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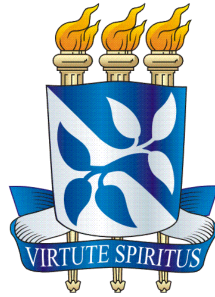

UNIVERSIDADE FEDERAL DA BAHIA
FACULDADE DE FILOSOFIA E CIÊNCIAS SOCIAIS
PROGRAMA DE PÓS-GRADUAÇÃO EM ANTROPOLOGIA

AISCHA SCHUT

TRUSTING HOMEBIRTH:

EMERGENT EPISTEMOLOGIES IN CAETÉ-AÇU, BAHIA

Salvador
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Orientadora: Profa. Dra. Cecilia Anne McCallum

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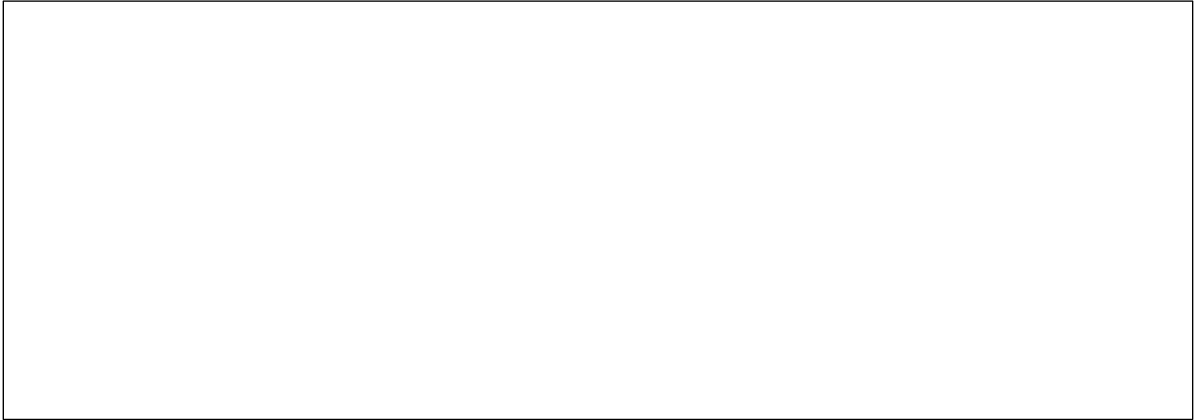

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Salvador, 27 de maio de 2021.

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Para Noah, meu monstrinho delicioso

“Na medicina e no amor, nem nunca, nem sempre”
- Áureo Augusto

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limitless creativity and fantasy, musicality and for trusting me to be your mother. With your presence, this dissertation has become infinitely more challenging and profound – and I am so grateful for that.

ABSTRACT

This dissertation provides an investigation of the ways in which women and birth attendants in Capão have engaged in acts and notions of trust related to homebirth. The inherent contingency of childbirth has been a reason for all women and birth attendants in this research to embark on a journey in search for trust. The hegemonic obstetric practices in Brazil are quite distant from what have been considered 'good practices' in homebirth, even more so in the highly hybrid and 'mutually accommodated' birth assistance in Capão. Because of this 'distant' and subversive character of homebirth in the context of Brazil, 'choosing' to birth at home seems to intensify or increase the need for this search for trust. I highlight that the counter-hegemony and the intensified search for trust related to homebirth in Capão have resulted in 'emergent epistemologies', or a variety of local and structured contexts in which in which knowledge (and 'truth') is continuously produced. I expose an *assemblage* of what these epistemologies consist of and argue that thet, and the inevitable challenge they pose to authoritative epistemologies about childbirth in Brazil, are ever-emerging in large part because the search for trust and the engagement in notions and acts of trust are too. The 'emergent' character of these searches for trust is highly connected to the contingency of women's 'reproductive navigation'. This contingency is due to the many 'vital conjunctures' resulting from the 'sociality and physicality of the body'. Because giving birth at home in Brazil seems to intensify the search for trust and, consequentially, produces emerging epistemologies, and because Capão is a national reference for homebirth assistance, it has proven to be a particularly interesting context to investigate and contribute to existent literature on notions and acts of trust and emergent epistemologies. The fact that homebirth is the main 'modality' of birth in Capão is the result of a variety of social, political, economic and cultural forces. More specifically, the unique conjunctures of Capão's residents and visitors, the wider, hegemonic context of obstetrics in Brazil, the local historical development of birth assistance, its birth attendants and geographical localization. I question underlying structures of women's 'decisions' to give birth at home and the possible negative outcomes of what happens when birth enters the realm of commodification by stimulating the adoption of a 'consumer identity' (CRAVEN, 2007) through which women seem to have the agency to choose however, wherever and with whoever they would like to give birth. I argue that through these mechanisms, homebirth practices and the emergent epistemologies related to them might actually contribute instead of challenge what Ginsburg & Rapp (1995) have called 'stratified reproduction'.

Keywords: homebirth, trust, authoritative knowledge, stratified reproduction

RESUMO

Esta tese apresenta uma investigação sobre as formas com quais mulheres e acompanhantes de parto no Capão se engajam em atos e noções de confiança relacionados ao parto domiciliar. A contingência inerente ao parto foi um motivo para todas as mulheres e acompanhantes de parto desta pesquisa embarcarem em uma jornada em busca de confiança. As práticas obstétricas hegemônicas no Brasil estão bastante distantes do que têm sido consideradas ‘boas práticas’ no parto domiciliar, sobretudo na assistência ao parto altamente híbrida e ‘mutuamente acomodada’ no Capão. Por causa desse caráter 'distante' e subversivo do parto domiciliar no contexto obstétrico brasileiro, 'escolher' o parto domiciliar parece intensificar ou aumentar a necessidade dessa busca por confiança. Destaco que a contra-hegemonia e a busca intensificada por confiança relacionada ao parto domiciliar em Capão resultaram em ‘epistemologias emergentes’, ou uma variedade de contextos locais e estruturados nos quais o conhecimento (e a ‘verdade’) são continuamente produzidos. Exponho um conjunto em que consistem essas epistemologias e argumento que elas, e o desafio inevitável que representam para as epistemologias autoritativas sobre o parto no Brasil, estão em emergência contínua em grande parte porque a busca pela confiança e ao engajamento em noções e atos de confiança também emergem continuamente. O caráter ‘emergente’ dessas buscas por confiança está altamente conectado à contingência da ‘navegação reprodutiva’ das mulheres. Esta contingência se deve às muitas ‘conjunturas vitais’ resultantes da ‘sociabilidade e fisicalidade do corpo’. Pelo fato de o parto em casa no Brasil parecer intensificar a busca por confiança e, consequentemente, produzir epistemologias emergentes, e por Capão ser referência nacional em assistência ao parto domiciliar, tem se mostrado um contexto particularmente interessante para investigar e contribuir com a literatura existente sobre noções e atos de confiança e epistemologias emergentes. O fato de o parto domiciliar ser a principal ‘modalidade’ de parto no Capão resulta de uma variedade de forças sociais, políticas, económicas e culturais. Mais especificamente, as conjunturas únicas dos residentes e visitantes do Capão, o contexto mais amplo e hegemônico da obstetrícia no Brasil, o desenvolvimento histórico local da assistência ao parto, seus acompanhantes de parto e sua localização geográfica. Eu questiono as estruturas subjacentes das 'decisões' das mulheres de dar à luz em casa e os possíveis resultados negativos do que acontece quando o nascimento entra no reino da mercantilização, estimulando a adoção de uma 'identidade de consumidora’ (CRAVEN, 2007) através da qual as mulheres parecem ter a agência para escolher onde e com quem eles gostariam de dar à luz. Eu argumento que, por meio desses mecanismos, as práticas de parto domiciliar e as epistemologias emergentes relacionadas a elas podem contribuir, em vez de desafiar a ‘reprodução estratificada’.

Palavras-chave: parto domiciliar, confiança, conhecimento autoritativo, reprodução estratificada

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PREFACE

Like many other 22-year-old women, I had never really thought about pregnancy, birth, or myself in relation to them. In June 2012 however, I noticed on a social network that many Brazilian women I knew were talking about the ‘humanization of birth’ and, specifically, protesting against the proposal of one of the nation’s main obstetric councils to prohibit obstetricians from working outside the hospital (in other words, assisting homebirths). I had never heard of the phenomenon of ‘humanization’ and, at first, was very puzzled about it; what could possibly be ‘humanized’ about birth, such an intrinsically human event? Nevertheless, I was reminded of a forgotten desire I had expressed to my mother when I was only 11 years old, about one day wanting to be a midwife. The thought of studying and working with pregnant women and birth enchanted me and I decided that I had to take advantage of this moment in which birth was becoming such a ‘hot topic’. Slowly I immersed myself in the overwhelming amount of information, birth stories, evidences, social and political movements, policies and NGOs that were involved in the so-called ‘humanization of birth’. The stories and statistics frightened me, especially those about maternity hospitals that had a close to 100% caesarean rate and the large scale of interventions during births. ‘Obstetric violence,’ ‘maternal mortality’ and ‘birth trauma’ were expressions that seemed omnipresent in Brazilian obstetrics and the stories that fleshed out these phrases made me understand more of why such ‘humanization’ was urgently necessary. Eventually I conducted my undergraduate research in the first and only free-standing birth centre in Salvador (capital of the state of Bahia), that is, a centre independent of any maternity hospital where women can have normal births. There, I witnessed births for the first time and, as is true for many birth assistants, it felt like love at first sight. All of this affected me in such a way that, besides documenting and analysing everything that happened at the time, I became actively involved in protesting and in discussions on social networks. I also attended a course to become a doula[1] and have assisted births since then.

Everything I experienced made me reflect on the situation in my country of origin, the Netherlands, and on why and how it contributed to making the Brazilian reality seem so hostile to me. The Netherlands is known for its relatively high proportion of homebirths. Birth is normalized as a social rather than a medical event (though nowadays things are changing at a fast pace). As I thought about the Brazilian situation, I realized that I was raised with the idea that there is not much to birth other than giving a woman the time, space and emotional and

[1] Non-medically trained birth assistant that provides informative, physical and emotional support during pregnancy, birth and the post-partum period.

physical support she needs to receive her baby. At the time I was born, homebirth was a woman's first option, and only if a complication emerged that was impossible to deal with at home would she be transferred to the hospital (often still giving birth vaginally), as was the case with my mother. As such, when I heard of Brazilian women giving birth at home -in spite of the hostile context-, and when I started to give support during homebirths as a doula, I wanted to understand their situations and experiences more in depth. I discovered homebirth in Brazil was often labelled as 'something of the past', and even 'backward' or 'irresponsible'. It intrigued me to see that women who grew up in a place where hospital birth and elective caesareans are highly normalized, somehow decided to give birth in such a counterhegemonic way.

Consequentially, homebirth in Salvador was the focus of my Master´s dissertation in Medical Anthropology & Sociology at the University of Amsterdam (Schut 2014). It was a truly interesting and gratifying experience to work with women who, in such an urban and 'high-tech' context, decided and were able to birth as they wished, either because that was what they found to be their actual desire or because they wanted to avoid what they understood to be violent and disrespectful options.

These women guided me into the highly intimate, social and complex world of trust. Besides trusting me with their birth stories and all of the emotions and sensations they were going through or had gone through, they showed me how much birth and the time-space building up to it is impregnated with many ways of trusting. They spoke of trusting themselves, their bodies, nature, the midwife(s), their partner, their baby, and 'the process' itself. They also spoke of mistrusting the normative birth assistance, *cesaristas* (obstetricians with a great tendency to perform ('unnecessary') caesareans), hospital protocols and routine interventions on them and their babies. I realized that the lack of control on this physiological process and, as we will see in this dissertation, its contingency, almost obliged women to engage in trust-building. However, I still found it very difficult to make sense of the overwhelming amount of notions of trust that crossed my way.

Then, in September 2016 I gave birth at home to my first son. When I got pregnant, common questions in the Netherlands would be: will you give birth at home or in the hospital? With or without epidural? In Salvador, however, had it not been for my previous involvement as a doula and in homebirth assistance, people would have constantly asked me whether I would give birth vaginally or by caesarean. I knew I was privileged: even before getting pregnant, I had had access to information about how the general Brazilian obstetric system functioned; what it meant in terms of health for me and my baby to undergo a caesarean; to information

about what my rights and options were; to a social network that supported natural and homebirth and, my Dutch health insurance covered all costs of the homebirth assisted by a team that consisted of an obstetrician and obstetric nurse. Going through this experience myself, prolonged and deepened my interest in understanding how trusting 'works' in the process towards and during homebirth.

For this dissertation, I have chosen to deepen the research I have been conduction formally and informally for over the past 10 years. This time however, I decided to focus on trust related to homebirth in an area from whence high-tech hospital birth is much harder to access than in Salvador: the small village of Caeté-Açu in the Chapada Diamantina mountainous hinterland of State of Bahia. Commonly known as Capão, it has become something of a mecca for women looking for an alternative homebirth experience, distant from the high risk of surgical, medicalized deliveries in so common in the urban centres.

Capão is a refuge from the hot, noisy and crowded capital, always welcoming to visitors and inhabitants, both natives and settlers from many places of the world. With its brown-coloured freezing waterfalls, its green and lush nature and atmosphere of a community where, in some places, one can feel as if in a stereotypical 1970s hippie community. It takes a day´s (or night's) journey to reach it from Salvador. During the many visits I have made there since I came to Brazil for the first time in 2009, I got to know some of its inhabitants and important figures. The highly heterogeneous population, which consists of a mixture of native inhabitants, tourists and temporary and permanent settlers from all over the world, has formed a community in which notions of 'modernity' and 'tradition' are highly ambiguous, reflected in many dimensions of the local life-worlds.

It was only after I became aware of the national efforts to 'humanize' birth that I began to think about birth assistance in Capão, located at least an hour of unpaved road from the closest urban centre and another thirty minutes of highway before getting to the nearest hospital. Also, it has been very well known for its high rate of homebirths. I made assumptions about 'traditional midwives' that worked there and, even though those were true in part, the reality was much more interesting and complex than I had imagined. What caught my attention were residents (mainly 'outsiders') and birth attendants who treated birth as a spiritual, holistic process, especially 'outsiders' and their apparent coexistence with native birth attendants and notions of birth. This complexity intrigued me. Many people spoke of the 'fertility' of the place and how Capão was a place that 'called babies to be born there'. Soon it became clear that there were even women and couples that moved to Capão with the intention to give birth there. I

became friends with the local naturalist family doctor (a trained obstetrician), who little by little told me about the history of this movement and his experience of birth assistance in Capão.

Altogether, this place, which contrasts with Salvador in so many ways and is home to people from many different cultural and social backgrounds, unites a special variety of ways of birthing at home. Because of this specific context, I decided to engage in an empirical study so as to shed new light on notions of trusting in homebirth.

1. INTRODUCTION

It is a bit after midnight in Capão when midwife Naima and doula Laila once again try to cover Grazi's partly naked and trembling body with thick, woollen blankets in the humid cold so typical for nights in June. There is no heating nor fireplace, and the birth team and Grazi's partner and friends try to keep warm moving around and drinking tea. In the candlelight it is hard to see one another's facial expressions, but the smells and sounds speak for themselves: the birth is getting closer and Grazi is getting tired. Laila, who is a nurse technician as well as a trained doula, has laid out the obstetric emergency-kit on their improvised table. To 'move the energy', Grazi's partner suggests they do a few acroyoga poses, which they often used in their work as street artists travelling around the world. As he lays down with his both legs up, she takes advantage of the break in between the 'waves' (contractions) and climbs on his feet, where she sits with her legs spread and moans through a few contractions. 'Trust your body, it knows what to do', whispers Naima to Grazi. Impressed by the scene and as promised, I take some pictures. Little did we know that it would still take another 8 hours, lots of cotton leaf tea, bellydancing, massaging and moaning before Paz would be born in his parents' small, cold and temporary house. [fieldnotes, 11/06/2018]

For many Brazilians this scene might sound horrific, and one could wonder why somebody would want to give birth in these conditions. Grazi and her partner Davi are Spanish, and once they discovered they were pregnant, neither doubted their desire to give birth at home in Capão. They had lived there before, created a group of friends (mainly foreigners and travellers like themselves) and had seen what a 'paradise for children to be born and raised in' it was. She was six months pregnant when they arrived and I got to know her right away during my participant observation in the prenatal consultations. She was very open and willing to share her story with me, and slowly we became friends. We exchanged information about our experiences during pregnancy, of my birth and the first months of motherhood, and as her birth got closer, she invited me to be present at her birth. The invitation was a great honour to me, because I know how much of an intimate moment it is for many women. Besides that, it provided me with many different insights about how, during birth, the people that are present tap into an enormous 'repertoire' of notions and acts of trusting that, altogether, cause a sense of calm and control in a highly uncertain and relatively uncontrollable situation.

Capão is known for a large variety of 'alternative' and 'holistic' therapies, workshops and retreats that are offered throughout the year. Its 'mystic' image has been developing since a large urban exodus occurred in the late 70s, in which many Brazilians who were either disenchanted with what they argued to be a capitalist way of living in urban centres, or who pursued what they imagined to be a calmer, alternative and close-to-nature lifestyle. Hand in hand with these developments, efforts were made to maintain, adapt and redefine homebirth practice which, for the majority of Brazilian women were a reality only until the 1960s. In sharp

contrast with dominant birth practices in Brazil, nowadays homebirth is the main ‘modality’ of birth in Capão. Moreover, over the past 10 years women with and without partners have (temporarily) moved to Capão with the specific intention to give birth there.

Giving birth at home in Brazil, which has appeared in the media as the ‘world record-holder of caesareans’, is frequently experienced as being a challenge. Generally speaking, hospitals, obstetricians and technology are highly valued in Brazilian obstetrics, turning ‘natural’ and ‘hands-off’ vaginal births into rare events. This is even more so in the private health sector, where most maternity hospitals hold caesarean rates between 80 and 90% (LEAL & NOGUEIRA DA GAMA, 2014). A variety of factors is responsible for this reality: obstetricians who prefer to make more and faster money and when it suits them by scheduling a few caesareans per day; lack of information about the short- and long-term risks of caesareans without medical necessity; worries about vaginal aesthetics and sexuality; fear of pain; previous traumatizing birth experiences; over-valorization of technology; generalized emphasis on the ‘risks’ perceived as inherent to birth (either ‘high risk’ or ‘normal risk’); among others (e.g. CARNEIRO, 2015; DINIZ, 2005; WILLIAMSON, 2019). Together, these factors contribute to a widespread understanding that, in most cases, women are unable to give birth naturally without external medical and technological intervention. Among critics, it is not uncommon to hear of blaming of two social groups: women who are said to desire caesareans and obstetricians who are said have ‘dehumanising’ and interventionist practices. However, McCallum (2005) has showed us that, in the case of Salvador and arguably in many other places in Brazil, the situation is much more complex. Considering the blaming of women, she argued that ‘rather than coming to the obstetrician with a ready-made ‘culture of caesarean’, the series of social encounters during pregnancy and childbirth lead them to accept the surgery. Thus ‘culture’ emerges within specific social relationships, like that between doctor and patient, rather than existing independently of them’ (IBID.). In the case of the obstetricians, she observed that ‘health professionals are not so much socialised into a ‘culture of dehumanisation’, as subject to the effects of accumulated experiences in different institutions (private and public) and the impositions of their day-to-day routines. The organisational features of public and private obstetrics channel them to practise as they do’ (IBID.). Therefore, she argues that, in order to change these rates, the system as a whole, which is sustained by stratified reproduction[2] through ‘inequalities of race, class and gender’, has to be changed (IBID.)

[2] For more on stratified reproduction, see Ginsburg & Rapp (1995). At the end of Chapter 2 I will discuss this further.

In spite of this, a small but growing minority of Brazilian women has been choosing to give birth at home. During my previous research on *planned* homebirth (*parto domiciliar planejado*)[3] in Salvador, it became clear that many of the women who chose to give birth at home actively engaged in challenging and redefining the common and hegemonic knowledge about birth[4] (SCHUT, 2014). They used many different forms of such redefinition (and, arguably, acts of trusting): in-depth reading of scientific articles and evidence on all possible outcomes and interventions; demonstrations against medical councils' efforts to discourage and even prohibit obstetricians to assist homebirths; sharing posts and videos and reading and writing about homebirth on social networks; and participating in women's circles and 'womb blessings. Some of these women felt part of or actively participated in a larger, national movement also known as the 'humanization of birth', which unites a variety of social and policy initiatives, NGOs, activists, and health professionals. Whilst in the media, and amongst the majority of health professionals homebirth is commonly pictured as something 'backward' and even 'irresponsible', these women have been claiming this way of birthing as exactly the opposite, emphasizing its safety, normality, modernity[5], high levels of satisfaction about the birth experience and its long-term positive impact on public health.

These collectivized efforts of challenging and redefining the dominant discourses and practices about birth are part of what could be called 'emergent epistemologies' (MCCALLUM, nd), or a variety of local contexts in which in which knowledge (and 'truth') is continuously produced (TOREN & PINA-CABRAL, 2011). Taking into consideration that both pregnancy and childbirth are processes that change through time and space, the 'emergent' character of such epistemologies is particularly present: in a timespan of nine months and even during birth, 'new' or 'alternative' knowledges about birth constantly emerge - including the knowledge that a constantly changing pregnant and birthing body provides.

Such anti-hegemonic efforts all seemed to share an important goal: creating the trust necessary to navigate around the lack of certainty during what is often experienced as a physically and emotionally challenging moment, and even more so to deal with the great emphasis on risk that so strongly permeate Brazilian obstetrics. In my research I noted that some women had carried trust in homebirth with them since they were little; their grandmothers and/or mother had given birth at home and they had never questioned why they would not do

[3] In the following section I write in detail about 'planned homebirth'.
[4] About birth in general, about homebirth specifically, and often also about their bodies, breastfeeding and parenting.
[5] Highlighting the planned character of homebirth was and continues to be an important strategy to redefine and contrast the 'urban' modality of homebirth with the 'traditional' and 'rural' homebirth as commonly stereotyped among Brazilians, and relating it to 'evidence-based medicine'; see section on planned homebirth.

the same. However, the majority of the women I interviewed had not been raised in such a context and wanted to give birth at home precisely because they mistrusted the other available options –either after studying about them or hearing some of the many stories of obstetric violence[6] that circulate informally and in social media, or because of their own previous negative experiences. For many women, therefore, mistrust worked as a stimulus for them to seek a means to avoid going down a road they thought would be likely to hurt or traumatize mother and child.

The women I interviewed at the time were privileged, mostly white women living in a metropolis, all of whom had accessed information about giving birth at home and, most importantly, who enjoyed financial conditions enabling them to actually give birth at home. Especially in Salvador, capital to the blackest state of Brazil, access to health care, reproductive health and options are highly racialized[7]. Giving birth at home in the 'planned' modality in Brazil is a costly practice[8]. This is one of the reasons it has been pictured as (and mostly is) an elite practice, which in Brazil inevitably intersects with structural racism, or as a kind of birth that is only quite acceptable outside of Brazil, as in the case of TV celebrity Bela Gil or of Duchess Kate of the UK. There is only one public hospital in Brazil (Belo Horizonte, capital of the State of Minas Gerais[9]), where we find a policy that allow women to give birth at home through the public health system and it has been very rare for health insurances to refund costs related to homebirth. As we will see, the participants of the present research are quite distinct from the women I interviewed in Salvador and, moreover, financial and 'elitist' issues gain different meanings.

Capão brings together unique characteristics related to its population, options for birth assistance and its localization. The sociocultural heterogeneity that characterizes Capão provides a kind of laboratory for an ethnographic investigation of 'emergent epistemologies'[10] about subjects and bodies during pregnancy and birth – that is, it will allow a study of the inter-subjective processes that underlie the production of knowledges and 'truths' about (home)birth. As I will argue, trust-building in the time-space of pregnancy and homebirth is integral to these processes. Therefore, I seek to uncover what different acts and notions of trust these women

[6] In Chapter 2 I will explore what 'obstetric violence' means in the context of Brazil.
[7] MCCALLUM 2005; MCCALLUM & REIS, 2008; DE ZORDO, 2012
[8] Prices of homebirth 'teams' varied between 5000 and 15.000 Brazilian reais in 2018 (between U$ 1000,- and 3000,-)
[9] https://www.sofiafeldman.org.br/por-que-o-sofia/maternidade-1
[10] I refer to 'emergent epistemologies' mainly recognizing McCallum's observed limitation of the notion 'culture' in the specific context of 'emergent risk cultures' of birth care in Brazil. As 'risk' is a notion much less present in the discourses of people who chose to have, have experienced and work with homebirth, I argue that, for this specific context, the notion of 'emergent epistemologies' provides a more neutral theoretical lens through which to investigate the ever-emerging knowledges and 'truths' about homebirth. I will explore this notion throughout the dissertation.

and the people involved with them during pregnancy engage in as they journey towards birth and how the challenging and redefinition of existent knowledge, as well as production of 'new' knowledge about birth, affects such trust-building. Through this dissertation, I intend to contribute to the literature on the diverse modes of the production of (mis)trust across and within cultures, highlighting the social role of trust in highly intimate processes such as pregnancy and childbirth.

Increasingly more research is being conducted on birth in Brazil. However, homebirth – in all its modalities – is still very little explored. The majority of studies on homebirth focus on 'traditional'[11] homebirths that generally occur in rural areas (MENEZES ET AL., 2012). As I will analyze in more detail below, a few studies explore the urbanised modality '*planned* homebirth' (the main modality of homebirth in Capão). Nevertheless, only Souza (2005) conducted an ethnographical analysis on the subject through which she observed some processes of trust-building. Analysing (home)birth rites in Florianópolis, she provides insights into how the domestic environment is being re-valorized as a 'space of sociability'. She briefly explores some of the notions of trust that emerged during the research, in which she notes that couples and their midwives prepare for homebirth through the

> '*construção de vínculos de intimidade e confiança entre os participantes a partir de um intenso intercâmbio semântico. Tais comunicações, afetivamente carregadas, baseiam-se numa rede de suposições e pré-entendimentos compartilhados e estão empenhadas na construção de um horizonte semântico que visa potencializar a atuação conjunta dos participantes durante o parto'*[12] (SOUZA, 2005:88).

She argues that such semantic exchanges contribute to the creation of social movements and groups with affinity of lifestyles (IBID.:131), and, arguably, to what Giddens called 'active trust' (1994:186–7)[13]. In the next section, I provide a brief introduction to trust research and its relation to childbirth.

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[11] 'Traditional' is put in quotes due to the highly problematic connotations commonly associated with it (e.g. static, backward, opposed to 'modern' etc.). In the context of this research, 'traditional' is a category frequently used by the people involved in birth care; I will explore the different meanings attached to this notion in the chapters to come.

[12] 'Construction of relationships of intimacy and trust between the participants through an intense semantic exchange. Such communications, affectionately charged, are based on a network of shared suppositions and pre-understandings and are committed to the construction of a semantic horizon, which aims to potentialize the joint action of the participants during birth.' (my translation)

[13] Briefly, the concept of 'active trust' recognizes the possibility of the 'trustor' actively engaging in the process of trust-building, as opposed to the more common understanding of the 'trustor' who passively relies on the 'trustee' (mainly related to institutionalized contexts). As such, it recognizes the processual character of trust and the presence of mutual exchange (Giddens, 1995).

1.1 Birth & Trust

The anthropological literature about how trust is built and acted out, how it is conceived and what kind of work the notion does (JIMÉNEZ, 2005 & GRIMEN, 2009) is very scarce. Most of it is carried out by philosophers, psychologists, sociologists, economists and internet scientists, who often ‘seem to have been informed by a number of theoretical entanglements’ (HAAS, 2016:102). A central critique is that studies on trust are often ‘thinly’ conceived, as if it was ‘a thing in itself’, universal and easy to quantify and compare (BROCH-DUE & YSTANES, 2016:3). Also, many studies investigate trust as a singular concept, looking at it only from the ‘Truster’ perspective. In other words, approaching it from an ethnocentric, individualistic and neoliberal idea of a rational and self-governing ‘self’ (IBID.). Haas observes two unifying threads in the different studies of trust she considers. First of all, ‘the association of trust with risk and its calculability’, which results in understanding trust ‘as a threshold point determined by an [overly] cognitive assessment of trustworthiness and the interest or need to trust’ (HAAS, 2016:90). Secondly, she notes the association of ‘trust with lack of control’, and, consequentially, with its social function to ‘deal with’ lack of control. In the same volume, Ystanes challenges existing notions about trust, family and intimacy in Latin societies, such as ‘the idea that trust in its essence is a taken-for-granted aspect of the intimate sphere’ (BROCH-DUE & YSTANES 2016:14). This critique, based on Ystanes´s research in Guatemala, is particularly relevant for the present research, as it has been widely considered as an ‘untrustworthy’ place for giving birth.

In anthropology, trust is an unknown country. Even here, trust has frequently been reduced to notions such as ‘reciprocity’ and ‘contract’ (see, for example, SAHLINS, 1974[1965] and INGOLD, 1986). In my previous research, I approached trust from a sociological and, in retrospect, quite limiting perspective by looking at how trust contributed to reduce uncertainty (SCHUT, 2014). With that in mind, I have been challenged and inspired by a small group of anthropologists who united recently to deepen the understandings of this complex phenomenon within anthropology (LIISBERG, PEDERSEN & DÅLSGAARD, Eds., 2015; BROCH-DUE & YSTANES, Eds., 2016). They emphasize how an anthropology of trust can contribute to deepening the understanding of trust by looking beyond problematic individualistic and universal assumptions of the phenomenon and ‘by giving a more serious treatment to the diversity and intricacy of notions of self and social order’ (BROCH-DUE & YSTANES, 2016:21). Known for its investigation of cross-cultural practices, values and symbols, anthropology can also provide new insights into trusting behaviours through the description and analysis of ‘the entanglement of trust and mistrust with different cultural styles

and different ways of shaping subjects and sociality.' (IBID.). Finally, ethnographic methods based on long-term participant observation, are designed to provide detailed and culturally sensitive accounts not of abstract notions of 'society', but rather of the relationship between the phenomena that social theory has often reified as such and small-scale and locally structured intimate spheres. In the intimate sphere that encompasses and grows out of experiences of pregnancy and birth, such methods offer a means to capture processes of trust-building.

When we look at research on birth and homebirth specifically, trust is a disturbingly absent subject, especially when we consider that trust (and, moreover, 'risk') is such a recurrent topic in health professionals' as well as women's discourses about birth. As I will show below, the few times trust is mentioned in relation to pregnancy and birth it is limited to notions of risk and 'sense of self'[14]. In Brazil, Claudia Rezende has been one of the few anthropologists to approach this phenomenon in relation to pregnancy and birth from an anthropological perspective. In her research in Rio de Janeiro (2017), she argues that 'trust is not just about forming bonds of cooperation, as it appears in many studies in the social sciences. By treating trust as a moral relational idiom, I point out that this notion fundamentally refers to the way people are thought of and how they should behave.' Let us first turn to a brief exploration and historical overview of the ways in which childbirth has been conceived of in anthropology in order to situate the present research.

1.2 Childbirth in Anthropology

Just like many other sciences, anthropology was practiced mainly by male scientists until the 1970s. Consequentially, 'female' domains such as reproduction and, more specifically, childbirth, hardly appeared in early anthropological research. Influenced by upcoming women's movements, the anthropology of women's health, bodies and reproduction in particular have analyzed women's reproductive experiences as 'sources of power as well as subordination' (GINSBURG & RAPP, 1991:312). Upcoming feminist movements in the 1970s problematized issues such as male dominance in different areas of human life; the medicalization of the female body and power relations in Western biomedicine; the essentialization of women as reproducers (through which women's health has often been equated with reproductive health); and the right to access to information and autonomy[15]. Following this lineage, Scheper-Hughes and Lock

[14] See PARRAT & FAHY, 2003; SCAMELL & ALASZEWSKI, 2012; COXON ET AL., 2012; COXON ET AL., 2014; CHEYNEY & EVERSON, 2009

[15] See, for example, BROWN, 1998; INHORN, 2006; JOHNSOSN & SARGENT, 1990; JORDAN, 1993 [1978]; MARTIN, 2001 [1987]; MCCLAIN (1975); GINSBURG & RAPP, 1991; DAVIS-FLOYD, 1992; DAVIS-FLOYD & SARGENT, 1997.

identified what they call ‘body politic’, which they define as ‘the regulation, surveillance, and control of bodies’ (1987:7). They note that the body politic of a society regulates and controls bodies when the social order is perceived to be threatened, or in order to produce a politically and culturally ‘correct’ body: the body a society ‘needs’. One could argue that this notion represents the body as a passive receptor of cultural inscription. Instead, however, it helps to uncover the intimate relationship between bodies and power relations through which the body can be seen as an active participant in the ongoing production of social and cultural values, symbols and practices. Finally, influenced by the Cartesian body-mind dualism, some scholars argued that the male body came to be seen as ‘the prototype of the properly functioning body-machine’ (DAVIS-FLOYD, 2001:2). As a result, in many medical contexts the female body was and is seen as deviating from this prototype, and therefore as dysfunctional, defective and ‘in need of constant manipulation by man’[16] (IBID. & MARTIN, 2001 [1987]), reproducing power differences in gender relations and medicalizing the female body.

On the other hand, as a result of a more general paradigmatic shift in anthropology that has focused on social constructedness (VAN HOLLEN, 1994 & GINSBURG & RAPP, 1991), reproduction has been interpreted not only as a social construct itself but also as a *locus* of social and cultural production. In the past thirty years, these perspectives have been of significant influence on (medical) anthropological studies that have documented ‘health concerns from women’s own perspectives’ (INHORN, 2006:346), highlighting the interplay between representations and experiences.

As a fundamental aspect of reproduction, childbirth is one of the events that has been specifically put under the microscope of anthropology. When referring to the anthropology of childbirth it is virtually impossible not to mention Brigitte Jordan, also known as ‘midwife to the anthropology of birth’ (HAHN IN DAVIS-FLOYD & SARGENT, 1997:3). She was the first to conduct a cross-cultural study of birth systems, arguing for a ‘fruitful accommodation’ (JORDAN, [1978] 1993:136) of biomedical and indigenous birth systems. Hereby, she presented the birth practices she observed in four different cultures as reflections of underlying cultural patterns.

Such interpretation of birth practices as reflections of a static culture has been criticized for ignoring the variety of practices *within* a birth system, in which dominant perspectives on childbirth are not only reproduced in different ways, but also contested and transformed (VAN

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

HOLLEN, 1994). In 1993 Jordan adjusted this interpretation by developing the notion of 'authoritative knowledge', recognizing power relations and a variety of hegemonic perspectives *within* a birth system. She developed this notion to better understand the ways in which 'decision-making power' (1993 [1978]:151) in the context of childbirth is legitimized. Therefore, childbirth is understood as an event in which certain power relations are produced and reproduced. Here, the central observation is that 'for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others' (IBID.:152). The process by which authoritative knowledge is created and maintained, and hierarchical social structures are generated is also known as 'misrecognition' (BOURDIEU & PASSERON IN IBID.:153): A certain knowledge system (in this case a paradigm of childbirth) comes to be perceived as natural and legitimate instead of socially constructed and relative, independent of its 'correctness'. As a result, non-authoritative knowledge systems are devalued. In addition, related to the social constitution of childbirth, she states that 'authoritative knowledge is an interactionally grounded notion' (IBID.:154). These notions helped to interpret childbirth as a social and 'biosocial' *process* in continuous production and (re)definition. As I mentioned briefly earlier on, the notion of 'authoritative knowledge' is particularly useful for the investigations of trust practices related to homebirth in Brazil: the challenging and redefining of authoritative knowledge about childbirth have been essential practices women engaged in to reinforce mistrust about such knowledge and its related practices and contribute to trust-building towards homebirth.

Davis-Floyd added to this by analysing the processes that contribute to the creation of ideologies related to birth. She does not only recognize a variety in representations of childbirth within a given culture, but also of experiences of childbirth, which provide a great potential for internalization, contestation and transformation of authoritative knowledge. Studying these representations and experiences of childbirth in America (1992), she distinguished three paradigms of childbirth. Even though she recognizes that these paradigms are socially constructed and fluid, she identifies some key characteristics. First of all, she mentions the technocratic paradigm, in which 'successes are founded in science, effected by technology, and carried out through large institutions governed by patriarchal ideologies in a profit-driven economic context' (2001:1). Technology reigns supreme and obstetric practices are 'routinely performed not because they make scientific sense but because they make cultural sense' (ibid.). It 'entails a pathologizing of the "normal" by placing birth under the domain of the professional doctor' (VAN HOLLEN, 2003:12). As I will become clear, a variety of characteristics of this paradigm can be found in current dominant obstetrics in Brazil.

Second is the humanistic paradigm: as a reaction to the technocratic paradigm, it aims to 'humanize' technomedicine[17]. First of all, it is founded in Evidence-Based Medicine (EBM)[18]. EBM in birth care in a general sense redefines pregnancy and childbirth: the female body as capable of giving birth, most often without the need for interventions; birth as a physiological process necessary for the transition to the extra-uterine life and as a highly personal, sexual and familiar event (DINIZ, 2005), recognizing its social construction and importance of social configurations in this event. The second premise focuses on human rights, claiming a nonviolent delivery assistance guided by women's experiences and desires. In this sense, the right to be 'correctly' informed (based on evidences) about the procedures, physical processes and consequences during childbirth and the right to decide about them are fundamental in the ethics of the humanistic paradigm.

