the rural region of Amazonas. **Sexualidad, Salud y Sociedad (Rio de Janeiro)**, p. 79-100, 2020.

WHO. **Care in Normal Births: a practical guide**. Geneva: World Health Organization, 1996.

WHO. **Munich Declaration**. June 2000. Available at: http://www.index-f.com/lascasas/documentos/lc0062.pdf. Accessed on: June 15, 2023.

OMS. **Nursing and Midwifery in the History of the World Health Organization 1948–2017**. Geneva: World Health Organization, 2017.

OMS. **Resolution WHA 64.7:** Strengthening nursing and midwifery. May 24, 2011. Sixty-fourth World Health Assembly. Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_R7-en.pdf. Accessed on: June 15, 2023.

UN. Economic and Social Council of the United States. Permanent Forum on Indigenous Issues. **E/C.19/2019/L.10**. Seventeenth session. New York: 2018.

PINTO, Benedita Celeste de Moraes. Everyday experiences of midwives and "experienced" women in Tocantins. **Revista Estudos Feministas**, vol. 10, p. 441-448, 2002.

SAMPAIO, Juliana; BRILHANTE, Marita de Almeida Assis; HERCULANO, Thuany Bento. Doulas: Social movement and the fight for public policies on sexual and reproductive rights. **Revista Gênero**, v. 18, n. 2, 2018.

SANTOS, Bruna dos; SILVA, Cíntia Cristina Lisboa da. **Traditional midwives as subjects of resistance to multiple colonialities**. VI CEPIAL, 2021. Available at: https://www.researchgate.net/profile/Cintia-Silva-6/publication/357002590_As_parteiras_tradicionais_como_sujeitas_de_resistencia_as_multiplas_colonialidades/links/61b7c8c0fd2cbd72009b72bd/As-parteiras-tradicionais-como-sujeitas-de-resistencia-as-multiplas-colonialidades.pdf. Accessed on: May 14, 2023.

SILVA, Raimunda Magalhães da, et al. Qualitative evidence on doula support during labor and childbirth. **Ciência & saúde coletiva**, v. 17, p. 2783-2794, 2012.

SILVA, Raimunda Magalhães da, et al. Use of complementary and integrative practices by doulas in maternity hospitals in Fortaleza (CE) and Campinas (SP). **Saúde e Sociedade**, v. 25, p. 108-120, 2016.

TASSINARI, Antonella. The "mother of the body": Knowledge of Karipuna and Galibi-Marworno women about pregnancy, childbirth, and the postpartum period. **Horizontes Antropológicos**, v. 27, p. 95-126, 2021.

TEMPESTA, Giovana Acacia; FRANÇA, Ruhana Luciano de. Naming the unnamable: Problematizing obstetric violence and outlining a counter-hegemonic reproductive pedagogy. **Horizontes Antropológicos**, v. 27, p. 257-290, 2021.

TEMPESTA, Giovana Acacia. Working for good relationships: Anthropological reflections on the work of doulas. **Anuário antropológico**, v. 43, n. 1, p. 37-66, 2018.

TENDERINI, Helena (Org.). **Mestras do Nascer:** Parteiras Indígenas Pankararu (digital book). 2020.

TORNQUIST, Carmen Susan. Popular midwives: between folklore and listening. **Revista Gênero**. 1st semester, v. 6, n. 1, p. 61-80, 2005.

UNFPA. **Message for International Day of Professional Midwives.** 2014. Available at: https://brazil.unfpa.org/pt-br/news/mensagem-para-o-dia-internacional-das-parteiras-e-parteiros-profissionais-2014. Accessed on: June 13, 2023.

UNFPA. **UNFPA and nine other organizations launch interagency campaign calling for actions to reduce maternal mortality in Latin America and the Caribbean**. 2023. Available at: https://brazil.unfpa.org/pt-br/news/unfpa-e-mais-nove-organizacoes-lancam-campanha-interagencial-para-reduzir-morte-materna. Accessed on: June 15, 2023.