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Complementary and integrative practices by doulas in maternities in Fortaleza (CE) and Campinas (SP), Brazil

Uso de práticas integrativas e complementares por doulas em maternidades de Fortaleza (CE) e Campinas (SP)

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Abstract

This study aimed to analyze the Integrative and Complementary Practices (ICP) applied by doulas in the cities of Fortaleza (CE) and Campinas (SP). This is a qualitative study encompassing fifteen doulas: nine from Fortaleza and six from Campinas. The data were collected in the second half of 2010 by conducting semi-structured and pre-organized interviews following the procedures of thematic content analysis. The interpretations of the results were based on the idea that institutionalization of knowledge and practices happen through the conformation of nuclei and fields. The nucleus demarcates the identity of an area of knowledge and the professionals' practices, and the field demarcates the blurred limits among disciplines that can be submitted to conflicts. We observed that the support offered by doulas permeates a variety of practices framed in traditional medicine as well as in complementary and alternative medicine. ICP was associated with decreases in length of labor, superior pain management, ability of making decision and empowering of women. It is understood that the range of activities offered by doulas and the use of ICP converge to the uniqueness, respect and autonomy of women. Furthermore, it proposes a new model of awareness and practices centered on the importance of the natural process of childbirth.
Keywords: Integrative and Complementary Practices; Pregnancy; Labor and Delivery; Doulas.

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Resumo

Objetivou-se analisar as Práticas Integrativas e Complementares (PICs) utilizadas por doulas nos municípios de Fortaleza (CE) e Campinas (SP). É um estudo de natureza qualitativa, com 15 doulas: nove de Fortaleza e seis de Campinas. Os dados foram coletados no segundo semestre de 2010, mediante a realização de entrevistas semiestruturadas, e organizados seguindo a técnica da Análise de Conteúdo na modalidade temática. A interpretação dos resultados baseou-se na noção de que a institucionalização dos saberes se dá pela conformação de núcleos e de campos. O núcleo demarca a identidade de uma área de saber e de práticas profissionais; e o campo, um espaço de limites imprecisos entre as disciplinas, mas que pode ser submetido a conflitos. Observou-se que o suporte das doulas permeia uma variedade de práticas emolduradas na Medicina Tradicional (MT) e das PICs. Essas práticas contribuíram para a diminuição do tempo de trabalho de parto, melhor controle da dor, ajuda na tomada de decisões e empoderamento da mulher. Compreende-se que o espaço de atuação da doula e o uso de PICs convergem para a singularidade, respeito e autonomia da mulher e propõem um novo modelo de saberes e práticas centrado na importância do processo natural do parto.

Palavras-chave: Práticas Integrativas e Complementares; Gestação; Trabalho de Parto; Doulas.

Introduction

This essay represents a part of the preliminary results from an inter-institutional study conducted collectively by professors and students in the Graduate Programs in Collective Health Care of the Universities of Campinas and Fortaleza. The research focuses on analyzing the institutional and private work of doulas who provide support to women at childbirth, in public and private maternity wards in the municipalities of Fortaleza (CE) and Campinas (SP).

Nowadays, basically three childbirth care models are in force in several countries: the medicalized model that uses high technology and does not often include midwives, which is found in the United States of America, in most European countries and in Brazil's urban regions; the humanized model that is more often performed by midwives and does not include medical interventions so often, which is found in Holland, New Zealand, and Scandinavian countries; and the mixed model, in force in Great Britain, Canada, Germany, Japan, and Australia (Wagner, 2001).

As a matter of fact, maternity care in Brazil is observed to have high indices of interventions, with a special mention to the fact that in the year 2000 the number of caesarean sections reached 38% of total births. In 2008, Brazil was considered one of the world leaders in caesarean sections, with rates ranging from 32% in 2008 to 52% in 2013 (Fiocruz, 2011). At the global level, according to the Brazilian Ministry of Health (MH), cesarean section rates are highlighted to have increased from 5% in the 1970s in the developed countries to over 30% as of the 1990s, reaching 50% in the early 21st century (BRAZIL, 2011a).