Even though there are many 'Brazilian' particularities that do not necessarily 'fit' in these paradigms, one could conceptualize Brazilian obstetrics as balancing between a kind of technocratic and humanistic paradigm. Even though a humanistic paradigm is on the rise and has influenced public policies and health indicators, technocracy continues to reign, reflected in the current statistics on caesareans, interventions during birth and perinatal morbimortality.

Finally, Davis-Floyd identifies the holistic paradigm. Holism in health care can be characterized by the 'inclusion of mind, body, emotions, spirit, and environment of the patient in the healing process' (DAVIS-FLOYD, 2011:12). Body and mind are understood to be in continuous connection and integration, which places the ultimate authority and responsibility for health on the individual; care, therefore, is individualized; life is seen as a continuous process in which birth and death are only two steps; there is a focus on healing from the inside out in which, for example, intuition is an important element. Concerning the latter aspect, Davis-Floyd & Davis argue that intuition is not only valued when experienced by the laboring woman, but also by the attending midwives. As we will see, this paradigm resembles birth assistance in Capão is carried out in many ways.

Cheyney (2011) highlights another perspective that is important when studying homebirth specifically. She mentions that, in the United States, giving birth at home is a political and ideological act: she demonstrates how homebirths are 'intentionally manipulated rituals of technocratic subversion designed to reinscribe pregnant bodies and to reterritorialize childbirth spaces (home) and authorities (midwives and mothers)' (2008:519). Therefore, she

[17] 'That is, to make it more relational, partnership-oriented, individually responsive, and compassionate' (Davis-Floyd, 2001:6).
[18] Created by the European Committee in 1979 with the aim of studying interventions to reduce perinatal and maternal morbidity and mortality in the continent.

emphasizes the social constructedness of authoritative knowledge, pointing out that people are able to challenge and even transform it by claiming redefinition(s) of it. Studying homebirth in the US, she found that for many women 'the decision to give birth at home was embedded in a refutation of the cultural norm of the medical model of childbirth, a public narrative, and a challenge to obstetricians as indisputable experts and the exclusive holders of authoritative knowledge' (2011:59). This either generated or reinforced the valuation of a new authoritative knowledge. In her study, she identifies three main 'techniques' women used to challenge the dominant birth model and redefine the implicit authoritative knowledge. First of all, she mentions 'unlearning and relearning a new authoritative knowledge' (IBID.), referring to the process of acquiring alternative birthing knowledge through the internet, books, and informal knowledge-sharing networks where women shared their stories. Secondly, the importance women also give to what she calls 'embodied knowledge'; 'a way of knowing that is not intellectual, rational, or logical, but more bodily and experiential' (IBID.:61). Finally, 'exploring the individualized pros and cons of procedures' as opposed to the 'void of information' in the case of hospital-based birth, Cheyney notes that engagement in informed consent is a way to challenge publicly accepted notions of birthing. In my previous research on homebirth, women actively engaged in all of these practices. It seems to be the case that in the context of the present research many women do the same, however other 'techniques' have also appeared. Further on, I will explore if and how such 'techniques' could be interpreted as actions of trusting.

Considering the fact that pregnancy and childbirth are both highly physical processes, in the next section I will discuss some anthropological notions of the body and how they help to understand these processes.

1.3 Social & physical bodies

Looking at fertility matters, 'where interrelations between bodies are *sine qua non*' (VAN DER SIJPT, 2011:22) and through the talks I have had with pregnant women in Brazil, I became aware of the fact that looking at human beings as free and rational individual bodies results in too narrow an understanding of women's experiences during pregnancy and delivery. In her research on pregnancy interruption in Cameroon, Erica van der Sijpt provides us with some very useful insights into understanding the social constitution of pregnant bodies, as well as women's actions and experiences related to reproduction. First of all, she argues that an individualist approach tends to 'ignore the mutual implication of women's reproductive agency

with social others and structural factors' and 'overlooks other social relations – and their power dynamics – often implicated in reproductive decision-making' (VAN DER SIJPT, 2011:17). She argues that women's 'social configurations'[19] intersect and therefore mutually influence their *reproductive navigation*. Because of the many specific conditions involved in these social configurations, a woman's reproductive navigation turns out to be 'highly contingent' (IBID.:21).

However, she draws attention to the physicality of pregnancy by observing that if the focus would be merely on women's decision-making, one runs the risk of adopting a 'mere mentalist representation of the choices and actions surrounding reproductive happenings' (VAN DER SIJPT, 2011:23), when, in fact, the body *itself* is an active and often unpredictable actor in this process. In light hereof, she concludes that 'the body does not only enable or constrain women's [reproductive] navigation, but it needs to be navigated itself as well' (IBID.:211).

Many of the stories I heard from women who suffered greatly during and after childbirth showed that these experiences highly influence their future and other women's and decisions about and ways of trusting related to childbirth. As Lock (1993:136) already said: 'The question of the body requires more than reconciling theory with practice. It brings with it the difficulty of people both having and being bodies.' Therefore, the importance of the physical body and its sensations should not be undermined by its inherent social constitution. Reproduction and all its related experiences are 'not only possible or constrained because *others* and *individuals* act, but also because *bodies* act' (VAN DER SIJPT, 2011:211). In other words, while the idea of producing and challenging or redefining authoritative knowledge and related actions of trust might sound as processes in which women are free and rational agents, they are highly influenced by their own (often unpredictable) bodily sensations: 'the body 'both *directs* and *demands* navigations' (IBID.). Therefore, in this research I adopt the notion that pregnant and birthing women *have* and *are* intrinsically socially constituted bodies.

When talking about childbirth specifically, notions of physical pain almost inevitably emerge. Tornquist (2003:423) observes the social constructedness of experienced pain when she says that

> *'Sabemos que a dor, como as doenças, não são apenas manifestações universais de processos orgânicos, mas construções simbólicas que variam conforme os*

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

contextos socioculturais e a própria subjetividade do doente'[20]

In addition, in the context of Brazil Béhague et al. noticed that 'many of the factors influencing maternal behaviours, such as fear of pain, are meaningful precisely because they are understood to differ by socioeconomic status and to be embedded in discriminating practices' (2002:4). Such 'maternal behaviours' might also include ways of trusting that are influenced by past experiences of physical and 'emotional' pain or stories about pain they heard from other mothers. It is thus assumed that social and cultural representations of and social interactions (such as authoritative knowledge) about the body, childbirth, and homebirth specifically are essential to understanding the ways in which they are experienced and trusted.

In the following section, I will turn to the ways in which I have tried to make sense of these complex conjunctures of notion, symbols, and ways of trusting that women and birth attendants in Capão have employed.

1.4 Methodology: grasping acts of trusting

Recent ethnographic accounts have shown that people often unconsciously engage in trusting acts and that the ways in which they do so vary immensely across and within cultures. Through these accounts it has become clear that modes of trusting are highly contingent, emerge within intersubjective spaces and, moreover, they change over time due to 'the plasticity of the brain itself, creating new connections and wiring along with the maturing of the experiencing subject' (BROCH-DUE & YSTANES, 2016:16). This anthropological approach contrasts with the many cognitivist approaches that have defined trust as a conscious and calculated decision[21], for example through, 'a cognitive assessment of trustworthiness' (HAAS, 2016:90).

How then, does one investigate such a complex and often unconsciously experienced and *performed* 'phenomenon'? And what does it mean when I, as an anthropologist, question and interfere in something that so frequently remains unspoken? Exactly because of these characteristics there is no all-encompassing answer to this question. Therefore, the main intention of this section is to set out some of the lessons drawn from recent ethnographic research on trust that informed the ways in which I conducted the research and specify the methods I used to provide insights about the main and specific objectives of this research as mentioned in earlier.

[20] 'we know that pain, like illnesses, are not solely universal manifestation of organic processes, but symbolic constructions that vary according to socio-cultural contexts and the subjectivity of the 'sick'

[21] E.g. LUHMANN, 1979; GAMBETTA, 1988

The highly contingent nature of trust implies that 'any deep analysis of trusting needs to pay particular attention to the specificities of context, history and the wider connectivity of each case to translocal and global networks.' (BROCH-DUE & YSTANES, 2016:32). To study modes of trusting, one needs to look at trusting in its ethnographic particularity. In Capão, a place that houses a wide variety of intersubjectivities, cultural practices, values and symbols related to pregnancy and childbirth, a sensitive ethnographic approach involves listening closely to and observing interlocutors. Such an approach contrasts to that adopted by studies conducted under the disciplinary banner of sciences such as philosophy, psychology, sociology, economy and neurology. A common approach has been to investigate its 'function' in 'society' – usually taken as 'universal', though referring to Euro-American notions and styles. In doing so, many of the existent trust theorists have engaged in forms of ethnocentric universalism by approaching trust as a universal phenomenon that is valid across space and time (see BROCH-DUE & YSTANES 2016). Despite these efforts, trust continues to be a highly elusive and polemic concept. Therefore, when we consider the cultural, intersubjective and personal/intimate variety of how trust is experienced and acted out, 'we might take a more open and exploratory approach and allow for empirical findings to guide the search for definitions' (IBID.:9). This is precisely the approach adopted in the present study.

The data that are exposed in this research were collected through empirical research, including participant observation, during which I have acted upon the ethical considerations as established by the ABA[22] and have, during the whole process of fieldwork, analysis and writing tried to avoid to harm the interlocutors.

This research has been ongoing since the time I went to Capão for the first time in 2009, and started getting involved in and more intimate with the local population and practices. By the time I arrived in Capão to start my research in a formal sense at the beginning of 2018, I had already become close with some of Capão's residents, including the local obstetric nurse, Natália, a former obstetric nurse, Mariane, and the family doctor (who trained as an obstetrician and was one of Capão's main 'midwifes' until about 10 years ago) Áureo Augusto. My partner at the time had arrived in Capão at the end of the 1980s, bought a piece of land a constructed a house. He was a part of the community that Pellisier (2014) has described as 'neo-rural' (see below). He had spent a lot of time there before and, by the time I went to do my research, had organised a few editions of the Jazz Festival of Capão, which has been a touristic attraction for

[22] *Associação Brasileira de Antropologia*, see section on Ethical Considerations.

people from all over the country. As his partner, I carried a similar status of 'neo-rural' and I felt people sympathized with me more easily than if I had arrived there by myself, as only another *gringa* (foreign woman, depending on the context used in a loving or pejorative way). I knew my way around the village and the rest of the valley and, during the markets that were held on Thursdays and Sundays I would always stick around to chat with friends. Also, when I arrived for the research, I arrived together with my one-and-a-half-year-old son Noah. His presence and my status as a mother who, as some people already knew and others discovered during the research, had given birth at home as well, besides limiting the time and space I could dedicate to the research, was very enriching and afforded me greater closeness to the women with whom I 'hung out'.

I kept up a continuous literature review before, during and after the fieldwork, in order to engage in ongoing triangulation of my analysis. The participant observation I conducted during the research consisted of 'hanging around' in the waiting room of the health post, where women sat to wait for their prenatal consultation and where I had the opportunity to start a conversation and observe the conversations the women had among them. In these interactions, I usually quickly 'revealed' my status as a researcher and, except for one native woman who preferred not to talk about herself, all woman expressed excitement about possibly participating in it. Through these interactions, I got a little closer to some of these women and, whenever I felt we had established a more intimate level of *rapport*, I asked them if they would allow me to accompany them during the prenatal consultation. All of the times I did so, they accepted my presence. The prenatal consultations were a great source of participant observation, as it provided a space in which trust was clearly interactively negotiated and many notions, acts and gestures that contributed -or not- to trust-building could be observed.

As a doula and 'birth-lover', I had already participated in the weekly birth circles the local homebirth team, *Equipe Parir*, organised before I started my research. During the research I participated in eleven circles, which proved to be another, even more dynamic space in which 'semantic horizons of shared suppositions' (SOUZA, 2005) would be constructed and interactively negotiated. Usually, the theme of the next circle would be decided upon by the participants at the end of the circle. Once, Natália invited me to suggest a theme that would give me more insights in my research. The theme of 'trust' created a kind of 'focus group' in which the topic was discussed and provided me with many interesting insights, however I analysed them conscious of the fact that it was an 'artificial' and 'performative' space in which 'subconscious' and symbolic notions and acts of trust would not emerge.

As will become clear throughout the dissertation, there is a bias of data regarding native and 'outside' women. During the research, I found it to be more difficult to create *rapport* with the majority of the native women compared to the women who were not born in Capão. Besides the fact that they would rarely go to the weekly circles -an important moment of intimacy and information for me as a researcher- I felt that the fact that I myself am a white, 'outside' woman and researcher would sometimes limit the access I had to more connection with the native women. The time limitation I had also made it more difficult to become more intimate with the women that might have felt barriers during our interaction. I have made a strong effort to get closer to some of the native women, and a few have let me into their homes and lives. I am aware of this bias and the fact that anthropological accounts always have to be interpreted as a representation of 'reality' that is enriched and limited by the researchers' own 'social configurations'; this dissertation is, therefore, an attempt to transmit the insights I have gained from the field in as large detail as possible – no complete account of what happened and continues to happen in Capão. I would strongly recommend future researchers to engage in more research on reproductive justice related to birth care[23] in ('neo') rural contexts such as Capão and contribute to and problematize intersectional questions that emerge from them.

As I became closer to some of my interlocutors, I visited them at their homes, we had a coffee or lunch together, I would help them with things around the house or with the new born baby, and went for a hike to take a bath in one of the waterfalls. These were all moments in which at many moments I lost my perspective as an anthropologist and was 'just a friend', however there were other moments in which I consciously started talking about topics related to pregnancy and birth. During all of these participant observations, I would take field notes of what I witnessed and tried to be even more aware of discourses and acts that seemed to be related to processes of trust-building.

Besides this, I participated in prenatal and postpartum home visits with the women who had given birth, in the first Perinatal Forum of Chapada Diamantina in Seabra (where new policies related to perinatal health were presented and discussed), and in one birth. As the rapport I established with some of the women I met in the waiting room and during the weekly circles became stronger, I asked some of them if they would feel comfortable sitting down with me to have a 'more formal' conversation about their ideas about homebirth. Three native women and six women *de fora*[24] agreed to participate in such a semi-structured interview. In

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[23] See also GOES, 2018, 2020; DAVIS, 2019; LEAL ET AL., 2017; WERNECK, 2016

[24] '*De fora'* means 'from outside': a common way of calling people who were not born in Capão. See next chapter for more details about this identification.

addition, three birth attendants I interviewed as such ended up sharing their experiences of their own births as well. During my research, which took place from March 2018 to July 2018, I accompanied eight of these women in their last trimester. Another woman who had given birth in Capão 23 and 27 years previously also shared her experiences of pregnancy. In other words, I was doing fieldwork day and night, writing down anything that seemed relevant in my fieldnotes. In the same way, I interviewed seven of the active *de fora* birth attendants, and two native birth attendants – including Dona Áurea, who had already retired at the time of my research. With their informed consent, I recorded and transcribed all of the interviews[25]. The women and birth attendants I interviewed were expert natives to me, who besides providing me with information about homebirth and childbirth in general, also made meta-commentary on ongoing debates surrounding birth assistance in Brazil (BERNARD, 1995). However, my role as an anthropologist required an outsider's view, because I was interested in uncovering specific discourses on homebirth and trusting. Therefore, the data and interlocutor's discussion of them I offer here are not only objects of analysis, but also sources of information.

Due to the high level of involvement characteristic of ethnographic methods and, in my case, due to my personal involvement in the area of birth care and homebirth specifically, I have tried to be very sensitive and conscious about how I present myself to the people with whom I conduct the research. Moreover, I have been careful and reflexive about how I interpret the data that emerge. As Souza (2005) already mentioned, interactions during prenatal consultations and in discourses about homebirth are often based on a semantic horizon of shared suppositions. I am aware that as a doula and homebirth-mother, I often take such suppositions for granted. As an exercise of distancing myself from the subject and my personal involvement I have, at all times, taken notes on the kind of situation I found myself in, my responses during conversations and interviews, and the moments in which I noted that I 'lost' my perspective as an objective 'observer' and found myself 'only' participating. In light hereof, I have to reflect on the lack of intersectional perspective I have engaged in during the research. It has become clear that gendered and racialized power relations were in play in the context of childbirth in Capão, however more research has to be done to execute a profound intersectional analysis.

I undertook a statistical analysis of the available data on births in Capão and the municipality of Palmeiras (available in the health post and Secretary of Health in Palmeiras), and of the socioeconomic data of Capão's residents at the Office of Social Service in Palmeiras.

[25] The topic lists for these interviews can be found in Annexes II & III.

The intensive interviews with pregnant women and new mothers and their partners, and the participant observation during prenatal consultations and the weekly pregnancy circle, allowed me to address a number of issues that provide insights into the main objectives of this research: the ways in which pregnant women, their partners, midwives and others involved with the processes of pregnancy and birth engage in acts of trust; and how such acts of trust are related to the redefinition of authoritative knowledge and vice-versa. Also, considering the 'plasticity of the brain' as mentioned above, I searched for accounts of earlier trusting experiences that might have shaped and continue to shape the ways in which my informants conceive of and act upon trust. During the interviews and participant observation, I paid special attention to acts and discourses that imply certain notions of trust, despite the fact that the word 'trust' wasn't always used as such.

This leads to the necessity of a closer analysis of *words* of trust and *acts* of trusting. In Portuguese, 'trust' is generally translated as '*confiança'*. Nevertheless, many different meanings can be attributed to *confiança*, and many other words are used in similar ways. For example, '*segurança'* (security) and '*força'* (strength, force) were words that also appeared in places where I would have expected trust/*confiança,* or when the initial subject of the conversation was *confiança*. Therefore, we have to ask ourselves 'whether the myriad words that dictionaries translate into 'trust' can be meaningfully understood to be about the same social phenomenon.' (BROCH-DUE & YSTANES, 2016:9). Without pretending to provide such meaningful understanding, I describe the linguistic differences in my interlocutors' uses of what 'we' could understand as 'trust' and analyze how they interact with local and other notions of trusting. Consequentially, the analysis of such local concepts 'may constitute a powerful critique of theories that do not take cultural difference into account (YSTANES IN IBID.:40). Moreover, it is important to note that, especially because of its partly unconscious manifestation and the limitations of words and their meanings, it was necessary to go beyond linguistics and focus on trust as a verb, in other words, *acts of trusting* (BROCH-DUE & YSTANES:24). 'This is because trust, as a noun, tends to emphasize an individual subject's deliberation to enter a contract or take a risk, while trust as a verb conjures up an intersubjective space of social anticipation binding subjects together'(IBID.). In this light, Broch-Due and Ystanes (IBID.) propose 'more performative approaches to trusting, which focus on various forms of agency'.

Another methodological issue arises from the notion and the space of intimacy. Ethnographic methods based on long-term participant observation are designed to provide detailed and culturally sensitive accounts not only of abstract notions of 'society', but especially

of small-scale and locally structured intimate spheres. In the 'intimate' case of pregnancy and birth we could argue that such methods belong to some of the few that are intended capture processes of trust-building as close to reality as possible. Even though it is important to be very careful with ethnocentric notions of the relationship between childbirth and intimacy[26], intimacy is an often-discussed subject in conversations about homebirth, specifically. Typically, it is argued that in Latin America trust is foremost located within the intimacy of the family (e.g. FUKUYAMA, 1996). From an anthropological perspective this is a problematic approach, as it tends to dismiss the fact that there is no guarantee for intimate and familiar relationships to be harmonious nor shattered or deceptive. Therefore, I have tried to explore trust in the intimate sphere, despite the 'hierarchization of intimate relationships that inevitably follow from the power asymmetry between children and adults, and often also from the stratification of gender and unequal access to resources, networks of influence and so on' (BROCH-DUE & YSTANES, 2016:13).

Finally, childbirth could be seen as the ultimate conjuncture of the gendered and bodily relationships as mentioned before, in which the importance of *acts* over *words* is explicitly valid and informs methodological considerations also noted by Brigitte Jordan (1993 [1978]:10-11):

> 'Since the process of giving birth is characterized by a high degree of non-public intimacy, as it has to do with bodily functions and bodily displays, collecting data by asking questions proves unsatisfactory in fundamental ways. Quite apart from taboo topics and culturally conditioned inhibitions, birth is an event of great interactional complexity, where people know how to do without necessarily being able to talk about the details of what they do. […] To deal with this problem, I used anthropological participation as an explicit methodological device intended to give the investigator access to the knowing how of birth, that is to say, to the behaviours in which participants engage as competent performers of system-specific ways of doing birth.'

Fortunately, I was able to participate in one birth and a variety of prenatal consultations and observe the specific acts of trusting that occur in this moment. Some of the -mainly native- birth assistants actually answered some of my questions saying that they knew how to, for example, realize a certain examination, but did not know how to describe it. Such embodied knowledge has shown to be an important aspect in acts of trust and highly contributes in the trust-building process.

[26] Looking at Brazil's highy technocratic model of birth assistance (DAVIS-FLOYD, 2000; emphasis on risk; doctor- and hospital-centered; technology highly valued, women seen as 'patients', see section on childbirth in anthropology for more details), for example, the presence and continuous appearance of strangers during birth is often normalized. Also, there are accounts of societies in which childbirth is relatively 'public' event in the sense that many people –especially women- participate in the moment. Notions of 'intimacy' in the context of childbirth are, therefore, highly heterogeneous and polemic. As such, I will look for native conceptualizations of intimacy to set out a sensitive approach to trust in relation to intimacy.

Alltogether, I intend to facilitate and deepen the understanding of the latter by providing a kind of *assemblage* of the intersubjective spaces, 'flows' and various kinds of words and acts of trust that emerge during the research.

1.5 Ethical considerations

The research and its elaboration through the data analysis and writing of the thesis live up to the Code of Ethics of the Anthropologist established by the Brazilian Association of Anthropology (ABA)[27]. The data that are exposed in this research were collected through empirical research, including participant observation, during which I have acted upon the ethical considerations as established by the ABA[28] and have, during the whole process of fieldwork, analysis and writing tried to avoid to harm the interlocutors.

1.6 Organization of the dissertation

In the next chapter – Chapter 2 - I provide an overview of birth care in Brazil. First, I briefly describe the historical, social and political developments related to birth care in Brazil. Then, I focus on the counter movements that have challenged the dominant ways in which pregnancy and birth have been cared for and which, in different ways, interact with conceptions of birth (care) in the local context of Capão. This overview underpins the analysis in the thesis of the motivations of women to birth at home and, specifically, the ways in which they have trusted and/or mistrusted in the build-up towards the birth.

In the third chapter I investigate the context in which the present research is conducted, through a more detailed description of Capão's historical, social, cultural, economic, political, populational and geographic characteristics, especially focusing on those that have affected birth care and possible ways of trusting. In order to situate the context of this research and the home of my interlocutors, I first provide an overview of the geographical and historical developments of Capão as well as of the national park in which it is located. In the second part, I build upon my own ethnographic research and experiences in Capão, besides one of the few 'thick' ethnographical accounts of Capão's population written by Yann Pellisier (2014) to depict the hybrid population of which the interlocutors are a part. Finally, I present an in-depth

[27] See http://www.portal.abant.org.br/index.php/codigo-de-etica and Annex V

[28] *Associação Brasileira de Antropologia*, see section on Ethical Considerations.

account of pregnancy and birth care in this particularly 'homebirth-oriented' village and briefly introduce how notions and practices of pregnancy, childbirth and trusting practices emerge in the context of mutually influence among natives and non-native residents.

In the fourth chapter, I focus on the ethnographic analysis, to tell the story of how the birth attendants in Capão learned how to trust their own capacity to attend homebirths, and the variety of other mechanisms of trust that led to this. What does trust mean to them, and how do they see it? I analyze in-depth how they grew into their 'calling' and how, nowadays, they engage in acts and adopt notions of trust that help them to maintain and develop it. As we will see, they have all become part of each other's processes towards trust. This discussion allows an understanding of how they learned to stand back from their own authority as a person conducting a childbirth so as to open space for the women who are birthing to come to trust themselves.

In Chapter 5, I provide an ethnographic exploration of the large variety of notions and acts of trust related to homebirth that the women have provided me during our conversations and observations of prenatal consultations, *rodas* and other informal meetings.[29] The result portrays an *assemblage* of the intersubjective spaces, 'flows' and various kinds of words and acts of trust that emerged during the research. The first section focuses on the native women and their partners. It shows that, while people are very different in sociological terms, in the social, temporal and spatial context of Capao, the relationships constituted over time among residents and settlers have allowed for the growth of forms of trusting (or talking about it) that are multiple in origin, that are expressed and justified in distinct and at times contradictory discourses, philosophies and forms of knowledge. Further, when conjoined in the events of prenatal care and childbirth itself, they take place as if unified, producing in practice what in discourse cannot be seen as singular. More importantly, I argue that both notions of trust and birth itself are experienced as inherently contingent. In other words, all pregnant and birthing women face contingency somehow. The *assemblage* of the (contingent) intersubjective spaces, 'flows' and various kinds of words and acts of trust shown here have proven to be ways of managing such contingency.

In the concluding chapter I synthesize the arguments I have made throughout this dissertation. In short, they consist of an understanding of contingency as inherent to childbirth; the need for a search for trust this contingency has proven to awaken in the women and birth attendants in this research; the potential of mutual accommodation for the generation of trust;

[29] During my master research, one of the main objectives was to explore pre-established notions of trust related to homebirth.

the emergent epistemologies that have arisen out of the various processes of trust-building in relation to homebirth in Capão; and I have questioned commodifying notions and practices related to birth, which are likely to sustain and reinforce ‘stratified reproduction’.

2. (MIS)TRUSTING ENOUGH TO GIVE BIRTH AT HOME: AN OVERVIEW OF OBSTETRICS IN BRAZIL

One of the main subjects that emerge when discussing birth care in Brazil is its caesarean rate. Considering that the WHO recommends (1986) that a country's caesarean rate does not exceed 15% to avoid iatrogenic perinatal morbidity and mortality (such as prematurity, respiratory problems, haemorrhage), Brazil's rates are alarming. The most recent statistic is an overall percentage of 57% of all births (CANCIAN, 2017). In 2014, the average number of caesareans in private maternities was 88% (LEAL & NOGUEIRA DA GAMA, 2014). Interventions such as episiotomy (a cut in the perineum), use of synthetic oxytocin (to induce or accelerate labor), Kristeller manoeuvre (external pressure on the top of the uterus to 'push' the baby out) and continuous fetal monitoring are virtually guaranteed (DINIZ & CHACHAM, 2004). This is why Diniz & Chacham (IBID.) observed that Brazilian women, when and if they even get into labor, can either expect the 'cut above' (caesarean) or 'cut below' (episiotomy). Together, these characteristics have resulted in what Diniz (2010) calls the 'perinatal paradox': despite the institutionalization of childbirth and advances in and increased use of obstetric technologies, the improvement in maternal and child health indicators in the last fifteen years has been very minimal.

Figure 1: Graphic extracted from the 2010 survey by Perseu Abramo Foundation; 'phrases heard during birth', such as 'don't cry because next year you'll be here again', or 'when you were making the baby you did not scream, why would you scream now?'

In addition, the extensive survey "Brazilian Women and Gender in Public and Private Spaces" published by the Perseu Abramo Foundation (2010)[30] showed that one in four women suffers some kind of institutional and gender-based violence during childbirth, also known as 'obstetric violence'. More than 23% of the respondents heard humiliating phrases, about 25% of them also reported having suffered some kind of violence during labor. The most common complaints are: painful measuring of dilation (10%); negative comments about or not receiving some kind of pain relief (10%); being shouted at (9%); did not receive information about any procedure (9%); was denied care (8%); being cursed at or humiliated (7%) and, they added, received information and interventions that were not based on evidences. Other studies show that the situation is worse for the black population and low socioeconomic classes (BATISTA, 2004; GOES, 2018, 2020; WILLIAMSON, 2019, 2021). As such, notions of 'modernity' and 'suffering' appear as markers of class, race and ethnicity; those who have a caesarean (in private health practically a free choice) are surrounded by 'advanced' technology and do not have to go through the labor pains (SCHUT, 2014).

Such practices have led to what Diniz calls the 'pessimization of childbirth’ (2010: 49). Although most Brazilian women at the beginning of their pregnancies want a 'normal' (e.g. vaginal) birth, the majority eventually ends up desiring and actually undergoing a caesarean section (HOPKINS, 2000; POTTER ET AL., 2001; BÉHAGUE ET AL., 2002). In light of the practices mentioned above, it becomes clear that a caesarean section can indeed offer an escape from a violent vaginal birth and that 'what some interpret as women’s ‘cultural’ inclination towards abdominal birth may simply be compliance, born in the absence of both a coherent, culturally appropriate critique of existing practices and knowledge about vaginal delivery’ (MCCALLUM, 2005:230).

The underlying structures that form the substrate for this reality are multiple and vary according to each context. However, Cecilia McCallum (nd) dedicated one of her most recent works to an ‘assemblage’[31] of Brazilian birth care, in which she identifies five key characteristics that, together, have contributed to the persistence and consolidation of ‘technobirth’. First, she points to the dual health system that consists of an ever-lacking public sector and a commercialized private sector. In the public sector, women are likely to experience

[30] http://www.apublica.org/wp-content/uploads/2013/03/www.fpa_.org_.br_sites_default_files_pesquisaintegra.pdf

[31] In short, drawing mainly on Deleuze & Guattari (1987 [1980]), assemblage theory can be understood as an ontological framework that critically approaches the category of ‘culture’ as known in, for example, anthropology. It recognizes the hybrid, fluid and dynamic character of relationships within and among continuously emerging global, national and local and bodily contexts. As such, it is an attempt to understand social complexity by *assembling* situated interactions and practices on all these levels.

a highly ‘pessimized’ normal birth, as described above. On top of that, health professionals and beds are commonly lacking, which can result in spending hours of labor –and even birth itself- in a corridor if one is not rushed to the delivery room to clear the bed for the next one in line. Depending on one’s health insurance, normal birth is not experienced very differently than in the public sector. However, in the private sector women are basically guaranteed to have a caesarean, likely scheduled by the obstetrician that has realized their prenatal consultations. Again, depending on the health insurance and the private financial condition of the pregnant woman, such caesareans can be performed in a five-star hotel setting or in a close-to-public-hospital. Paradoxically, the sectors are highly interlinked as (1) students learn and practice in public maternity hospitals and are likely to continue doing weekly shifts there and (2) they often also run shifts in private maternity hospitals and are likely to have a private consultancy.

As follows from this characteristic, McCallum notes the highly urban and hospital-centered birth care, in which ‘risk’ is a characteristic of childbirth that, even when ‘habitual’, is assumed to be possibly life-threatening at any moment. As such, birth is generally considered to ‘belong’ to the hospital and (third characteristic) hands of obstetricians, where the latter ‘are inclined to adopt technological intervention as a means to prevent such an outcome (Williamson & Matsuoka, forthcoming; Perpétuo, Bessa & Fonseca, 1998)’ (McCallum nd:8). Fourth, she shows how childbirth and care practices can be interpreted ‘as sites of symbolic production’ (IBID:10), where ‘power hierarchies and care practices within the institutions privilege biomedical precepts and involve semiotic processes that serve to naturalize the status quo’ (IBID.:5). Finally, these sites are also used for the production of another symbolic system briefly mentioned above; an over-valorization of ‘modernity’, fuelled by a ‘wide acceptance of an ideology of modernization, fundamental to maintaining hegemonic practices and the system as a whole’(IBID.). In the next section I will discuss how similar notions of modernity are used against this symbolic system by proponents of the humanization of childbirth and homebirth.

Going back in time, we see that the first steps to remove the birth of the domain of the house were taken through its institutionalization with the inauguration of the Medical School in Salvador in 1808 (SOUZA, 2005). Until then, women generally gave birth to their children at home, often in the presence of a midwife. Towards the end of the 19th century, hand in hand with the intensified institutionalization of medicine, urbanization and sanitation processes emerged. Souza (ibid.) notes that in the context of a 'modernizing' society, the lack of health was seen as a sign of backwardness, resulting in changes in hygienic practices and changing authority over these practices to the 'competent' male domain. Another reason for the move of childbirth from the home to the hospital was the perception of childbirth as an inherently ‘risky’

and pathological event (MENEZES ET AL., 2012: 5). New instruments and technologies such as forceps (invented in the sixteenth century but widespread in the nineteenth century) have emerged and provided more steps towards the 'modernization' of childbirth.

From another point of view, Gonçalves et al. (2014: 237) mention that the common and negative posture in relation to vaginal birth can also be attributed to the 'presence of the Christian inheritance that shames sexuality and understands the pains of childbirth as punishment'. Indeed, some of the women who participated in my Master's research referred to God's punishment '*com dor darás à luz filhos' (*'with painful labor you will give birth to children', GENESIS 3:16) as part of their 'faith' of being a woman.

They observe a taboo on the relationship between sexuality and childbirth in Brazilian society and note that this could be a possible reason for turning childbirth into an 'aseptic' event and the difficulties in allowing male presence in the delivery room (in the form of fathers).

These changes occurred in parallel with changes in the conception of childbirth: from an intrinsically physiological event, belonging to the home and to the hands of midwives and women in general, to an inherently pathological event requiring –preferably masculine- medical control (TORNQUIST, 2004).

Altogether, it is not surprising that the home is often seen as an 'inappropriate' and 'backward' place to give birth (KRUNO & BONILHA, 2004: 399), as reflected in the words an obstetrician from Salvador said on the radio two years ago: 'homebirth is a return to the Jurassic era!'. As a result, women report that they have been called 'hippie', *'natureba'* or even 'irresponsible' for wanting to give birth at home (FEYER ET AL., 2013: 299) and, therefore, often maintain their choice to birth at home a secret.

The 'popularization'[32] of home birth should be understood within the context of 'humanization of childbirth'. Therefore, in the next section I will briefly explore the various expressions of resistance to and change in the dominant model of obstetrics in Brazil.

2.1 Emergent epistemologies: humanizing (home)birth

In this section we turn to the important and more recent developments in the *assemblage* of birth care in Brazil in which this research is also situated. Ways of knowing about childbirth are continuously challenged and redefined, not only by health care professionals and 'evidence-

[32] Due to the increase in media attention and urban homebirth teams, one might think homebirth is becoming a common practice in Brazil. However, representing less than 1% of all births in urban centers, one has to be careful with the interpretation of 'popularization'.

based medicine', but also by pregnant women, the people involved in their pregnancies, and, in a more general way, certain cultural imaginaries that appear in, for example, movies, books and newspapers. Therefore, we could think of such epistemologies as 'emergent': they are 'reborn' each day and (re)constituted in local and structured contexts. I will focus on the epistemologies related to birth care that, like many other ways of knowing about birth, continuously emerge in different ways and have challenged and redefined the dominant knowledge systems present in Brazilian obstetrics. The people that produce and adopt those epistemologies are highly heterogeneous, which makes it impossible to categorize them as constituting certain 'cultures'. Here we talk about the emergent epistemologies that generally consider the 'risks' of birth to be iatrogenic, caused by overmedicalization: the various expressions of the 'humanization of birth' and, within those, new ways of knowing about homebirth in Brazil.

The developments related to –especially *planned*[33]- homebirths in Brazil should be understood within broader social and political initiatives and movements commonly called the 'humanization of childbirth'. Efforts to humanize and promote evidence-based care in childbirth have been made since the 70s, when various professionals, inspired by practices of traditional midwives and indigenous communities already formulated a discourse with elements of *parto humanizado* (humanized childbirth) (DINIZ, 2005). In the 1980s distinct groups began to organize themselves and mobilize others throughout the country, proposing changes in obstetric practices and promoting natural childbirth. An important moment has been the creation of the Letter of Fortaleza, resulting from the conference about appropriate technology in childbirth organized by the PAHO and WHO's European regional offices in 1985. This letter has provided the basis for recommendations on safe motherhood by the WHO (1996), nowadays often referred to in Brazil among homebirth activists and professionals (DINIZ, 2005:630). Recommendations in this letter still constitute the main assumptions of the *parto humanizado* as framed by activists and, recently, by governmental initiatives. In 1993 the Rehuna-Network (*Rede pela Humanização do Parto e do Nascimento*) was founded for the Humanization of Childbirth, consisting of a variety of health professionals and feminist movements, which since its inception has contributed to disseminate proposals favorable to humanized birth (DINIZ, 2010). The most recently implemented programs by the Ministry of Health are the *Programa de Humanização do Parto e Nascimento* ('Program of the Humanization of Labor and Birth', since 2000) and the *Rede Cegonha* ('Stork Network', since 2011[34]).

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[33] See section on 'planned homebirth' below.

[34] For a deep analysis of the implementation of the Rede Cegonha, turn to Williamson (2019).

These developments did not occur in a vacuum, and until today people within the homebirth scene in Brazil make references to similar movements in Europe and the US. In Europe, concepts such as *birth without pain* in the 1950s; *birth without fear* following Dick-Read; and *birth without violence* as developed by Lamaze and Leboyer were of the most influential at the time (SOUZA, 2005). Another branch is *natural birth* movement, which emerged mainly from American and European hippie movements in the 1970s. One of the main expressions of the latter has been the American community known as The Farm, established by midwife Ina-May Gaskin (2002).

