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## Original Article

# Practising childbirth activism: A politics of evidence

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**Abstract** The literature on childbirth organisations focuses on their critique of medical definitions of birth practices, their efforts to promote 'natural' or 'normal' birth, their espousal of choice rhetoric and their relationship to feminism. It says little, however, about the practices these organisations use to achieve their aims. Our study of the United Kingdom, Ireland, Portugal and France explores the centrality of knowledge-based activities to childbirth activism. Through these activities, we show, organisations (i) elicit the emergence of a concerned public through constituting evidence about women's experiences of childbirth and obstetric practices; (ii) produce evidence about obstetric practices from women's perspectives; (iii) articulate this vision of obstetric practices with a critical appraisal of scientific literature; and (iv) make visible international networks of actors who share similar concerns and conceptions. Drawing upon our empirical data we propose the notion of evidence-based activism in order to capture the specificity of birth organisations' modes of engagement and to describe what they bring about. Through evidence-based activism childbirth organisations get involved in policy making and become recognised as legitimate stakeholders; reframe the issues at stake; open debate with other stakeholders; and bring about changes in the health system. Knowledge-based activities also shape the missions and objectives of the organisations.

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What do childbirth organisations in Western countries do and what do their actions bring about? Existing literature reveals similarities in their aims clustering around four key goals: (1) problematising medical/technical intervention in birth; (2) promoting 'natural'/'normal' or 'mother friendly' birth; (3) demanding birth practices and settings

that are attentive to and respectful of the desires of birthing women and their families; and (4) championing women's right to make informed choices about type and place of birth.

The literature discusses contested relationships between birth activist groups and various feminisms (Reiger, 1999, 2000; Beckett, 2005), focusing on tensions generated by articulations of normality and choice in childbirth politics. The notion of choice, for example, was deployed by first-wave feminist birth activists advocating women's right to pharmacological pain relief but also underpinned calls for alternatives to medicalised hospital birth during second-wave feminism, while in contemporary contexts of postmodern and third-wave feminism it is used to articulate the right to choose elective caesarean section (Beckett, 2005). This championing of self-determination and choice, which comes with the recognition of differences between women, is seen by some commentators to promote a form of individualised relativism unable to provide a basis for group activism for change (Gillis and Munford, 2004; Reiger and Dempsey, 2006; Tong, 2007; Thoma, 2009). Some critics view the imperative to choose as a new constraint (Samerski, 2009), while others challenge the assumption that women can actually make choices and exert control around childbirth given the asymmetry of knowledge, experience and authority between women and professionals (Crossley, 2007; Shaw, 2007; Hensley Owens, 2009; Halfon, 2010). Donovan (2006) argues that having to make choices about pregnancy and birth ultimately puts medicine at the heart of women's experiences and is contrary to making these processes 'natural' and 'normal'; while Luna (2009) explores how a focus on reproductive justice helps activists to overcome these difficulties. Similar controversies are articulated in research on reproductive technologies, about which feminists historically display little agreement (see Thompson, 2005, Chapter 2).

Attempts to elaborate childbirth policy have also proved contentious. Discussions of concepts such as 'natural birth', 'normal birth' and 'good birth' feature frequently in birth activist literature. 'Natural' childbirth in the 1930s meant birth without medication or obstetric intervention where women, educated about their bodies and labouring in supportive environments, would draw on their innate capacities to birth (Dick-Read, 1956). This understanding of 'natural' birth was promoted by childbirth organisations in the late 1950s and early 1960s in the United Kingdom and the United States to challenge the scientification of motherhood, which disempowered women to the benefit of doctors (Weiner, 1994). More recent feminist theorising argues that such politics assume a universal female essence and an essentialised understanding of the female body as outside of history and culture, which if left alone will perform a natural birth (Murphy-Lawless, 1998; Halfon, 2010, p. 71). Other critics assert that women define normal birth in highly individualised ways (Downe, 2004; Hunter, 2007). Despite these criticisms, Darra (2009, p. 300) notes that in contemporary British childbirth policy and practice "normalisation [of birth] is ... the current driving force": the desirability of 'normal' birth and guidelines to promote its achievement are widely espoused and integrated into international and national guidelines for the governance of health (WHO, 1996; NICE, 2007), into the professional self-definition of many midwifery groups at international and national levels and into the objectives of a range of lay childbirth organisations.