In the context of maternal health care, maternity care is characterized by practices following the biomedical model; it proposes the institutionalization of women and the excess number of procedures, gaining distance from the humanist model (Helman, 2003). In Brazil, most hospitals and maternity wards do not have room for a practice focused on the needs of the mother-to-be, as their technical capacity and social power to act legitimately on behalf of science

impose the criteria for dealing with women's bodies, submitting them to a kind of symbolic violence that depersonalizes them.

In Fortaleza, in the year of 2011, the total number of babies born alive through caesarean sections reached 67.2%, whereas in Campinas, over the same period, the rate was 66.2% (BRAZIL, 2013). In contrast, the World Health Organization (WHO) since 1996 has defended the argument that childbirth should not be medicalized and that its supervision must be conducted with the least interventions as possible (WHO, 1996). As a matter of fact, MH invests in the creation of policies and programs, such as *Programa de Humanização no Pré-natal e Nascimento* (Program for Humanizing Prenatal Procedures and Childbirth - PHPN) (Brasil, 2002) and *Política Nacional de Atenção Integral a Saúde da Mulher* (National Comprehensive Women Health Care Policy - PNAISM) (Brasil, 2004). To strengthen those programs, MH has released Ordinance no. 1,459, which regulates *Rede Cegonha* (Stork Network), an innovative strategy that intends to implement a care network to ensure women their right for reproductive planning and humanized maternity care (Brasil, 2011b).

Due to that, it is vital to highlight the publication of Law no. 11,108, which recommends the presence of a companion (Brasil, 2005). In regards to accompanying women during childbirth, the support form doulas is highlighted. According to Silva et al. (2010), they can provide emotional, physical, information, psychosocial, and decision-making support, reduction of anxiety, emotional protection, encouragement and reduction of stress, preventive interventions, and promotion of safety, trust, encouragement, and ease.

The work of doulas, intrinsic to the context of humanized maternity care, is tied to the use of Traditional Medicine (TM) and Complementary and Alternative Medicine (CAM). The work of doulas was regulated in 2006 by the MH, through the publication of Ordinance 971, which created *Política Nacional de Práticas Integrativas e Complementares* (National Policy of Integrative and Complementary Practices - PICs) with the scope of ensuring the prevention of illnesses, promoting and recovering health (Barros, 2006). These practices resume the search for simple therapeutic methods that seek the autonomy of being and of health (Tesser et al., 2008; Otani et al., 2011).

The PICs also highlight the importance of women becoming responsible for their fates, being aware of their abilities, and competent in the control of their own health and bodies. Therefore, these health care practices aim to enable subjects to acquire competences of self-esteem and self-care, as well as the ability to critically analyze the reality they live in (Kleba et al., 2009).

Thus, a national movement exist seeking to rethink the childbirth model in force in Brazil, recovering elements of humanization and use of integrative and complementary practices. In the work of doulas, the emergence of a new form of organizing childbirth knowledge and practices is highlighted, outlining another professional knowledge field that is committed to the needs of women. This new method for organizing and institutionalizing the knowledge and its organization in practices is conducted from the conformation of cores and fields that take into consideration a certain standard of commitment with the production of values of use (Campos, 2000). For the author, the core would outline the identity of a knowledge field and of a professional practice; and the field, a space of inaccurate limits where each discipline and profession would seek; in others, support for the conduction of their tasks and practices.

That notion of field and core rises from the need and the unavoidability of establishing social identities for knowledge professions and field (Campos, 2000). However, it also suggests the possibility that such institutionalization may happen more democratically, which makes room for the socially constituted dimension; i.e., the social action of individuals, groups, and movements is contrasted with the weight of scientific structures. Thus, knowledge is also produced by other fields, even if they are not dominant. The PICs and the work of doulas may be said to still occupy a secondary position in the scientific field as compared to the medicalizing model of childbirth, but they certainly are a knowledge form that is made legitimate by the action and practice of

some agents. This notion of core indicates a certain concentration of knowledge and practices, without, however, indicating a radical breach with the field dynamics.