The 60s and 70s also proved fertile for the emergence and intensification of feminist movements, which have generated a discourse of care based on the conceptualization of sexual and reproductive rights as human rights (DINIZ, 2005:629). Diniz notes that, among others, Sheila Kitzinger's psychosexual approach to birth, Michel Odent's redescription of the physiology of birth, and Janet Balaskas' concept of *active birth* have been influential in these discourses (ibid.). More recently, conceptualizations of birth as a sexual and sensual experience are being spread (DAVIS & PASCALI-BONARO, 2010). Many of these conceptions of birth are also part of discourses about birth in Capão, for example in the discussions held during the weekly pregnancy cycles. A more recent development in this context is the foundation of the grass-roots organization Human Rights in Childbirth in 2012, mainly advocating for the right to informed consent and self-determination in childbirth. Finally, and another response to the increasing medicalization of birth care, birth care and childbirth itself became objects of study within the social sciences.

Just like the general movement for the humanization of childbirth, the homebirth movement in Brazil highly values a rights and evidence-based medicine discourse (DINIZ, 2005.). Many adherents emphasize a woman's right to give birth wherever she feels safest[35] and to receive care and information based on the best available evidence.

The past eight years have been especially fertile for the development of actions related to the humanization of birth: a variety of events have contributed to an increased awareness about the Brazilian obstetric reality and reinforced insatisfaction among women and other interested people. As mentioned in the previous section, one of them was the publication of the research about obstetric violence by the Perseu Abramo Foundation in 2010. Nowadays, this 'new' phenomenon has become a quite polemic subject of debates within the creation of health

[35] The WHO and International Federation of Gynaecologists and Obstetricians (FIGO) respect a woman's right to decide where she wants to give birth and recognize that, assisted by licenced professionals, there are considerable benefits for women who want to give birth at home (Gonçalves et al., 2014:242).

policy and public and private maternities, however continues to be suffered by many women before, during and after labor. In 2013, the ONG 'Artemis'[36] was created in São Paulo, which until today provides juridical and informative support to women, health professionals, journalists and other companies about obstetric and domestic violence.

The government has adopted some of the goals the social movement for humanization has been promoting by launching the *Rede Cegonha* program in 2011. The program mainly promotes and finances the reorganization of and improvement of access to antenatal care; humanized practices in birth care; guarantee of a companion during birth; guarantee of a bed in the hospital upon arrival; and access to and improvement of family planning in public health care (MINISTRY OF HEALTH, 2012:12,27). Nevertheless, there have also been severe critiques about the policy[37].

In 2014, the national research about pregnancy and birth care in Brazil, '*Nascer no Brasil'*, was published by the Fundação Oswaldo Cruz. It revealed many forms of the structural and institutional violence Brazilian women suffer, and percentages of interventions and c-sections far above those indicated by the WHO. Also in 2014, the first *Simpósio Internacional de Assistência ao Parto* (SIAPARTO) took place. With a 5-day program full of workshops, lectures and *vivencias*, reuniting some of the most valued obstetricians, midwives, doulas and psychologists within the humanization movement, being there felt like a kind of pressure pan in which all participants would come out 'converted' to the humanization of birth.

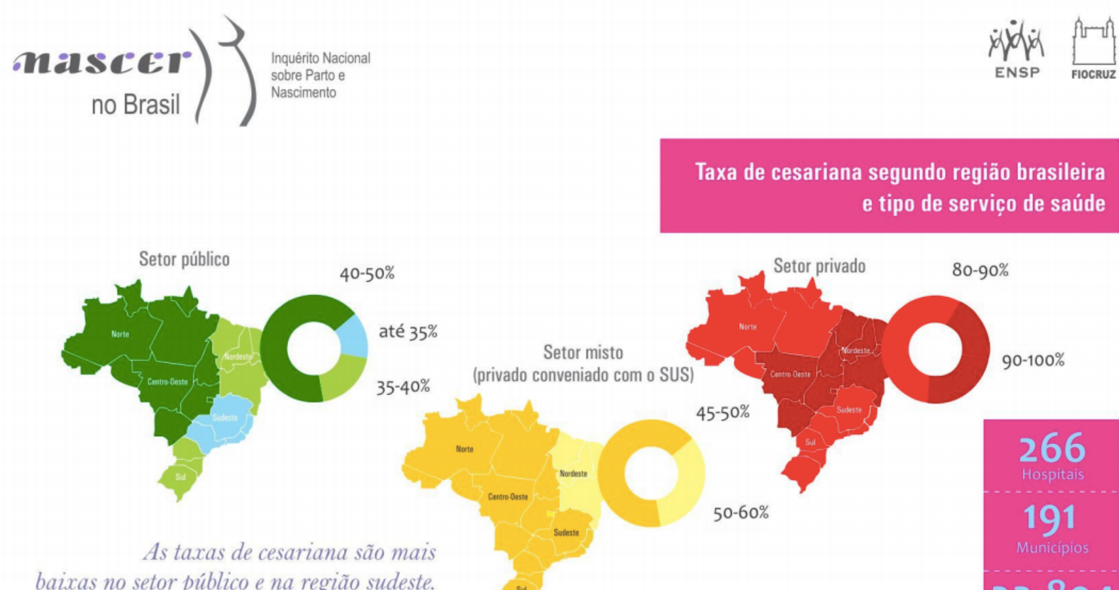

Figure 2: Graphic from the Nascer no Brasil research, on caesarean rate according to region and kind of health service (private, mixed, public)

[36] https://www.artemis.org.br/

[37] See Carneiro, 2013

In 2015, a new resolution was declared by the *Agência Nacional de Saúde* (ANS) (resolução normativa 368), which stated that all the c-section/normal birth and intervention percentages of each obstetrician should be made available if asked for by their clients; promoted the use of the *Cartão da Gestante*, on which all details of each pre-natal consult are registered, facilitating the early identification of risk and admission in the maternities; and the obliged use of the *Partograma*, a form and graph in which the obstetricians/midwives inform the progression of labor and justify the interventions they realized, providing a way for both women and health insurance plans to verify the actual medical necessity of those.

In 2016, the *Conselho Federal de Medicina* published a resolution (2.144) in which elective c-sections (without medical indication) are only allowed from 39 weeks of pregnancy[38]. Finally, in 2017 the new guidelines for care in normal birth (*Diretrizes Nacionais de Assistência ao Parto Normal*) were published by the Ministry of Health (BRASIL, 2017), which showed some advances towards a more physiological approach of birth care.

2.2 A movement emerging within a movement: homebirth

As mentioned before, homebirth has been characterized as backward and a 'rural' practice. On the other hand, considering the inaccessibility of and activism related to urban 'planned' homebirth that is almost exclusively made up of middle and upper-class women, it has been stigmatized as an elite movement. As such, these attitudes towards homebirth are 'serving for ideological attacks that tend to disqualify any idea that one day homebirth can be a procedure performed by the public health system' (GONÇALVES ET AL., 2014:246).

The main political efforts made in relation to homebirth have been expressed in programs related to traditional birth attendants. In 1985 (with revisions in 1991 & 1994) the Ministry of Health launched the booklet '*Diretrizes para a atuação da parteira tradicional'* (Guidelines for the performance of the traditional midwife), the '*Manual da parteira leiga'* (Lay midwife's manual) in 1992, and the booklet '*Assistência ao parto normal'* (Normal birth assistance) by WHO in 1996 (BRASIL, 2010). In 1991, following the UNICEF, WHO and those involved in the implementation of Safe Motherhood (DAVIS-FLOYD, 2000), the Ministry of Health created the *Programa Nacional de Parteiras Tradicionais* (National Traditional Midwifery Program, PNPT) with some resources for events, training, scholarships and publications, its main objective being the reduction of maternal and neonatal mortality.

[38] For a more extensive overview of recent developments in Brazilian birth care, see Williamson & Matsuoka (forthcoming).

'*Trabalhando com parteiras tradicionais'* (Working with traditional midwives) and '*Livro da parteira'* (Midwife's book) launched in 2000 nowadays are the official didactic materials for training courses.

The initiatives taken by the government in relation to midwives to date have been mainly concerned with their 'qualification' in light of the absence of institutional structures for childbirth care and maternal mortality in rural areas of Brazil. Despite these efforts, the Ministry of Health itself recognizes that:

> '*contudo, [o parto domiciliar assistido por parteiras,] por não estar incluído no SUS e nem mesmo ser reconhecido como uma ação de saúde que se desenvolve na comunidade, ocorre de forma precária e em situação de exclusão e isolamento, sem respaldo e apoio da rede de atenção integral à saúde da mulher e da criança. A grande maioria das parteiras tradicionais não recebe capacitação, não dispõe de materiais básicos para a assistência ao parto domiciliar e não é remunerada pelo seu trabalho*.[39]' (BRASIL, 2010:9).

Other difficulties raised are transportation costs to a more distant place such as a health post or hospital; treatment of midwives upon arrival at the hospital; and meanings attributed to traditional midwives and biomedical professionals, which may result in resistance to childbirth assisted by them (TITALEY ET AL., 2010; DAVIS-FLOYD, 2000).

Homebirth generates a specific controversy in these debates, exactly because of the difficulty to 'translate' this practice into the biomedical system and integrate it into the public health system, especially in countries such as Brazil where childbirth is highly medicalized. This controversy appears in the sense of not including 'traditional' homebirth and midwives in the movement for humanization and the continuation of the historical repression of their activities, even though '[...] *pelo fato de fazerem sentido dentro de lógicas próprias de cuidado com a saúde, elas tenderão a manter um papel de destaque'* (FLEISCHER, 2008: 890). Besides that, Fleischer also observes that '*nacionalmente, temos cerca de 10% dos partos realizados de forma domiciliar. Se pensarmos na Região Norte, 60% dos partos são domiciliares, então seria irresponsável desconsiderá-los na hora de se pensar a política pública*[40].' (IBID. IN HUMANIZASUS, VOL. 4, 2014:465)

[39] 'altogether, because [homebirth attended by traditional midwives] is not included in the SUS and not even recognized as a health action that is developed in the community, it happens in a precarious way and in a situation of exclusion and isolation, without support and help from the integral network of attention to women's and children's health. The majority of traditional midwives do not receive training, do not own basic materials to attend homebirth and is not remunerated.'

[40] '[…] because of the fact that they make sense within specific logics of health care, they will tend to maintain an important role.' and 'nationally, around 10% of births occur at home. When we think about the Northern Region, 60% occur at home, so it would be irresponsible to disconsider them when thinking about public policy,'

2.3 ‘Planned’ homebirth

Planned home birth, known as the 'urban' mode of homebirth (however also practiced in rural areas including Capão), is little known and surrounded by controversy. It is quite different from traditionally stereotyped homebirths in the urban population and among health professionals: with a 'traditional' midwife, without medical training, in a rural area, practiced because of a lack of 'more advanced' options and without the presence of biomedical technology. Generally, planned homebirths occur with the assistance of an interdisciplinary team, made up of varied combinations of obstetrical nurses, midwives[41], obstetricians, neonatologists, and doulas[42]. Often a 'birth plan' is made during pregnancy, in which the pregnant woman declares her wishes for childbirth and postpartum, including a plan B and C if the labor deviates from the normal risk' or the birthing woman wants anaesthesia and needs to be transferred to a hospital.

In addition, there is a tendency to associate planned home birth with specific 'lifestyles' (FEYER, 2012: 22); certain concepts of motherhood (*active*, for example) and parenting (*attachment*, for example); evidence-based medicine; participation in pregnancy circles, online forums and yoga for pregnant women; exclusive breastfeeding (on demand) until 6 months; placentophagy (the consumption, in many ways, of the placenta), 'exterogestation' (based on the theory that during at least the first three months of life a baby needs care and an environment that mimics the uterus, through the use of slings, cloths to carry the baby in a tucked up position, skin-to-skin contact, low light, white noise, etc.); as well as to a political stance towards and conscience of giving birth outside of and challenging the dominant model of childbirth (CHEYNEY, 2008), demedicalizing human life and altering power relations (GONÇALVES ET AL., 2014: 244). All of these associations are frequently shared among women, both in pregnancy circles and social networks, where the majority of participants are middle-upper class (SCHUT, 2014). In the particular context of this research, as will become clear later, such associations, childbirth planning itself and its financial issues are quite present but gain new meanings.

As mentioned above, Feyer noted that women who choose to give birth at home in Brazil often do it ‘because it makes sense’ and it resembles a certain lifestyle (2012:22). Quite differently, Cheyney (2008) emphasizes that, in the USA, homebirth is often a political act

[41] One becomes a midwife/*obstetriz* through a 4-year undergraduate course in obstetrics. It is a similar course to the American ‘direct-entry midwifery’ and the Dutch ‘verloskunde’. ‘*A profissional obstetriz é responsável pelo acompanhamento da saúde da mulher em todo seu ciclo vital, com foco prioritário na atenção à saúde da mulher durante a gravidez, pré e pós-parto. Até o momento, a Escola de Artes, Ciências e Humanidades (EACH) do campus USP Leste é a única instituição do país a oferecer o curso de graduação em Obstetrícia.*’ (http://www5.usp.br/26660/graduacao-em-obstetricia-forma-para-uma-visao-ampla-da-saude-da-mulher/)

[42] Non-medically trained birth assistant that provides informative, physical and emotional support during pregnancy, birth and the post-partum period.

intentionally manipulated to challenge the dominant model of childbirth care. In Salvador the distinction between homebirth as a natural and obvious choice and as a political act with the intention to undermine the obstetric model is permeated with ambiguity. Some women were raised with the idea that childbirth is a completely natural part of a woman's life. Others learned that their bodies were dysfunctional in a certain way, needing hormones to regulate their – dispensable- menstruation, ovulation inductors to get pregnant, and caesareans or many medical interventions to give birth. Some were very conscious of the fact that they were 'birthing outside the system' and contributing to a kind of social movement, while others preferred to 'just give birth' and not get too involved in activism. In Capão, due to its highly hybrid population, I have encountered women who would identify with all of these meanings. Nevertheless, the way they have used them to build trust are notably different from the context in Salvador where I did my earlier research.

Nowadays in Brazil, planned homebirth has been seen, especially by the proponents of the various expressions of the 'humanization of childbirth', as a powerful 'device' for the demedicalization of birth due to the dislocation of the power that medical knowledge often has (GONÇALVES ET AL., 2014: 245). Besides that, planned homebirth promotes important contributions to the reduction of perinatal morbimortality, when 'evidence-based' assisted (e.g. DE JONGE ET AL., 2009; DE VRIES & BUITENDIJK, 2012).

More and more studies are being conducted about childbirth in Brazil, however homebirth – in all its forms – is still very little explored. The majority of studies about homebirth is focused on homebirths with 'traditional' midwives that generally occur in Brazil's rural areas (MENEZES ET AL., 2012), also the best-known 'modality' of homebirth in Brazil. These studies mostly investigate how childbirth moved from the home to the hospital[43]; experiences of women who have reclaimed the home as a rightful birthplace[44]; the experiences of health professionals assisting homebirth[45]; and statistical outcomes of planned homebirth[46]. There are a few that provide insights about women's motives to give birth at home[47], however nothing is written specifically focused on the importance of acts of trusting and mistrusting related to homebirth.

[43] MENEZES ET AL., 2012; GALVÃO & MENEZES, no date

[44] LESSA ET AL., 2014; SANFELICE & SHIMO, 2014; SANFELICE & SHIMO, 2015; SANTOS ET AL., 2014; BAIÃO, 2012; AVILA ET AL., 2017

[45] ANDRADE SOUZA & ESPIRITO SANTO, 2011; BURIGO ET AL., no date; MARTINS ET AL., 2012; FRANKS & PELLOSO, 2013; SOUZA ET AL., 2014; SANFELICE ET AL., 2014; MAGALHÃES, 2017; MATTOS ET AL., 2014

[46] CRISTÓZOMO ET AL., 2007; KOETTKER ET AL., 2012; COLACIOPPO ET AL., 2010; CARVALHO ET AL., 2014

[47] MELO & OLIVEIRA, 2008; KRUNO & BONILHA, 2004; SOUZA, 2005; MEDEIROS, 2008; KOETTKER, 2010; FEYER, 2012; FEYER ET AL., 2013; TURA, 2014; COLLAÇO ET AL. 2017

2.4 Homebirth in the media

A TARDE

Defesa do parto em casa mobiliza 23 cidades no País

Partidos deixam a definição do vice para a última hora

ATOR BAIANO

Heder Novaes, da periferia para o primeiro mundo 2

Barco do Greenpeace dá lições de ecologia às crianças

Seguro residencial cresce este ano 17% na Bahia

PROCESSO

Frans Krajcberg reage com dossiê em defesa de suas obras e contra ação movida em Curitiba

Figure 3: National march for homebirth is front-page news in Salvador

Although still rare, reports about 'planned' homebirth increasingly appeared in the media during the period 2010 to 2020. When my interest in the subject was first piqued, there was one moment that seemed to give an impulse to widespread debates about and public 'appearances' of homebirth. In 2012, a planned homebirth went 'viral' in Brazil: a video about the homebirth of a couple from São Paulo proved to be an immense success[48]. Three days after it had been uploaded, more than a million people from all over the world had watched it (nowadays over 9 million views) and stimulated many debates and interest around the whole of Brazil. Later that year, a known obstetrician from São Paulo, Jorge Kuhn, expressed his positive attitude towards homebirth on public television. Meanwhile, opponents geared their loins. Showing its highly

[48] https://www.youtube.com/watch?v=qiof5vYkPws

Figure 4: Picture of the national march for homebirth Salvador. Banner says: 'Birth at home is just as safe as in the hospital and much safer than a cesarean without necessity'.

critical stance towards homebirth, the Regional Medical Council of Rio de Janeiro (*CREMERJ*) proposed to prohibit university trained midwives and doulas from working in the hospital, or medical personnel from working out of the hospital. They also proposed to prohibit hospitals from receiving women transferred from their homes or birth centres during labour (resolutions nº 265 and nº 266.). Consequentially, on the fifth of August 2012, in 23 in different cities in Brazil, including Salvador, women organized the *marcha nacional do parto em casa (the* national march for homebirth).

In late 2013, a documentary - long-awaited by the proponents of the humanization of childbirth - was launched: 'Birth Reborn' (*O Renascimento do Parto*[49]*)*. This documentary, showing the Brazilian obstetric reality including stories from women that were traumatized through the way they had been treated during birth, next to women who had a highly pleasurable experience of their homebirth, became one of the best-watched documentaries in Brazil. Its creators maintain active pages on online networks, contributing to the spread of birth stories, information, and the demystification of obstetric practices in Brazil. In May 2018 *O Renascimento do Parto 2*

[49] http://www.orenascimentodoparto.com.br/

Figure 5: One of the posters launched by the producers of Renascimento do Parto, saying 'cut you cord with the system'.

was launched, which focuses especially on obstetric violence[50]. Also, Brazilian celebrities who chose to give birth at home (such as Bela Gil and Gisele Bündchen) have inspired many debates on social media and television[51].

Finally, homebirth has especially appeared in the media when things did not happen as 'planned'; such as in the cases where the mother or the baby died[52]. Such news is often used as an argument to 'prove' that homebirth is unsafe and that anyone involved in it is irresponsible. In turn, the proponents of homebirth argue that in hospitals, mothers and babies die much more frequently and that, in some of the cases that were published, the deaths were caused by complications that had nothing to do with homebirth itself (such as a post-caesarean haemorrhage after a transfer from home).

[50] See trailer: https://www.youtube.com/watch?v=yRRAluSomDg
[51] https://bebemamae.com/parto/bela-gil-divulga-video-emocionante-de-seu-parto-natural-em-casa
[52] http://g1.globo.com/pr/campos-gerais-sul/noticia/2016/10/bebe-morre-durante-parto-domiciliar-em-ponta-grossa-no-parana.html; http://www.bbc.com/portuguese/brasil-38340476; https://www.diariodaregiao.com.br/_conteudo/cidades/enfermeira-tenta-parto-em-casa-por-48h-sofre-complica%C3%A7%C3%B5es-e-morre-no-hb-de-rio-preto-1.352477.html, among others.

2.5 Legal perspective

In 2007, the Brazilian Federal Medical Council (CFM) declared itself against homebirth, stating that it ‘does not approve homebirth’ (CREMERJ, Parecer 185/2007) and ‘decided to recommend physicians and society to realize births in hospital environment for being safer’ (CFM, August 2012). In sharp contrast to this, the Medical Council of Bahia declared in 2012 that they ‘remind the public that the patient has total autonomy to decide whether she will give birth at home or in a hospital’ (translated from CREMEB, 2012)[53]. However, Brazil’s Federal Constitution states that ‘nobody is obliged to do or refrain from doing something except by virtue of law’[54]. Following this statement, as there is no law banning homebirth, women are indeed permitted by law to give birth to their children at home. Also, in 1992, Brazil signed the American Convention on Human Rights (also known as the Pact of San José). One of the declarations in this convention says that people have the right to privacy and to having their honour or reputation protected from unlawful attacks. It is also following this convention that women in Brazil have the full right to choose where their birth happens. Besides that, the WHO as much as the International Federation of Gynaecologists and Obstetricians (FIGO) respect women’s right to choose where they want to give birth and recognize that, when assisted by licensed professionals, there are considerable benefits for women who want to and can have homebirths (Gonçalves et al., 2014:242).

2.6 Critical notes

Even though Brazilian women have the right to give birth at home, there is only one public hospital that has a policy for free homebirth assistance. Besides that, it has been very difficult for women with a health insurance to receive even only a part of the reimbursement of the homebirth costs. Consequentially, there are no protocols or national guidelines that refer to homebirth assistance; the majority of homebirth teams have an informed consent form established by its members that has to be signed by the pregnant women upon contracting the team. As such, planned homebirth is an inaccessible option for the majority of Brazilian women; in 2018, homebirth teams generally charged between 5000 and 20.000 Brazilian Reais

[53] ‘Parto domiciliar: médico e mãe têm autonomia para decidir‘– 21/06/2012, (http://www.cremeb.org.br/cremeb.php?m=site.item&item=1459&idioma=br)
[54] http://vilamamifera.com/causajusta/parto-em-casa-pode-ou-nao-pode/

(US$ 1000,- to 3000,-) not mentioning the costs of, if that is the desire, contracting a doula, a photographer and the convenience of a health insurance that allows the entrance of the homebirth team in a private hospital (and, therefore, continuity of care) in case of transference. It has been argued that, as we have seen, homebirth often represents a 'flight' from the structural and institutional (and obstetric) violence commonly experienced in public and private maternity hospitals. However, due to the inaccessibility for the majority of Brazilian women, especially for the women that suffer most from these forms of violence, planned homebirth as it is nowadays arguably reinforces the gender and racial inequality so characteristic of Brazilian birth care. In Capão, the mechanisms of such inequality function in a different way. Many women and couples in Capão would not be able to have a homebirth with the local team if they were not open to negotiate the payment, and for native women they established a fixed thousand reais, which is also negotiable. Natália, the obstetric nurse, always reinforced that she would never not assist a birth because of money. However, many of the native women I spoke were not aware of this or, if they were, did not feel comfortable to negotiate, which in some cases made them avoid homebirth. Some of the non-native women also did not have the financial conditions to pay for a homebirth assisted with the team and some of them decided to either have their homebirth unassisted (without any birth assistant) or with a native midwife who, generally, doesn't charge for her assistance[55].

The ways in which activism is adopted by the proponents of the humanization childbirth in Brazil also require a critical analysis that focuses on their possible undesired effects. One of them might be a contribution to what Ginsburg & Rapp (1995) called 'stratified reproduction', or 'the power relations that give some groups access to reproductive choices while limiting the choices of others' (CRAVEN, 2007:702). An important observation Craven makes in her ethnographic research about market-based advocacy strategies for planned homebirth in Virginia, US, is that 'the commodification of maternity and child-rearing practices to the commercial relationships between parents and childbirth practitioners, the "consequences of capitalism for motherhood" (Rothman 2004:279) are deeply ingrained in women's experiences of childbirth and mothering' (IBID.:702). We should, therefore, question the accessibility of such commodified practices, whom it serves, and who is actually able to have a planned and safe homebirth, not mentioning a birth without violence in the first place[56]. In this light, Craven argues that adopting a consumer identity can thus have serious consequences (IBID.706):

[55] For a more detailed critique, see also Carneiro, 2011; 2015

[56] For a further discussion on how discourses of risk, blame and responsibility influence birth place decisions, see Coxon, Sandall & Fulop (2014)

> 'Understanding themselves as consumers has also made the issue of choice – and, more to the point, who has reproductive health care choices – more complicated. [...] Feminist scholars have also reminded us that "choice" and the ability to consume reproductive rights and services mean different things to different women as a result of their cultural and economic circumstances. Research on stratified reproduction demonstrates how choices are always made within the context of larger institutional structures, ideological messages, and fisical limits (Ginsburg & Rapp, 1995).'

In this chapter I have provided a general overview of the developments within Brazilian obstetrics over the past 50 years. Globalization and the increasing access to flows of information from all over the world have not only informed authoritative knowledge and hegemonic practices in birth care, they and the iatrogenic and violent practices that have emerged from them have also inspired Brazilian women, health professionals and other interested people to rise up against what they consider to be a 'dehumanizing' system of dominant discourses, practices and symbols. With this overview, I intend to provide a panoramic context in which the women that participated in my research consciously and unconsciously moved through, affected and were affected by. By doing so I seek to understand in more detail the motivations of women to birth at home and, specifically, the ways in which they have trusted and/or mistrusted in the build-up towards the birth.

In the following chapter, I will zoom in at the more specific context of my fieldwork. In order to do so, I first provide an overview of the geographical and historical developments of Capão as well as of the national park in which it is located. In the second part, I build upon my own ethnographic research and experiences in Capão, besides one of the few 'thick' ethnographical accounts of Capão's population written by Yann Pellisier (2014) to depict the hybrid population of which the interlocutors are a part. Finally, I write more in-depth about the pregnancy and birth care in this particularly 'homebirth-oriented' village. There, I will briefly introduce how notions and practices of pregnancy, childbirth and trusting practices related to these processes have been mutually influenced among natives and non-native residents.

3. TO BIRTH AND BE BORN IN CAPÃO: SITUATING A ‘FERTILE VALLEY’

3.1 Introducing the field

The present study concerns a relatively remote (however not exactly ‘rural’[57]) place, where most inhabitants have chosen their homes as their place to give birth. Capão, or ‘Valley of Capão’ (*Vale de Capão*), which as noted above is localized at the border of the Chapada Diamantina National Park (*Parque Nacional Chapada Diamantina*), is home to almost 2000 people. Its population is highly dynamic due to a large number of fluctuating residents – people who spend some time every month, or who go and spend a period of months or years. Over the past 50 years Capão has turned from a small village without electricity that sustained itself mainly through diamond-mining and coffee plantations into a paradise for eco-tourists and backpackers from all over the globe. Travellers seek it for its reputation as an enchanting location with many waterfalls, hiking trails, natural pools, and for its ‘alternative’ communities and therapies.

Capão has close to 30 *pousadas* (bed-and-breakfasts), a few camping sites, and many restaurants and small shops. Therefore, it houses a mixture of people from many different cultural, social and economic backgrounds. A large part of the shops and *pousadas* are owned by outsiders (*neo-rurais*, see next section), contributing to an unequal socio-economic system. The local economy is heavily reliant on tourism and the internal market; lodging, shopping, restaurants, snack bars and walking / trail services make up the highest income.

Crops such as banana, coffee, coconut, tomato, cassava, passion fruit, and pineapple, among others represent the main activity of the agricultural sector.

To reach it requires a one-hour drive on an unpaved road from Palmeiras, the closest urban centre, and another hour to access the closest hospitals in Iraquara (private hospital with public quotas) or Seabra (public hospital - see Figure 6 below). Departing from Salvador, one takes the BR-242 towards Brasília where, after about 500 kilometers and past some of the typical table-like mountains of the Chapada Diamantina National Park, you arrive in the municipality of Palmeiras. From there, it is after an hour of bumps and, depending on the season, dust or mud that the view opens up to the green valley that houses the district of Caeté-Açu and its villages including Capão. During the past 40 years, Capão has been transformed from a village with less than 500 inhabitants, ‘lost between the mountains of the Chapada

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[57] Pellisier (2014:21) notes that Capão could be understood within the concept ‘nova ruralidade’ (new rurality): ‘*o meio rural contemporâneo não é a reprodução de um modelo passado, homogêneo e agrícola, ele é um território diverso inserido na dinâmica do mundo globalizado, “uma mutação caracterizada pela morte da civilização camponesa e pela emergência, ainda confusa e indistinta, de uma nova cultura de corte urbano*” (VEIGA, 2006, p. 335)’

Diamantina at an altitude of 1,000 meters, to one of the main centers of ecological tourism at the Seabra - Iraquara - Palmeiras - Lençóis - Capão and Capão – Vale do Patí - Andaraí – Mucugê axes' (ARAÚJO, 2010: 75). Capão hosts a very particular and dynamic population, where categories such as *nativos* (natives) and *os de fora* (outsiders) are continually challenged and subject of controversy (NASCIMENTO, 2008; PELLISIER, 2014).

Figure 6: View on the valley upon arrival. The mountain in the middle is called Morro Branco ('white mountain')

'Caeté-Açu', Capão's official district name, comes from the indigenous *tupi* and means 'really big forest': *ka'a* (forest, "*mata*"), *eté* (real, "*verdadeiro*") e *gûasu*(big, "*grande*"). The *povoado* (village) 'Vale do Capão' (Capão valley) or 'Capão', is found just outside the borders of the 1.520 km2 area that in 1985 was declared the Chapada Diamantina National Park (PNCD). The park houses the sources of Bahia's main rivers, Rio Paraguaçu and Rio De Contas and, due to its altitude (800-1200 meters) and subtropical climate full of canyons and waterfalls, consists of a great biodiversity and 'fresh' and rain seasons. Cave paintings found all over the park are signs of its first human residents, however more is known about its more recent inhabitants, the indigenous *maracás*, which originated from the *tapuias* and fled from the *tupis* in the beginning of the 15th century (NASCIMENTO, 2008). When *bandeirantes* discovered gold in the 17th century, it became a great mining attraction resulting in a growing population. For 30 years, the PNCD was the centre of Brazil's colonial diamond production, however as the value of diamond dropped increasingly at the end of the 19th century through the discovery of mines in South Africa, many miners quitted.

Áureo: "*O que aconteceu foi assim, tinha o diamante e... em torno da década de 30, o diamante ele dançou radical. E o Capão ficou muito pobre. Década de 30 do século passado. Aí ficou uma situação muito ruim. E aí o povo já plantava um pouco de café e o café se transformou numa alternativa, então as pessoas emigraram em massa, mas os que ficaram plantavam café. Só que teve a erradicação dos cafezais, por que o café começou a perder preço no mercado internacional e aí o Brasil viu que era preciso reduzir a produção para conseguir manter o preço. E aí eles não iam erradicar cafezais em São Paulo. Tinha que erradicar em um lugar mais pobre, é óbvio, tinha menos poder político e ocorreu a erradicação aqui. Aí quer dizer, depois voltaram a plantar e tudo, mas já não era uma coisa assim tão forte, né? E também aqui tem certas dificuldades, né? O transporte. Você tinha que transportar em lombo de burro.*"

From the 20th century on, the production of coffee became one of its main sources of exportation and income, and until today the coffee is known for its high quality. Dona Áurea, one of Capão's oldest TBAs, recalls: "*trabalhava com roça, apanhava café pra ganhar dinheiro, que tinha muito café aqui. Vendia, a gente ia pra Lençóis com um balaião na cabeça pra vender, eu ia domingo e voltava terça-feira.*"

Pushed by the great drop of the value of coffee in the 1950s, Ganem & Viana (2006) identify a rural exodus at that time, which left its inhabitants highly isolated until the 1980s. Up until today, many native inhabitants have family members living mainly in São Paulo. Nevertheless, Dona Áurea recalls that nobody was ever hungry, mainly thanks to the successful plantations of bananas, coffee, mangos and manioc most native inhabitants owned. (NAVE TERRA, 2016: 96).

Figure 7: Map of Chapada Diamantina

In 1952, the *Cachoeira da Fumaça* (‘Smoke Waterfall’) was discovered and became a touristic point; nowadays it is Capão’s main natural attraction. Visualizing its potential, the mayor of the municipality of Palmeiras decided to create the district Caeté-Açu. Nevertheless, the following 30 years were marked by another economic crisis, which, together with the ongoing military dictatorship forced a rural exodus and pushed many inhabitants to urban centres such as São Paulo. Even though the urban exodus of the 1980s did not impact Capão as much as in the capital of the PNCD, Lençóis, it did mark the beginning of a local economy basically sustained by tourism.

From the 1960s on, the valley was slowly discovered by youth that were influenced by the hippie movement and resistance towards the military regime (1964-1985). This resulted in the creation of a certain mysticism concerning the valley and its enchanting nature, mainly in the ‘New Age’ lineage (PELLISIER, 2014). From the 1980s on, especially driven by a great urban exodus from Brazilian as well as European and Latin American cities, processes of ‘*patrimonialização*’ and ‘*touristificação*’ (IBID.:30) and urbanization have marked the development of the PNCD. It was also in the 80s that electricity arrived in Capão. While mining ended in the face of the new environmental protection laws, the same environmental protection

Figure 8: Map of the village.

and the immigrants and tourists it attracted provided a drastically different economic impulse to the area.

The past 35 years have marked the arrival of electricity; cars; internet; transformations in notions of health and environmental preservation; health post; 1 state high school and a variety of 'alternative' elementary schools; restaurants, shops, supermarkets, pousadas, hostels and campings; presence of weekly workshops and retreats related to holistic therapies and artistic expressions; an association of hiking guides (ACVC, *Associação de Condutores do Vale do Capão*); the main square that houses the two-weekly (largely organic) market, the main supermarket, a variety of bars and restaurants, artistic presentations in the *coreto* and, since 2010, a yearly Jazz Festival with international attractions; among others.

Figure 9: Weekly market on the main square

In one of the main touristic guides about Chapada Diamantina it is stated that in Capão '*O clima de esoterismo e paz está presente no dia a dia da comunidade e foi trazido por jovens ainda embalados pelos sonhos dos anos 70.*[58]' Such 'esoteric atmosphere' has often been imagined as result of continuous efforts to keep the 'dreams of the 70s' vivid. However, Pellisier noted that, even though tourists arrive for and enjoy certain local cultural events such as *São João* and the *Festa do Padroeiro,* '*o patrimônio material e imaterial da cultura valorizada não é rural e tradicional, mas híbrida e moderna, isto é, neo-rural*[59]*'* (2014:40). The dynamic and ambiguous use of notions of rural-urban and traditional-modern are highly

[58] http://www.guiachapadadiamantina.com.br/cidades-e-vilas/cidades-e-vilas-vale-do-capao/

[59] 'the material and immaterial patrimony of the valorised cultures is not rural and traditional, but hybrid and modern, in other words; neo-rural.' More on 'neo-rurais' in the next section.

characteristic of Capão's hybrid population; I will look at them and how they are also reflected in birth practices in-depth in the next section.

3.2 Between visitor and resident: notes on Capão's hybrid population

Between 2005 to 2014, the number of registered inhabitants registered increased from 1,581 to 1,899, of which 53% were not native to the municipality of Palmeiras[60]. 20.1% of this population was non-Brazilian, originating from 15 different nationalities (NAVE TERRA, 2016: 96). Considering the large fluctuating population (both tourists and immigrants from different parts of the country and the world), it is difficult to have a precise notion about how many people are in the valley at any moment.

In 2015, about 60% of the locally resident population had a monthly average income of up to a minimum wage (R$954,- in 2018, US$ 178,-), with 21.8% of registered families enrolled in the *Bolsa Família* (BF - 'Family Grant') Program (data collected at the Social Assistance Office in Palmeiras)[61] (meaning that these families have an income of up to R$ 89,- per family member and have registered for the BF). The amount of money provided through the BF depends on the amount of family members, their ages and on pregnant women in the family. Next to the monthly Basic Benefit of RS$ 89,-, there are monthly Variable Benefits (VB) for families with an income of up to R$ 178,- per family member. These include the VB for children or adolescents from 0 to 15 years of R$ 41,- each child (between 6 and 15 years school enrolment is required); VB for pregnant women of R$ 41,- each pregnant woman; VB for nursing children from 0 – 6 months of R$ 41,- each child; VB for adolescent between 16-17 years of R$ 48,- each adolescent. For the families who, after receiving their benefits, continue having an income of less than R$ 89,- per family member, an individually calculated monthly amount of money is provided through the *Benefício para Superação da Extrema Pobreza* (Benefit to Overcome Extreme Poverty). Laila, the assistant at the Secretary of Social Assistance in Palmeiras, explained me that the VB for pregnant women can be requested from the first prenatal consultation by informing one's Social Identification Number (NIS) at the health post. The local health post should inform its municipality's Secretary of Health, which then informs the Secretary of Social Communication, which informs the *Cadastro Único*, the general register of the families enrolled in the BF Program.

[60] This was the most recent statistical information available. It was collected by *agentes de saúde* (health agents) connected to the health post.