This literature provides useful insights into debates and conflicts within childbirth politics; it highlights that the concepts underpinning the aims of most childbirth organisations, while lacking definitional consistency, are widely deployed, reflecting historical developments in

maternity practices and feminist theorising (Goer, 2004). However, it does not provide a satisfactory answer to our opening questions: what do childbirth organisations do and what do their actions bring about? Attention to the production of political discourses around childbirth and their deployment in specific sites, while valuable, does not systematically describe or interrogate how these organisations try to change childbirth policies and practices. As Epstein (2011) points out, the actions undertaken by patient organisations as well as their outcomes and consequences may differ significantly from their stated goals. Tyler's (2002) comparative review of 19 childbirth organisations in Germany, the Netherlands and the United Kingdom showed that despite similar agendas the organisations had developed very different strategies, actions and relationships to their environment, resulting in variable achievements. The activities and practices of birth organisations and the effects they bring about are thus the central focus of this article.

The objectives of this article are twofold. First, drawing on a study of four organisations in Ireland, the United Kingdom, France and Portugal, we provide empirical descriptions of contemporary childbirth activism. Showing that each organisation engages in a range of activities involving the production, elaboration, re-shaping or translation of knowledge, we argue that 'evidential work' is a major characteristic of childbirth activism. The involvement of patient organisations in knowledge work has already been well documented, especially with regard to HIV/AIDS, rare diseases and genetics (Epstein, 1996; Rabeharisoa and Callon, 2002; Rabeharisoa, 2003; Jasanoff, 2005; Barbot, 2006). In their overview of UK health consumer movements including childbirth organisations, Allsop *et al* (2004) highlight the role of lay expertise in constituting groups and as a key aspect of their contribution to policy making and underline the work performed by these organisations in building knowledge and expertise. Our analysis of childbirth organisations' practices, however, reveals engagement in knowledge activities that goes beyond the production and use of knowledge as a form of cultural capital or political leverage.

Second, drawing upon the empirical description of our four organisations, we propose the notion of *evidence-based activism* in order to capture the specificity of their modes of engagement and to describe what they actually bring about. Through their knowledge-related activities, childbirth organisations get involved in policy making and become recognised as legitimate stakeholders in this domain. Through evidence-based activism they reframe issues at stake, open debate with other stakeholders and bring about changes in the health system. These activities, we argue, result in a dynamic process through which the missions and objectives of the organisations themselves are shaped and reshaped.

It is important to note that engaging in evidence-based activism does not mean moving towards evidence-based policy as reflected in the general meaning of that term, that is policies that are based on 'objective evidence' (Sanderson, 2002). The organisations we studied use evidence in a different way. They do not seek to root policy making in 'science', as would be the case in a technocratic or purist understanding of evidence-based policy making. Instead, they mobilise evidence to constitute and highlight 'matters of concern' (Latour, 2005) and not solely to establish indisputable 'matters of fact'. In the latter case, the role of evidence is to close the discussion by defining an empirically verifiable 'reality'; in the former case, evidence opens or re-opens discussion by including issues and actors that were previously excluded. In this understanding matters of concern are heterogeneous assemblages of people and the objects/issues with which they are concerned (Latour, 2008).

How can the work done by birth organisations be considered as constituting matters of concern? As we will show, these organisations collect, build and disseminate different kinds of evidence linking women and their experiences to the organisation of care, to obstetric practices and to formalised obstetric knowledge, in order to create a space of discussion with policy makers, professionals and other concerned parties. As detailed below, this work can be classified into four categories of action: birth organisations (i) elicit the emergence of a concerned public through constituting evidence of women's experiences of childbirth and obstetric practices; (ii) collect evidence about obstetric practices as seen from women's perspectives; (iii) articulate this vision of obstetric practices with a critical appraisal of scientific literature; and (iv) make visible international networks of actors who share similar concerns and conceptions. In so doing, they build an 'interestment' device (Callon, 1986) inextricably linking people and things and capture – or at least try to – the attention of traditional stakeholders, forcing them to engage together in an enlarged space of discussion. Through this process the cohort of concerned people and the scope of issues raised are enriched. Moreover the childbirth organisations themselves are transformed by shaping these matters of concern, thus dispelling the idea that activism could be understood solely by reference to the general stands taken by the organisations.