Campos (2000) proposes a new view on Bordieu's (1983) stance on the issue of disputes concerning the scientific field. The scientific authority, to Bordieu, is backed by the combination of technical abilities, symbolic power, and legitimacy a scientist has due to their position in the scientific field, which is defined as a system of objective relationships between acquired positions that compete for the monopoly of scientific legitimacy. That is, the cores dispute for the power to impose the criteria to define what is scientific or not. In this field, the competing agents develop strategies for conservation and exclusion according to their position in their group. These strategies are executed by those who occupy dominant positions. On the other side are those who occupy dominated positions in the field or who are excluded from it (Campos, 2005). With the formation of disciplines, however, the closing or institutionalization of part of the field and the creation of controlling and management devices of social practices regarding knowledge take place. In contrast, as seen before, Campos (2000) presents a notion of porosity among the disciplines or cores that may coexist within a field.

Considering this debate, this article focuses on the possibility of making a more democratic practice regarding childbirth, in which women have more autonomy, by appropriating their wishes and subjectivities; in which they are entitled to access good maternity care practices and to be ensured a companion during childbirth (Brasil, 2011b). This new core of knowledge is legitimate and backed in the PICs. However, as it is still incipient, it has trouble imposing itself before the hegemonic health care model.

Upon conducting a non-systematized review of the literature using the keywords "complementary" "therapies", "delivery", "pregnancy", and "doulas" on the MEDLINE, LILACS, PubMed, and SciELO databases, from 2004 to 2014, we found 26 studies with qualitative and quantitative approaches, of which only four discussed the topic related to the use of PICs at childbirth and mentioned the support from doulas, showing how scarce research on the topic is.

Thus, this study seeks to analyze the PICs used by public and private doulas in the municipalities of Fortaleza (CE) and Campinas (SP). By considering the use of PICs by doulas in the field of maternal health care, the following questions arose: How do doulas use alternative and complementary practices during labor? Which are the contributions mothers-to-be are given due to these practices in doulas' point of view? What is the reaction from health care professionals regarding the work of doulas?

Experiment design

This article describes a qualitative study that seeks to understand the use of PICs by doulas who work at public and private maternity wards in Fortaleza (CE) and Campinas (SP). Choosing these two cities was due to the fact they are stage to relevant social movements in the field of childbirth humanization. Fortaleza is located in Brazil's Northeast region, and it is the capital of the state of Ceará. It is estimated to have 2,421,185 inhabitants[1]. This city was the stage of the movement of traditional midwives and of the drafting of the document that describes proper childbirth techniques, understood to be key for humane care. This movement was led by obstetrician Galba de Araújo, who proposed, in the 1980s, the integration of Ceará's traditional midwives in hospital maternity care (Rehuna, 2005).

Campinas is located northwestern to the capital of the state of São Paulo, and occupies an area of 795,697 square kilometers, with 1,080,113 inhabitants[2], and currently uses PICs as health care program status, focusing on women's health. It has support groups to active childbirth, with the support of private doulas who can be hired to supervise the mother-to-be at home or maternity wards. Campinas is the city where the *Rede Nacional de Humanização*

1 Available on: <http://cidades.ibge.gov.br/painel/populacao>. Accessed on Oct. 25, 2015

2 Ditto.

do Parto e Nascimento (National Childbirth Humanization Network) was founded in 1993 (Rehuna, 2005), and it currently houses movements that fight for the empowerment of doulas and their integration in public maternity wards.

The research subjects in Fortaleza were found through searching for private doulas who were enrolled in the *Associação Nacional de Doulas do Brasil* (Brazil's National Doulas Association)[3]. Seventeen doulas were initially identified in the city, among which nine were located and accepted to take part in the research. In the city of Campinas, the access to those professionals took place in childbirth support groups. A "snowball" scheme was used later. Six doulas were located in total, who cooperated and experienced childbirth, took part of seminars and support groups, and had certificates for training courses in their own municipality, with priority to the ones with 40 hours or more. We conducted the selection of groups representative of the study through their implication in the investigated reality.

The research subjects are 15 doulas: nine from Fortaleza, among which six worked as volunteers in a tertiary maternity ward that belonged to the public network in the city, whereas other three had been certified by Brazil's Doulas Association and provided private support to mothers-to-be. In Campinas, the six doulas who took part in the study belonged to support groups to pregnant women in public and private maternity wards, and rendered private services at institutions and households. In Fortaleza, the composition of the final number of subjects was backed by theoretical saturation, which was operationally defined when the obtained data started being repeated according to the rater's assessment (Polit et al., 2004).