[61] For an analysis of the *Programa Bolsa Família* and the meanings attributed to the money offered through it, see Eger & Damo, 2014

In June 2018, I sit next to Laila in her office as she manually counts the families living in Capão that receive the BF from her computer screen: a total of 115 families, amounting to 194 people. During a conversation with Cândida, who works at Palmeiras' CRAS (Reference Center for Social Assistance), she contemptuously says: 'Yeah, why do you think so many people receive the BF? People omit information all the time! The other day we found out that one of the city councillors was enrolled in the BF, and do you think he fits the profile for enrollment?! He is a rich guy!' Five women in Capão receive the VB for pregnant women, a number that shocks Laila: 'My God! So they are not informing them. The post has to inform them! I always inform them; go there, hand in your number!' Also, 74 families receive the *Benefício para Superação da Extrema Pobreza*. When she notices my surprised reaction, Laila mentions that the majority of these people are registered as 'autonomous' and 'rural workers' who live from *bicos* ('beaks'), meaning that they do a variety of untrained jobs to make a living. Such jobs often include cleaning, cooking, fixing cars and motors, selling fruits, vegetables and homemade products, constructing houses, gardening, and handicrafts.

Considering the fact that Capão is often seen as a '*laboratório de vida alternativa*'[62] (PELLISIER, 2014) and home to a hybrid, dynamic and fluctuating population, it is not an easy task to describe its inhabitants, visitors and everybody 'in between' these fluid categories. Yann Pellisier's work (2014), practically the only anthropological investigation of Capão's population and, specifically, social mechanisms of tourism, will provide the basis for this section.

A first category often heard of in Capão and found in the literature about its population is *nativo* (native). In his sociological investigation about Chapada Diamantina and the different forms of tourism employed in the park, Nascimento (2008:8) notes that:

> *'Ao nos referir aos 'nativos', consideramos que estes têm origem em uma pequena comunidade rural tradicional que, apesar de levar como carga histórica os ciclos do diamante, do café, e, mais recentemente, do turismo, nunca tiveram destaque econômico, predominando uma economia de subsistência com baixa circulação de dinheiro e relações sociais primárias, extremamente pessoalizadas.*[63]*'*

Even though *nativo* is an emic category, at times stereotyped as 'backward' and 'primitive', it is very heterogenous and constructed mainly in opposition to *os de fora* ('outsiders'). The intensified urban exodus of the 1980s effected changes in social configurations in Capão that

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[62] *'laboratory of alternative life'*

[63] 'when referring to 'nativos', we consider that they are originated in a small rural traditional community that, despite having the diamond, coffee and, more recently, tourism cycles as its historical charge, they never experienced an economic peak; an economy of subsistence with low circulation of money and primary and extremely personalized social relationships prevailed.'

have led to the crystallization of the current conceptual opposition between *nativos* and *os de fora*. Generally, a *nativo* in Capão is born into a family that inhabited the village before the influx of outsiders. Most are descendants of miners and workers on coffee plantations and often constitute an urban imaginary of country life as 'more balanced, traditional and close to nature' (PELLISIER, 2014:43). Quite contrary to this urban imaginary, Araújo (2010:82) observed that: '*Hoje o Capão é um exemplo de lugar integrado à globalização, com as antenas parabólicas captando o mundo pela TV, a Internet divulgando as suas belezas em um número cada vez maior de sites, a quase totalidade das residências com aparelhos que falam por DDD e DDI*[64]'. Additionally, there are numerous groups of residents on social networks that facilitate meetings, exchanges, workshops, rides and merchandising.

A large proportion of the *nativos* work as service providers, nowadays the majority is officially hired. However, some of them, like the 'motor-taxis' and guides, depend largely on the touristic cycles of events and holidays. Characteristic to the '*nova ruralidade'* (see description below) brought along by the living together of *nativos* and 'outsiders', these modernizing processes have had great influence in the lives of the *nativos*. Besides the technological changes as mentioned above, their coexistence provokes a redefinition of mutual behavioural patterns and resignification of practices and values (LUEDY, 2009:39).

It is important to note that the ways in which *nativos* perceive their lives and modernization in opposition to the outsiders are highly varied and it is common to find 'adaptations' of practices and technologies considered 'modern' as well as 'traditional'. The same should be borne in mind for the following categories.

In the view of the *nativos, os the fora* are from outside of Capão, either foreigners or Brazilians (PELLISIER, 2014:43). Generally speaking, they indeed come from urban centres and other countries and are there either for leisure or ended up making Capão their home as *neo-ruralistas* ('new ruralists', IBID., further analysis below).

Within the 'leisure-outsiders' he observed *os turistas* ('the tourists'), who represent the mass of consumers during the holidays and events and sustain local tourism. Arriving either by bus, (rented) car or by plane (twice a week flights from Salvador to Lençóis -the capital of the park- come in), the objective of the journey is often 'ecotourism'[65]. Many of the *pousadas* and

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[64] 'Nowadays, Capão is an example of a place which is integrated in globalization, with parabolic antennes capturing the world through television, the internet spreading its beauty on an ever-growing number of websites, almost all residences have phones that make calls nationally and internationally.'

[65] EMBRATUR defines eco-tourism as '*um segmento de atividade turística que utiliza, de forma sustentável, o patrimônio natural e cultural, incentiva sua conservação e busca a formação de uma consciência ambientalista através da interpretação do ambiente, promovendo o bem-estar das populações envolvidas'* (1994, http://www.turismo.gov.br/sites/default/turismo/o_ministerio/publicacoes/downloads_publicacoes/Ecoturismo_Versxo_Final_IMPRESSxO_.pdf)

campings –with prices that vary from R$20,- to R$500,- a night) – have embraced the ‘eco’- and ‘therapeutic’ tourism often looked for, and offer, for example, ‘rustic rooms’, a variety of holistic therapies and massages, vegetarian and ‘natural’ food and have alliances with trained hiking guides. The tourists are the main target *and* critics of the campaigns for environmental conscience, while, in turn, it is not uncommon to hear natives criticizing tourists for polluting the environment. They circulate around the village and trails, and rarely get socially involved with the natives.

The second, and possibly most polemic category identified by Pellisier (2014:58) has a variety of emic names: *Roots*, *hippie*, *viajante* (‘traveller’), and even *micróbio* (‘microbe’). They can be distinguished from *touristas* mainly by the fact that they are not making ‘trips’ in the touristic sense -hiring a guide-, not having or spending (a lot of) money and, even though sometimes for only a few days, ‘live’ in Capão. The label *micróbio* refers, besides a supposed lack of hygiene, to the idea that they ‘live’ in Capão trying to make some money often through street performances or selling food or handicrafts, without spending much themselves. For some inhabitants, this means that besides not contributing (in the way tourists do) to the local economy, they even ‘take money away’ from the tourists. Being ‘long term tourists’ and therefore part of the local economy during the whole year, many of them opted for a ‘voluntary and temporary poverty’ and rarely buy land for a place of their own (PELLISIER, 2014:59). Some are connected to the same international and travelling ‘alternative’ networks such as the Rainbow (People) Gatherings and come to Capão after festivals/meetings related to those networks. However, as mentioned before, it is a heterogenous group.

Inhabitants of secondary residences form the final category within the ‘leisure-outsiders’. In general, they have a socio-economic profile quite similar to tourists, and because of that are valued, or rarely criticized, by the local population. They go to Capão for relatively brief but frequent stays (IBID.:60). Due to my frequent visits and previous secondary residence, I am typically identified as part of this group.

Finally, we also encounter what Pellisier has called *neo-rurais* (‘neo-rurals’), who live there to be far away from the urban centres, not through financial or professional obligations or needs (IBID.:61). They are mainly European, Latin American of Brazilian ‘foreigners’ who completed high school or university and whose professional activities focus on ‘alternative’ practices (such as holistic medicine, organic agriculture and artistic expressions) and tourism (owning *pousadas*, restaurants and therapeutic centres). Forming the beginning of the urban

exodus of the 1980s, they first introduced new practices of community-life (such as Capão's first community 'Lothlorien'), nutrition (directed towards organic, non-industrialized, vegetarian), education (such as the elementary school 'Brilho do Cristal') and construction (bioconstruction). Some of them, such as some people identified in the previous category, got involved in this exodus because of political and ideological issues. However others, such as Fabi, do not identify with such motives: *'eu não fui daquelas pessoas que veio morar no Capão revoltadas com o sistema, brigando com o sistema, me apartando da família, me apartando dos meus valores. Como tinha muita gente na época. Eu não vim carregando nenhuma bandeira. Eu vim morar aqui porque eu me encantei com esse lugar.*[66]'

Nowadays, it is common go find natives working for neo-rurals, either in their pousadas, restaurants or (building their) homes. Even though one can observe a generalized acceptance and respect between these groups, conflicts, inequalities and differences in interest appear:

> A questão que se apresenta é como equacionar melhor as vantagens das atividades do turismo em uma comunidade sem deixá-la (a comunidade) com os problemas geralmente encontrados pelo turismo de massa: ociosidade de mão-de-obra local durante a maior parte do ano, elevação anormal de preços, especulação imobiliária, segregação entre nativos e visitantes, trânsito, violência (consumo de drogas), prostituição e vulgarização da autenticidade. [...] A dura realidade de uma localidade turística não favorece as esperanças alternativas, entre desejos e práticas, as tentativas de reinvenções dos neo-rurais são questionadas. (PELLISIER, 2014:65)

One of these *neo-rurais* has been of great importance and impact on birth care in Capão: Doctor Áureo. More recently, other *neo-rurais*, including the obstetric nurse that is part of the homebirth-team, have contributed to changes in and an increase of homebirth practices. In the next section, I will provide a panorama of Capão's health care and the developments that occurred together with the arrival of these different 'outsiders'.

[66] 'I wasn't one of those people who came to live in Capão upset with the system, fighting with the system, separating from my family, from my values. As did many people at that time. I wasn't carrying any flag. I came to live here because I got enchanted with the place.'

3.3 Health care in Capão

Áureo tells me that before he arrived in Capão in 1982 access to biomedical care was limited. The closest doctor, Doctor Freire, lived in Palmeiras. If a patient was very debilitated and, as was common, no car was available, he or she would be carried on a *marquesa* (stretcher) to Palmeiras (at least a 3-hour walk). Pellisier (2014:46) notes that he observed that almost all families who resided in Capão before 1980 identify a case of death due to fever or a snake bite

Figure 10: Marilza

that had not been taken care of adequately due to Capão's isolated localization. Marilza, a native nurse technician, opened a '*posto de curativos e vacinas'* in 1977, where one could get wounds disinfected and bandaged. Upon his arrival, the Frei Justo Hospital in Seabra (a philanthropic hospital that went bankrupt) had already been founded and became the main place of referral for the surrounding communities. With the arrival of the SUS (Sistema Único de Saúde – Brazil's public health system) in 1988, the health post received the support of the Ministry of Health and gained access to vaccinations, medical exams, and more effective transferrals to hospitals of the region.

An important shift in the local health care occurred with the arrival of doctor Áureo, in 1982. Together with his wife at the time and two other couples, they bought 18 hectares of land in Capão and created the community 'Lothlorien'. Nowadays it functions as *Centro de Cura* (Centre for Cure), offering a variety of holistic therapies and providing participative lodging for tourists and volunteers. At the time of its foundation, it did not take long for Áureo to

become known as ‘the doctor’, and soon many residents started knocking on his door for help and advices of all kinds (including marital advices and help with writing letters). Áureo started to offer free care and courses for pregnant women to the local community in Lothlorien, a practice he continued for 25 years. In his consultations, he combined his extensive experience with naturopathy and biomedicine and incorporated many of the local health practices based on phytotherapy (use of roots, herbs and other medicinal plants). Capão’s native inhabitants already had many plant-based health practices of their own, so Áureo’s consultations and recommendations were and continue to be very well accepted and respected. Further on we will have a closer look at the importance for and influence on the local health and birth practices of such ‘fruitful accommodation’ (JORDAN, 1993 [1987]).

In 1987, he also organized a ‘*formação de agentes de saúde*[67]’, which attracted people from all over the country and, moreover, brought him very close to Marilza[68], (who was still working at the health post at the time of my research, but retired in 2020):

> ‘O médico realizou cursos gratuitos que tiveram grande impacto para a população do campo, isso entre os anos de 1987 a 1995, intitulados Agentes de Saúde (antes mesmo que o Governo Federal criasse os Agentes Comunitários de Saúde). As associações camponesas da Bahia eram convocadas a encaminhar para o Vale do Capão as pessoas das comunidades que se destacavam por cuidar dos vizinhos. Nos cursos elas recebiam aulas sobre práticas integrativas, alimentação integral e outros temas ligados à saúde, e se comprometiam a compartilhar os ensinamentos com as suas comunidades.’[69]

Marilza and Áureo started working together and, as she knew everybody and he often found it difficult to understand common local health practices and ways of talking, she became a kind of intermediator between him and the local community.

Capão´s health post officially turned into what is called an *Unidade de Saúde da Família*[70] (Family Health Unit) in 2005. Before he got hired in 2006, there had been three other female doctors at the post who, according to him, ‘did not work out’. The community did go there for consultations but continued to ask Áureo for help. With his arrival at the health post, a great variety of holistic health practices[71] were implemented and nowadays the post is a national reference for the *Política Nacional Práticas Integrativas e Complementares* (PNPIC),

[67] Health agents’ course.
[68] Picture Marilza: https://www.ahumanatlas.com/somos-brasil/marilza-nery-de-almeida/
[69] https://jornaldachapada.com.br/2017/10/18/chapada-medico-atuante-no-vale-do-capao-recebe-titulo-de-comendador-pelo-ministerio-da-saude/
[70] http://bvsms.saude.gov.br/bvs/publicacoes/implantacao_unidade_saude_familia_cab1.pdf
[71] Such as Naturopathy, hydrotherapy, geotherapy, fytotherapy, iridology, thetahealing, chakra alignment, Bach florals and yoga.

Figure 11: Capão's health post on the main square

that was implemented by the Ministry of Health in 2006. It is also well-known for its 'humanized' and holistic -(home)birth- care and continuously receives interns from the Federal University of Bahia's Medical School. In 2011, Áureo started his own YouTube channel[72], which today reached over 800.000 visualizations. He also owns an Instagram account with over 10.000 followers on which he publishes his art work, naturopathic recipes and promotes events[73]. In October 2017, he received the title '*condecoração Comendador da Ordem do Mérito Médico'* indicated by the Ministry of Health[74]. Considering the fact that Capão is a national reference for an enormous variety of holistic therapies, it is important to note that many of its residents in some way or another engage in these therapies also outside of the health post. Even though these are often charged for, it is not uncommon to find trading agreements for people to have access to each other's' services without monetary involvement.

In the following section, we will further discuss the historical development of birth practices and analyze the dynamics of the current ways in which birth is perceived and cared for.

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[72] https://www.youtube.com/channel/UC0bKWCDPlAra6keJ2eAeb2A
[73] @augustoaureo
[74] http://institutochapada.org.br/2017/10/17/dr-Áureo-augusto-recebe-a-condecoracao-comendador-da-ordem-do-merito-medico/

3.4 Childbirth in Capão

3.4.1 Before Áureo

As in many villages in the countryside of Bahia, births used to be assisted by *parteiras* (in the international literature referred to as TBAs - traditional birth attendants). In Capão, *parteira* is the common name for those who attend births; even Áureo is frequently called *parteiro,* a loving way of including him in what is generally seen as a women's profession. In Brazil, *parteira* is mostly used for birth attendants without a biomedical training[75], however more recently *parteira* has been adopted by obstetric nurses or obstetricians who attend *planned* homebirths in urban settings (some identify as *parteiras urbanas*). In Capão, *parteira* is an often-heard name for almost all of the birth attendants. Nevertheless, Natália is also well known as the *enfermeira* (nurse), and Àureo as the *médico* (doctor). As we will see, in Capão we find a quite particular coexistence of these apparent opposite realities of homebirth modalities and their birth attendants. Besides that, many of the birth attendants, with or without a biomedical training, continuously transit between what could be considered 'biomedical' care and various forms of 'traditional' or 'alternative' care.

Generally, these were *nativas* (local women) who became unpaid birth attendants in a few possible ways; either they learned midwifery skills from relatives, else they accidentally witnessed one or more births, or -and arguably in combination with the latter-, as Dona Áurea, a retired *parteira*, mentioned: through a *tino de Deus* ('a sense of God'). Delgado et al. (2017:9) observed in Capão:

> 'Há cerca de cem anos atrás e mesmo até hoje elas são designadas a essa função por intuição, um dom que se transmite de geração a geração. Munidas da prática empírica, ser parteira envolvia um misticismo e adoração da comunidade, afinal elas estão em contato com o momento mais íntimo das famílias, o nascimento de um filho. Não havia exame de toque e nem a manipulação quanto aos posicionamentos dos bebês na hora do parto pois o conhecimento científico era escasso. Usava-se os temperos dos alimentos como uma forma de estimular a contração uterina, a calça do marido como uma rodilha na parturiente para estimular a expulsão do feto, sendo que a calça tinha que estar usada e não podia ser tirada da gaveta. Um ovo era rapidamente aquecido, retirado o topo da casca e adicionado condimentos no seu interior para ser ingerido pela gestante como forma de estimular as contrações. As comadres eram peça-chave, não só pela energia da sua presença como também para esquentar a água e fazer compressas que traziam o alívio ao parir.'

[75] For example: "O parto realizado por parteiras, em regiões de vazio assistencial, e o parto realizado em centros urbanos, por equipes interdisciplinares para o público de classe média." (GONÇALVES ET AL., 2014;246)

In chapter 4, I analyze in greater depth the meanings and implications of the ‘intuition’ or ‘spiritual calling’ that many birth assistants describe.

One of the first visits I made during my research in Capão was to Dona Áurea. Arriving in the middle of the valley, One of Capão’s oldest TBAs, Dona Áurea, tells me her mother died at age 30, having given birth to 13 children, five of whom did not make it to their fifth birthday.

Figure 12: Dona Áurea in front of her house

Dona Áurea is the youngest and the last one alive of the eight brothers and sisters. She recalls that at the time she had her children, between 1945 and 1960, women did not do any prenatal consultations. They would only see the *parteira* whenever the ‘pains’ started or else if some kind of complication occurred during pregnancy. If any kind of medication was needed, they would go to Dr. Pedro in Palmeiras or to ‘*Piroca’*, a ‘kind of doctor’ who ‘gave medication to children’ and lived in the Mata area of the valley. She gave birth to six children, two of whom, girls, died in infancy, one at two years and the other at three months, from *bexiga* ‘blather’ and ‘bronquitis’. The *parteira* who attended her during the births of her children was Dona Antoninha, who is commonly remembered as the most experienced and competent midwife of that time. Áurea also remembers Hermenegilda and Candinha. However, by the time she had her children they had already died. After the 1960s, Dona Áurea and Dona Maria do Bomba

became Capão's main midwives, as well as Dona Liu da Lagoa (retired and in her nineties) and Dona Hilda; who lives in Seabra but was sometimes summoned (and still was in 2018) [76]. I asked Dona Áurea what she used to do when she was called for a birth. She responded thus:

> *"Aí você dá um banho, você faz um chá, um banho de erva-cidreira e dá a ela aqui nas cadeira, bota ela na bacia e dá um banho. Quando a dor aperta mesmo que é pra ter, você deita ela no ponto [da cama] e fica ali esperando... [...] porque quando tá pra ter tem aquele líquido da força da criança que vai nascer... e quando é pra cesárea não tem nada disso, é seco. Você pode dizer assim "vai encontrar o doutor", senão perde. [...] aí cortava umbigo de menino, media assim, uns três palmos, né, de dedo, aí apanhava um ferro, esquentava no fogo, desfazia assim com o umbigo do menino... agora ali fazia um paviozinho de algodão e aí enrolava assim e botava no umbigo do menino, amarrava assim, e apertava."*

To help to get the placenta out, she used to give the woman a strained infusion of ashes and salt, besides reciting a prayer: *"Santa Margarida, não tô prenha nem parida, me ajude eu acabar de parir."*

Figure 13: the street in which Dona Aurea lives was named after her

Quite a few of the practices Dona Áurea and other midwives used to engage in have been adopted and adapted by the current birth attendants in Capão. Herbal sitz-baths, mainly from cotton-leaves and *barbatimão* (stryphnodendron) are commonly prescribed by Áureo, Natália and the Equipe Parir, besides a variety of herbal teas that they recommend for consumption during pregnancy, birth and post-partum (such as *folha de algodão* (gossypium),

[76] Dona Maria lives in the 'Bomba' area of the valley. Retired, at the time of my research she was ill and unable to talk with me.

erva cidreira (melissa officinalis) and *funcho* (foeniculum vulgare), mainly to help the bleeding to stop, to stimulate or diminish milk production and for intestinal problems). Another important influence on births mentioned by Dona Áurea that continues to be valued is the moon. She tells me that girls are born under a full moon, boys with a new or waxing moon. However, when the moon is 'too new', it is too weak, and births do not occur. About ten years ago she stopped 'catching babies' ('*pegar menino'*). One of the last ones was a boy from a foreign couple, which was not the only foreign one. As far as she recalls, nobody ever paid her for attending their births, a fact her husband did not like at all. When Áureo arrived in Capão, they attended quite a few births together, at times also in the company of Cecília, another doctor who lived there. He taught her some new techniques and rules, such as not to pull the umbilical cord after the baby is born (risking pulling out the placenta and possibly causing serious hemorrhage); how to sterilize scissors and to not put any herbs into the vagina (which used to be a common practice to stimulate contractions and dilation). On the fifth of May 2021, a short documentary about Dona Áurea was launched by Hewelin Fernandes[77].

3.4.2 Between Áureo and the creation of *Equipe Parir*

Before his arrival in Capão, Áureo was already known in Salvador as a naturopath and *parteiro* (masculinization of the word *parteira*) who assisted homebirths, and, as I mentioned, upon his arrival he offered free consultations. Besides participating in the foundation and construction of the still existent community *Lothlorien*, he learned a lot about medicinal plants from the local population. In the past there have been workshops and meetings promoting exchanges among the post's health professionals and the *parteiras*[78] and currently there is a mix of different kinds of birth assistants.

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[77] For more information, see @aureaofilme on Instagram.
[78] See, for example, the 'Três Marias' project (BRASIL, 2009).

Figure 14: Áureo Augusto. Source: https://jornaldachapada.com.br/2019/07/30/chapada-medico-do-vale-do-capao-e-seu-trabalho-sao-referencia-nacional-conheca-a-historia-de-doutor-aureo/

Áureo had been a doctor and OB/GYN for a few years and was one of the pioneers in attending homebirth in Salvador and in supporting the practice of '*parto de cócoras'* (birth in a squatting position). After his experience in Salvador and having visited Capão only once, he moved there and naturally started attending the local community. For 25 years he attended everybody for free in Lothlorien, the community he helped to found, except for those who came for private naturalist consults with him – as people still do today. Already in his first year living in Capão, he was called for when a native woman's labor started and the midwife was not there. From that moment on, he slowly managed to implement prenatal consultations and 'convince' the women of their importance. Also, he started a kind of pregnancy circle together with two other women who founded Lothlorien. Fabi, one of Capão's 'oldest' *neo-rurais*, remembers their value, and their contribution to her sense of trust:

> *'Então quando engravidei de Lis eu participei na roda em Lothlorien. Rodas de conversa, de demonstração e de vivências. Era com Sônia, com Cecília e com Áureo. Então por exemplo, me lembro muito bem, foi uma coisa que me ajudou demais, tanto no meu parto, quando eu fiz o parto de Maria. Porque quando Maria teve Mila, quando Áureo chegou, Mila praticamente tinha nascido. Então quem fez o parto foi eu. E o que eu tinha aprendido nos cursos de parto, nos cursos de grávidas que eu fazia pra mim porque tava grávida, foi o que me deu assim super confiança, foi o que usei, o que tinha aprendido. A gente simulava o nascimento, com almofadas, uma mulher virava bebê, outra era a mulher que tava parindo, outras eram as parteiras, e a gente nascia né, por dentro das almofadas, era muito engraçado! Mas assim, a coisa de pegar a cabecinha, do movimento de pegar a cabecinha pra ajudar o fluxo da passagem do ombro, da criança, de segurar fúrcula aqui embaixo entre a vagina e o ânus, a gente aprendia. Era bem detalhista, era muito lindo.'*

Some of my interlocutors vividly remember the time when there was no electricity. At that time, once labor had started one had to drive to the doctors' house and hope Áureo was home (this continues to happen as not all inhabitants have access to a phone or internet at their homes). Áureo mentions how much he has learned from the midwives at that time, and how much he continues to learn from the 'new' and 'humanized' practices Natália and the other birth attendants have brought to the valley. By the time Natália arrived, Nara, the granddaughter of Dona Maria do Bomba, who used to be one of Capão's main birth assistants, had also started assisting births. From the stories told by Áureo as well as native and foreign inhabitants who have lived in Capão for over 20 years, it becomes clear that Áureo's arrival occurred at a crucial moment in terms of birth care. Even though the local TBAs were still attending births, they were already diminishing their workload, which occurred hand in hand with an intensification of the demand for hospital births. However, the fact that right at that moment there was a doctor experienced in and enthusiastic about homebirths in Capão, who respected the role of the native midwives and worked together with them seems to have prevented what has happened virtually everywhere in Brazil from the 1970s onward: generalised hospitalization and medicalization of birth, having turned homebirth into an almost extinct practice and caesareans into the most common modality of giving birth. Besides that, the local population easily adapted to his naturalist treatments, as Áureo recalls:

> '*aí, de repente, rolava um médico, de repente ficava tempos sem médico, vinha caminhonetes de Palmeiras fazer consulta comigo. Entendeu? Então com isso foi um momento propício, que as pessoas experimentaram, viram o resultado e gostam dos tratamentos naturais. Entendeu? E aqui tem essa complementaridade bem forte, que usa medicina alopática, usa natural... florais, e coisas de psicologia, e reza...*'

Due to the dynamics among and between medically trained birth attendants and non-medical *parteiras*, it is difficult to apply notions about 'traditional' birth care typically associated to rural areas. Common notions about 'planned' homebirth in its urban forms also do not apply, as practices and discourses surrounding homebirth are hybrid and a mixture of practices of care considered 'traditional' – among which the 'shamanic' variants and those others considered 'modern'. Finally, the distance to the nearest hospital (at least 1.5-hour drive) also changes the ways in which homebirth is 'planned' (such as more anticipation needed). Silvia, a neo-rural woman in Capão, told me that she felt that "*essa coisa do parto domiciliar no Capão já não é mais modismo; as parteiras estão bem mais sérias e transferem para o hospital com maior*

firmeza e freqüência"[79]. Here, she observes a change in what she sees was a tendency to give birth at home because it is something 'fashionable' and, a common criticism against homebirth mothers and attendants, to do 'everything' to give birth at home, in other words, to risk lives doing so.

3.4.3 Arrival of *Equipe Parir*

Figure 15: logo of the Equipe Parir

In 2010, Natália had been working as a nurse for a few years already and finished her specialization in obstetrics. She had travelled to Capão before and had fallen in love with it. When she heard that there was a job opportunity for a nurse at the local health post, she decided to try and got the job. She told me it took some time for her to win the trust of the community, but soon they all felt comfortable with her presence and, as we will see in Chapter 5. She started to assist births together with Áureo and with Maristela, an obstetrician from the south of Brazil

[79] "This homebirth thing in Capão is no fashion anymore; the midwives are much more serious and transfer to the hospital more firmly and frequently."

who was living there at the time. In the same year, Maristela Sens and Natália founded the *Grupo Parir*, 'Team Birth', which also marked the start of a more 'officialised' and 'urbanised' option for planned homebirth in Capão. It was an independent team that privately attends planned homebirths and offers prenatal consultations, access to a weekly pregnancy circle and a few specific services during pregnancy and postpartum – such as making a plaster belly and placenta medicine. Initially, Áureo was not an official part of the team, he was only called in case of more serious complications, when the team considered someone more experienced should be present. In 2015, he joined the team in an official capacity because Maristela, the obstetrician who founded the team together with Natália, had left. Mariane, another obstetric nurse who is originally from Salvador entered and participated for two years, besides Livia, a psychologist and doula, and Lisandra, a holistic midwife from the South, who were active in *Equipe Parir* at the time of the research. Lisandra has been living in Capão for around 10 years and had already initiated her personal and spiritual studies related to childbirth. Talking to and learning with many different midwives, she has independently been attending women with a variety of holistic consultations, including closing ceremonies (a Mexican practice in which the mothers' body is first massaged, then literally closed with '*rebozos'* -big woven cloths- and finally a kind of ritual sauna in which the intention is to 'liberate' emotions that are still 'stuck'

Figure 16: moment during a massage that was part of a 'closing ceremony'. In the middle, birth attendant Lisandra

after birth and process the 'death' of the woman she used to be) and a kind of prenatal consultation in which she connects with and transmits messages she receives from the baby.

Some women, some born in Capão, others from other places in Brazil and the world, do not have the financial capacity to pay the *Equipe Parir*. At the time of my research, giving birth with the team would cost R$ 4400,- (US$ 824,-). For the majority of the native women and for some women *de fora*, this was an inaccessible amount of money. Natália told me that for native women they would offer a price of R$ 1000,- (US$187), however, there were times in which she would also assist them for free and would make other negotiations, also with the women *de fora*. The women who did not want to contract *Equipe Parir*, or who thought they did not have access to giving birth at home with the team, had a number of options. Those who do not wish to give birth at home generally went to the closest maternity hospital in Seabra or Iraquara. They made this trip either during labour or else arranged temporary accommodation in the city close before labour.

Figure 17: Nara at her sewing table

Nowadays, the only active native birth assistant is Nara, Dona Maria do Bomba's granddaughter. She learned how to assist births accompanying her grandmother from when she was nine years old and is recognized for the fact that she comes from a lineage of birth assistants. She notes that she does not assist more than around ten births a year, some of them

being with natives who prefer to birth with a native birth assistant, and some of them being '*de fora'*, mainly without money to hire the birth team. Her main income comes from her work as a seamstress, recycling clothes people donate to her and transforming them into new ones. Sometimes she receives some money for the births, not more than R$ 300 (US$ 56,-); often she receives nothing. She has also assisted births together with Áureo and sometimes together with Natália, when the woman asks, when she receives a share of the team's payment.

As I mentioned above, there are also a few women, such as Lisandra and Federica, who have not had any 'official' medical training nor learned the 'craft' from women in their families, but who have accumulated experience through courses, interactions with other midwives from all over the country, and attending births. These self-taught birth attendants also assist births in Capão and in 2018 Lisandra was participating as an official member of the team. In addition, Sarah, a German woman who trained as a medical midwife in her home country occasionally assists births. Finally, some women have had unassisted births, sometimes intentionally, sometimes accidentally.[80]

After participating in the team for two years Áureo noticed that it was too much and too intensive work for him. He no longer wished to work full time in the health post and attend births at the same time. He left the team in 2015, however at the time of research he remained available and on call in cases of complications or emergencies. At the end of 2018, the *Equipe Parir* decided to quit due to internal differences and with the intention to diversify and 'open up space' for more doulas and birth assistants to become visible and start working. This resulted in the foundation of '*Coletivo Roseira Branca*' in 2019, which organizes weekly circles at the health post and is open for anyone interested in birth, whether pregnant or not. In January 2020 Natália, who continued to assist births independently and work as a nurse at the health post, created her own format of assisting births, called '*Espaço Barriguda'*.

It is with these developments in mind that we should understand the particular ways in which people perceive and 'practice' childbirth in Capão.

[80] Births without the presence of either medically trained or 'traditional' birth attendants.

3.5 Statistics

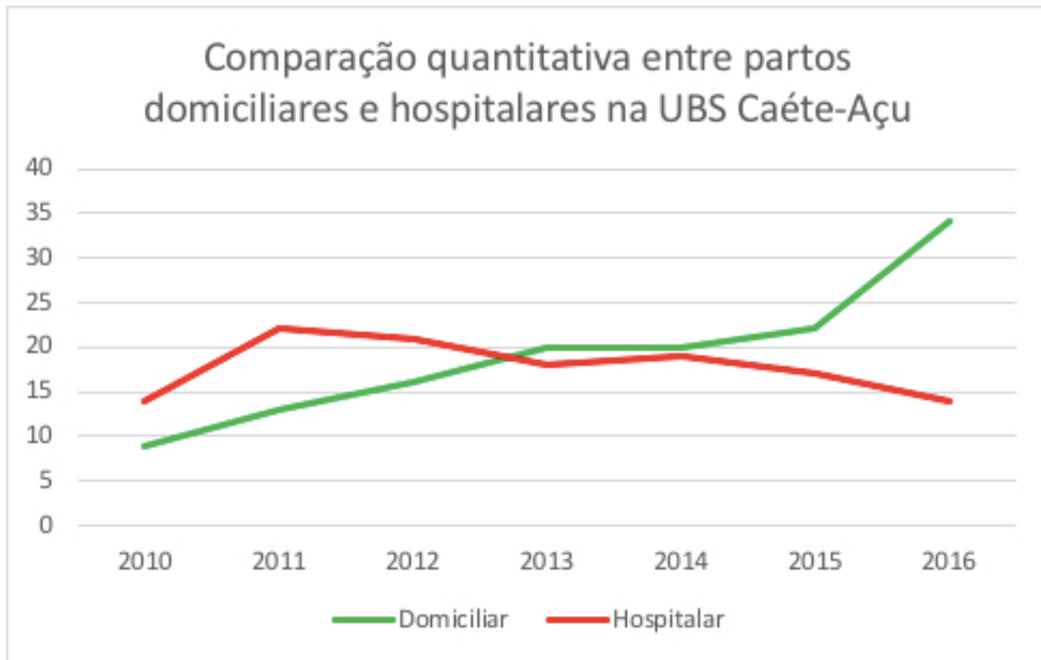

Figure 18: Comparison between homebirths and hospital births attended by the health post (source: Livro do Pré-Natal da UBS Caeté Açu

In 2017, interns from UFBA's Medical School conducted a brief quantitative study about birth care in Capão for the period 2010 – 2017 (DELGADO, SANTOS, BARBOSA & CAIRES). They based the study on the data gathered by *Equipe Parir* since its foundation in 2010. Analysing the birth registers of the health post, the authors note that in this period the number of hospital births decreased and homebirths increased (see Figure 18); and that the number of pre-natal consultations per pregnancy also increased. They relate these changes, among other factors, to the increase in the numbers of foreigners and Brazilians from other regions who go to Capão to give birth. In 2016, for example, homebirths represented 54.8% (n=34) of the births registered by the health post. In total, from the start in 2010 until 2016, the *Equipe Parir* team attended 109 births. 81% of these were homebirths and 19% occurred in the hospital either in Iraquara, Seabra, Irecê or Salvador. Half of the women who gave birth in the hospital had a caesarean, the other half a vaginal birth. Delgado et al. note that '*devido à distância do Vale do Capão aos centros hospitalares e à dificuldade de transporte adequado, o Grupo PARIR atua com bastante rigor quanto à necessidade de encaminhamento para hospital*[81]. They do not explain what they mean with '*bastante rigor'*, but I as Natália and Áureo told me, they engage in very close observation (more than during usual in 'urban' homebirths) of any variations of

[81] 'Due to the distance between Vale do Capão and hospital centres and the difficulty with appropriate transport, the *Grupo PARIR* acts quite rigorously in relation to the need for transferral to the hospital.'

normality during the progression of labor and have recourse to relatively early referral to the maternity hospital in cases they feel unable to attend. Delgado et al. (2017:16) conclude that:

> *'Diante dessas considerações, é possível elucidar uma relação entre o aumento na procura de pré-natais na UBS de Caeté-Açu com a atenção e cuidado que é prestada para com o parto humanizado, tarefa que foi potencializada pelo Grupo PARIR. A UBS Caeté-Açu se tornou uma referência para o SUS na realização de parto humanizado e domiciliar em zona rural, onde se evidencia uma redução gradual dos partos hospitalares e uma considerável elevação nos partos domiciliares.[82]'*

Following my analysis of the birth register of 2017 (combination of the 'big birth book' that is stored in the health post and an excel document), 55 children were born to residents of Capão that year. Of these, 30 (54.5%) of them were born at home with the Equipe Parir; two were born at home without the presence of birth assistance; 19 children were born in hospitals of the region and one in a hospital in Salvador. 12 of the hospital births were caesarean deliveries; and there was no information available for four of the 55 children. Compared to 2016, the homebirth rate (58.2%) increased indeed.

3.6 Being pregnant & giving birth in Capão in 2018

Every Wednesday, the birth assistants at the health post (both Áureo and Natália) offer prenatal consultations. Generally, these involve regular clinical examinations -a quick physical examination in which they feel the position of the foetus and listen to its heartbeat. Sometimes blood tests and ultrasounds are requested, for which women either have to go to Palmeiras to get a stamp from the Health Secretary that authorises the procedures through the SUS, or go to private clinics in Seabra (1,5 hour drive). When the results are sent back, the women return so the birth attendants may analyse them.

[82] 'In light of these considerations, it is possible to elucidate a relationship between the increase in the search for prenatal consultations at the health post of and the attention and care that is provided related to humanized birth, which has been potentialized by the *Grupo PARIR*.'