In the next section we provide a brief outline of the four organisations involved in the research and of the methodology we employed. This is followed by descriptions of the key evidence-based activities the organisations engage in: representing women's experiences; producing evidence about obstetric practices; (re)appraising scientific literature; and mobilising international networks. After briefly evoking relevant examples, we concentrate on actions of one organisation in each area, unpicking chains of activities and effects that proceed from an investment in the production or mobilisation of evidence. As already suggested, these various investments are not separate areas, but rather take their strength and efficacy from the capacity of the organisations to build a continuous chain of inter-relations between them. As we will show, although each organisation does evidence-based activism, they engage in different ways with evidential work. These differing engagements result from the dynamic interaction between the organisations' current characteristics, their histories and accumulated competencies, and factors external to the organisations themselves. It is important to note that we do not undertake a comparison of the organisations with a view to identifying variables that would explain their differences (as does Tyler, 2002). Rather we focus on the capacity of the organisations to transform and redefine their environments by eliciting the emergence of new actors and new facts.

## **Childbirth Organisations in France, Ireland, United Kingdom and Portugal as Pluralist and Evolving Organisations**

The organisations we studied are: the National Childbirth Trust (now NCT, UK), the Association for the Improvement of Maternity Services, Ireland (AIMSI), the Collectif interassociatif pour la naissance (CIANE, France) and the Associação Portuguesa Pela Humanização do Parto (HUMPAR, Portugal). Our studies were conducted between 2009 and 2012 using a common set of methodologies, described in detail in EPOKS Partners (2009): thematic textual analysis of the organisations' websites, online forums and reports,

leaflets and publications; formal recorded interviews with key and ordinary members; and ethnographic observations of meetings, events and classes held by each organisation. During the project we convened three 2-day team meetings in which we compared and analysed preliminary findings across the four countries, and drew comparisons with the three other 'condition areas' studied within the EPOKS project (see other papers in this volume). In September 2011 we facilitated an international participative conference, inviting stakeholders in each condition area and from each country (among others) as well as academics. Our preliminary findings were presented and debated at length with participants and all debates recorded and summarised. Our analysis in this article has been subject to detailed review by key stakeholders from participating organisations and relevant academics through written drafts and oral presentations in relevant conference settings.<sup>1</sup>

The four organisations differ in many aspects; date of creation, size, membership and type of activities. The sharpest contrast is between the NCT – an old and large organisation that is also a service provider (antenatal and parenting classes and breastfeeding support) – and the other three younger and smaller organisations, which are primarily committed to activism with two of them also having a support dimension. None of these organisations receives substantial funding from governmental agencies. With the exception of the NCT, which employs professional staff and a large pool of volunteers, they rely upon a small number of volunteers, mainly women from educated, professional backgrounds.

Table 1 summarises the organisations' mission statements as they appear on their websites. From this we observe significant overlap with the birth activism discussed in the existing literature, referring to 'normal birth', 'physiological birth', 'humanised birth' and 'choice'. We also note the use of terms such as 'evidence-based research', 'international best practice' and 'WHO recommendations'. These terms bring the idea of knowledge as a normative reference to the fore, an idea that has not been widely highlighted in the literature with the exception of the writings of some birth activists (Zwelling, 2002; Goer, 2003, 2004; Phan, 2010; Beech, 2011), and those of a few scholars who evoke it in passing (Graham, 1998; Beckett and Hoffman, 2005; Williamson, 2008).

The multiplicity of normative principles evoked or employed by the organisations is significant but unsurprising in light of the tensions, contradictions and conflicts between such principles identified in the introduction. In the cases we studied, this engagement with a multiplicity of principles constitutes a form of internal 'pluralism' that appears to result from the way the organisations have formed and evolved. For example, the NCT has shifted from an original focus on 'natural childbirth' to the promotion of 'informed choice' and the development of the concept of 'normal birth'. The CIANE comprises about 30 organisations, each bringing its own historical background and aspirations including: promotion of homebirth with an emphasis on childbirth as a natural/physiological process; respect for the rights of parents to make choices, whatever their preference; women's self-determination; and reference to evidence-based medicine (EBM). Organisations' mission statements are thus the products of an evolving 'sedimentation' and 'aggregation' process, which is always in flux: as such they do not provide a set of static principles from which actions flow. To understand actions, then, we need to observe organisations in practice.