The 15 subjects are in the age range between 26 and 55 years. Regarding marital status, 13 of them were married and 2 were single; regarding their household income, the doulas institutionalized in Fortaleza earned up to twice the monthly minimum wage; one of them was a missionary in the community, and the ones who worked privately in Fortaleza and Campinas earned from seven to eight times the monthly minimum wage, and were graduated in pedagogy, psychology, physical therapy, journalism, law, and nursing.

The data were collected throughout the second half of 2010 through a semi-structured interview on sociodemographic data, motivation, and benefits of being doulas, and on perceptions regarding the use of PICs, through the following guiding questions: "Which alternative and complementary practices do you use during pregnancy, labor, and childbirth?", "How do you perceive the contributions from those practices in pregnancy and labor?", "How is the reaction from health care professionals concerning your practices?".

Individual meetings in private spaces were scheduled with the study subjects to conduct the interviews, which lasted two hours, in average. The inclusion criteria included: providing support to pregnant women for over six months, and being trained and certified to perform such practice.

Intending on preserving the anonymity of interviewed subjects, their speeches are identified by the letter D, according to their numbers and locations. Besides that, in the identification of private doulas, the word private is added before the letter D. The data were organized and analyzed based on Content Analysis, theme modality, according to Bardin (2008). A pre-analysis was conducted first. It consisted of a preliminary and full reading of descriptions, to capture the meaning intended by the subjects. Two other readings of the descriptions took place later in a more intense and exhaustive manner, and the meaning units were identified. Following that, the meaning contained in each unit was sought to be apprehended to formulate the categories that emerged from the speeches, and central ideas, convergences, and divergences were identified in the meaning units (Bardin, 2008).

The results were interpreted based on the idea that the institutionalization of knowledge takes place upon the conformation of cores and fields (Campos, 2000). A core outlines the identity of a knowledge field and professional practices. A

3 Available on: <http://www.doulas.com.br>. Accessed on: April 18, 2012.

field, in turn, is characterized as a porous space of imprecise boundaries, where each discipline would seek support from others to fulfill its practical and theoretical tasks, even if this process implies conflicting relationships within the field.

The study met the requirements of Resolution no. 466/2012, from the Brazilian National Health Care Council/Brazilian Ministry of Health (Brazil, 2012), and it was approved as per official opinion no. 423/2011 from the Human Research Ethics Committee of the University of Fortaleza.

Results and Discussion

The results are presented under three guiding parameters: work of doulas and use of Integrative and Complementary Practices; Contributions from the use of Alternative and Complementary Practices in the perception of doulas; and Difficulties for the work of doulas in the institutional space and in their relationship with professionals and mothers-to-be.

Work of doulas and use of Integrative and Complementary Practices

The work of doulas is based on the field and core of Traditional Medicine (TM) and Complementary and Alternative Medicine (CAM), or PICs[4], and it concerns the theoretical and practical implications, approximations, and tensions in this field. The first one gathers native knowledge, practices, and beliefs in distinct cultures, whereas the second one prioritizes health care that is not integrated to the dominant health care model (Luz, 2005).

That being said, the use of TM was seen by doulas when they recommended the use of medicinal tea and herbs, and the use of CAM when they recommended acupuncture, reiki, homeopathy, flower remedies, shiatsu, and by their using hydrotherapy, therapeutic massages, meditation, visualization, relaxation, breathing techniques, yoga, and moxibustion. The fragments below show the use of such practices, which, in Luz's (2005) opinion, consists of the integration or harmony between man and nature, and between nature and a culture of balance for people, originated from knowledge that is accessible to the community.

> *By the end of pregnancy we recommend that women start drinking sesame seed milk - according to the midwives, it softens the flesh; when women go into labor and contractions are started, there is a technique that is also often used by traditional midwives, which consists of women washing themselves from the waist down with half a liter of alcohol and half a bowl of water; the chili broth during labor, when she goes into labor and the contractions start increasing, she can drink the chili broth to facilitate dilation* (Private D1 – Fortaleza)

> *We use herbs after birth* (Private D9 – Campinas).