Figure 19: Prenatal consultation, with the presence of the father and 2 interns

The attendants also ask questions about vaginal fluids, contractions, other bodily sensations. There is often a very informal and relaxed atmosphere in which the people present in the consultation talk about their relationships, their children, preparations for the birth, and other daily issues. One possible way of seeing this is as an atmosphere of 'intimacy', which is both a result of and facilitator of affectionate 'semantic exchanges' (SOUZA, 2005:88) including mutually established and reinforced suppositions about homebirth and the preparations for it.

This intersubjective space of semantic exchanges is an important moment in which a variety of words and acts of trust emerge. As an example, during one of the consultations I observed, Natália said that she recommends that pregnant women´s diets be as natural and organic as possible. She mentioned she and her colleagues do not usually prescribe folic acid and iron sulphate, but instead recommend daily juice of kale, lemon and molasses. In response, the pregnant woman said:

> '*ah, que bom ouvir essas coisas. Eu já tava tomando suco de couve mesmo, só que com rapadura porque não aguento o gosto do melaço. Os outros médicos que já fui me indicaram um monte de medicações químicas e quando questionava e dizia que preferi tomar algo natural sempre olhavam estranho*.[83]'

[83] 'Oh, it's so good to hear these things I was already drinking kale juice, only with cane sugar instead of molasses because I can't handle the taste. The other doctors I saw recommended I'd take loads of chemical medications and when I questioned that and said I preferred to take something natural they'd look at me in a strange way.'

Figure 20: Waiting Room of the health post

Another example of the preparations for homebirth emerged when the obstetric nurse asked the couple she was attending if everything was ready for birth. The couple knew exactly what she was talking about and responded: '*sim, já cortamos a lenha para a fogueira; a bomba para a piscina tá pronta; compramos fogos*[84]*; tem um monte de comidinhas gostosas e acho que tem velas para iluminar a casa durante 5 dias*!'[85]. In the following two chapters, I will provide more details and an in-depth analysis of such interactions.

Every Tuesday night, the *Equipe Parir* organized a *roda* (circle), in which pregnant women and couples, the midwives and doulas and other interested people discuss themes related to birth; watch movies about birth and tell and listen to each other's birth stories. As will become clear in the Chapter 5, this is a has proven to be a moment in which a variety of suppositions about homebirth and its preparations are exchanged and reinforced and a key space space for creating trust and redefining dominant knowledge about birth.

The only qualitative study on childbirth in Capão was carried out by the current *parteira*/obstetric nurse (ANDRADE SOUZA, 2011). She conducted semi-structured interviews with six women who had a 'planned' and 'humanized' homebirth in Capão, from

[84] It's a tradition in Capão to explode fireworks after a baby is born at home.
[85] 'Yes, we already cut the wood for the campfire; the pump for the pool is ready; we bought fireworks; they are a lot of nice things to eat and I think we have candles enough to illuminate the house during 5 days!'

Figure 21: Setting of the weekly roda do PARIR

which she concluded that '*além da força e autoconfiança para optarem pelo parto domiciliar, deixando de lado o que a elas foi oferecido pelo sistema de saúde, as depoentes tinham muita informação*[86].' She notes that all women she interviewed already knew they wanted to give birth at home when they got pregnant, and that being in Capão during pregnancy encouraged and empowered them even more to read about it and get '*autoconfiança'* (self-confidence). One of them even said that they travelled to Capão especially because of its 'rare homebirth culture'. Another theme, quite recurrent in general discourses about homebirth, is autonomy, or as Andrade Souza says: *'[as mulheres] serem sujeitos ativos do processo parturitivo*[87]*'*. She also argues that the hospital is conceived of as a place in which such autonomy is 'stolen' and where one cannot trust the people around you, which is perceived as indispensable to go through the 'transformative processes of birth' (IBID.).

Her observations lead me to a discussion of choice and agency, here understood as embedded in social, cultural, political, economic and gendered power relations. Today, many social scientists agree that these concepts, which were long conceived of as acted upon by 'free' and 'unaffected' individuals/agents, are, in reality, 'something that is always interactively

[86] 'Besides the strength and self-confidence to choose for a homebirth, not considering what was offered to them by the health care system, the participants had a lot of information.'
[87] '[The women] being active subjects of the birthing process'

negotiated' (ORTNER, 2006:151). McCallum (2005:234) provided the insight that the overwhelming amount of caesareans performed on women in Salvador are not simply to 'blame' to a 'culture' of caesareans in which either women or doctors convince themselves and each other that surgery is the best 'choice'; they are complex results of the fact that 'hegemonic culture is negotiated and imposed at a quotidian level, not pre-existing as an abstract *conscience collective'*. It is in this light that 'choices', therefore, might be 'mere' expressions of compliance. As Célia, one of the pregnant women *de fora*, who had experienced a very traumatic caesarean before, told me during her interview: '*a escolha de parir em casa não veio de um lugar romântico, não. Veio de trauma mesmo.*' Even though for some a variety of options might sound as a privilege, Van Hollen points to the 'contextualized nature of choices'. Her observation is especially valid for Capão:

> 'There is a tendency to glamorize the proliferation of "choices" in the modern world, and thus some think that those communities where multiple "traditional" medical practices exist side by side with "modern" practices are inherently more fortunate than communities with fewer options. In reality, however, we must always consider what is gained by such "choice" and how these choices are structured by such things as political-economic inequalities.' (Van Hollen, 2003:209)

During this research, besides looking at the trusting motives that drive women to opt for a certain way of birthing, I investigated if and what kind of socio-economic inequalities shape their decisions. As I mentioned, for many different reasons, not all options are possible for all women[88].

Finally, during previous conversations and more recent interviews, I noticed that many spiritual references are made to nature, the female body and reproduction. '*Gestar uma vida é algo sagrado'*, '*a natureza é sábia'*, '*fazemos todos parte da Mãe Terra'* and '*eu acredito na perfeição divina'* are some of the phrases that are not uncommon in conversations about pregnancy and birth. However, such references have been practically absent in discourses of *nativas* about birth; it is mainly *neo-rurais* who engage in such a spiritual perspective. In Chapter 5 I will analyze these discourses more profoundly and question in which ways they contribute to trust-building.

In this Chapter, I have highlighted the main historical and social developments Capão has experienced over the past 40 years. Alongside these developments, the ways in which its residents were born changed aswell, and I have argued that due to the populational

[88] For another anthropological analysis on the commodification of 'traditional' birth practices and its 'unwanted' outcomes, see Vega (2016).

characteristics of Capão, they have developed in very unique ways. A number of ‘vital conjunctures’ (VAN DER SIJPT, 2011) have taken place, which have fertilised the soil for the birth care as we know it today: a highly eclectic, fruitfully accommodated and stratified set of notions and practices that continuously emerge and transform under the forces of daily social interaction and the search for trust.

As such, this chapter lays the foundation for the following chapter, which explores this set of notions and practices in further detail from the perspective of the birth attendants I interacted with in Capão. I track their trajectories towards assisting homebirths in Capão and analyse how they have come to trust not only the practice of homebirth itself, but their own capabilities in being an assistant in homebirths. By doing so, I intend to provide a wide assemblage of the notions and acts of trust employed by the birth attendants and highlight the ways in which these notions and acts have contributed to ‘emergent epistemologies’ that have continuously challenged authoritative knowledge about childbirth.

4. BIRTH ATTENDANTS' JOURNEYS TOWARDS TRUST

The story this chapter tells concerns how birth attendants in Capão learned to trust their own capacity to attend homebirths, how trust can be understood as a social interaction and shows how in practice this many-sided trusting actually happens. In the light of an analysis of the ethnography of birthing in Capao, and of a critical discussion of key concepts and debates in the anthropology of childbirth, it asks what kinds of paths they followed. It will become clear that they have all become part of each other's processes towards trust. This includes an understanding of how they learned to stand back from their own authority as a person conducting a childbirth so as to open space for the women who are birthing to come to trust themselves. With respect to these trajectories, it considers the question: What does trust mean to the birth attendants in Capão, and how do they see it?

As we have seen, Capão's birth attendants have radically different backgrounds. There are established health professionals, who followed an institutional and clinical path and learned through experience. On this path, they acquired a set of biomedical skills which, many times, they had to distance themselves from. This - in the Brazilian context - quite radical posture towards what they have learned has proven to be a mixture of chance (e.g. intentional/unintentional exposure to natural birth -movements) and, once they identified with approaches to birth so different from what they were taught, their individual active search for 'alternative' authoritative knowledge about birth care. The birth attendants who did not follow such an institutional path walked other very diverse roads towards becoming birth attendants. Here, I will present how these different paths have highly influenced their ways of building trust in relation to birth itself and in their own capacity to attend homebirths.

Initially, I started off organizing my analysis in a sociological frame where I decided to look at the health professionals in their separate categories. However, due to their highly heterogeneous journeys towards attending birth, I realized I would represent them in a very limiting and generalizing way had I 'labeled' them into categories of 'biomedical' versus 'alternative/traditional' birth attendants. I decided to focus not on what separates them (different beginnings and contexts), but what unites them: their parallel trajectories towards learning to trust their own capacity as homebirth attendants and the themes that emerged during my observations and when talking with them about trust. In this chapter I analyze in some depth how they grew into their 'calling' and how, nowadays, they engage in acts and adopt notions of trust that help them to maintain and develop it.

The high degree of mutual accommodation I perceived among the birth attendants is another reason not to make distinctions based on pre-designated sociological categories. The birth attendants have all become part of each other's processes towards trust. This includes an understanding of how they learned to stand back from their own authority as a person conducting a childbirth to opening space for the women who are birthing to come to trust themselves and "allow nature to take its course" (the subject of the next chapter). On the other hand, some specific biomedical practices have also been exchanged among the birth attendants and have created a common sense about when one 'really' should or should not intervene during birth (e.g. maneuvers for shoulder dystocia, or pulling the umbilical cord to get the placenta out, among others).

As I mentioned, this dissertation is based on analysis of semi-structured interviews and the participant observation I engaged in around these interviews. This chapter and the following are the result of a contextualized analysis of these interviews in order to understand trust as a social interaction and show how in practice this many-sided trusting actually happens. Here, a few scholars will be especially helpful to understand these notions and acts. In her investigation of the process in which women in the United States decide about homebirth, Cheyney (2008) observed two 'techniques' employed by these women: unlearning and relearning a new authoritative knowledge (see introduction). Similar techniques were present in the discourses of the women I interviewed in the urban setting of Salvador; I found they formed a strong basis for trust-building processes. However, they played out quite differently in the birthing scene in Capão. Compared to Salvador, homebirth in Capão is much less of a 'counterhegemonic' practice. Therefore, we will see that many of the women (and birth attendants) who gave birth at home in Capão had either previously relearned a new authoritative knowledge which allowed them to naturalize and legitimize homebirth or had always conceived of homebirth as the 'authoritative way' of giving birth. The latter was the case especially for the native women and birth attendants. In this chapter and the next it will become clear how these techniques were employed by many women and birth attendants as well. I have structured this chapter according to analytical categories grounded in birth attendants' concepts and practices, as these have developed and sedimented over time, in social interactions with a variety of distinct kinds of people, including the other birth attendants, and of course in innumerable experiences of women's pregnancies, gestations, births and postpartum processes.

4.1 Experience & normality

For all of the birth attendants, practical experience either observing or assisting births arose as a very important generator of trust. The medically trained attendants both mentioned how witnessing births, initially during their training, but also in the present, strongly influences their trust in themselves and 'security' (*segurança*) in assisting births. Not only in their own capability and knowledge, but also in what may be called *o processo* (the process). Seemingly paradoxically, Natália told me that the more births she assists, the more she notices how every birth is unique and how little control she has over its 'processes'. However, it is exactly her experience that increases with every birth she assists that provides her with the trust that she is experienced enough to deal with such lack of control and that she has a growing 'repertoire' of techniques and knowledge that will help her out in whatever 'process' arises.

Áureo observes that after his initial enchantment with birth (discussed below) he acquired a lot of experience, during his studies as well as afterwards:

> *"Eu joguei duro, duro, duro. Eu fiquei louco. Eu dava plantão em Tsylla Balbino, que eram 70 partos por dia, dos quais eu fazia até no mínimo 20. Depois eu ia pra maternidade de Alagoinhas e fazia, eu mesmo fazia 15 partos por dia, era uma loucura. Eu fazia tanto plantão de obstetrícia que nas aulas das faculdades de medicina, eu dormia nas aulas. O pessoal já brincava comigo, eu enlouqueci, realmente eu fiquei doido. E amei fazer aquilo."*

This amount of experience led him to have such trust in himself through the amount of experience -and knowledge- he acquired, that even before he graduated, he assisted some professors in obstetrics teaching the new students of the Faculty of Medicine.

For both Aurea and Nara, the experience of assisting a birth was actually their first contact with birth, as they simply helped out their grandmother or were the only woman available when a woman got into labor. Nara tells me about her grandmother Dona Maria do Bomba, and how often the lack of presence of a midwife and the necessity of any woman who was there at the moment would make a woman go down the path of midwifery:

> *"Então muitas vezes acontecia é... a pessoa ficar parteira por que viu, né? A mulher tava ali, já, daqui a pouco ia dar à luz, ali a pessoa mesmo fazia. Minha avó começou assim."*

Thanks to the fact that she was socialized in the normalization of homebirth, Nara recalls the first time she witnessed a homebirth: "*Pra mim parecia que era uma coisa que já tinha vista há muito tempo. Normal… […] Não me assustei nada*." Her grandmother taught her some

'essentials' while she experienced births together, and eventually she had to 'take over' because her grandmother's back did not allow her to realize certain procedures:

> *"É... pra amarrar o cordão usava... normalmente, como ela me ensinou depois, um barbante, alguma corda que fosse forte, esterilizava e usava. No começo pedia, depois não, por que depois eu já sabia o que tinha que fazer e o que não. Mas assim, depois que eu comecei a fazer mesmo ela ia, mas ela não fazia por causa da coluna dela, a posição pra coluna ela já não deixava fazer."*

Dona Aurea, the oldest midwife alive in Capão, had a similar experience to Dona Maria do Bomba. At the time she attended her first birth, she was 'already 30 to 35 years'. Dona Antoninha, Nara's great grandmother, was the main midwife in the valley.

> *'O primeiro parto que eu fiz foi de minha sobrinha... ela incomodou e eu fui atrás da parteira e a parteira não veio. Antoninha tava doente e não pode vir, aí foi o jeito eu ir e aí eu peguei.'*

In the cases of Dona Aurea, Nara and Dona Maria do Bomba their almost 'forced' experiences and the embodied knowledge generated through those, attending births ended up resulting in what I would call a kind of 'embodied self-trust'. Neither Nara nor Dona Aurea ever made any mention of being 'forced' into the profession; both mention it being a 'calling', a notion often spoken of by midwives (DAVIS-FLOYD, 2001; CHEYNEY, 2008). 'Embodied self-trust' in this context is therefore very much related to the fact that both midwives did not intentionally start attending births, but through the embodiment of orally passed knowledge and a variety of acts and notions of trust, trust enough to do so. Such embodied trust has resemblances with what Áureo observed with native women as '*confiança contingencial'*, or 'contingent trust'. This 'contingent trust' could be understood as trust that is a consequence of the normalization of homebirth in daily life and women's lives in general. It is a kind of trust that emerges almost implicitly through the fact that many women -especially the generation of Dona Aurea and Nara's grandmother and Nara herself to a certain extent- grow up witnessing or experiencing homebirth because of its normality and frequency. Further on in this chapter we will analyze the notion of contingent/embodied trust more in-depth in relation to the pregnant women.

4.2 Studies

Especially for the biomedically trained birth attendants and some (only few, very different from the women I interviewed in Salvador) of the homebirthing women, acquiring (scientifically and other orally transmitted) knowledge about birth in general and homebirth specifically, has been an important key in the trust-building process for birth assistants. Being able to theoretically

understand the physiological and pathological processes involved in birth and the options one has to deal with each of these processes 'empowered' them to trust these processes and their ability to assist them. In Chapter 5 I will go into how such knowledge acquisition occurred for some of the pregnant women and their partners in Capão. It was mainly for them that the techniques Cheyney described as 'learning' and 'unlearning' of authoritative (alternative) knowledge about homebirth/childbirth in general appeared relevant.

Even though their obstetric training provided them with the theoretical knowledge and official license to assist births, neither Áureo nor Natália refer to their (Medical School) studies as a crucial factor to the building of trust in (home)birth. In this specific context of homebirth (which is often intended to be as much of a 'low-tech' and 'hands-off' birth as possible and in which individualized care is generally considered very important), practical experience seems to overrule theory in the trust-building process. Cheyney (2011:18) observed a similar notion in her research about homebirth in the US: "*Several of the older midwives who participated in this study emphasize the extent to which "birth itself teaches you" and how, over time, experience alters views and approaches to care*". This reminded me of my undergraduate research, in which a well-known homebirth-obstetrician from Salvador told me that in Medical School, even though she and fellow students learned about it, physiology was not taught as 'the normal'. Often times, the focus was (is) on pathology and intervention. She also mentioned that during medical residence it was hard for any student to actually observe an 'undisturbed' birth, or see a woman birth without any intervention:

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

Individual studies after Medical School however, and more specifically directed towards a 'humanized' and homebirth assistance, were more significant to the biomedically trained birth attendants. Not only because they enabled them to widen their range of knowledge, specialize in attending homebirths and built trust to assist homebirths, but also because they made them feel connected and *belonging* to an (inter)national community with similar approaches to birth. For example, Áureo remembers: "*Depois eu li o livro de Frederick Le*

Boyer. Quando eu li aquele livro a obstetrícia adquiriu uma outra configuração pra mim. Me encantou, e vi que não era o único que pensava assim." He identified with Le Boyer, a French obstetrician who became well known in the international and Brazilian homebirth community because of how he described birth through the perspective of the baby, with the intention to sensitize birth attendants towards a more humanized and empathic approach to birth care. In the section on 'political and collective mission' I will explore this sense of belonging more in-depth.

4.3 Fruitful accommodation through orally transmitted knowledge

Nara tells me that, besides respecting and also learning from the local birth attendants in Capão, Áureo also taught things he learned during his training that did not coincide with local practices. Locally, the transmission of knowledge was mainly based on experience, on 'a gift' and on oral transmission. She explains:

> *"Talvez seja pela pouca experiência do pessoal de antigamente, entendeu? Que já vinha, era uma coisa que já vinha de outras pessoas mais velhas que elas, entendeu? Tipo assim, alguém que era parteira primeiro que a minha bisa, aí falava que não podia e aí minha bisa já passava pra minha vó que não podia. É uma coisa que já vem delas mesmo, por que elas eram parteira não é por que elas estudaram pra ser. É por que era uma coisa que elas tinha que ser, um dom talvez... né? ou... não sei, não foi uma coisa que elas estudaram pra ser. Tipo Áureo, que estudou. Só que aí com o Áureo eu aprendi que não, foi tudo diferente."*

Áureo continues his account describing how he shared parts of his medical training with the local midwives:

> *"É... bom, a coisa de... de... não tocar no cordão umbilical depois que a criança nasce. Que eu tive dois casos aqui de ruptura de cordão. Por que puxaram o cordão pra soltar o... e aí isso foi uma coisa que eu reiterei muito "Nunca puxe o cordão. Nunca puxe cordão". Isso eu fui bem incisivo, e depois isso nunca mais aconteceu. Como aconteceram dois eu pude dar exemplo, né? Disse "Olha, rompeu por que puxou". Também não puxar... deixar que a placenta saia por si. Não puxar pra poder tirar as membranas, deixar que as membranas vão..."*

However, he, Natália and especially Lisandra also 'studied' with local midwives and ended up utilizing a lot of their practices, including the use of a variety of herbs and birthing positions. Similarly, Áureo also remembers 'comparing' himself to 'traditional' midwives, who have always attended homebirths, and asking himself why he wouldn't do the same:

> *"Eu ia pros partos e a gente ficava conversando. E elas me diziam as coisas que elas faziam e eu gostava muito disso, entendeu? E eu aprendi aquelas coisas e aplico até hoje. Coisas que elas me ensinaram, entende?"*

Fabiana, who was one of the first 'neo-rurals' to give birth in Capão (first daughter, 29 years ago, a caesarean, second daughter, 27 years ago, homebirth), also recalls these dynamics 30 years ago:

> *"E era muito lindo também porque Áureo as vezes acompanhava junto com as parteiras. Ele não tirava o lugar delas entendeu? Foi uma coisa bem linda também. Ela ia e trabalhava junto com ela e ele trouxe muito uma coisa que as parteiras não tinha, que vem da formação acadêmica, da cidade, que era a questão da higiene né? Fazer essa mudança das coisas que eram tradicionais, fazer essa mudança. Então por exemplo tinha um negócio de botar borra de café no cordão umbilical. Teia de aranha, né, rsrs. E antigamente na época que eu tava aqui, já não rolava mais isso assim. Mas ainda tinha esse fantasma da 'criança morrer de umbigo', que era tetano. Então veio trazendo todo esse conhecimento da esterilização. [...] E, outra coisa também muito linda, foi que ele assimilou todo o conhecimento das parteiras, ele assimilou todos aqueles que eram compatíveis com o que ele conhecia da medicina. Então por exemplo, a gente fazia parto com Áureo mas a gente continuava bebendo e se lavando com chá de algodão. Até hoje.. Então ele não chegou tirando o que já era, colocando uma coisa diferente, ele chegou somando e melhorando."*

From the interviews, it became clear that for both the local and the medically trained birth attendants, the acquisition of new knowledge *experienced* as helpful has been very important not only for their individual trust-building processes in themselves, but also for consolidating mutual trust among the birth attendants. I also observed such knowledge exchange and accommodation during the prenatal consultations and pregnancy circles; often a woman would mention that she had used an herb, a way of breathing or other 'techniques' of pain relief, calming, and nurturing their bodies which, most of the times the birth attendants received with: 'that sounds great, I will try it too!'.

These mutual processes of knowledge acquisition and trust-building can be seen as examples of what Jordan (1993 [1978]:135, 139) has called 'fruitful accommodation' in her research on Maya obstetrics: '*to include not only an analysis of Maya practices according to the criteria of medical obstetrics, but also an analysis of medical obstetric practices according to the criteria of the indigenous system*. […] *The adoption of such recommendations would require that the "upgrading" training of traditional midwives in the direction of modern obstetrics be complemented by training of medical personnel in traditional skills and practices, thus upgrading them in the direction of the indigenous system.'*

As we have seen and will see later in this chapter, it is important to engage in a critical analysis of possible unwanted outcomes of such fruitful accommodation. In a context such as

Capão in which ‘traditional’ birth attendants and formally trained birth attendants meet in life and in work, it is important to highlight not only the importance the native birth attendants have always had and still have, but also note the risk of presenting and controlling prejudiced images of them without them having the possibility to offer a counterpoint from their point of view and maintain a critical stance towards ethnocentric practices of ‘educating’these birth attendants. It is therefore important to reaffirm that the data presented here, especially the views presented by Aureo, are representations as I observed them in the field and do not represent my own views and do not carry a moral judgement. In this research I have not had the chance to problematize this more in-depth, however in the section on ‘financial involvement’ in the next chapter, for example, it does become clear that the commodification of birth care in Capão has resulted in inequal access to resources.

4.4 Personal enchantment, calling

Some of the birth attendants built trust in relation to homebirth through the meaning they gave to their experiences of (home)birth and the ‘passion’ or ‘enchantment’ this generated. Natália recalls:

> *“Pra mim assim, trabalhar em parto, antes de vir aqui no vale do capão, era uma opção. Mas não era ainda, minha paixão era saúde da família. Mas eu optei por fazer a especialização em obstetrícia. Mas quando cheguei aqui vi outra forma de nascer e de parir, aí a única coisa que explica trabalhar é a paixão. Porque é uma jornada de trabalho bem desgastante. A questão do parto e nascimento demanda muito do profissional porque é algo muito intenso para aquelas pessoas que estão vivendo ali, então é único e especial e incrível para cada família que tá vivendo aquele processo. Na minha opinião é só se apaixonando mesmo.”*

Áureo had a similar experience:

> *“Quando eu assisti o primeiro parto foi uma emoção, uma coisa assim, parecia que era eu que tava parindo, foi uma coisa muito incrível, muito. Eu fiquei completamente tomado pela aquela experiência. [...] É uma coisa inexplicável, é uma coisa que foi de coração mesmo. Não sei o que aconteceu comigo, só sei que até hoje eu sou assim, quando eu vejo uma criança nascer eu fico “uau”. E olha que quando eu fiz o parto dois mil eu parei de contar, e isso já tem muitos anos, muitos anos, muitos anos.”*

Aruana, the technical nurse born in Capão also remembers the first time she witnessed a birth at home in Capão:

"Eu lembro... quando eu assisti, que foi um parto lindo. Lindo, lindo. Eu lembro quando ela começou a sair, que eu vi o rostinho assim começando a sair, toda amassadinha assim, bonitinha e tava toda cheia de vernix, que eu falei "meu deus, perfeito!" e quase não teve... foi aquele parto meio limpo assim, sabe, que não teve muito sangue, muita coisa, e ela saiu limpinha, perfeita, eu falei "gente! Demais!", que eu nunca tinha visto, né, saindo assim. Aí eu falei "não, é muito lindo, demais", acho que é isso... E a mãe também, depois que nasce, a mãe pega e aí tem aquela coisa, olha assim um pro outro "ai, filho" (risos)... e toda a família envolvida, é muito lindo."

Besides motivating them to continue attending homebirths in spite of the difficulties the work imposes, the passion and enchantment they describe in relation to homebirth allowed the birth attendants to trust their feeling of realizing their 'mission'; as if every birth they witness (and the feeling of enchantment and passion it provokes) is a confirmation and reinforcement of the trust they have that they are doing 'what they are supposed to do'[89].

4.5 Sharing responsibility

One of the main 'battles' of the proponents of the humanization of birth in Brazil is women's autonomy and the deconstruction of medical authority. Even though this can be an uncomfortable place for medical professionals as well as for pregnant women themselves (who, in the middle of a huge amount of information and opinions sometimes do not know what to decide for themselves or prefer that an 'authority' makes the decisions), the shared responsibility that emerges out of this approach has proven to be important in the trust-building process. The notion of 'shared responsibility' in childbirth is particularly explored by Davis-Floyd (2001:13) in her description of the humanistic paradigm of childbirth:

> 'Most health professionals are trained to bring linear information to bear in their decision-making; in addition, the humanistic paradigm allows non-linear, subjective processing to play a significant role. This is the balanced or empathic style of thinking. 'Empathic' refers to the ability of one person to understand another's reality even if that reality is beyond their direct experience. Even when straightforward evidence of disease is present, doctors still have considerable latitude regarding how mutual they are willing to allow decision making to be. […] open discussion of treatment choices leads naturally to an exploration and sharing of values, and doctors are more likely to respond favorably or at least neutrally to a patient's wish to try alternative methods or to employ no treatments at all.'

[89] See Cheyney (2011) for more information on the notion of 'calling' among midwives in the US.

As I mentioned in the section on 'mutual accommodation', it often happened that during consultations, home visits and the pregnancy circle, the birth attendants would step back from their 'authority' and receive the knowledge women would pass them as valid or even more valid than their 'own' or medical knowledge. It was apparent how such interactions where the birth attendant would validate (and trust!) a woman's (body)knowledge and 'level' with her without a sense of (medical) authority proved to be, for both parties, great examples of acts of trust. At times, birth attendants would actually be the ones to stimulate women and themselves to trust women's (body)knowledge more than their 'own', medical knowledge. This happened especially during the birth I witnessed, where both birth attendants would repeatedly ask the woman to 'listen to her body', 'do whatever her body asked her to do', and 'trust her body'. As I will mention later in this section, their ability to trust 'whatever a woman's birthing body asks her to do' is mainly a result of their experience with and knowledge about physiology and, on a more abstract level, nature.

In my previous research women related how they found an approach promoting women's participation in decision-making and shared responsibility challenging, however very empowering and strengthening the relationship with their midwives (SCHUT, 2014). Besides that, midwives told me that the mutual agreement that the woman decides upon her own body and that both she and the midwives are responsible for guiding the pregnancy and birth in an as healthy as possible way 'relieved' them in a certain sense of a quite heavy sense of responsibility they felt. Áureo perceived this approach in a more holistic way, reinforcing that the birth doesn't depend exclusively on his skills or knowledge: "*O que importa é o todo. O entorno interno, assim como o entorno externo. [...] Sabia que as vezes pessoas precisavam aprender determinadas coisas, precisavam passer por certas experiências.*"

This approach to responsibility resembles what Davis-Floyd (2001:18) described in her holistic paradigm of childbirth, in which she argues that authority and responsibility are inherent to the individual:

> 'A basic tenet of holistic healing is that ultimately, individuals must take responsibility for their own health and wellbeing. No one can really heal anyone else; individuals must decide for themselves if they want to be healed, and if so, they must take action to achieve that goal give up smoking, exercise, eat right, maybe even give up a lucrative job that makes them unhappy or a relationship that is harmful to their health. Holistic practitioners in general tend to see themselves as part of a healing team, of which the patient is a full-fledged, indeed the most significant member.'

This shared responsibility contributed to mutual trust-building, which here appears as a highly interactional process, resulting from that fact that the birth attendants in Capão continuously transit between different approaches (or 'paradigms') to birth care.

4.6 Modified assistance

Another way of trust-building for Capão's medically trained birth attendants has been modifying the way in which they assist homebirths. In the case of Capão this means more intense monitoring, anticipating ('even more than in normal homebirths') possible complications and pathologies, which made them trust despite the fact that a transferal to the hospital is complicated and time-consuming. Áureo recalls the time when he still attended homebirths alone:

> *"eu dizia que tinha que ter um carro disponível pra levar. E também eu dizia "Ó, mesmo que o parto vá ser normal, mas que eu suspeite de alguma possibilidade da criança ter um problema, eu vou mandar". Sempre, sempre eu fiz isso. Então... Agora, claro que eu tinha que tá mais atento do que outras pessoas. Então num parto hospitalar o médico pode ficar mais tranquilo, no parto em casa eu ficava ligadão! Eu auscultava muito mais do que quando eu tava no hospital, por que qualquer sinal eu já queria..."*

Knowing that they are being extra cautious and anticipating much more when it comes to possible complications (compared to homebirths in urban areas and even more so compared to hospital births), helped the birth attendants to build trust in the safety of the care they provide.

4.7 Capão as source of trust

As I mentioned in the introduction, I have noticed that, when asking around about pregnancy and birth in Capão specifically, many people –especially *de fora*- emphasize a few particular characteristics: the 'fertility' of the place (in the sense that many women get pregnant and also go there specially to give birth), its 'strong connection with nature', and a certain generalized effort of living in harmony with nature. This kind of mysticism in relation to birth was also expressed by Áureo and Aruana. Áureo, however, did have a critical note about it:

> *"Então... o Capão realmente tem algo, entendeu? Mas eu devo dizer pra você algo sobre essa questão de misticismo, e tal, que também muitas pessoas têm essa coisa mística, né? De que aqui tem uma proteção. Eu sinto que tem. Mas a proteção mística só é válida na medida que tenha uma estrutura de conhecimento que contribua."*

He is not the only person to criticize some people's attitude towards homebirth in Capão (from within Capão; people from urban areas are eager to criticize its birth care). Interestingly, we could interpret such criticism to be directed to an overload of trust in relation to birth. When we turn to the pregnant women and their notions and acts of trust I will explore this more in depth.

Aruana, who was born in Capão, agrees there is 'something magical' about Capão:

> *"Eu acredito nisso muito e eu sou louca por esse lugar, eu acho que é um dos lugares mais incríveis e 'mágicos'[..] Eu acho que ele tem essa natureza, essas montanhas, essa coisa mais natural mesmo. Do lugar, né, em si. Da estrutura. Dos rios, essas cachoeiras assim no meio do vale que você vê de qualquer lugar, tipo assim... Eu acho que isso e... e isso. Mais a natureza assim, né? Eu vejo que é um lugar que tem uma potência grande mesmo. Assim, uma energia bem boa... e eu acho que isso acaba atraindo também as pessoas, né? Eu acredito nisso, que as pessoas meio que... o lugar chama as pessoas, também. Apesar de elas escolherem também, mas tem uma sintonia aí. Eu acho que aqui é um lugar bem fértil, né, a gente vê muitos casos de casais que vem pra cá e tal, e quando chega aqui ou descobrem que tão grávidos, ou engravidam aqui. E acabam voltando pra parir aqui também... não sei o que é não, Aischa. Sei que é mágico."*

It seems that the interpersonally sustained idea that Capão is 'magical' and that there is some kind of 'mystic protection' in relation to pregnancy and birth has provided birth assistants as well as pregnant women (see below) with an increased sense of trust in the possibility and safety of homebirth in Capão.

Also, 'we have seen earlier that a society's view of the birth process as natural, personal, medical, and so on powerfully influences the shape of the whole system. It defines the parameters for birth location, admissible personnel, support systems, and the like.' (JORDAN, 1993 [1978]:132). In this light, we could imagine Capão as a microsociety in which the view of the birth process has historically been 'natural and personal' and in which, as we have discussed earlier, highly medicalized notions and practices have not been received and validated as they are in an urban context such as Salvador.

4.8 Political and collective mission

A sense of being not only on a spiritual mission, but on a political one is well known among homebirth and humanized birth care professionals. Sometimes against the dominant obstetric system, sometimes more in defense of women's rights and autonomy, other times in defense of the babies' rights to be born in a respectful and healthy way. Imagining the importance and meaning of their work beyond the mere assistance and tapping into a sense of collective

responsibility and connectedness have been other acts of trust that strengthened the birth in their feeling of belonging and of 'doing the right thing'. Natália, with an excited voice, tells me:

> *"Você enlouquece com aquilo dali, vê que aquilo dali é essencial da vida sabe? Pra mim mesmo, me tornei até uma forma assim, de que eu como cidadã, eu preciso disseminar mais isso entendeu? Já não é mais só o meu gosto, a minha paixão, o meu prazer que tá, é uma coisa assim, não sei se a palavra é político, não sei o que é, mas pelo amor de deus gente? Pelo amor de deeeeus! Não se pode tratar as pessoas dessa forma que se trata, não se pode nascer do jeito que se nasce. É absurdo demais! É uma coisa assim que não tem volta, quando a gente se toca, e a gente vive o que é realmente assim, um parto e um nascimento respeito mesmo e natural, que você vê que aquilo dali faz parte do processo para você cuidar de outro ser, de você crescer, virar uma guerreira, é a única forma."*

Livia, the main doula and psychologist of the *Equipe Parir*, has a similar experience:

> *"Quando você vai tomando dimensão da luta, da importância, que você sabe.. e eu acho que tem uma coisa muito forte também de ah é bom, é bonito, como é prazeroso, como é um processo que pode ser vivido de uma forma muito positiva, de auto conhecimento, contato com o feminino, com a natureza, então assim, essa coisa de vamos viver essa coisa de uma forma mais bonita.. fazer um mundo melhor, partindo daí."*

Such political approaches to birth care are highly related to the notion of 'authoritative knowledge', and especially the challenging/redefinition of it. In her research on homebirth in the United States, Cheyney (2011: 54) has conceived homebirth as 'biomedical critique' and home to 'narratives of resistance', with the potential of changing dominant medical practices. In the next chapter I will get into a theoretical discussion about this.

4.9 Creating intimacy

Even though it is not always conceived as such, intimacy can be seen as an essential aspect in birth. Nudity, blood, sweat, amniotic liquid, moaning, screaming, pain, pleasure, love, fear and so many other things that happen during birth, potentially creating a highly intimate space. Trust has been recognized as a vehicle that can allow women to 'surrender' to such intimate exposure and disclosure (CHEYNEY, 2011:67). In the next Chapter I will look at how women perceived trust and intimacy during pregnancy and birth. First, let us look at what the birth attendants in Capão have mentioned about the importance of and their participation in creating intimacy through trust, and vice-versa.

When I listened to Áureo telling me his story about arriving in Capão, the development of his relation with the inhabitants, it became very clear that intimacy was a factor that had

played a large role in the way they trusted him. He tells me that upon his arrival, the fact that his family came together with him provoked a empathy among the local inhabitants. As we have seen before, slowly he built up his reputation as a loved doctor and even as a kind of social leader among the people:

> *"Eu vim com minha família, minhas filhas, eles ficaram encantados com elas, elas iam na casa de todo mundo. Gerou toda uma coisa muito familiar que até hoje eu sinto aqui no Capão. Com as pessoas mais ... mais assim, velhas, né? Os adultos jovens, e os adultos e os idosos eu sinto uma familiaridade muito grande. Os mais jovens não tanto, embora alguns mantém isso, né? Por que também eles já estão em outra, né... Por que antes era assim, eu era o cara que escrevia as cartas! Eles precisavam de escrever uma carta, eu escrevia, entendeu? Briga de marido e mulher, era eu quem ia resolver. Era tudo, era tudo. Tudo era Áureo. Entende? "Ah, porque a prefeitura me botou pra fora. O que é que eu faço?", "Você vai ter que ir em tal lugar pra fazer a denúncia, por que ela não lhe pagou, e pererê, os direitos...". Tudo.Tudo!"*

He also tells me that the native women who work in the medical post nowadays have been his patients since they were very little, generating a very personal-professional atmosphere. Besides his 'familiar' arrival and integration in the valley, it became clear that Áureo has a personality and way of transmitting his knowledge and care which has enchanted many of the local inhabitants and people '*de fora*'. He has always played around, joked with his patients, made fun of himself and made friends with the people he interacts with:

> *"Ó, a coisa era tão forte que teve um homem aqui no Capão que já morreu, que ele era bem velhinho, um dia ele me encontrou e disse pra mim assim "Ó, tem um homem aí que tá dizendo que é médico, mas ele não e médico não", eu disse "Por quê?", "Por que ele não brinca com a gente!". Como eu sou muito brincalhão ele achava que era parte da medicina ser brincalhão com as pessoas."*

With Natália, he has an internal joke in which they agreed to that, for every time she needs to call him for some kind of complication during a birth, she would pay him a special type of dinner (pasta) he loves. Whenever she calls him and says: "*Doutor querido do meu coração*", he already knows that he is needed.