1 The views expressed in this paper are not necessarily those of the organisations we studied.

**Table 1:** Summary description of the organisations studied

	<i>NCT (UK)</i>	<i>AIMS Ireland</i>	<i>CIANE (France)</i>	<i>HUMPAR (Portugal)</i>
Date of creation	1956	2007 (re-creation of an organisation that has been active from 1979 to late 90s)	2003	2006
Approximate membership (individuals)	100 000	120	40 childbirth organisations	700
Type of membership	Users (+ a professional staff alongside volunteers)	Users	Users who are all volunteers in the member organisations	Users and medical professionals (obstetric nurses, doulas)
Activities	<ul style="list-style-type: none"> <li>● Education and support</li> <li>● Campaigning</li> <li>● Involvement in policy making</li> <li>● Commercial activities</li> <li>● Research-related activities</li> </ul>	<ul style="list-style-type: none"> <li>● Support</li> <li>● Information</li> <li>● Campaigning</li> <li>● Undertaking research</li> </ul>	<ul style="list-style-type: none"> <li>● Campaigning</li> <li>● Involvement in policy making</li> <li>● Involvement into the writing of guidelines</li> <li>● Research-related activities</li> </ul>	<ul style="list-style-type: none"> <li>● Support</li> <li>● Campaigning</li> <li>● Involvement in policy making</li> </ul>
Mission statement	<ul style="list-style-type: none"> <li>● Information and support</li> <li>● To improve maternity care</li> <li>● Informed choices for parents</li> </ul>	<ul style="list-style-type: none"> <li>● Normal birth and mother-friendly birth practices</li> <li>● Supported by evidence-based research and</li> <li>● International best practice</li> <li>● Informed choices for parents</li> </ul>	<ul style="list-style-type: none"> <li>● High quality care supported by evidence-based medicine</li> <li>● Personalised and respectful care</li> <li>● Diversification (free standing birth centres, homebirth)</li> <li>● Informed choices for parents</li> </ul>	<ul style="list-style-type: none"> <li>● Humanisation of birth</li> <li>● Childbirth as a normal physiological event</li> <li>● Legalisation of homebirth</li> <li>● Reduction of medical procedures (WHO recommendations)</li> </ul>

## Representing Women's Childbirth Experiences

Epstein (2011) points to the capacity of health movements to represent affected people (members and non-members) as an important asset in their attempt to promote change. Some analysts have argued that birth activism is weakened by a lack of representativeness and a separation from grassroots realities of birth (Armstrong and Declercq, 2011). All the organisations we studied were involved in the collection, analysis and dissemination of information about women's experiences of birth. Such activities involve representation in two senses: through representing women's experiences, organisations build a claim to be representative.

In terms of representation, the NCT is clearly set apart from the other organisations by its size and by the fact that, through its activities such as prenatal classes, its staff and volunteers are constantly in contact with pregnant women and familiar with their concerns. But as well as its internal use of such informal knowledge, it has always had an interest in engaging more formalised evidence. In its earliest manifestation, it circulated Grantly Dick-Read's (1956) educational film "Childbirth without Fear", documenting his techniques of 'natural' birth. From the mid-1970s, the organisation became increasingly committed to producing their own evidence, publishing research written by then NCT member Sheila Kitzinger among others about women's experiences of medicalised birth (Kitzinger, 1975, 1987; Kitzinger and Walters, 1981). Such evidence was used both as a source of information for women and also to make political claims.

The deployment of evidence has also always been part of the CIANE's repertoire. As a coalition of numerous and diverse organisations – local support groups as well as internet discussion groups – the CIANE collects and mobilises various forms of evidence about women's experiences. Testimonies from forums or support groups and a few small surveys have been employed to make interventions in professional conferences or support their arguments when asked to express their views in expert groups elaborating clinical guidelines. More recently, CIANE implemented a permanent web survey on childbirth experiences that initially received about 7000 answers in 8 months. Drawing upon this survey, the CIANE has published reports on, for example, the induction of labour, respect for women's wishes and the cost of childbirth for parents. The last report on 'returning home' – a topic about which the CIANE had no previous expertise – was mobilised in policy making in a context where the State Health Insurance organisation put in place a system to reduce hospital stays.

The collection of evidence about women's experiences has played a particularly significant role in the development and orientation of AIMS. The following extended discussion shows how an organisation can to a large extent ground its strategy on a knowledge base produced through surveys of women's experiences.