> *I recommend medicinal herbs for sickness, mainly in the beginning of pregnancy; I also indicate homeopathy and flower remedies for couples, sometimes* (D4 - Campinas).

> *I refer many women to acupuncture, homeopathy, and shiatsu* (Private D5 - Campinas).

The findings point towards a convergence of practices conducted by private doulas in Fortaleza and Campinas. The doulas inserted in these contexts are highlighted to represent a group of activist women who are concerned with improving women's quality of life and wellness, and who seek to once more have support from women, their families, and partners during childbirth.

According to Brazil's National Doulas Association, these professionals propose practices based

4 For the World Health Organization (2002), the term Traditional Medicine (TM) is the designation of a complex medical system, which is coherent within itself and originated from a tradition/culture of a certain people. As examples we may name Traditional Chinese Medicine, Ayurvedic Medicine, etc. In turn, the term Complementary/Alternative Medicine (CAM) is usually used to describe all medical practices that are not only part of allopathic medicine and traditional medicines, such as Phytotherapy, Homeopathy, and Anthroposophic Medicine. In Brazil, these two treatment systems were combined and called *Práticas Integrativas e Complementares* (Integrative and Complementary Practices - PICs) by the Ministry of Health (BRASIL, 2006).

on the recommendation from the World Health Organization, on Evidence-Supported Medicine, and on the knowledge of traditional midwives, with a special mention to being able again to have natural childbirths with the least possible number of medical interventions, and deep interest in and respect for the psychology and physiology of childbirth[5].

When it is intended to advance towards practices, values, and representation of health, it is necessary to take into account the multiplicity and diversity of models and practices concerning both traditional or current knowledge and complex medical systems (Luz, 2005).

It should be pointed out that the work of doulas consists of a multiple framework of knowledge and practices, which is inserted into an extensive repository of therapeutic care.

> *I use moxibustion, baths, and massages to alleviate lower back pain during childbirth; I use phytotherapy, hydrotherapy, mediation, visualization, strong breathing work a lot* (D4 - Campinas).

> *Besides providing that support with help from other devices such as exercise balls and therapeutic techniques such as touching, which is very important (holding hands, stroking hair); comforting words, and stimulating walking* (Private D8 - Fortaleza).

These knowledge and practices, as several studies point towards, follow a distinct paradigm (Luz, 2008; Tesser et al., 2008; Queiroz, 2000). The same way, the proposal of PICs favors the inclusion of integrative logic, which combines the "hard core" of several practices with quality, safety, and effectiveness, surpassing the excluding view (Barros, 2006). This conception seeks to offer full health care, and it is not a mere combination of conventional medicine with CAM, but rather a treatment based on evidence that is backed by scientific research (Otani et al., 2011).

Upon the use of such practices, the working spaces of doulas are clarified as well as the variety of support types these professionals perform.

> *I take her to shower, I talk to her a lot to calm her down* (D5 - Fortaleza)

> *I use phytotherapy a lot, I work with hydrotherapy, especially to alleviate pain. I have already worked with moxibustion, but hydrotherapy is the only one I use frequently in all births* (D5 – Campinas).

Thus, doulas can do part of the volunteer work at hospitals and be trained to give support, as shown in the study by Silva et al. (2010). They can also be professionally qualified and hired to provide physical support, information, to ensure immediate contact with babies, and to provide guidance on breastfeeding (Brüggemann et al., 2005).

To consider humanized care is to consider, above all, the right for women's freedom of choice, comprehensive, beneficial practices to the wellness of mothers and their babies, the respect to the rights of users, the valuing of popular knowledge, and the extent of therapeutic modalities that can be associated with the conventional model.

The use of PICs by doulas is thought to favor the visibility of the work that is performed by the professionals in the context of childbirth. It refers to the humanistic paradigm, which focuses on women and meets the latest recommendations of the Ministry of Health by publishing Ordinance no. 1,459, which regulates *Rede Cegonha*, and by making good use of "good practices of maternity care" (Brazil, 2011).