Lisandra, one of the midwives that at the time of my research was a member of the *Equipe Parir*, identifies differences in the conception of birth which make intimacy a necessary aspect of birth, or not:

> *"Acho que esse atendimento que estão começando muitas mulheres a fugir, nos meios mais urbanos, porque não tem mesmo intimidade, não tem cuidado, não tem olhar, não tem troca. E esse é um momento assim incrível na nossa vida, totalmente especial né, nosso filho chegando e as vezes é tratado com tanta frieza. Acho que mais do que tudo, no ambiente hospitalar, num ambiente mais*

duro assim, as pessoas recebem seus filhos e recebem isso num lugar de muita frieza. De pouco contato, pouco contato com seu filho, e aí fica uma experiência sem vida. Recebendo a vida, mas com um lugar de pouco calor e pouca vida. E acho que antigamente eram as parteiras tradicionais onde as comunidades, assim, todo mundo já conhecia aquela parteira né. Então já tinha uma intimidade, ela era como se fosse uma entidade-mãe assim né, E aí depois foi quase desaparecendo, e agora tem os profissionais da área. Que também tão representando um pouco esse lugar, da pessoa que traz um pouco essa segurança para vc se entregar nessa hora né, e principalmente isso, a coisa do acolhimento. E aí chegou acho que num nível tão extremo assim, de falta de contato, que acho que ninguém mais tá, quer dizer, muitas pessoas ainda estão ali, mas muitas pessoas já tá percebendo que não dá para continuar assim. Por isso que vai crescendo essa outra vertente ne, dos partos humanizados, ou parto em casa. Que é uma tentativa de resgatar essa troca né, esse contato, a vida, para chegar numa intimidade que é o que você mais precisa nesse momento. Essa intimidade com você mesma, com seu filho..”

These accounts are characteristic of what Davis-Floyd (2001) has called the holistic paradigm of childbirth, in which ‘holistic physicians are finding that they need much more engagement with the patient to get at those intangibles of mind and emotion now seen to be as much a part of the illness as its physical manifestation.’

An important time-space where many acts of trust occurred and resulted in trust-building were the prenatal consultations, at the medical post as well as at women’s homes. I will get into this further in the section on ‘trusting the team’ in the next chapter where I observed how intimacy emerged there.

Finally, there is the almost inherent intimacy present in homebirths; birthing at one’s *home*. Gonçalves et al. (2014:245) have noted before that:

> “A casa, ao ser incluída como ambiente propício para a realização de partos de baixo risco, tem grande potencial de desmedicalização e alteração das relações de poder que incidem sobre a vida. Quando se considera a possibilidade de que um parto seja realizado em casa, o saber médico e o hospital/maternidade são deslocados do lugar de centralidade para lugar de retaguarda. A defesa de um PD seguro não dispensa uma rede assistencial médica e hospitalar, mas sua função é ressignificada. [...] A casa como ambiente de parto, mais que um hospital humanizado, desloca de forma intensa o poder que o saber médico passa a ter sobre o tempo de gestação e sobre os procedimentos de intervenção no corpo da mulher.

In this light, whereas women have frequently experienced lack of intimacy and trust in a hospital setting, being in your own home where, theoretically, you are the one ‘in charge’ and, arguably, live some of your most intimate experiences demands a certain level of trust and intimacy from the people who come in.

4.10 Spirituality, intuition, nature

Spirituality, including different kinds of mystic relationships with and understandings of nature are recurrent themes among many of Capão's inhabitants and also among its birth attendants. It is no exception to hear, during one of the birth circles, that we, women, 'are part of nature', that 'we were born to give birth', and that birth 'opens up many spiritual channels'. Besides the notions of trust attributed to Capão specifically as I mentioned above, the birth attendants provided me with insights about other notions and acts related to spirituality, 'intuition' and nature which proved to be important in their trust-building related to homebirth. As for the local birth attendants, the fact that they became midwives and even their skills/knowledge were sometimes attributed to a spiritual connection or God. When I asked her why she thought that she continued assisting births after the first 'coincidental' birth, she responds: "*Não sei, é, é deus que ajuda, né não? Que me deu aquele tino pra pegar... Deu aquele tino pra pegar, a gente pega.*" Similarly, Nara told me that she believes that there was some kind of force involved, possibly from God, that showed her that being a midwife was her 'mission': "*Eu acredito... Eu acho que sim. Por que é como eu te falei, ninguém me mandou fazer, ninguém me forçou, vó não me chamava..*" In midwifery, especially in what could be conceived of as 'holistic models' of midwifery, the sense of being on a 'mission' or having a 'calling' is a recurrent theme (CHEYNEY, 20011:23).

Áureo himself has a strong experience with and trust in nature through the natural treatments he himself has done and has studied and prescribed. His personal experience of cure through natural treatment led to the trust that the body does what it has to do, also in birth:

> *"Repare, as práticas de medicina natural elas tem como fundamento o corpo. A ideia não é que, vamos supor, eu como médico e você, vamos supor, como paciente que eu interfira em seu corpo. A ideia é que eu contribua para que o seu corpo resolva o problema. Essa é a ideia, entende? A naturopatia é um vitalismo, então acredita que existe uma energia de cura dentro das pessoas. O meu papel é limpar o organismo pra que essa energia de cura possa se manifestar e fazer o trabalho dela, entende? Então essa é a proposta, e é isso que a gente trabalha e o... qual é a proposta do parto atual? Nós confiamos que o corpo da mulher vai fazer o que tem que ser feito e o parto confia no corpo."*

Another important aspect of the kind of holistic midwifery which is practiced in Capão, but has been observed in other places (DAVIS-FLOYD & DAVIS, 1996), is intuition. Even in the urban setting of Salvador where I interviewed the midwives that assisted homebirths there, and even an obstetrician friend of mine who works in a high-risk maternity and doesn't like the idea of homebirth at all, have recognized that they sometimes 'feel' that something is happening that

needs their attention or intervention. In Capão, this was not different. Nara tells me of two cases she remembers:

> *"Outro dia mesmo eu tava lá no Bomba, na casa de mãe, tava com minha irmã e meu cunhado e tinha ido pra dormir lá, de sábado pra domingo. Aí a gente dormiu, no domingo de manhã cedo tinha uma vizinha que tava pra ganhar neném, só que aí eu não sabia que ia ser naquele dia, aí eu senti assim, acordei no domingo de manhã cedo e falei assim, senti vontade de voltar, aí falei assim pro meu irmão "Eu vou voltar, eu vou descer", ela falou bem assim "Ó, toma a chave da casa. Então tu desça que a gente vai ficar aqui." Meu coração pedia pra descer. Aí eu desci, eu nunca me esqueço disso, eu tinha uma pop 100, eu desci. Assim que eu cheguei, que eu tava com a chave abrindo a porta a irmã dela veio correndo, e falou que ela tava sentindo contração, que tava, que já ia lá no Bomba me chamar. Então não precisou me chamar, eu senti. E aí... eu só entrei dentro de casa, nem tomei banho, só entrei, lavei as mãos, peguei as coisa e fui. E aí demorou o quê? Umas duas horas a menina nasceu. [...]*
> *Já aconteceu outra vez também. E aí foi ao contrário, foi uma mulher que morava lá do lado, perto do Bomba, antes tem o poço da Cruzinha, assim do lado... e eu morava cá embaixo e ela já tinha me falado antes que ia me chamar. E aí no dia eu senti vontade de ir pro Bomba, do nada assim, sabe? Senti que eu tinha que ir, e aí eu fui e encontrei o marido dela na estrada. Que já tava vindo me procurar. Eu só terminei de subir, fui lá falei com mãe, foi perto, no Bomba e já voltei. Esse aí deu um pouco mais de trabalho."*

Such intuitive actions have also been documented in the United States and, moreover, have been conceived of as holding 'rich potential for restoring the balance of intimacy to the multiple alienations of technocratic life.' (DAVIS-FLOYD & DAVIS, 1996:260). Morover, it is understood as influential to birth attendants' construction of trust:

> 'The trustworthiness of intuition is intrinsically related to its emergence from that matrix of physical, emotional, and spiritual connection -a matrix that gives intuition more power and credibility, in these midwives' eyes, than the information that arises from the technologies of separation. That midwives nevertheless carry with them and freely utilize such technologies demonstrates not only that they also value ratiocination, but that they are becoming experts at balancing the protocols and demands of technologically information with their intuitive acceptance of women's uniqueness during labor and birth.' (IBID.)

In this chapter, I have analyzed in-depth how birth assistants in Capão grew into their 'calling' and how, nowadays, they engage in acts and adopt notions of trust that help them to maintain and develop it. As we saw, they have all become part of each other's processes towards trust. This includes an understanding of how they learned to stand back from their own authority as a person conducting a childbirth so as to open space for the women who are birthing to come to trust themselves.

The analytical categories grounded in birth attendants' discourses and practices showed that they found trust in a large variety of sources, within them as well as among them. An important source of trust has proven to be the feeling of being on a 'calling', 'mission' and of 'doing the right thing'. Such feelings emerged from and were reinforced by different factors; the normalization of and enchantment with witnessing births; spiritual/religious experiences; studies that convinced them and made them feel even more skilled and connected them to similar international and politicized communities; and external and spiritual characteristics birth attendants found in relation to childbirth in Capão. Besides these, adapting their assistance to the specific context of Capão, creating a space and understanding of the shared responsibility with the women they attended and engaging in a various; highly individualized forms of creating intimacy; acting upon their intuition were practices that built more trust their way of attending homebirths.

The self-trust and mutual trust amongst these birth attendants in Capao detailed here is a key element in the process whereby the pregnant women who seek out their care of come to develop and consolidate a trusting relationship with them. This is the topic of the next chapter.

5. WOMEN'S JOURNEYS TOWARDS TRUST

Why do women trust, how, and in what/who do they trust to get to the decision of giving birth at home? In this chapter, I explore the large variety of notions and acts of trust related to homebirth that the women and their partners revealed to me during our conversations, and during observations of prenatal consultations, *rodas* and other informal meetings.[90] The result, an analytical compilation of their journeys towards trusting themselves and their attendants before and during birthing, is a kind of *assemblage* of the intersubjective spaces, 'flows' and various kinds of words and acts of trust that emerged during the research.

The notions and acts of trust that are put forward in this chapter together form what Souza (2005:88) visualized as a semantic horizon of shared supposition. Analysing (home)birth rites in Florianópolis, she provides insights into how the domestic environment is being re-valued as a 'space of sociability'. She briefly explores some of the notions of trust that emerged during the research, in which she notes that couples and their midwives prepare for homebirth through the

> 'construção de vínculos de intimidade e confiança entre os participantes a partir de um intenso intercâmbio semântico. Tais comunicações, afetivamente carregadas, baseiam-se numa rede de suposições e pré-entendimentos compartilhados e estão empenhadas na construção de um horizonte semântico que visa potencializar a atuação conjunta dos participantes durante o parto'[91]

She argues that such semantic exchanges contribute to the creation of social movements and groups with affinity of lifestyles (IBID.:131). In what follows I will argue that such a horizon was especially visible in the exchanged interactions during prenatal consultations and the weekly pregnancy circles. Further, I show that, even though these suppositions were sometimes established before encounters with the midwife or other pregnant women, very often they emerged through interactions in which there was a 'mutual implication of women's reproductive agency with social others and structural factors' (VAN DER SIJPT, 2011:17). In other words, such 'reproductive navigation' is 'highly contingent' (IBID.:21) and further, I will show, so are the notions and acts of trusting that women engage in this process.

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[90] During my master research, one of the main objectives was to explore pre-established notions of trust related to homebirth.

[91] 'Construction of relationships of intimacy and trust between the participants through an intense semantic exchange. Such communications, emotionally charged, are based on a network of shared suppositions and pre-understandings and are committed to the construction of a semantic horizon, which aims to potentialize the joint action of the participants during birth.' (my translation)

In this chapter I follow Áureo's observation that there are distinct ways of trusting of *nativas* on the one hand and women *de fora* on the other. In line with this distinction, I treat them separately in two sections. Arguably, such a distinction can reproduce and reinforce existing generalizations and stereotypes when comparing native women with women *de fora* and could lead to an underestimation of the contingency among all women in Capão who opt for homebirth. Interestingly, it is exactly this contingency that Áureo observed to be an almost exclusive characteristic of native women's relations with attendants and an important aspect of how they develop trust related to homebirth. The intention is that by following this separation, both differences among native women and differences among women *de fora* and, through the contingency that Van der Sijpt mentioned, many similarities and indeed, mutual implications, in the trajectories towards homebirth emerge. It will become clear that while these people are very different in sociological terms, in the social, temporal and spatial context of Capao, the relationships constituted over time among residents, and settlers, have allowed for the growth of forms of trusting (or talking about it) that are multiple in origin, and that are expressed and justified in distinct and at times contradictory discourses, philosophies and forms of knowledge. However, when conjoined in the events of prenatal care and childbirth itself, trust takes place as if unified, producing in practice what in discourse cannot be seen as singular.

5.1 Native women

I start with the native women, specifically with a notion of trust that Áureo observed to be highly characteristic of the native population, an insight I confirmed to be present in the discourses of many native women, both during intervews and in observed interactions between native women and birth attendants.

5.1.1 *Confiança contingencial*

Áureo spoke of how he thought that one of the main characteristics of the ways in which native women decided upon and 'trusted' homebirth was their 'contingency', or *confiança contingencial* ('contingent trust') as he called it:

> *"Daí a gente espera e observa que a pessoa de fora ela tem muito maior quantidade de necessidades psicológicas. Muitas vezes informacionais, outras vezes a gente precisa desconstruir o excesso de informações. Vai ter que ter a sensibilidade de ver qual é o caso daquela mulher. Por que... algumas têm... por exemplo, aqui tem nativa que a mãe morreu de parto, mas ela tá parindo aí alegre e feliz. Não tem uma coisa tão definitiva como... os traumas, assim, do*

pessoal da cidade é uma coisa que é muito maior do que os traumas aqui, entendeu? Não tô dizendo que não tenha trauma aqui, mas aqui parece que isso dilui mais. Por que tem a... o mundo aqui é mais contingencial, enquanto que o mundo lá é mais opcional, entende?

Aqui a contingência é parir com o que tem, a parteira. Depois que eu cheguei tinha um médico, tudo bem. Mas lá na cidade a contingência é vou parir com.... vou parir no hospital, vou parir com médico, existe a possibilidade de eu parir com a parteira, mas existe parto... posso fazer um parto natural, posso fazer uma cesárea. Enfim, eu posso chegar pra qualquer médico e dizer "eu quero cesárea" e ele vai com certeza ficar feliz, entendeu, de fazer cesárea. Tem muitas opções. Nem sempre ter opções é o ideal, às vezes não ter opções nos tira este peso. "É isso, pronto. Beleza. É isso que tem? Vamo fazer isso". Sacou?"

We can see that Áureo contrasts 'contingency' with 'optionality', which on the one hand relates to Van der Sijpt's notion of 'mutual implication' with other people and structural factors; however, it does not consider a possible 'reproductive agency' within these implications. It seems that Áureo interprets 'optionality' as a privilege as well as a limiting factor in the process towards trusting homebirth. He suggests that for a native woman the fact that her mother died in childbirth is not as traumatizing and, arguably, does not diminish her trust in homebirth as much as it would for a woman *de fora*, because a native woman does (or did) not have many other options anyway. In this example, it becomes clear that the understanding of contingency as 'intersecting social configurations' that influence reproductive navigation among women can also be seen as a consequence of what has been called 'stratified reproduction' (GINSBURG & RAPP, 1995). Later in this section I will come back to this.

Another idea he transmitted in relation to this contingency is that the native women had a more 'simplified' way of trusting compared to '*as de fora'*:

"A gente tem que se lembrar de uma coisa interessante, que é o seguinte, a mulher nativa, claro que as mais jovens já estão perdendo esta peculiaridade, pra elas o engravidar e parir é algo que faz parte, digamos assim, é uma sequência lógica e natural, entendeu? Todo mundo... ou melhor, todas as mulheres vão engravidar, vão parir e vão engravidar de novo e vão parir. E é isso entendeu? E se espera que seja assim, e pronto. E se espera que seja natural, por que é natural, por que não tinha outro jeito, sempre... todas as mulheres aqui foram formadas em uma situação em que "Ó minha velha, se você não parir normal você vai morrer". Sacou?"

In his vision, these women are the ones who, in Luhmannian terms, were socialized into trusting homebirth through family experiences (in Jalava, 2003:178) and through what McKnight & Chervany have called 'situational normality' (2001:38). Here, trust is generated through the 'perception that things in the situation are normal, proper, customary, fitting, or in proper order'

(IBID.). Therefore, it is no surprise that women who grew up with the idea that birth is normal and the home a normal place to give birth (including myself), perceive that homebirth is 'conducive to situational success' (IBID.). Áureo recalls one of those 'success stories':

> *"Aí aconteceu que também teve um parto, de uma jovem aqui no Capão que foi um parto assim que se tornou famoso no Capão por que ela deu uma gargalhada na hora da criança sair. Por que ela deu uma gargalhada por que ela olhou a cara das amigas olhando e achou as amigas com uma cara engraçada e aí riu e a criança saiu. Aí isso ficou assim, todo mundo comparando, entendeu?"*

During one of the birth circles, in which it was rare to find the presence of native women (I did not observe any), Natália says the following:

> *"É muito diferente, parto do pessoal daqui, e que vem de fora. Não tem aquela cerimônia, que as vezes a gente até fica um pouco receosa. Mas aqui é tv ligada, gente conversando, acha que eu e Livia mandamos em tudo. É mais naturalizado, coisa do cotidiano."*

The native technical nurse, Aruana, who was part of the *Equipe Parir*, explains the difference between native women and women 'from outside' as related to more or less 'conscience':

> *"Eu vejo que as nativas, a maioria, tem vontade (de parir em casa) porque... elas sabem que é possível, porque as mães pariram aqui, né, tinha parteiras e tal, mas... eu não sei explicar, mas é menos consciente, assim, do que as que vem de fora e falam "não, eu vou parir porque é natural, porque é isso mesmo, porque é assim, assim..." é uma coisa mais... não passa muito pela mente, tipo assim, sabe. É uma coisa rotineira, tipo, parir assim, não é uma coisa que elas ficam muito... pensando assim."*

As an example of the mutual implications that constitute the contingency of trust, some native women built trust in their own ability to give birth at home because they remember their family members have also given birth at home before them.

> *"Minha mãe teve vários filhos em casa. E naquele tempo lá não tinha remédio, não tinha vacina, não tinha nada. Paria por parir, tinha que parir e dava tudo certo, não é hoje que vai dar errado, né?"* (Cleide)
>
> *"Minha sogra nunca foi de... ela nunca fala nada, ela fica quieta, ela fala assim, "o pessoal de fora vem parir aqui, por que vocês vão parir fora, lá no hospital?" Ela teve os dois dentro de casa."* (Vera)

Vera's mother in law provides us with the reflection that, just like the women 'from outside', native women can, and maybe even should, make the 'conscious' decision to give birth at home. In Áureo's words, she showed that native women can and actually do also engage more in 'optional trust' and less in 'contingent trust', even though they continue to give birth at home like they have for many decades. In the section below we will look at this phenomenon in closer detail.

5.1.2 Financial involvement

The financial involvement of birth attendants and pregnant women and their partners was a theme that did not emerge often during consultations, circles and conversations. However, as I mentioned above, for many women it has been a theme in the decision-making process of homebirth in Capão. At the time of my research the team had a fixed price of R$4000,- for the 'whole package', which included home visits before and after birth, the birth itself, and more (online) support and 'extras' (such as making a belly out of chalk, or creating a tincture from the placenta). This price is less than half of what is charged in Salvador. Nevertheless, for many women it is still inaccessible, mainly for native women in Capão. Natália knows about this and established the amount of R$1000,- for native women. However, during the consultations and in our conversations she has always been open to negotiation, lowering and dividing the price, and in some cases attending for free.

For some native women, the fact that there was a price tag on giving birth at home with the team was a logical consequence of the symbolic capital – education of these attendants. For them, it symbolized the 'scientific' knowledge, studies and experience the team represented, compared to native birth attendants (who did not charge anything). A possible problematic consequence of such a logic, however, is the idea that the higher the price tag, the more trustworthy the birth attendant(s).

Nevertheless, as in the case of Cleide, there are native women who do not know about the possibility of paying less to give birth at home with the team and prefer a native or other birth attendant, or going to a (public) hospital because of lack of money (and/or because of other reasons I will explore later). In this research I did not have the opportunity to talk to one of these women, but I have heard the experiences of some of the native birth attendants and the financial involvement the families had with them. Dona Aurea recalls:

> *"Uai, quem chega, que vem me chamar como é que não ia? Não pode deixar a mulher sofrer, como é que não vai? Mas não ganhava nada não. [...] Não tinha! Como é que dava? Nos tempo o povo tudo fraco, não tinha. Mas agora eles tão*

> *cobrando, dizem, que eu não sei... mas é cobrado. Agora é que todo mundo cobra, eu que nunca cobrei."*

Nara remembers that the few times she received money, was when she assisted births together with the team:

> *"Nunca cobrei nada não, se a pessoa quiser dar alguma coisa... Já rolou de eu receber, uma vez eu recebi 200, outra vez eu recebi 200 e outras vezes eu recebi 400. Foi o que eu já recebi. [...] Foram esses que eu ganhei, os que eu fui junto com o Parir."*

The problematization we have to engage in here, is that for some women, money plays an important (or crucial) role in what kind of and in the actual experience of birth. When commodification gets into the realm of trust, structural inequalities come to the surface. Exactly who has access to what kind of birth care becomes apparente. Thus trust itself can get commodified. Moreover, birth attendants themselves might be excluded from any of its benefits[92]. Trusting because of the high price tag, trusting because of incapacity of paying for the high price tag and, in another context, trusting because of the presence of high-tech, expensive 'machines' are all examples of how financial capital affects how, why and who we trust.

As an example, Áureo notices that nowadays many native women are highly aware of the option of birthing in the hospital, and that there has even been a time (which has been changing since the arrival of *Equipe Parir*) in which mainly native women preferred to give birth in the hospital; questioning this so called 'native' attitude towards homebirth. Rosângela was the only native woman I observed during one of the prenatal consultations who did not want to give birth at home. She said: "*não tenho coragem não*." During the years I have lived in Salvador, the idea that it requires a lot of courage to give birth at home has been a recurrent argument for many women to not do so. However, this same argument has been used as an element of the relearning process of many women I observed in Salvador, who made an inversion stating that it requires courage to give birth in the hospital in Brazil, not at home. Later in the consultation, Rosângela mentions that, besides the lack of courage, she has high blood pressure and is afraid it goes up, which would require a transferral to the hospital, and the roads are really bad. She is also worried about her age: '*não tenho mais 18, fiz 40 agora*.' Finally, she notes that her mother, who was her '*porto seguro'* died, so she feels less confident.

[92] For more insights, see Vega's recent critical examination of the 'fetishization' of indigenous birth practices in Mexico (2018).

After her arguments, it is clear that Natália does not try to inform her further about home birth nor convince her to take another decision.

Cleide, a native woman pregnant with her second child, during one of the prenatal consultations, explains her doubts:

> *"(Antigamente) Tinham que parir em casa, não tinha opção. É por que hoje fica essa insegurança, de achar que tem o hospital, então a pessoa não se entrega totalmente aquilo que quer. Fica naquela balança, vai, não vai, vai, não vai. Aí tem hora que acontece de dar errado por que não tem segurança mesmo do que quer."*

During this same consultation, she revealed that she had a desire to give birth at home, but doubted she would be able to afford it. When Natália answered that money would be the last thing she would have to worry about, she practically immediately decided that she would give birth at home. The same thing happened to Very, who had her first consultation with Natália at 6 months pregnant. Natália told me she belonged to one of the poorer families of Capão. When I asked her during one of the prenatal consultations where she would like to give birth this time (to her fifth child), she said: "*to sem alguém para me acompanhar. Agora 1ª consulta com Nat, tá ligada? Mas queria ter em casa*." Right after that, already indicating that there would be no financial involvement, Natália responded: "*oxe, é só me chamar*."

Here, we are confronted with another problematic that comes along with the particular case of Capão, in which an originally 'contingent', 'normalized' and, basically, the only possible way of giving birth has been transformed into not only an option, but a commodified option. Cleide might have gone to the hospital if it were not for this differentiated price of the team's planned homebirth care. In other words, besides the fact that she had already decided to trust Natália and the safety of giving birth at home, the financial conditions 'allowed' her to act upon that trust.

We should, therefore, problematize the accessibility of such commodified practices. We have to ask ourselves whom they serve, and who is actually able to have a planned and safe homebirth. As I mentioned in the introduction, in the specific context of Brazil, this also includes access to a birth without violence in the first place[93]. In this light, Craven argues that adopting a consumer identity in relation to homebirth can have serious consequences (2007:706):

> 'Understanding themselves as consumers has also made the issue of choice – and, more to the point, who has reproductive health care choices – more complicated. [...] Feminist scholars have also reminded us that "choice" and the

[93] For a further discussion on how discourses of risk, blame and responsibility influence birth place decisions, see Coxon, Sandall & Fulop (2014)

> ability to consume reproductive rights and services mean different things to different women as a result of their cultural and economic circumstances. Research on stratified reproduction demonstrates how choices are always made within the context of larger institutional structures, ideological messages, and fisical limits (Ginsburg & Rapp, 1995).'

Such individualist commodification therefore tends to 'ignore the mutual implication of women's reproductive agency with social others and structural factors' and 'overlooks other social relations – and their power dynamics – often implicated in reproductive decision-making' (VAN DER SIJPT, 2011:17).

5.1.3 Previous experience/comparison with hospital birth

Trust through mistrust has, unfortunately, proven to be a common mechanism for women who want to give birth at home in Brazil. Béhague et al. (2002) observed that for some women, the preference to give birth through a caesarean was the result of a desire to avoid a violent vaginal birth (which they have either experienced in the past or heard of from other women). Similar strategies are also employed by women who have the desire to give birth at home. In my previous research in Salvador (SCHUT, 2014), there were a few women who arrived at the possibility of giving birth at home after having experienced a traumatic birth at the hospital, as well as one of the women *de fora* we will look at later on.

For two native women, the lack of freedom they considered a part of hospital assistance was a reason for them to mistrust:

> *"O Capão mesmo eu não sei, mas muitas pessoas falam que prefere parir em casa por que é bem diferente, né? Você tem mais liberdade. Tipo assim, um exemplo, minha cunhada, a primeira filha dela, minha primeira sobrinha foi no hospital. E aí ela disse que sofreu bastante, ela passou dois dias sentindo contração, sem conseguir ter a menina e com fome. E aí ela disse que sentia... foi em Iraquara, ela disse que sentia tanta fome que ela foi no fundo assim do hospital, no quintal e comeu uma goiaba verde e uma manga quase podre. De fome."* (Nara)

> *"Acho que por isso agora prefiro em casa, por que eles não dão comida no hospital, dá aquela... fica ali naquele soro, aquele... não dá água, não dá comida, então a gente sofre mais. E em casa já Nati falou, 'você vai comer uma coisa mais leve, vai beber água, você vai poder andar' e no hospital eles lhe colocam o soro e o que é que você anda? Com soro, com dor, com o ferro, porque aquele ferro pesa."* (Cleide)

Besides that, women complained about bad medical care, which compromised their trust in the hospital personnel. Nara observes the well-known compulsory episiotomies that have become a routine practice in Brazil, in contrast to the autonomy she perceives in homebirths:

> *"De corte, dessas coisa, todos leva corte por que já é uma coisa de rotina e não são todas, todo mundo que gosta de corte. Não é por que eu acho, tem uns que não tem necessidade. Por que é da rotina. Eles nem te ouve tu dizer que não quer, nada, já é uma coisa que é de rotina mesmo."*

Cleide notices the fact that in the hospital you never know who will attend you, and that there is a good possibility of not being attended well. The factory-line organization of care typical for Brazil's public health system and the lack of intimacy this implies can cause women to mistrust, especially when a viable trusted alternative becomes available:

> *"Porque chega no hospital tem hora que lhe atende bem, tem hora que lhe atende mal. Tem hora que você topa com gente boa, e tem hora que você topa com o povo já tudo dormido, que tá acordando. Então eu acho que a confiança é essa, em casa, por que vai ter mais calma."* (Cleide)

Áureo also sees a connection between the increase of native evangelical women giving birth at home with the team and a negative hospital birth that has become a part of the 'unlearning' process of some women:

> *"Mas eu devo lhe dizer uma coisa que foi muito interessante, que você falou a coisa da confiança e da desconfiança, é... muitas pessoas fizeram parto comigo depois de ter tido uma horrível experiência nos hospitais daqui da região. E aconteceu um fato muito interessante, na festa de 100 partos do grupo Parir tinha uma quantidade de evangélicas muito grande, que foram pra festa. Foi interessante isso, porque isso aconteceu a partir de uma experiência horrível que uma evangélica teve no hospital. Em que fizeram uma episiotomia completamente errada, cortaram os grandes lábios dela, fizeram a sutura com fio extremamente grosso, ela sofreu com aquele ponto ali futucando e aí ela foi pro posto e eu fiquei chocado com o que fizeram ali com aquela mulher. E ela foi sendo acompanhada, eu cuidando dela, fazendo os curativos e Natalia também e tal. E a partir daí as evangélicas tão preferindo parir com o Parir. Sacou? Então assim, por que tiveram uma experiência muito ruim lá fora."*

Another negative experience related to the hospital was the experience of lack of hygiene.

> *"E no hospital você já vai com aquele medo de doença. E aqueles pano, aquelas roupa, já é tudo aquela loucura, sabe? você já vai insegura. A gente vai pro hospital mesmo é por que tem que ir, se precisa vai, né? Não pode ficar em casa, mas assim, no hospital dá muito medo. Quando eu tive ele, depois elas me colocam um lençol, uns lençóis esquisitos, não deixa colocar o da gente. Eu levei o meu todo bonitinho, passadinho, arrumadinho, eles não deixa, eles querem que use só o de lá. Então assim, são umas coisa que quando você olha assim,*

você já dá nojo só de olhar. Você vai lá saber quantas pessoas usaram aquilo, aquelas roupas esquisitas, aquelas cama... Quando eu tive ele mesmo o chuveiro soltou, a gente tomava banho de um cano." (Cleide)

Finally, having to make the journey back from the hospital to one's house was perceived as another negative aspect of the experience of a hospital birth:

"Menina, eu sempre ouvi dizer que em casa é melhor do que no hospital. As meninas, minhas amigas mesma, tem uma ali que teve criança, a menina dela vai pra 2 anos agora, ela disse que é tudo totalmente diferente, porque do primeiro também ela disse que sofreu muito no hospital. E aí a segunda foi em casa e foi super tranquilo. Ela disse que sofreu e tudo, mas depois que passou tava em casa, né? Eu acho que a gente vai pensando, e a gente pensa assim, se o que a gente vai passar lá no hospital a gente vai passar em casa, então você fica logo em casa." (Vera)

5.1.4 Trust in the team, intimacy

Trust in the team and the birth attendants, which in the case of the native women that participated was basically Natália, became especially clear during the prenatal consultations I observed. Natália, who, next to Áureo, has been the medical post's main health professional, has lived in Capão for about eight years and slowly and carefully built up *rapport* with the native community. She said that it took quite some time for the native residents to open up to her and actually reach out specifically to her for help, but nowadays, as I observed it, she has a capacity to fluently adapt to the reality and specific situation of any of her native patients. As she attends her different patients, I notice changes in use of language, in intonation of voice and in emphasis on certain subjects. When attending native women, she engages in a specific vocabulary characteristic to the region, while with women '*de fora'* she engages in a more 'urban' way of talking. She changes the kind of questions she asks, sometimes very specific ones, showing her high level of involvement, intimacy and trust with her patients. During a consultation with a native woman who, in her words, is 'known for her complicated relationship with her husband and drug use' and pregnant with her fifth child, she asks calmly if she has been using drugs, if she is worried about money, if she is fighting a lot with her husband, if she is smoking, tried to abort with some kind of tea, states that she is happy the HIV test turned out negative, and suggests '*ligamento de trompa'* after this pregnancy. As far as I have seen, she does not ask these kinds of questions to other women, but for this woman they make sense, are received calmly and they seem to make her feel understood taken care of. She also says: "*É ruim sair nas pressa ir pro hospital. Nat é a pessoa que já confiava. Tem outra menina Nara, mas confio mais na pessoa estudada*." Here we see what I mentioned before, the possibility of

a -native- woman giving up on homebirth of because of the assumption that the more 'studies' a birth attendant has, the more one has to pay.

To Cleide's husband, who was cautious about his wife giving birth at home, she says:

> *"O que ela vai sentir em casa, vai sentir no hospital. A dor é a mesma. Nunca um bebê morreu. Teve bebê que não nasceu bem, a gente reanimou. Mulher que sangrou demais, a gente cuidou. A gente não tá cego, eu tenho conhecimento, experiência. É o nascimento do seu filho, mas o corpo da mulher. Num lugar cheio de luz... lá faz toque.. eu sou suspeita para falar, mas... A gente leva tudo, como se fosse um quarto de hospital."*

I would say that due to the fact that way she explains to Cleide's husband that he can trust her that homebirth is safe and that she is experienced enough to deal with possible complications is very 'compatible' with how they have interacted about birth so far, he received these affirmations very well and told her that he did not have a doubt about his trust in her. The way she tried to calm him down and convince him, without going into great detail about why homebirth the way they attend it is considered a safe option, but tuning in on what she assumes to be his worries (more pain at home, risk of the baby dying, less technology and experience/knowledge) are examples of the level of intimacy they have and Natália's ability to be sensitive to the various postures towards homebirth she encounters during the prenatal consultations. When I talked to Cleide later, and asked her how she felt about Natália and Áureo as birth attendants, she told me:

> *"Olha, Nati (a loving nickname) pra mim é uma pessoa maravilhosa, ela e doutor Áureo aqui no Capão é tudo! Se eles saírem filha, pode ir embora que não vão chegar outros. Então assim, Nati ela passa muita confiança e a gente confia nela, por que a gente já anda no posto com ela. Aí então todos os exames que faz quando a gente precisa ir no posto é primeiro com ela, aí depois ela avalia a gente e depois ela 'volta' pra doutor Áureo, então... a gente, mulher com mulher se entende mais, então a gente já... pra mim é Nati, eu já acostumei, é raro eu entrar na sala de doutor Áureo. Primeiro é Nati, depois ela vê e me encaminha pro Áureo. É o jeito dela. E o trabalho dela a gente sente que ela tem garantia, né, confiança no que ela tá fazendo, então passa confiança pra gente."*

Cleide provides some quite different notions of trust invested in the birth attendants. She notes that she trusts Natália because of the fact that they have known each other for a long time because of the medical consultations at the health post. She sees Áureo much less, and besides that, she notes that for her the fact that she is attended by a woman generates trust as well. Also, she feels that Natália transmits trust through 'her way' of attending. Through the observations during the consultations and home visits (as will become apparent in the next section as well, I perceived that this 'way' has a lot to do with the intimacy Natália and the rest of the team is able to create, and the openness of the women to allow such intimacy.

These accounts can all be seen as examples of how in Capão this intimacy has become the result and a generator of 'semantic horizons of shared suppositions' (Souza, 2005) that have emerged during prenatal consultations, and consequently highly contribute to trust-building among the birth attendants and their clients.