Contributions from the use of alternative and complementary practices in the perception of doulas

The contributions from doulas are highlighted as representative of a knowledge field and professional practices based on the needs of individuals. The contributions from doulas' use of PICs are inferred to regarding the issue of empowering

5 Available on: <http://www.doulas.com.br>. Accessed on: April 18, 2012.

women at the time of childbirth. Actions that favor the reduction of labor times, head engagement, the natural induction of the process, and the improved control of pain help in the making of decisions and promote a pleasant environment for birth, contributing to improve the quality of life of mothers-to-be.

In this perspective, the use of hydrotherapy, mantras, and moxibustion, according to the subjects, provides a more pleasant environment and facilitates labor:

> *Both showers and bathtubs are things that help dealing with and reducing pain* (Private D3 - Fortaleza).

> *The use of mantras harmonize and support the dilation process, and moxibustion greatly favors relaxation* (D4 - Campinas).

Corroborating the findings, the literature signals the fact that hydrotherapy promotes increased diuresis, diminished edema and arterial blood pressure, enables improved fetal rotation, speeds up labor, and reduces perineal trauma (BRUGGEMANN et al., 2005), whereas moxibustion enables fetal wellness (CLUETT et al., 2004). The use of PICs by doulas promotes decision-making by mothers-to-be and enables them to choose which techniques and positions they should adopt during labor. Thus, mothers-to-be take active part in childbirth, going beyond the possibilities imposed by professionals.

By this outlook, the need for overcoming the dominant model becomes evident, as it focuses on high rates of medical interventions and defines the criteria and the monopoly of legitimate exercise under the medicalized childbirth. According to Storti (2004), humanization as professional and corporate legitimacy requires that roles be reconfigured in a childbirth setting. That involves several changes, such as the location, which is changed from operating rooms to delivery rooms, rethinking procedures that are exclusive to medical professionals, among others, inserted in the field of conflicts and struggles for space and legitimacy.

In this perspective, doulas recognize that support to women must be provided according to the specific characteristics of each individual, as shown in the following speech:

> *There are mothers-to-be who respond better to visual stimuli, and therefore to visualization techniques; others respond better to tactile stimuli, massages, and touching* (Private D4 - Fortaleza).

> *When she manages to deliver her baby as she thought she would, I sense she ends up feeling empowered, self-confident, and that feeling grows in such a beautiful way that it gets stronger* (D6 - Campinas).

The testimonials regard to the situation that is contrasted to the medicalized model of maternity care that is currently in force, in which the organization of obstetrical assistance and the demand for caesarean section by mothers-to-be – "caesarean sections as per request" – are attributed to sociocultural factors, to the fear of pain at the time of childbirth and to the training of professionals, which privileges the use of sophisticated technology rather than the learning of normal maternity care, which emphasizes a pathological conception of the labor process (Hodnett et al., 2005).

The dominant position of Biomedicine is expressed in the power to define the criteria and to establish the monopoly of the legitimate exercise of one's body (Bourdieu, 1983). The technical ability and the social power to act and speck legitimately on behalf of science creates a power field. Thus, the legitimacy that is given to medical interventions is socially granted by peers in the scientific field, but also by the very women who believe in the symbolic power of science and opt for caesarian interventions. However, the work of doulas points towards the existence of conflicts and to the coexistence of other cores inside this scientific field that is not hegemonic, but rather competes as a legitimate way to view health and science.

Before the domination model that governs the space of childbirth institutionalization, the role of doulas represents another knowledge core based on light technologies:

> *A matter that involves ethics, as you, as a doula, cannot choose a woman's path, because if that happens it becomes very noxious, as doulas cannot become authorities for women* (Private D8 - Fortaleza).

The role of doulas in supervising women permeates a future mother's relationship of choice through several ways that can be elected, thus starting from the premise that choosing to take a decision must originate from a will that arises during pregnancy.

Therefore, it is essential to point out that obstetrical assistance, even in a hospital context, can be experienced in a reality of humanization that is simple, pleasant, and singular. The need for humanized care arises from the fact that the process of giving birth in itself creates moments of great vulnerability, as signaled in the following speeches:

> *Sometimes the very presence of a woman right there beside you, a look of tenderness and affection is also everything* (Private D2 - Fortaleza).

> *At childbirth time, women sometimes feel very fragile, and that feminine presence, that sharing, that embracing, that support, I think it is fundamental for women to be able to relax, for them to be able to get in touch with themselves, with their babies, with what they are experiencing* (D5 - Campinas).

Some national and international studies signal the notion that, in the perception of mothers-to-be, doulas stimulate the mother-child relationship, provide guidance to successful breastfeeding, contribute to prevent postpartum depression, help mothers have positive experiences, and were considered by all mothers as important, as the only people who were beside them during the whole process (SCHROEDER et al., 2005; SANTOS et al., 2009). Thus, doulas were highlighted to contribute towards the taking back of the natural childbirth environment through the use of PICs.

Difficulties for the work of doulas in the institutional space and in their relationship with professionals and mothers-to-be.

The findings point towards the contributions the work of doulas can bring to a more humanized childbirth. Nonetheless, they experience several difficulties and struggles while working in institutional spaces and in their relationship with professionals and mothers-to-be.

Many doulas point out that their main difficulty is the very deficiency in the structure of hospitals for the conduction of their activities, which, according to them, also denotes the invisibility of their work:

> *Lack of infrastructure in the very hospital, as the culture of lack of companionship is present, even though it is a woman's right* (D8 – Fortaleza).

> *There are no proper environments in private hospitals, there is no space for use to calmly perform our duties* (D5 - Campinas).

On the other hand, difficulties shown in the working field of doulas are observed to also be related to lack of knowledge from both sides (professionals and mothers-to-be) on the work of doulas, which results in the lack of appreciation of the work they do. That is reflected in the several names doulas are given, such as labor companions and/or labor and childbirth assistants (HODNETT et al., 2005). However, it should be said that the work of a doula should not only be considered as the one of a companion, as childbirth support consists of the participation of a trained person who offers advice, measures aiming physical and emotional comfort, and other ways to help future mother during labor and childbirth (HOTIMSKY; ALVARENGA, 2012).

As pointed out by the following reports, the work of doulas is still barely known to a great deal of health care professionals:

> *Most professionals do not know our work and get really curious; they ask what we are, if we are therapists* (D3 - Campinas).

> *There are professionals who ask us to do things, such as opening packages, which we already know we may not* (D2 – Fortaleza.).

> *Sometimes there are many people, right there in the hospital, who do not know or value what we do (D4 - Fortaleza).*

Lack of knowledge or interest from health care professionals, and oftentimes the very users, regarding complementary therapies leads to misleading concepts, which may result in difficulties in the relationship between physicians and patients and among colleagues in these specialties (Franco et al., 2002). Such difficulties shown in the work of doulas reflect the current context of the health field, which is interspersed with struggles between corporations and political pressures for space in the field of PICs (Tesser et al., 2008).

The invisibility of the work of a doula in the reality of childbirth reflects in it being devalued. Some studies also point towards fear and ideas preconceived as negative that health care professionals have regarding the presence of companions in the context of childbirth (Ratto et al., 2001; Florentino et al., 2003). The literature signals that in health care services nurses were shown to be more open than physicians to unconventional practices (Nunez et al., 2003). However, the use of PICs as specialty or professional qualification for nursing professionals is still incipient. Few nurses are aware of alternative therapy specialties being supported by the law (Nunez et al., 2003).

Some doulas also report mothers-to-be are unaware of their work, and consequently resist of decline receiving support from them:

> *There are some who do not even want help, they ask us to get away from them; we talk to nurses, and they say, "look, that one does not want any help". We tell them it is a good help during childbirth, but they say, "no, I want to be lying down" - mainly the ones who arrive at night* (D3 - Fortaleza).

> *Some women have already refused doula support, and I have already suffered due to lack of awareness, from people ignoring, belittling, and refusing our support* (D1 - Campinas).

Medicalization in the Brazilian society is rooted on Conventional Medicine, and it is oftentimes characterized as a depersonalizing medicine due to its interventionist nature. It is worth pointing out that denying mothers-to-be help from doulas may be linked to not being aware of the benefits that are required for the preparation of labor during prenatal visits, or even before they get pregnant. That would help women recover the control over their own bodies, reduce the stress level they experience during labor, and avoid the excessive use of medical interventions during childbirth (Behruzi et al., 2010).