Native midwife Nara described a birth of a native woman she attended a few years ago, where we may observe other forms of such a semantic horizon of shared suppositions that show the level of intimacy and trust the woman and Nara have established:

> *"Antes de ir pro culto ela preparou o jantar, a gente tinha tomado banho de rio, me lembro, lavado o cabelo no rio nesse dia o sol tava quente. E aí quando ela voltou do culto a gente sentou, eu, ela, o esposo dela, é... minha tia, minha outra tia que mora junto com ela e os dois filhos. Os dois filhos tava com o quê, um tava acho que com 10 e o outro com 9, que é um próximo ao outro. E aí a gente tava jantando, ela levantou assim e foi no banheiro. Aí eu falei "Tia, já terminou?", "Não, pode deixar meu prato aí que eu vou comer ainda". Aí esse comer... ela ficou demorando lá dentro do banheiro, aí claro que eu percebi, né? Aí pensei assim, não falei nada, não comentei nada, mas eu já sabia de tudo. Onde tava o colchão, que ela não falou pra ninguém, falou pra mim, onde tava o colchão, onde tava a lona, os lençóis que a gente ia usar, tudo, as coisas todas. Aí ela ficou eu acho que mais ou menos uma meia-hora lá dentro do banheiro. Aí eu pedi pra ela abrir, ela não quis abrir, só que eu escutava, assim, ela fazendo força.*
>
> *[...] Aí ela falou assim, "Nara, vai lá no depósito e pegue o colchão e aquela lona que eu te falei. Tá tudo guardado já, separadinho"*
>
> *[...] Aham. Aí eu fui lá correndo, peguei, trouxe pro quarto aí o esposo dela falou assim, "Tu quer que eu vou chamar tua mãe agora?", aí ela falou assim, "Não, agora não", aí ficou mais uns 10 minutos. A gente pedindo pra ela abrir a porta e ela não abria. Aí depois de uns 10 minutos ela falou assim, o esposo dela é Nem, ela falou assim "Nem, vai chamar a mãe. Vai rápido.", aí ele falou assim "Bora Nara, chamar tua avó.", ela falou assim, "Não, Nara não vai não.". Aí ele foi, pegou o carro e foi. Aí nessa que ele saiu ela abriu a porta, aí tem o corredor, eu nunca esqueço disso, tem um corredor assim, e o banheiro fica assim, e a porta do quarto dela é desse lado.*
>
> *[...] Aí ela já saiu que não tava aguentando nem dar um passo mais. Aí minha tia pequenininha assim, magrinha, e ela fortona com aquele barrigão, que ela é bem forte, aí tentando ajudar, aí ela se agachou assim na porta do quarto e a gente viu que não tinha como dar um passo mais. Minha tia tentou segu... tentando arrastar ela assim, eu falei "não tem como", ficou ali mesmo na porta do quarto e eu aparei a menina, 'Ester'.*
>
> *[...] Acho que o barulho do carro ainda tava. De meu tio que tava indo pegar a avó.*
>
> *[...] Aí deu tempo, Ester nasceu, eu limpei Ester, cortei o cordão, coloquei a roupinha. Foi o primeiro cordão que eu cortei foi o de Ester."*

Besides the intimacy (the woman was Nara's aunt, they were having dinner together, Nara knew where everything was) and shared suppositions (she suddenly went to the bathroom, took quite

some time there, which was an obvious proof to Nara that labor had started, and it was clear that Nara would stay when the husband left), we can also observe a high level of contingency in her account. Her aunt decides to stay in the bathroom; at first, she does not want them to call her mother (who is the main -however retired- native midwife Dona Maria do Bomba), then - probably because she realized the baby was being born- does ask her husband to go call her mother, but things go so fast that when he left the baby was born in Nara's hands. Her account is also a clear example of how contingency is actually inherent to birth -for all women, native or not- not only 'because *others* and *individuals* act, but also because *bodies* act' (VAN DER SIJPT, 2011:211).

Also, the fact that the native women still have all or a big part of their family living in Capão, with experiences of homebirth themselves, provided a sense of security and intimacy:

> *"A família tá aqui, a maioria da família das mulheres pariu aqui normal, né? E até com parteiras também... e meio que já sabem, mais ou menos, como é. E eu acho que o amparo da família, ter a família por perto também nesse momento dá uma segurança maior, né, porque... é muita coisa."* (Aruana)

All of the examples mentioned in this final section, showing the intimacy and the fine-tuned shared suppositions among the birth attendants that have been in Capão for a long time (in this case, Natália, Áureo and Nara) and native women resulted in what one could call a form of 'generational' trust and familiarity, in other words, a kind that derives from many years of care and social involvement in the native community.

In the second part of this chapter, we will turn to the women *de fora*, Brazilian women who are non-native to Capão and actual foreigners who have sometimes been seen as having opposed or very divergent notions of trust or ways of deciding about homebirth compared to native women.

5.2 Women *de fora*

In this second part of the *assemblage* of the intersubjective spaces, 'flows' and various kinds of words and acts of trust that emerged during the research, I will start with the opposition related to trust-building and homebirth as observed by Áureo: contingency versus optionality. Through the notions provided by the women *de fora* it will become clear that such an opposition is quite problematic, as it reinforces a tendency to generalize and 'simplify' the native population and underestimates the highly interactional and contingent character of any woman's reproductive decisions (VAN DER SIJPT, 2011). However, some particularities did

emerge from my interactions with women *de fora;* one of which could be related to a high degree of access to information about a variety of birth experiences and possibilities. A few women actually noticed that they might even have had access to 'too much' information, which led some of them to, in a quite rational way, intentionally 'simplify' and, arguably, 'essentialize' their decisions related to birth, not in the least by focusing on the contingency rather than the optionality of birth. Another particularity of women *de fora* was their frequent involvement in certain spiritual or mystic ideas about birth and nature, which I did not observe with the native women I talked to and saw in prenatal consultations. Also, I observed different kinds of intimacy between the birth attendants and the women *de fora,* compared to the kinds of intimacy they had with native women. I argue that one of the causes of these different kinds of intimacy is a more equal access to information about birth and its possibilities, generating a different semantic horizon of shared suppositions that led to trust-building.

5.2.1 'Optional trust': making informed decisions by redefining authoritative knowledge

As we saw, Áureo spoke of how he thought that one of the main characteristics of the ways in which native women decided upon and 'trusted' homebirth was their 'contingency', or *confiança contingencial* ('contingent trust') as he called it. The idea he transmitted was that the native women had a more 'simplified' way of trusting compared to '*as de fora',* that women would 'just' get pregnant, give birth, get pregnant again, without worrying too much about where or how they would give birth. He made an opposition between 'contingency' and 'optionality', arguing that the women *de fora* had more options, or at least, were more conscious and demanding of their options. For him, such 'optionality' mainly appeared in the form of a caesarean:

> *"Mas as mulheres de fora não. Tem a opção da cesárea como uma coisa muito lógica e óbvia. Lá na cidade a contingência é vou parir com.... vou parir no hospital, vou parir com médico, existe a possibilidade de eu parir com a parteira, mas existe parto... posso fazer um parto natural, posso fazer uma cesárea. Enfim, eu posso chegar pra qualquer médico e dizer "eu quero cesárea" e ele vai com certeza ficar feliz, entendeu, de fazer cesárea. Tem muitas opções."*

Áureo opposes this variety of options in 'the city' with a lack of options in Capão. I would argue that the latter idea is questionable: as we have seen in the first part of this chapter, native women do have options. Questions we have to ask, however, are which women have access to information about their options; what options are discussed during the prenatal consultation; if a woman has the 'urban desire' to have a caesarean (regardless any medical indication), would

that be an option; until what extent does financial investment interfere in or limit this 'lack' of options? What happens to trust-building when a woman knows about her options and has access to information about them? Here I will contrast the women de fora to native women, with the intention to answer these questions.

Aruana, one of the birth attendants of the team who herself was born in Capão, put it this way:

> *"Ah, é, eu vejo como uma coisa mais natural assim, sem muita coisa, sabe? Porque quando a gente, assim, nem sempre né, mas a maioria das mulheres que vem de fora tem todo um... tem todo um preparo também, né, assim. Não que as nativas não tenham preparo, mas eu digo... aquela coisa no mental também de... Né? De querer saber direitinho as coisas e tal e arrumar tudo, né? Às vezes até tira foto e... aquelas coisas todas.."*

The 'mental preparation', or 'to know about everything and organize everything' Aruana mentions are characteristics I also found during my research in Salvador (2014) quite typical for what could be seen as an urban, middle-class, white logic of reproductive choices. An often-repeated slogan among homebirth attendants and involved women in Salvador has been 'knowledge is power'. In the national humanized birth movement, you will repeatedly hear that a woman cannot have autonomy over her choices regarding birth if she does not know what the options are and if she is not (well-)informed about these options, and that regaining autonomy in the birthplace is one of the main 'battles' of its proponents.

These characteristics, which have also appeared in many 'outside' women's discourses, raise even more questions in the context of Capão, such as whether 'autonomy' is an actual operative concept for native women in Capão, and what autonomy would look like in the absence of choices or poor access to information about them and resources to act upon them. I will reflect more upon these issues later; however, I unfortunately was not able to investigate them in detail.

Similar to the women I interacted with in Salvador (2014), before most of the women *de fora* I talked to became aware of the possibility to give birth at home (in Capão), the options they had besides and within that way of giving birth and, consequently, achieved a sense of autonomy and 'optional trust' ('I choose to give birth at home because I know what my options are and why I can trust it or myself'), many had gone through a process of unlearning and redefining existing authoritative knowledge – if that had not also happened in other ways, such as a negative previous experience with a hospital birth (see section on lack of trust in hospitals). For some, this process had occurred before moving to Capão, for others, this happened while they were living there, or as the pregnancy evolved. Áureo observed this need to redefine

existing authoritative knowledge, and sometimes even to take the focus away on knowledge and the more 'rational' part of building trust as following:

> *"Daí a gente espera e observa que a pessoa de fora ela tem muito maior quantidade de necessidades psicológicas. Muitas vezes informacionais, outras vezes a gente precisa desconstruir o excesso de informações. Vai ter que ter a sensibilidade de ver qual é o caso daquela mulher."*

For Sarah, a 28-year-old woman from the state of Pará, married to an Argentinian man, the trust-building towards homebirth happened after they had moved to Capão, through listening to other women's birth stories and reading books:

> *"No começo com certeza, né, fiquei com medo, por saber que aqui não tem hospital aqui né, e mesmo sem conhecer como era, como tratam as grávidas os bebês tudo, mas depois que fui conhecendo, ouvindo relatos de partos domiciliares aqui mesmo no Capão, aí fui pegando confiança. Tanto eu como ele também. No começo: será, em casa, mas a gente foi estudando, pesquisando, conversando muito com as pessoas daqui e aí depois disso a gente: não, não tem outra forma da gente..."*

Dorothy, a nurse from Rio, visited Capão for the first time in 2016. She 'fell in love' and returned a few times. Her process of becoming aware of birth options and building trust towards homebirth had started before she arrived there first, but evolved as she visited Capão. One of the things that really enchanted her was the focus on naturopathy and the way health was interpreted, especially in the medical post and by Áureo. Her reality at that time was quite different; she did not know that humanized and homebirth were options, however her search for another way of understanding human life and health made her connect to homebirth:

> *"Vinha de uma época muito desiludida com o sistema de saúde que estava inserida. Não aquela já deteriorada de certa forma, sistema capitalista, visando só o dinheiro e a saúde das pessoas sempre em segundo plano. Acabei vendo que a vida humana era muito desvalorizada. Quando eu vim para cá e conheci a naturopatia, que existia uma outra forma de tratar as pessoas, de você considerar a vida, que não existe só a morte. Aquilo me despertou para outras coisas. Aí ouvi falar sobre parto natural domiciliar. Era um contexto que eu não estava inserida, porque minha realidade sempre foi hospital, centro cirúrgico, a minha família, a maioria das minhas amigas as crianças nasciam de cesariana. Na primeira consulta o médico já falava, que era mais seguro etc. Me interessei pelo parto humanizado nem tanto pela questão da maternidade em si, mas por ser enfermeira. Aí eu vi que no Rio tinha também equipes e associações de doulas e parteiras, mas não sabia. Porque não era normal. Talvez porque não era muito divulgado, talvez por interesses econômicos, políticos, de mudanças de estruturas... Quando vi isso eu entendi: 'peraí, existe um outro jeito.' Eu eu tava nesse momento de querer ressignificar a vida, não pode existir só a morte, a doença, você só tratar a doença. E o parto domiciliar*

me despertou essa questão da vida humana vir em primeiro lugar, não os outros interesses. E aí descobri que estava grávida. Nesse contexto. E aí decidi que queria uma outra coisa para minha vida, decidi morar aqui.”

When she spoke about her decisions to her friends and colleagues and did not receive much support -on the contrary- she made the decision to stay focused on her path of ‘redefinition’ without interference of the ‘old’ authoritative knowledge she had been submersed in:

“amigas enfermeiras me achavam louca, por mais que sabiam que não era. ‘Mas porque você vai sentir dor, com tanta tecnologia? Com tanta tecnologia, porque em casa, aquele sangue todo... Não tem necessidade.’ E eu falava, ‘não mas existe um outro jeito de nascer, onde não é tudo igual.’ Acabei me afastando de várias pessoas porque não sentia apoio. Não queria ouvir isso, sabia que era consciente.”

Cris, a 42-year-old paulista who moved to Capão when she was 20 years old, had always heard from her mother, who had had both experiences, that giving birth vaginally was better than a caesarean. However, homebirth was never part of that discourse and in São Paulo she did not have any contact with that option. However, she herself had always been fearful of hospitals, so when she heard of the possibility of giving birth at home in Capão she was ‘ready’:

“E como eu nasci em São Paulo, vim morar aqui com 20 anos, eu também, pra mim era filho no hospital. Eu nem imaginava de que se podia ter um filho em casa em pleno século 20. Eu nasci cesárea no hospital, uma semana antes porque era carnaval. E desde o parto da minha mãe que ela me conta que ficou muito nervosa e que ela teve que tomar muita anestesia e não fazia efeito. Então eu sempre tive muito medo de hospital, acho que traumatizou. Então hospital pra mim era um lugar que mesmo quando tinha um avô internado eu tinha muito medo de hospital. Então pra mim filho no hospital: não quero. E quando vim morar no Capão, que eu comecei a ver as mulheres... gente elas têm filhos em casa! Tipo, nossa, tô pronta! E aí eu vislumbrei que nossa, há outras possibilidades. Porque na minha mente paulistana, isso a 15 anos atrás, não tinha muito essa de parto domiciliar. Era algo que ainda era muito escondidinho, não se falava...”

Célia, a 37-year-old woman who moved to Capão 15 years ago, came to build a kind of ‘optional trust’ which, unfortunately, did not emerge from an indirect fear of hospitals, an ideological disenchantment with biomedicine, or because she had heard many beautiful stories of homebirth in Capão. She felt that giving birth at home was the *only* option for her, since she had experienced a very traumatic caesarean when she was 20 years old (see section on lack of trust in hospitals). However, after she had decided to give birth at home in Capão, she dedicated herself to study about (home)birth, which I interpret as a way of, even though homebirth had been an almost ‘forced’ option, regaining the autonomy over and building trust in her ‘option’

to give birth at home. After she gave birth to her first son, she met her current partner who had already been to Capão. She travelled there with him a few times, and felt at home. They moved to Capão and when she got pregnant with her second son decided to give birth there:

> *"E aí vim parir aqui, falei com a Natália que tava decidida a parir aqui. Se ela me acompanhava e ela topou. [...] E eu me lembro até quando tava lendo esse livro Parto Ativo, me preparei muito pro parto do meu segundo filho, estudei muito, era muito atleta do circo né, tinha um corpo muito preparado, muita força. Li tudo que tinha no Lothlorien, fazia os yogas com a Sonia, isso também me nutriu muito porque encontrávamos, ela fazia yoga pra grávidas 1x por semana. Não era yoga, não gostava de falar que era yoga, mas era uma coisa assim porque fazia vários exercícios de yoga, e a gente conversava, e lia os livros da biblioteca de Lothlorien, então li vários livros muito interessantes. Parto sem dor, e o livro que eu acho que foi o melhor pra mim, foi o Parto Ativo. Esse pra mim foi o livro que eu seguia assim, que eu me identifiquei muito, que realmente no parto foi o que eu usei."*

When we understand choices as embedded in social, cultural, political, economic and gendered power relations, they affect the possibilities to act upon one's (also informed/embedded) desires. As noted by Ortner, agency, or, in this specific context, autonomy, therefore, 'is, in reality, 'something that is always interactively negotiated' (2006:151) and resulting choices might be 'mere' expressions of compliance. In a similar way some Brazilian women end up preferring a caesarean to not go through a possible traumatic vaginal birth (again), Célia is an example of how homebirth can also be a way out of a possible traumatic experience in the hospital (vaginal or caesarean).   Even though for some the variety of options might sound as a privilege, Van Hollen points to the 'contextualized nature of choices'. This is an observation especially valid for Capão:

> *'There is a tendency to glamorize the proliferation of "choices" in the modern world, and thus some think that those communities where multiple "traditional" medical practices exist side by side with "modern" practices are inherently more fortunate than communities with fewer options. In reality, however, we must always consider what is gained by such "choice" and how these choices are structured by such things as political-economic inequalities.' (Van Hollen, 2003:209)*

In Célia's account we see that she consciously engaged in a kind of 'relearning' and redefining of the authoritative knowledge she had been immersed in during her first pregnancy and caesarean. I argue that in her case, this strategy of trust-building has fulfilled the role of transforming the choice for homebirth from 'compliance' and 'lack of trust' in the way she had given birth before, into a kind of 'optional trust' through which she could experience a sense of autonomy she had not experienced during her caesarean.

Finally, we know that in birth and in life in general, choices are enabled and constrained by bodies that act. In other words, if we focus only on women's decision-making, one runs the risk of adopting a 'mere mentalist representation of the choices and actions surrounding reproductive happenings' (VAN DER SIJPT, 2011:23), when, in fact, the body *itself* is an active and often unpredictable actor in this process. In light hereof, she concludes that 'the body does not only enable or constrain women's [reproductive] navigation, but it needs to be navigated itself as well' (IBID.:211). Some women I talked to were very conscious of the influence the body and nature -often understood as inherent to the body- could have on choices and on the actual process of pregnancy and birth. Even though one could think that this might take away trust because it reaffirms the lack of control one has on such processes, many women were able to transform this realization into a way of building trust; we will have a closer look at this in the following section.

5.2.2 Acting bodies & trustworthy nature: deconstructing optionality, 'back' to contingency

> *"acho que esse é um dos maiores pontos aqui no Capão. De alguma forma estar nessa natureza ajuda a gente a encontrar esse lugar da nossa própria natureza, né. Sinto que esse lugar do parto, do gestar e do parir, todo esse ciclo, ele é muito instintivo né. E é muito natural mesmo, mas a gente se distanciou demais, e aí até isso: 'pra parir tem que...' ser assim, fazer yoga, comer isso, e a gente também foi colocando isso numa caixinha. Por viver esse momento mais intelectual, mais mental. Então viver esse processo na cidade acaba, sinto que, implica em que você tenha que fazer parte daquele movimento, daquela caixinha, fazer aqueles tais movimentos pra talvez você conseguir né? E aqui acho que de alguma forma naturalmente isso acontece. A capacidade que a gente tem, acho que ela fica ampliada, da gente se conectar com nossa natureza mesmo."*

Lisandra, one of the birth assistants that had recently entered the *Equipe Parir* -who long before had been attending births autonomously studying with a variety of 'alternative' and biomedical birth attendants- notes how 'we' have distanced ourselves from a more intuitive, natural approach to birth, even people 'from the city' who might want to give birth naturally or at home but who have a more 'mental' approach in which they put certain conditions to give birth at home. Once Natália (the obstetric nurse) got pregnant she experienced such ambiguous feelings about certain 'conditions' or questions a woman 'should' ask herself - well-known among proponents of the humanized birth movement- even though she had been participating in many homebirths and sustains a discourse of the importance of intuition and connection with nature: "*caramba, será que é seguro mesmo parir assim? E eu Natália assim, eu tô pronta pra parir?*

Eu sei parir? Será que eu faço muita atividade física, será que sou bem resolvida com minha sexualidade, com minha mãe?" During one of the birth circles, she mentioned that what helped her to get out of this 'intellectual' place of thinking what you need or want (arguably a kind of 'optional trust' that might create an illusion of control) was to 'simplify' and think: "*sou bicho, sou animal, sou mamífera*." Many women notably put effort in 'leveling' themselves with nature, remembering that they and their bodies are part of nature and that because of that things are likely to go well:

> *"para mim foi muito importante lembrar que independentemente da gente, nosso corpo sabe parir e que, na maioria das vezes, dá certo. Na hora você vai sendo guiada pelo seu corpo. Ele pede o que tem que fazer."* (Daiana, 29 years, paulista who had given birth at home 8 months earlier)

Mariane, who had been an active obstetric nurse in Capão but stopped working for some time and gave birth at home in Capão to her second child remembers that her body asked her to do something that, rationally, as an obstetric nurse, was against what she thought was 'correct': "*com cinco centímetros de dilatação, eu senti vontade de fazer força. Hoje eu acho que isso foi porque meu filho era muito grande (4,3kg) e que foi o jeito do meu corpo de lidar com aquele tamanho. Os corpos são sábios*."

These are interesting examples of Van der Sijpt's observation about 'acting bodies'.Also, they serve as examples of women who knew that, independently of their rational wishes or choices, nature and, inherently, their bodies would act and that they could trust them because they 'know what to do' and are 'wise'. Arguably, we could say that these women engaged in an effort to transform a quite a kind of rationalized 'optional' trust into a more contingent way of trusting, focusing on the contingency of birth itself. Focusing on and trusting this contingency and nature has its 'dark sides', because, generally, it also implies a consciousness of the 'bad' things that can happen in birth. Áureo described it like this:

> *"Só que... você confiar na... a natureza é confiável. A natureza tá pouco se lixando se você vai morrer ou não. Mas ela é confiável, entendeu? Mas a sua mente também não é confiável tanto assim, né? Tem muitas coisas dentro de você, tem muitos traumas, tem muita onda que pode atrapalhar. Afora o fato de que a natureza é confiável, mas também se morrer pra ela é isso mesmo, faz parte da onda. Porque é, entendeu? De repente o menino fez muita estripulia lá dentro, ó... o cordão deu nó e fechou mesmo, morreu, pronto. Foi a natureza. Foi quem? A natureza. Né não?"*

As we have seen above, for some of the women *de fora* Capão itself was a source of inspiration and trust to connect to nature, not in the least because they were indeed in the middle

of a quite exuberant part of nature. Aruana, the team's technical nurse, made the following observation:

> *"Eu acho que ele (Capão) tem essa natureza, essas montanhas, essa coisa mais natural mesmo. Do lugar, né, em si. Da estrutura. Dos rios, essas cachoeiras assim no meio do vale que você vê de qualquer lugar, tipo assim... Eu acho que isso é... é isso. Mais a natureza assim, né? Eu vejo que é um lugar que tem uma potência grande mesmo. Assim, uma energia bem boa... e eu acho que isso acaba atraindo também as pessoas, né? Eu acredito nisso, que as pessoas meio que... o lugar chama as pessoas, também. Apesar delas escolherem também, mas tem uma sintonia aí. Eu acho que aqui é um lugar bem fértil, né, a gente vê muitos casos de casais que vem pra cá e tal, e quando chega aqui ou descobrem que tão grávidos, ou engravidam aqui. E acabam voltando pra parir aqui também... não sei o que é não, Aischa. Sei que é mágico."*

During the prenatal consultations, a 'natural' approach towards pregnancy and birth became clear and also constituted the 'horizon of shared suppositions' (SOUZA, 2005) among the team and the women *de fora*. Often, teas and juices were indicated for certain discomforts and Natália frequently suggested to 'connect with nature' by making walks, squatting to pee in nature, and taking a bath in one of the waterfalls (suggestions she gave more frequently to women *de fora* than to native women). Dorothy from Rio remembers that she was already in a personal process of reflecting on what she wanted with her life and with her job, which, when she arrived in Capão, intensified. She says that she felt that Capão 'awakens' something that you already have in you: *"Me reconheci aqui. Lembro que eu estava numa pousada aqui e me olhei no espelho. Era como se eu tivesse me reencontrado: essa sou eu, sabe? Aqui te desperta alguma coisa, o que é que estou fazendo com essa vida?*" Besides that, she discovered that Capão was a national reference in terms of homebirth assistance, which made her trust even more.

Fabi, one of the first 'neo-rurals' was inspired by Capão in a different way. She did not go to Capão to give birth, nor did she know beforehand that Capão had such a long and ongoing tradition of homebirth. However, this and the many births she heard of and witnessed in Capão before getting pregnant inspired her to the point that she redefined what had been 'normal' and 'authoritative' for her:

> *"Nossa, quando eu vim morar aqui, eu passei a viver, eu procurava viver da forma como as pessoas aqui viviam. Eu gostava muito daquela forma, eu admirava demais aquela forma. E parir em hospital passou a ser algo para mim que não fazia nenhum sentido, a não ser numa situação de emergência, de necessidade, né. E como eu morei aqui quase 5 anos até eu engravidar, então eu vivenciei muitas mulheres, muitas histórias de partos de mulheres, tanto nativas quanto não nativas. Mulheres que vinham aqui para parir."*

The hearing and witnessing of positive birth stories have been, as was also true for many of the birth assistants, important generators of trust. In this section we have seen that such trust was mainly built through the actual proof that, generally, nature and birthing bodies (considered as part of nature) are trustworthy. In the next section, we will focus on another space in which, among other things, birth stories have been shared: the birth circles that were promoted by *Equipe Parir*.

5.2.3 Birth circle as generator of 'optional trust'

Every Tuesday the *Equipe Parir* used to promote free birth circles in a cultural space owned by Natália and her husband (who teaches capoeira classes in the same space), which they also called '*a roda do Parir'*. This section does not appear in the previous chapter, because I have not witnessed a circle where a native woman was present. Natália confirmed that it was very rare for native women to go there, in her opinion because they sometimes felt ashamed or did not really want to do 'too much talking about the whole process'. During the prenatal consultations I did observe her inviting some of the native women for the circle, but in all of these observations they did not react very excited. Unfortunately, I did not have the chance to research this segregation in further detail. One might question, however, if financial involvement/capital was a reason for native women to not feel comfortable in these circles, or if they -possibly because homebirth has been a more normalized practice for them compared to the majority of the women *de fora*- did not feel the need to talk about it.

There were, however, a few circles in which Natália and other birth attendants shared the birth stories of some of the native women they had assisted recently. I am not sure if this happened with their permission, however they seemed to serve as examples for the women *de fora* of how homebirth can also be a completely 'normalized' and, compared to certain 'urban' expectations of homebirth and observing the participants' reactions, more 'banalized':

> *"Chego lá (Natália), TV ligada, ela deitada, irmã do lado. Ela já se torcendo, eu achei ótimo, mas o colo estava 3 para 4 cm. Jornal da BAND no fundo, noticiário só de morte [todo mundo na roda ri]. Ela pirada com as contrações: 'ai, que merda, porra!' [todo mundo ri]. A cama estava desmontando. A criançinha não nasceu tão bem. Aspirei e ficou melhor. Lívia fez um reiki e a criança foi melhorando logo depois a família chegou. Já ligou a TV logo depois. É bem relaxado, não tem enfrentamento."*

During another circle, a birth story of another native woman who did not participate in the circles and who ended up having a caesarean is shared, emphasizing how the circles are

important to demystify certain (‘native’) myths and practices that are considered a possible negative influence on the birth process:

> *“Aqui a gente recomenda que não tenha muita gente. Mas nesse parto tinha bastante gente, falavam muito, coisas incríveis, tipo histórias de partos complicados, que não deram certo, etc. [algumas pessoas na roda: ‘vixe!’] E aqui tem a cultura de não mandar as pessoas embora, né? Complicado. Ela não veio pras rodas, onde a gente indica que não chame pelo nome, que não converse muito etc. Ao ponto que não conseguiu nem remanejar, porque muitas vezes a gente consegue. Ela não saiu dos 4 cm. Não teve como. Tiramos ela de casa, para uma pousada. Aí começou, apertou, a mãe dela ainda veio de Seabra. Ela queria tanto parir em casa. Aí examinou de novo, mas não tinha andado. Aí mandou pro hospital. Fizeram a cesárea rápido.”*

Natália afirma: “*se tivesse vindo pras rodas provavelmente teria sido um cenário diferente. Se teria parido em casa, ninguém sabe...”* One could question the ethics of sharing such stories with the intention to find explanations for events (caesarean, in this case) that generate a sense of ‘blame’ and that reinforce so-called oppositions between native and ‘outside’ notions of birth. For the women *de fora* that did participate in the circles, however, some of these native birth stories served as clear examples of the contingency of birth itself and the consequential need to engage in ways of trusting that consider this contingency. As such, these stories provided a space for the mutual accommodation of ways of in which trust was built. Also, they contributed to the creation of an imaginary for their own births, not in the least because possible complicated and challenging situations were also discussed:

> *“A criança não ficou bem [depois do parto de uma nativa] mas fiquei imaginando a cena: povo sem dinheiro nenhum, chegar no hospital ainda dizer que nasceu em casa, ia mandar pro Irecê. “Deus me dá uma luz.” Vou aspirar de novo. Daquele jeito de hospital, enfiar mesmo ir lá no fundo, aspirei. Abri a roupa e fui chamar ele: “venha meu filho, bora, você não vai pro hospital.” Botei o peito, começou a chupar. Ela chorando, preocupada. Ele parou de gemer. “Hoje dá para passar a noite aqui.” E hoje ele já estava legal.”*

These stories always raised some concerned looks, however the people that were present in the circle generally continued asking for more information about possible other complications and what their options would be in such cases. After Dorothy’s birth she had quite significant bleeding in which they had to intervene, as Lisandra recounted in one of the circles:

> *"Depois do parto teve um sangramento legal.. Colocamos ocitocina pro útero contrair, mas também falamos para ela chamar o útero para de sangrar. Estamos num lugar rural, então temos que tomar algumas providências... Mas deu tudo certo."*

To me, these accounts of complications and the ways in which the team has acted upon them have served as examples of the contingency of birth. If the women who listened to them had a sense of 'optionality' or 'control' in birth in the first place, they were provided with clear proof of what Áureo once gave me as a piece of advice: "*Na medicina e no amor, nem nunca, nem sempre"*.

In almost all of the circles, and some with a specific theme such as 'the stages of labor', general information about the physiology of birth would be shared and discussed. Dilation, muscles of the pelvis, physiological positions to give birth and non-medical pain-relief techniques were commonly discussed. In a certain sense, these circles were a continuation of what Áureo had started when he founded Lothlorien. In earlier times, when he started attending births and offered free consultations at Lothlorien, he, his wife at the time and one of the other founders of Lothlorien started a '*roda de conversa, demonstrações e vivências'*, as Fabi, one of the neo-rurals, put it. As we will see, he shared information that would go beyond what women nowadays 'learn' in the circle, such as how to sterilize and how to cut the umbilical cord. At the time, he shared these kinds of information knowing that not all local midwifes knew about these essential practices and that he would not be able to be present at every birth, so that they would become a common sense among the people:

> *"A gente simulava o nascimento, com almofadas, uma mulher virava bebê, outra era a mulher que tava parindo, outras eram as parteiras, e a gente nascia né, por dentro das almofadas, era muito engraçado! Mas assim, a coisa de pegar a cabecinha, do movimento de pegar a cabecinha pra ajudar o fluxo da passagem do ombro, da criança, de segurar fúrcula aqui embaixo entre a vagina e o ânus, a gente aprendia. Era bem detalhista, era muito lindo. [...] Então veio trazendo todo esse conhecimento da esterilização, da gente esterilizar as gases que a gente comprava que as vezes não eram esterilizados, esterilizar os panos, os lençois, ele ensinava botar no forno, enrolado no papel craft aquele papel marrom. Tantos minutos, depois botava num saco plástico, então a gente se preparava pra ter o parto em casa, né. A gilette, o fio, pra cortar o umbigo. Fio dental pra amarrar o umbigo, preparava 4 dedos do umbigo da criança, amarrava de 2 lados, cortava no meio pra não ter sangramento da mulher, da criança, esperar o cordão parar de pulsar. Então todos esses detalhes ele ia nutrindo a gente, ensinando, para a situação que poderia acontecer dele não estar."* (Fabi)

Besides the theoretical and practical knowledge that was shared in the circles, many birth stories were told, either by the women who had already given birth or by the members of the team. These accounts proved to transmit a lot of trust to the women who had not given birth yet, especially in themselves, as they heard about real experiences of what they were about to live. Dorothy said: *"aqueles relatos me deram a confiança de que eu também ia conseguir. De que todas nos temos medos, mas ouvir que elas conseguiram parir mesmo com esses medos me dava um acalanto, uma força enorme, vontade de parir."*

These circles have been a great contribution to what we could call 'emergent epistemologies', spaces in which knowledge is shared, acquired, unlearned, relearned, and redefined. These processes, along with the sharing of personal birth stories, together created a highly fertile time-space for constituting 'a horizon of shared suppositions'. I argue that the sense of belonging that pregnant women so often seem to search for in an overwhelming amount of information, sensations and expectations, has been an essential form of trust-building that resulted from these circles.

5.2.4 Too much trust?

Giving birth at home in Brazil is, almost inevitably, a politicized practice, not least considering the highly normalized claims of the dominant and public discourses that favor hospital birth and caesareans. Capão has proven to be a kind of laboratory for the subjugation of these discourses and, arguably because of that, has also been a space for people who decide to 'reclaim' birth as social, non-medical event and give birth without any kind of attendant. Throughout the years I visited Capão, I was told a few of what in the literature is often called 'unassisted birth' stories. Here, I will not engage in the debate surrounding the topic, as the intention is to go beyond any kind of judgement commonly involved in it and focus on how these practices and discourses influenced processes of trust-building. Among my pregnant interlocutors at the time, there was one who seriously considered giving birth with only her partner present. During a coffee we had at her home, I asked her how she came to this desire:

> *"Aí eu falei: 'Nat, tô pensando em parir sozinha dessa vez. Porque isso era meio que o desejo no meu coração. Porque eu sinto que isso é o mais natural. Também me inspiro muito na minha avó e gostaria. Acho que é uma coisa meio romântica assim, de estar só eu, meu marido, meus filhos e uma amiga que é minha irmã. Eu quero meu companheiro... realmente a gente pare juntos. Ele é o que eu quero mesmo, que esteja mesmo com certeza absoluta. Os outros todos pode ser que sim, que não, mas ele... Não teria medo de parir sozinha, sabe? Já pari tantos, eu acho que eu já*

> *passei as fortes emoções que tinha que passar. E mesmo com tudo isso, deu tudo certo. E hoje em dia eu acho que até eu faria respiração boca-nariz, intuitiva assim, eu estudei também. Porque depois falei, cara, preciso estudar isso aí. Todo mundo precisa saber isso. E eu faria, eu acho. Acho que mesmo sem estudar, tem um instinto aí."*

She mentions how she used different resources of trust to arrive to the 'final' trust that she would be able to give birth without the presence of a birth attendant: memory of her grandmother (who had also given birth by herself); the fact that she feels she and her partner give birth together (she is not alone); her experience with birth, even with challenging moments in these births; and her trust in her intuitive knowledge to deal with possible complications. Birth attendants in Capão have shown different attitudes towards these desires. Áureo in particular has generally interpreted them as a 'mistake of self-sufficiency', arguably an excess of trust, especially because he has witnessed what could have possibly go wrong:

> *"Quando eu faço acompanhamento eu pergunto "Vai parir com quem? Como é que você vai parir aqui?", aí a pessoa me diz: "Não, é eu me meu marido somente." Aí eu digo, eu falo: "Olhe, repare, o parto é uma coisa natural, deve ser tudo bem. Porém eu particularmente não concordo que faça assim, você é primeiro filho, você não tem experiência, você não tem conhecimento, eu acho que você deveria pensar em fazer o parto com alguém que já tenha essa experiência." Eu sempre falo isso, entendeu? Teve um casal aqui que resolveu fazer isso, na hora exata chamaram uma das enfermeiras obstetras, por que a merda rolou feio e Mariane foi lá e disse "Olhe, isso aqui não é nem pra mim. Aqui tem que ser Áureo", me chamaram. Eu digo "Se não fosse...", era por que a criança tava num sentido de posição e ademais teve colo anterior... Tive trabalho. Nasceu. Normal. Mas a criança ia morrer, ia morrer, ia ficar ali naquela pressão até morrer, entendeu? Pronto. Depois que nasceu ainda teve alguma coisa que eu não me lembro, acho que uma coisa de placenta. Quer dizer, era uma coisa bem complicada e eles tavam na fantasia de que eles poderiam fazer tudo sozinhos, entendeu? Mas cometeram esse equívoco de... de autossuficiência, né?"*

We could state that in his account, Áureo observed that the excess of trust can lead to underestimating the contingency of birth. Aruana, the technical nurse, mentions another contingent factor in the reality of giving birth in Capão without birth assistants, especially in case of complications: "*As pessoas que vêm de fora tem uma ideia, mas quando chega aqui não é como, não é como a gente imagina. A estrada é mais difícil do que você pensa, mais longe, né*."