Actually, in the health care field in general – as in any other scientific field – different political positions are observed to struggle for a specific form of capital (which is scientific authority). Such epistemological debates and struggles which permeate the academic world cover up strategies for maintenance, exclusion, or achievement of the power to impose certain definitions of what is scientific and legitimate. The hegemonic power is dominant, but it is not the only one, nonetheless. The dominated also interfere in the social dynamics and in the inversion of values, which highlights the social and historical inadequacy of outdated structures thus increasing the possibility of change.

Under that perspective, some randomized clinical studies and systematic reviews show the usefulness and the form of support that is provided by family members, spouses, and friends of mothers-to-be, and the effects from the support that is given to women during labor by health care professionals, doulas, and laywomen (Brüggemann et al., 2005). Following that trend, some maternity wards in Brazil have been adapting physical areas to enable the permanence of a companion without jeopardizing the privacy of the remaining mothers-to-be (Storti, 2004), and one of the proposals of *Rede Cegonha* of 2011 is to enable maternity wards to be adjusted and to allow the construction of maternity facilities that make it possible for companions to be present before, during, and after childbirth (Brasil, 2011a).

Thus, some authors point towards the need to reorganize health care practices (Luz, 2005; Luz, 2008; Tesser et al., 2008). It is possible to point towards the incorporation of unconventional therapeutic practices in public institutional spaces, even if not enough yet. To achieve such a result, it is required to overcome the limits in

the search for objectivity and to include people's subjectivity into discussions, to rid ourselves from which is irreducible to scientific rationality in health care practices, and, in this case, regarding practices related to labor and childbirth.

There is a trend in Conventional Medicine to naturalize knowledge based on sciences; i.e., to treat them as if they did not have social origins (Luz, 2005; Luz, 2008). The scientific field expresses its own dynamics and, as any social field, is subject to conflicting interests that grants it specific structuring and operation characteristics that need to be apprehended by a sociologist's analytical effort. Thus, the pure world of science and the flawlessness of its products vanish, to give rise to a sphere of social practice that is crossed by interests not always explicit and by struggle positions that give new outlines to science.

Final remarks

The findings pointed out that the space of the work of doulas was tied to the use of TM and CAM, which were identified in the field of recommendations and uses during pregnancy and childbirth, as well as in the difficulties for the work of doulas in the institutional space and in their relationship with professionals and mothers-to-be. The interviewed subjects believe the use of such practices may promote the sensitization of pregnant women of a more humanized labor and childbirth model.

The speeches from the doulas regarding the practices they perform at public institutions or privately were not found to significantly differ in either of the cities. The doulas inserted their support in the empirical reality and they fight for space for their work, which faces institutional barriers, power struggles over the domination of care, devaluation of women's wishes, and, above all, the breach of a model that was previously configured as a physiological one, which is characterized by non-humanized care. The work of doulas is still very restricted, as their support could not overcome the institutional limitations and barriers imposed by the hegemonic health care model. Moreover, lack of knowledge from professionals and patients and the invisibility of the work doulas perform hinder the overcoming of such barriers.

We understand that much needs to be done for doulas to achieve their space, a small number of studies on that topic exist, contemplating the use of PICs, which make it possible to make comparisons of practices of doulas in national and international contexts. Such recovery contributes to a search for the creation of stimuli that favor the recognition of the support doulas provide to women at the time of childbirth.

The space for the work of doulas and the use of PICs are understood to converge to singularity, respect to the autonomy of women, and to propose a new model centered on the importance of childbirth humanization. It highlights the fact that the crystallization of the institutional model managed by the domination of knowledge on the woman's body renders invisible the field of expertise of members who fight for the valuation of practices and knowledge for the benefits of healthy pregnancy and childbirth.

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Authors' contribution

Raimunda Magalhães Silva, Nelson Felici Barros, and Regina Yoshie Matsue contributed with the conception of the idea, drafting, and critical analysis of the article. Herla Maria Furtado Jorge and Antonio Rodrigues Ferreira Júnior took part in the data collection, organization, and analysis.

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