5.2.4 Spirituality

> *"As pessoas que vem aqui para parir em geral já vem com a espiritualidade assim mais, mais aguçada não, com, com uma busca maior eu acho também, muitas, né? De aprofundar mais se conhecer e se conectar mesmo com as coisas mais simples e naturais que tem..."* (Aruana)

This 'bigger search' for different forms of spirituality was something that many women shared when they talked about what helped them in their journey towards trusting enough to give birth at home. Not only did many women understand birth as a spiritual moment, in which a possible reincarnation occurred and in which they connected with 'other dimensions', they also used this understanding to support the idea that they did not only have to trust themselves, their bodies or the birth attendants; there was support 'from beyond'. Some of them felt a certain 'spiritual/divine presence' that they knew would give them strength. For another woman, she felt that her midwife was a person with a strong spiritual connection to unborn babies and with a certain power to deal with complicated births. Knowing that this midwife would be present at her birth provided her with the trust that there would be help from 'other dimensions' as well:

> *"Então em geral eu vou na casa dela, ela tem uma salinha incrível ali que já tem egrégora. Do espiritual, já tem um individuo ali formado, as guianças dela a gente chega ali e já junta as nossas, já abre aquele portal do invisível. Você tem que conversar com ela na casa dela. É bem lindo mesmo. Então já tem um campo, já tem um egrégora. Então sinto que o lugar dali, tanto é que em muitos partos difíceis mesmo, era só ela. Não tinha ninguém mais, era bem ela de chamar mesmo, de chamar a criança pelo nome, chamar a criança de volta pra terra, para ver o espírito nessa missão de reencarnar. Então sinto que a ligação dela é muito forte com os bebês que estão chegando. Tudo chega pra ela, quase todos assim."*

Célia found great trust in a what had come to her in one of her 'mediumistic visions' and what she called 'divine perfection'. She mentions this trust especially in relation to the fear many women have -and she seemed not to have- of anything going wrong during birth and, in the worst case, the presence of death. This trust in the 'divine perfection' helped her dealing with, and, in her own words, even eliminating any kind of fear about and being at peace with whatever the outcome of the birth would be:

> *"Sinceramente eu acho que a raiz mesmo da minha confiança é a crença de que tudo está perfeito. A perfeição divina mesmo. Confiar que a morte não existe, que ninguém é de ninguém, ele não é meu, nenhum filho meu é meu, nos somos do universo, da força maior, da fonte. Existe uma fonte que cria tudo no universo e a vida é eterna mesmo. Acho que a minha consciência espiritual que me dava: tá, se você vai agora, a gente vai se encontrar depois. Sabe? E é muito uma consciência de que na verdade nos somos irmãos. Eu considero que sou um*

portal dimensional, sabe, tipo, a mãe é um portal que o ser vai passar de um plano pra outro e nos somos só uma porta. E a gente dá os primeiros ingredientes do plano da matéria para.. a gente cria a nave aqui dentro, mas o ser ele é eterno, ele pode ser inclusive mais antigo que eu. Então assim, acho que essa consciência de se a gente se separa agora nessa vida, quando a gente volta pro plano espiritual a gente se encontra, a gente vai poder ter mais consciência do porque que essa passagem foi tão... E eu também confio muito que nada.. a gente já traz experiências que a gente tem que viver. Então tudo que acontece na nossa vida é porque a gente tinha que aprender algo com aquilo. Então em vez de ficar ah.. aconteceu essa desgraça na minha vida... todas as situações fortes eu aprendi a olhar pra elas e falar: que eu tenho que aprender com isso? O que isso veio me ensinar? E agradecer muito as formas de ensinar. Eu estou estudando fortemente para poder aprender desde a luz, desde o amor, desde a alegria, sem sofrimento e sem sacrifício, que eu vejo que a gente nesse planeta há muitos séculos estamos aprendendo desde sofrimento, do sacrifício, e a gente pode aprender de outra maneira ne?"

These discourses can be seen as strong subjugations of the dominant technocratic and biomedical discourse in Brazil, in which we can find many resemblances with the Descartian notion of the 'body-machine' and where the only person who can possibly 'fix' it whenever a complication occurs during birth, is the obstetrician. They are a 'means of contesting the role of the obstetrician as absolute expert in hospital deliveries' (Cheyney, 2008:259), through which they not only put themselves, but a kind of 'divine conspiracy' as the protagonists of the birth scene and life in general. In addition, I argue that in this notion of 'divine perfection' we can also identify an understanding of the contingency of birth; even though there might be a certain 'larger plan', no one exactly knows what it looks like and, consequentially, what will happen in birth.

5.2.5 Mistrust in authoritative knowledge about birth and hospital assistance

Sadly, mistrust in the dominant biomedical birth assistance has proven to be an important generator of the will and need to trust[94] homebirth. Similar to what I have seen during my research in Salvador, some women generated this need through a lived traumatic experience with the hospital, others through a lack of identification with the way birth is understood and managed in medical contexts. In the latter case, such lack of identification frequently emerged after 'unlearning and relearning' of authoritative knowledge as previously discussed. It is not surprising that these processes, in which more and more people have access to information about areas that used to belong strictly to their professionals, have resulted in mistrust in these

[94] See Möllering, 2007 and McKnight & Chervany, 2001 for an exploration of the 'will' and 'willingness' to trust.

same areas. What has become clear is that mistrust often contributes to avoid taking a path (again) that the 'mistruster' understands as risky and with possible negative consequences ('too contingent'?), either because of previous experiences or because of lack of identification. In this sense, interestingly, the generation of mistrust has been understood not only as the opposite of trust, but also as a 'functional equivalent for trust' (Luhmann in McKnight & Chervany, 2001:42), considering the fact that both reflect 'movements toward certainty' (ibid.:43). However, mistrust only avoids uncertainty, it does not 'solve' it. In the case of birth, 'uncertainty' could be translated into 'contingency', which we know to be inherent to the birthing process. Mistrust in the dominant authoritative knowledge and birth assistance therefore does not automatically imply trust in homebirth. As we have seen and will see here, after a negative experience and/or lack of identification, women have used many other sources of trust to build the trust they needed to actually give birth at home in Capão. I will first turn to a few cases in which a lack of identification with the dominant ways of conceiving of and managing birth preceded their mistrust and, consequentially, search for trust in an alternative way of giving birth. Leo (28), an Argentinian who married Liza (26, 8 months pregnant of her first child) from Pará, sighed deeply during one of the circles and said:

> *"acho que tem a ver também um pouco com uma realidade cultural de como funciona a assistência médica no país. Na verdade, como não funciona. Então acho que muitos de nós deixamos de confiar no parto com a instituição de medicina, no hospital, coisa do tipo porque sabemos que lá falta uma ética da vida, uma bioética. creio que falta um pouco nos profissionais da saúde, de modo geral, também nasci numa cidade grande, falta amor pela vida. Muitos trabalham na saúde como uma profissão apenas, e creio que se a pessoa entra na área de saúde ele tem que saber que tem uma grande responsabilidade e um grande compromisso que tem que colocar num respeito e um amor pelo que tá fazendo para além de um pensamento de mecânica de trabalho. Porque é uma coisa muito delicada a saúde, primeiramente isso, e depois pra você estar negando um atendimento, você tá negando um ser humano, tratando como uma máquina. Então para lidar com ser humano você tem que lidar tipo com coração, você tem que ter gentileza, cuidado, saber onde tocar, onde não tocar, qual é a hora correta, levar uma série de coisa em consideração, por isso que as vezes vejo médicos que quero saber: o que te levou a escolher essa profissão? Porque o estilo que você se comporta deixa muito a desejar, sabe? As vezes isso é uma das coisas que até hoje eu sinto uma pequena revolta em relação a isso. Acredito que isso que elas tão fazendo aqui não somente um trabalho em relação a maternidade, mas é um exemplo para a saúde de forma geral, como se comportar num serviço desse tipo."*

As we saw in the beginning of the section about the women *de fora,* Dorothy, the pregnant nurse from Rio, notes that before she got pregnant and arrived in Capão, she had already been going through a process in which she felt highly disenchanted with the biomedical

system she was inserted and worked in every day. She experienced a similar ideological disconnection from the common and dominant way of managing health in general as Leo, and becoming aware of the possibility of giving birth at home pushed her towards her search for trust after mistrust.

Cris, who had always disliked (not necessarily mistrusted) hospitals, felt that she might not have a child because she would have to give birth in a hospital. In other words, she mistrusted that she would have a positive experience there. When she arrived in Capão and saw that women had been giving birth at home for ages and that there were medically trained birth attendants who could assist her too, she said:

> *"Falei gente, me achei! Agora posso ter um filho. Porque até então pensar em ter filho falava, nossa, vou ter que ir prum hospital e não quero. Hospital sempre pra mim me remeteu a um lugar de doente, uma pessoa que tá doente que precisa de assistência. Não é um lugar pra você receber uma criança."*

Before Célia experienced a violent hospital birth in Brasília, as one of the many women that suffer from obstetric violence in Brazil, her mother had already told her that vaginal birth was much better than caesarean – she had experienced both. Therefore, she also had a great desire to give birth vaginally, however the obstetrician that assisted her talked her into a caesarean. From then on, she has only traumatic memories from what she experienced there. I will share a few excerpts from a conversation we had in her garden, drinking a cup of tea. As she spoke, the indignation in her voice was clear. The kinds of violence she suffered are, as we have seen in the introduction, very common in Brazil. Nevertheless, I consider it necessary to share them as much as possible, with the intention to raise awareness and be part of, through this dissertation, the redefining of authoritative knowledges that have contributed to the violation of basic human rights.

> *"Ele falou pra mim que se eu parisse normal, meu bebe era muito grande. Porque o que acontece? Eles me encheram de vitaminas e suplementos artificiais, eu engordei muito, meu bebe engordou muito, ele foi meu maior bebe. E aí foi isso, aí o médico falou olha, seu bebe é muito grande você é muito pequena, se você tiver um parto normal ele vai te arrebentar. E você vai ter problemas na sua vida sexual pro resto da vida. E ó, não adianta não, ele falou bem assim: os homens falam que isso não importa mas a verdade é que importa sim!*
>
> *E aí eles ficavam conversando de qualquer coisa, assuntos super banais, e rindo, e era como se eu não tivesse ali. Era como se fosse totalmente, eu era a ignorada da sala. Eles blabla conversando de qualquer coisa, e eu completamente sozinha.*

Quando deito, me amarram. O que que é isso? Quando me amarram, paralizada. Aí já me senti completamente assim inútil e vulnerável. E aí quando eles abriram minha barriga, o bebe subiu, muito. Hoje eu vejo assim que ele não queria nascer. Não era a hora dele nascer. Ele fugiu! Ele veio para aqui em cima. E minha barriga foi sempre baixa, e vrah subiu. Subiu e não saia, não saia! Tiveram que empurrar muito ele. E aí subiram na minha barriga o médico e a enfermeira começaram a empurrar ele, que eu via assim, o médico tirou o pé do chão. Ele botou o corpo dele inteiro em cima. O que aconteceu? Travou minha respiração, menina, não conseguia respirar. Não conseguia gritar falar que não tava respirando. Cara, foi uma situação.. eu achei que ia morrer. Asfixiada que ninguém ia ver que tava asfixiada. E eu ah, oh, uh.. Cara foi, pânico, pânico

Enrolam ele que nem um charutinho, botaram o bebe no meu braço. E eu, drogadíssima, me sentia mesmo drogada. Me veio um super medo, não sei cuidar desse menino? Como vão deixar ele comigo? Aí fui pro UTI, aí aquela sala que fica umas que pariram, umas que abortaram, umas que o bebê morreu, tudo junto, então tinham elas e eu com meu bebe ali. Aquele clima, o lugar escuro, pesado, uma densidade. Para mim era como se tivesse no inferno. Inferno. Morrendo de dor. Aí passou a anestesia e veio uma dor, foi a pior dor que já senti.

E eu me lembro, ele fez uma cara meio estranha, ele tirou uma injeção do bolso, e ele botou isso no meu soro. Cara, na hora que tinha terminado de aplicar eu já tava.. eu acho que esse cara me aplicou morfina. Porque depois eu descobri que ele quase perdeu a licença médica porque era viciado em morfina. Ele já tinha perdido a licença medica uma vez. E a cara de louco que ele fez quando ele tirou essa injeção do bolso, amiga, tudo começou a girar. Me veio aquele prazer, fiquei doidona, com meu filho aqui. Mesmo. Só que depois, passou esse efeito desse negócio, voltei pra mesma dor, muita dor, criei um mantra assim: nunca mais eu vou ter filho, nunca mais eu vou ter filho, nunca mais eu vou ter filho.

Aí a enfermeira vem, tirou minha teta, menina, sem falar comigo uma palavra, tipo mãe, vamos fazer o procedimento do amamentar. Cara, é uma violência. Um abuso, abuso atrás de abuso. E aí ela tirou minha teta, pegou o bebe, espirrou o leite dentro da boca do bebe e aí o bebe já chpchpchp, mamou na hora.

É, e não foi uma decisão de um lugar romântico. Sinceramente foi uma decisão de um lugar de trauma. Eu não conseguia nem pensar em viver aquela situação de novo. Ir pro hospital pra mim me deixava em pânico. Então eu via minha mãe nossa é muito corajosa! E não era coragem! Era medo, era desespero."

From these unsettling accounts of her caesarean, it is not surprising to imagine her desire to never go through such experiences again. In similar ways, there are many women in Brazil who prefer a caesarean, next to many other factors that influence this preference, due to violent experiences in previous vaginal births or accounts from friends and family. McCallum (2005),

who broadly studied women's strategies in seeking a caesarean section in Salvador, concludes that 'what some read as women's 'cultural' inclination towards abdominal birth may simply be compliance, born in the absence of both a coherent, culturally appropriate critique of existing practices and knowledge about vaginal delivery.' I would add that inclination towards a caesarean as much as towards homebirth in the case of previously experienced violence with either one of the options can emerge not only from compliance, but from a great need to avoid the repetition of trauma, which is infused with a large spectrum of socio-economic and structural inequalities. These are clear examples of why 'reproductive navigation' and 'choices' are not the 'result of rational, informed decision-making about the best form of childbirth in an abstract sense, but as the best form under their own difficult social and economic circumstances.' (MCCALLUM, 2005)

5.2.6 Trust in the team & intimacy

From the months I spent in Capão and the years that I had been in contact with the members of the *Equipe Parir*, it became very clear that they managed to create a high level of intimacy with almost everyone they attended. This often started during the prenatal consultations, in which they got to know each other and shared personal stories and experiences, or got to know each other even better. As I mentioned, various shared suppositions were exchanged and all of the women I talked to felt understood and taken care of. One day, Natália spend more than an hour with Paty, who was pregnant with her second child and seemed quite distressed and in need of someone who would listen to her. When she arrived in the room, she talked for half an hour about what was worrying her. Natália asked her about her partner, his involvement in the pregnancy, how she got pregnant, if she was having worries about her financial situation.

Figure 22: Natália (lying on the matress) during one of the prenatal home visits

During the weekly circles, this intimacy continued to be constructed and, I would argue, the prenatal home visits and extra appointments for massages that occurred generally created a kind of intimacy in which the women as much as the partners felt comfortable to the point of sharing details about, for example, their (sexual) relationship and past traumas. If we consider Eurocentric notions of intimacy, one could argue that intimacy is inherent to birth, mainly because it implies nudity and the exposure of (instinctive) behavior that is rarely found in the public sphere. However, with the transferral of birth from the home to the hospital, much of such notions of intimacy got lost and a variety of techniques were developed to diminish the presence of intimacy in the birth place (caesarean section; standardized clothing in the hospital; routinized practices; protocols; and 'intimate strangers' (CHEYNEY, 2011: 66) or medical personnel who 'control' the birthing process, among others). In this light, homebirth challenges the notion of birth as a medical event – defining it as an intimate and sexual event that is

supposed to occur in an intimate space, the home - which is also a space that belongs to the woman, with her clothes, her belongings, her habits and routines.

In Capão, the majority of the women I spoke to indeed considered their homes to be a private space that required a certain level of intimacy with anyone they would receive there. This intimacy was mutually constructed in a variety of ways:

> *"O cuidado que elas têm de fazer massagem, de te responder as mensagens sempre, de fazer as visitas, a visita da Lisandra que era uma coisa que tava assim, não, era disso que eu precisava, mais isso né?! Lívia que me fez massagem e que, só as conversas mesmo de estar ali perguntando como você está, tá tudo bem? E o acompanhamento é bem próximo. É bem perto que elas fazem. Não tem como você não se sentir acolhida, e ver que elas se importam né?"* (Sarah)

For Sarah, 'to see that they care' in intimate ways through massages, messages, and empathic questions was an important form of building trust in the team. This idea can be contrasted with what I have heared women in Salvador report from their experiences in the hospital, in which many of them had felt 'just one more woman giving birth', and their child 'just one more baby being born', missing an individual and more intimate approach. Cris expressed a similar feeling, a feeling that she matters, however through a sense of love that she feels from the team:

> *"Natália no posto ela é incrível, ela passa muita confiança, muito boa assim. Ela é amorosa, ela tem amor pelos bebês mesmo, tanto é que quem pegou Chiquinho foi ela mesmo assim. Então eu tinha confiança por elas mesmo, pela presença delas, mesmo que não fossem minhas amigas, mas ali confiava 100%. Eu acho que o que eu sinto é muito na amorosidade. Não sei se eu sou do coração, então o que me pega é essa coisa do amor né, então ela é muito amorosa. Então toda a atenção vai através dessa linhagem do amor, então você vê que o que rege mesmo é essa coisa do amor."*

Cris also mentions that, compared to six years ago, she notices that Natália has much more trust in herself and in 'the process', and, I would say, they identify more on a spiritual level, which makes her trust Natália even more:

> *"Ela é toda certinha, claro que agora sinto que nessa, tanto Maristela quanto a Lisandra tira ela um pouco desse lugar da enfermeira obstetra, científico, faculdade, para uma coisa mais abertura espiritual. Uma coisa mais do invisível, então ela tá abrindo para esse outro campo das possibilidades. Então ela tá vendo muitos milagres com Thetahealing, de coisas que pra ela logicamente, tipo: como assim né? Um exame vai mudar por causa de uma sessão de Thetahealing?! Pra ela tá sendo assim uma abertura incrível, já vê a diferença mesmo. Chiquinho vai fazer 6 anos, então 6 anos depois tô pegando outra Natália. Bem mais tranquila, bem mais confiante, bem mais entregue ao processo."*

Célia mentioned that for her previous birth she trusted Natália not only because of her loving and informing care, but also because of her experience and knowledge founded in science.

> *"Então ela me orientou totalmente, e ela me deu muita confiança também porque eu vi que o que nutriu minha confiança é que Natália era, tinha muitos conhecimentos científicos mesmo, obstétricos, entende. E realmente foi muito necessário, porque esse parto foi pélvico. E foi um parto muito especial, né. Porque foi muito diferente de um parto normal, normal, normal. Não foi tão normal né. Foi singular. E depois eu fiquei pensando que no momento do parto, é tão bom quando você recebe um carinho que sabe o que tá fazendo. Um carinho de doula, um carinho de parteira, um carinho de alguém que sabe, sabe? Aquelas coisas, massagem, água quente.*

As we also saw in Cris' account of Natália who got more familiar with spiritual notions of pregnancy and birth, intimacy was also generated through the fact that the birth attendants were very skilled at tapping into the variety of (spiritual) ways in which each pregnant woman built her trust (e.g. horizon of shared suppositions) and nurtured her with individualized information that, in its turn, very effectively built trust in the birth attendants:

> *"Então ela tem um estudo mais específico da gravidez, mas ela também vai muito assim: ela fez uma coisa ontem comigo que foi bem importante. 'Você falou com o bebê?' Falei. 'Você perguntou pra ele se tá faltando alguma coisa?' Perguntei. 'O que ele te falou?' Falou que ele tá super bem, que não tá faltando. 'Então?! Sabe? Você tem que confiar no aqui e agora, no que você tá sentindo. Você se sente bem? Se sente fraca?' Me sinto bem. 'Você ta super bem.' Então ela também tem uma perspectiva muito da intuição que me encanta."* (Célia about Natália)

Finally, Fabi remembers the time she was pregnant and 'fell in love' with Áureo and the way he assisted the pregnant women in Capão:

> *"Sim, a pessoa dele né, tinha uma coisa de Áureo que realmente encantava muito a gente, que era a entrega dele. A entrega e o amor, o amor com qual ele realizava aquele trabalho. Isso dava muita confiança. Então ele tava sempre feliz com o que ele tava fazendo, tava sempre alegre, ele estava sempre disponível! Entendeu? Não tinha, a gente não tinha receio de buscar Áureo, porque ele não ia dizer não. Ele sempre vinha. Também acho que foi uma coisa que ele adqiriu a experiência aqui, amadurecendo, quando ele percebia que não ia avançar, ele mandava providenciar realmente que a família levasse, encaminhasse a mulher pro hospital. Fosse em Iraquara, fosse em Seabra, fosse onde fosse. Então isso dava muita confiança na gente. E também era bem lindo pq ele envolvia a família. Não era aquela situação que ele chegava e pra fazer o parto e pronto, ficava todo mundo na sala esperando e o médico dentro do quarto fazendo o parto, não, não era assim. Todo mundo participava. Quem tava na casa ele ia delegando, o marido segurava, quem tá ali esquenta uma água, faz um chá."*

Similar to what Cris and Sarah mentioned in relation to a loving way of caring, Fabi observes his dedication and passion for his work. Another important fact for trust was the seriousness in their work related to the remoteness of Capão and reduced access to medical intervention. Fabi was not the only woman who told me how important it was to perceive that they would 'do anything' or 'force things' only for the woman to give birth at home. If things got too complicated, they trusted that the team would transfer them to the hospital.

The various expressions of intimacy we have seen here can be understood in terms of what Robbie Davis-Floyd (1992) has called the 'holistic model of birth'. A model that in many aspects resembles the holistic one described in terms of North American ethnography could be linked to the way birth assistance is conceived of in Capão. However, although this comparison is important, it is worth recalling that in practice concepts and values are in constant re-eaboration, and that an appeal to 'models' should not lead to unwarranted reification of conceptual systems.

In this chapter we saw that Áureo spoke of how he thought that one of the main characteristics of the ways in which native women decided upon and 'trusted' homebirth was their 'contingency', or *confiança contingencial* ('contingent trust') as he called it. The idea he transmitted here is that the native women were inclined to 'take things as they come' and 'accept whatever happens' during pregnancy and birth, arguably because they have a 'less complex' perception of these processes and their desires for them. While there appears to be resemblance to this argument in the discourses of the native women I interviewed, I have argued that while these people are very different in sociological terms, in the social, temporal and spatial context of Capao, the relationships constituted over time among residents, and settlers, have allowed for the growth of forms of trusting (or talking about it) that are multiple in origin, that are expressed and justified in distinct and at times contradictory discourses, philosophies and forms of knowledge, but when conjoined in the events of prenatal care and childbirth itself, take place as if unified, producing in practice what in discourse cannot be seen as singular.

More importantly, I argue that not only ways and notions of trust highly are contingent, birth itself is inherently contingent. In other words, all pregnant and birthing women face it somehow. The *assemblage* of the (contingent) intersubjective spaces, 'flows' and various kinds of words and acts of trust shown here have proven to be ways of managing such contingency.

I have also tried to show that reproductive decisions and possibilities of trust-building were not *less contingent* for women *de fora*. However, structural inequalities that led to less access to information and financial capital made reproductive decisions and possibilities of

trust-building *less optional* for the women that were prejudiced by these inequalities; which in most cases were native women.

Nevertheless, it became clear that there were different forms of mutual accommodation regarding trust-building among native women and women *de fora*. As we saw, there were native women who engaged in efforts to make their 'contingent' trust more 'optional' by informing themselves about why they would 'choose' a homebirth -despite considerable difficulty in accessing the financial means. On the other hand, there where women *de fora* who -actively or passively- became more conscious of the inherent contingency of birth and, therefore, the lack of a supposed optionality. Such mutual accommodation shows us how notions and acts of trust are extremely hybrid and adaptive to time and space and, therefore, processual and ambiguous in character.

Finally, I argue that the search for and creation of intimacy and the understanding of contingency in birth are among some of the most subversive practices within the dominant obstetric assistance as we know it in Brazil. Therefore, we have to consider the important role the building of trust through such subversive practices can have in the redefinition of authoritative knowledge.

In the last chapter of this dissertation, I will provide an overview of the most important arguments that emerged from my research and synthesize them in relation to the literature that has provided inspiration and guidance as I unfolded the ethnographic discussion. I will point to some of its lacunas and show why further research is needed about the unknown country of trust.

6. CONCLUDING THOUGHTS

In this dissertation, I have investigated and analyzed the ways in which women and birth attendants in Capão engaged in acts and notions of trust related to homebirth during the first two decades of 21rst century. Through this investigation it has become clear that the inherent contingency of childbirth has been a reason for all women and birth attendants in this research to embark on a journey in search for trust. As I have exposed, the hegemonic obstetric practices in Brazil are quite distant from what have been considered 'good practices' in homebirth, even more so in the highly hybrid and 'fruitfully accommodated' birth assistance in Capão. Because of this 'distant' and subversive character of homebirth in the context of Brazil, 'choosing' to birth at home has seemed to intensify, or increase the need for this search for trust. I have highlighted that the counter-hegemony and the intensified search for trust related to homebirth in Capão have resulted in 'emergent epistemologies', or a variety of local and structured contexts in which in which knowledge (and 'truth') is continuously produced (TOREN & PINA-CABRAL, 2011). The various forms of trust-building I detailed in Chapters 4 and 5 could be interpreted as an *assemblage* of these epistemologies and, moreover, as the ever-emergent nature of knowledges and 'truths' about homebirth. I argue that these epistemologies, and the inevitable challenge they pose to authoritative epistemologies about childbirth in Brazil, are ever-emerging in large part because the search for trust and the engagement in notions and acts of trust are constant and non-ending. I have shown that this characteristic of these searches for trust is profoundly connected to the contingency of women's 'reproductive navigation'(Van der Sijpt 2011) . This contingency is due to the many 'vital conjunctures' resulting from the 'sociality and physicality of the body' (IBID.). The emergent character of these epistemologies becomes even more clear when we consider the highly socially constructed and physically contingent time-space of pregnancy and birth itself: (around and about) 9 months and several hours in which social structures, people and bodies (if it is possible to separate these from one another) continuously require navigation and thus, produce new knowledge all the time.

Because giving birth at home in Brazil seems to intensify the search for trust and, consequentially, produces emerging epistemologies, and because Capão is a national reference for homebirth assistance, it has proven to be a particularly fertile context in which to conduct and anthropological investigation and through this to contribute to existent literature on childbirth, knowledge and notions and acts of trust. The results, as is ever the case in anthropological studies, show that small-scale, localized ethnographic work contributes to illuminating the larger picture. It has become clear that the fact that homebirth is the main

‘modality’ of birth in Capão (unlike much of the rest of cosmopolitan Brazil) is the result of the coming together of distinct social, political, economic and cultural forces. More specifically, discussion of the geographical and demographic peculiarities and the unique conjunctures of Capão’s residents and visitors has helped bring into focus the interplay with the wider, hegemonic context of obstetrics in Brazil, against, or alongside, and sometimes beneath which, the local historical development of birth assistance and the epistemological journeys of its birth attendants and birthing women has occurred.

The dissertation has interrogated the structures underlying women’s ‘decisions’ to give birth at home. Like Craven, (2007) it draws attention to the possible negative outcomes of what happens when birth enters the realm of commodification and women are driven to adopt a ‘consumer identity’ which seems to confer on them the agency to choose however, wherever and with whoever they would like to give birth. Through these mechanisms, homebirth practices and the emergent epistemologies related to them might actually contribute to the constitution of ‘stratified reproduction’, instead of challenging it .

In Chapter 1, the introduction, I provided an account of the theoretical framework that has been the foundation for this research. I showed that trust research, throughout a variety of disciplines, has frequently employed a ‘thin’ and individualist perspective of a highly complex system of social, cultural, political and economic structures and processes in which women as well as birth attendants are inserted. More than anything, trust has appeared to emerge in interaction, which argues for sensitive ethnographical, cross-cultural analyses of this complex system. I showed how the notions of ‘authoritative knowledge’ (JORDAN, 1987[1993]), the challenge homebirth poses to such authoritative knowledge (CHEYNEY, 2008), ‘reproductive navigation’, ‘vital conjunctures’, ‘sociality and physicality of bodies’ (VAN DER SIJPT, 2011) and ‘commodification of childbirth’ (CRAVEN, 2007) have informed the present research. I described the actual process of the research and the methods I employed.

In Chapter 2, I provided a general overview of the developments within Brazilian obstetrics over the past 50 years. Globalization and the increasing access to flows of information from all over the world have not only informed authoritative knowledge and hegemonic practices in birth care, they and the iatrogenic and violent practices that have emerged from them have also inspired Brazilian women, health professionals and other interested people to rise up against what they consider to be a ‘dehumanizing’ system of dominant discourses, practices and symbols. This overview, provides a panoramic view of the context through which my interlocutors consciously and unconsciously moved, by which they were affected and upon which, through their enthusiastic adherence to homebirth, even left their mark. By doing so I

opened the way to a more detailed understanding of the motivations of women to birth at home and, specifically, the ways in which they have trusted and/or mistrusted in the build-up towards the birth.

In the third chapter I highlighted the main historical and social developments Capão has experienced over the past 40 years. Alongside these developments, I also discussed the ways in which its residents changed their views and practices, to argue that due to the populational characteristics of Capão, they have developed in very unique ways. A number of 'vital conjunctures' (VAN DER SIJPT, 2011) have taken place, which have fertilised the soil for contemporary birth care in Capão: a highly eclectic, fruitfully accommodated and stratified set of notions and practices that continuously emerge and transform under the forces of daily social interaction and the ongoing search for trust.

In the fourth chapter, I analyzed in-depth how birth assistants in Capão grew into their 'calling' and how, nowadays, they engage in acts and adopt notions of trust that help them to maintain and develop it. As we saw, they have all become part of each other's processes towards trust. This includes an understanding of how they learned to stand back from their own authority as a person conducting a childbirth so as to open space for the women who are birthing to come to trust themselves.

The analytical categories grounded in birth attendants' discourses and practices showed that they found trust in a large variety of sources, within them as well as among them. An important source of trust has proven to be the feeling of being on a 'calling', 'mission' and of 'doing the right thing'. Such feelings emerged from and were reinforced by different factors; the normalization of and enchantment with witnessing births; spiritual/religious experiences; studies that convinced them and made them feel even more skilled and connected them to similar international and politicized communities; and external and spiritual characteristics birth attendants found in relation to childbirth in Capão. Besides these, adapting their assistance to the specific context of Capão, creating a space and understanding of the shared responsibility with the women they attended and engaging in a various; highly individualized forms of creating intimacy; acting upon their intuition were practices that built more trust their way of attending homebirths.

As such, I provided a wide *assemblage* of the notions and acts of trust employed by the birth attendants and highlight the ways in which these notions and acts have contributed to 'emergent epistemologies' that have continuously challenged authoritative knowledge about childbirth.

In Chapter 5, I follow and problematise to some extent Áureo's insight that how native women decided upon and 'trusted' homebirth involves a process marked by 'contingency', or *confiança contingencial* ('contingent trust'). I have made it clear that contingency is, more than anything, inherent to childbirth. It transcends any kind of identification one might attribute to women, and in this dissertation, I have shown that this contingency was indeed experienced by all the women involved, independently of their 'status. I argued that while people are very different in sociological terms, in the social, temporal and spatial context of Capao, the relationships constituted over time among residents, and settlers, have allowed for the growth of forms of trusting (or talking about it) that are multiple in origin, that are expressed and justified in distinct and at times contradictory discourses, philosophies and forms of knowledge, but when conjoined in the events of prenatal care and childbirth itself, take place as if unified, producing in practice what in discourse cannot be seen as singular.

More importantly, I argued that not only are ways and notions of trust highly are contingent, birth itself is inherently contingent. In other words, all pregnant and birthing women face it somehow. The *assemblage* of the (contingent) intersubjective spaces, 'flows' and various kinds of words and acts of trust shown here have proven to be ways of managing such contingency.

I have also tried to show that reproductive decisions and possibilities of trust-building were not *less contingent* for women *de fora*. However, structural inequalities that led to less access to information and financial capital made reproductive decisions and possibilities of trust-building *less optional* for the women that were prejudiced by these inequalities; which in most cases were native women.

Nevertheless, it became clear that there were different forms of mutual accommodation regarding trust-building among native women and women *de fora*. As we saw, there were native women who engaged in efforts to make their 'contingent' trust more 'optional' by informing themselves about why they would 'choose' a homebirth -despite considerable difficulty in accessing the financial means. On the other hand, there where women *de fora* who -actively or passively- became more conscious of the inherent contingency of birth and, therefore, the lack of a supposed optionality. Such mutual accommodation shows us how notions and acts of trust are highly interactional, hybrid and adaptive to time and space and, therefore, processual and ambiguous in character.

Finally, I argued that the search for and creation of intimacy and the understanding of contingency in birth are among some of the most subversive practices within the dominant obstetric assistance as we know it in Brazil. Therefore, we have to consider the important role

the building of trust through such subversive practices can have in the redefinition of authoritative knowledge.

Much research is yet to be done, I would say, specifically with regards to the social, political, economic and cultural forces that sustain stratified reproduction in Brazil and that, as we have seen in this dissertation, also play out in homebirth practices. Understanding and questioning the commodification of homebirth, or indeed any kind of health care that has been proved to contribute to individual and public health, can be one approach to such research. In this dissertation I have shown that mechanisms of trust-building, with mutual accommodation and intimacy as two of its main pillars, exercise an influence on stratifying processes on the local, small-scale, inter-subjective level. Moreover, it may be said, if the processes, practices and forms that make up the building of trust during care for pregnant and birthing women in Capão were to be taken as a model elsewhere, it would most likely be found that they contain great potential for contributing to the creation of a less stratified production of emergent epistemologies and more equal access to good quality healthcare. It is necessary to expand research on these topics to other academic and geographical areas in order to develop socially and culturally sensitive understandings and policies.

ANNEXES

Annex I: Folha de rosto

FOLHA DE ROSTO Data entrevista ____________ Numero Entrevista _________

Nome ____

Idade ____

Data nasc. ____

Sexo F M

Cor/raça conforme declarada no censo ____

Naturalidade ____

Local de Residência ____

Tempo de residência na cidade ou região onde trabalha ______________________________

Formação

- Escolaridade (nível) ____
- Instituições de formação profissional (nome, se publico ou particular)

Escola 2do. Grau ____

3ro. Grau ____

Pos-graduação____

Profissão ____

Outras atividades de trabalho ____

Nome da escola / órgão / lugar de trabalho ______________________________________

Cargo ____

Como você (a pesquisadora) classifica o/a entrevistando/a em termos de cor / raça? ________

Nome Entrevistador ____

Obs.

____

____

____

____

____

____

Annex II: Topic list pregnant women/partners/new mothers

- How did the pregnancy come about (planned, unplanned, neither of both, first feelings, expectations)
- Previous contact with/ideas about pregnancy & childbirth – homebirth and hospitals
- Ideas/opinion about dominant birth care in Brazil
- Influence of living in Capão and interactions with other residents on ideas about pregnancy & childbirth
- Relationship with partner – interactions & opinions about pregnancy & birth. Support, disagreements, cultural/social differences etc.
- Life experiences related to trust – disappointments, confirmations, surprises
- Growing up: 'socialized' into trusting
- Cultural notions of trust, either related to Brazil, Capão, country of origin
- Relationship with body and reproductive health. Interaction as a child/adolescent with family/friends; menstruation; sexuality. Notions of body & nature

Annex III: topic list birth attendants

- Relation to and role in birth care in Capão
- Professional trajectory in birth care, arrival in Capão
- Knowledge about childbirth before the arrival of Áureo; before the *Equipe Parir*
- Perceived changes over the years in which you worked in birth care (in amount of births, place of birth, demands for care of women and their partners, exchanges with other health professionals/'traditional' midwives, transfers to & relationship with private&public hospitals, etc)
- Nowadays; interactions with other midwives in Capão
- Perceived changes in your own way of caring
- Influence of birthing/having children yourself
- Perceived differences in sociocultural notions of/desires for birth – how do you respond to these

Annex IV: Código de ética

CÓDIGO DE ÉTICA DO ANTROPÓLOGO E DA ANTROPÓLOGA
Criado na Gestão 1986/1988 e alterado na gestão 2011/2012

Constituem direitos dos antropólogos e das antropólogas, enquanto pesquisadores e pesquisadoras:

1. Direito ao pleno exercício da pesquisa, livre de qualquer tipo de censura no que diga respeito ao tema, à metodologia e ao objeto da investigação.
2. Direito de acesso às populações e às fontes com as quais o/a pesquisador/a precisa trabalhar.
3. Direito de preservar informações confidenciais.
4. Direito de autoria do trabalho antropológico, mesmo quando o trabalho constitua encomenda de organismos públicos ou privados.
5. O direito de autoria implica o direito de publicação e divulgação do resultado de seu trabalho.
6. Direito de autoria e proteção contra o plágio.
7. Os direitos dos antropólogos devem estar subordinados aos direitos das populações que são objeto de pesquisa e têm como contrapartida as responsabilidades inerentes ao exercício da atividade científica.

Constituem direitos das populações que são objeto de pesquisa a serem respeitados pelos antropólogos e antropólogas:

1. Direito de ser informadas sobre a natureza da pesquisa.
2. Direito de recusar-se a participar de uma pesquisa.
3. Direito de preservação de sua intimidade, de acordo com seus padrões culturais.
4. Garantia de que a colaboração prestada à investigação não seja utilizada com o intuito de prejudicar o grupo investigado.
5. Direito de acesso aos resultados da investigação.
6. Direito de autoria e co-autoria das populações sobre sua própria produção cultural.
7. Direito de ter seus códigos culturais respeitados e serem informadas, através de várias formas sobre o significado do consentimento informado em pesquisas realizadas no campo da saúde.

Constituem responsabilidades dos antropólogos e das antropólogas:

1. Oferecer informações objetivas sobre suas qualificações profissionais e a de seus colegas sempre que for necessário para o trabalho a ser executado.
2. Na elaboração do trabalho, não omitir informações relevantes, a não ser nos casos previstos anteriormente.
3. Realizar o trabalho dentro dos cânones de objetividade e rigor inerentes à prática científica.

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