From its inception in 2007 AIMS has distanced itself from a 1970s version of birth activism ("earthy, hippy you know ... this natural birth stuff", as one member described it) and put knowledge at the core of their activities: "Now we push evidence-based, that is our thing, evidence-based, evidence-based, evidence-based" (interview with founding member, 2010). One of their first initiatives was a survey entitled *What Matters To You 2007*. Addressing potential respondents on its website, AIMS articulated a clear rationale for the survey describing it as "an invaluable tool for us to evaluate what issues are important to you and how they need to be tackled". The survey was designed to systematically collect the experiences and views of consumers of Irish maternity services and was consistent with

AIMSI's self-description as a 'consumer-led' organisation. The core concerns identified in the 2007 survey informed three subsequent surveys undertaken by the organisation: *Availability of Information and Consent* (2008); *Rooming-In in Irish Maternity Hospitals* (2008); and *Care at a Time of Loss: AIMSI Pregnancy Loss Survey* (2009). The surveys provide information on numerous aspects of maternity provision including: the extent and nature of women's engagement with medical/clinical procedures and personnel during labour; the physical and infrastructural conditions in maternity units; management and organisational practices in the units and information giving and consent during labour. Data on the emotional, psychological and physical impact of specific practices and conditions were also collected. In 2010, AIMSI ran another generic survey, *What Matters to You: A Maternity Care Experience Survey*, to re-orient itself to key concerns among maternity service users. This ongoing surveying of consumers represents a strong, deliberate and continuous link between the production of knowledge and the definition of causes.

The simultaneous role played by surveys in defining causes and establishing a legitimate organisational identity was acknowledged by a former committee member who observed: "We always had that piece in there about conducting our own research in order to support women ... you know to kind of systematise what people were telling us and give it more clout" (interview with committee member 2010). The surveys also provided a mechanism for holding members' differing ideological positions in productive tension. As a former committee member noted "we didn't have a shared ideology ... we had a chat about feminism at one point ... I could say I approached it as a feminist. I know other people could but other people didn't ... it was just unresolved". However, AIMSI's public identification as a consumer advocacy group and its grounding of campaign issues in the concerns raised through the surveys avoided the need for a shared ideological position. AIMSI used the surveys to legitimate its representative role as an advocate for Irish maternity service consumers and delineate its spheres of actions; to give empirical credibility to its claims; and to stabilise diverse member ideologies.

### **Turning matters of fact into matters of concern**

The surveys allowed AIMSI to promote specific concerns as public and political issues, that is to "highlight issues ... [and] bring them to the table" as a former committee member put it. For instance, evidence from the *What Women Want Survey* (2007) was cited by the organisation in a meeting with the Irish Minister for Health to highlight the need for a nationwide extension of homebirth and Domino maternity services (midwife-led services). The survey also identified new fields of action for AIMSI and underpinned further knowledge-related initiatives. For example, difficulties in accessing comprehensive information on the benefits and risks of a range of maternity related procedures revealed in the *Availability of Information and Consent* survey (2008), prompted AIMSI to produce the *Healthy Birth Directory for the West of Ireland* (2011). Results from that survey also informed the launch of a campaign highlighting the inadequacy of consent procedures in Irish maternity units. This campaign included a call for an independent review of consent-related practices and the organisation of a public seminar in 2010 entitled "Informed Consent in Maternity Care: Perspectives from Ireland & the UK".



The dissemination of survey data to professional, media and public audiences further contributed to the opening up of discursive fields within which maternity issues receive attention. Although the results have become part of the epistemic repertoire of other maternity support groups and of some midwives (AIMS Ireland, 2007), those involved in the management and governance of maternity units have, for the most part, failed to publically acknowledge the surveys. A notable exception was the *Care at a Time of Loss: AIMS Ireland Pregnancy Loss Survey* (2009), which generated a response from managers in a small number of maternity units, some of whom contacted AIMS Ireland for recommendations on how to address the issues raised. Thus while it can be argued that the surveys “re-conceive[s] the nature and boundaries of expertise” (Epstein, 2008, p. 502), their limited impact on maternity care practices and the failure to engage obstetricians points to the very real challenges of establishing new ways of knowing (Hausman, 2005) within existing health governance structures.

### Reshaping epistemological boundaries

AIMS Ireland's survey data are empirical, evaluative and experiential: both quantitative and qualitative methods are employed and reports provide statistics alongside individual testimonies. While the surveys lack statistical power (they are based on self-selecting samples of women), their richness renders them powerful devices capable of adjustment for various purposes and audiences.

In deploying the knowledge produced through the surveys, AIMS Ireland do not contest medical knowledge in and of itself. Indeed, they frequently invoke credentialised knowledge and ‘evidence-based practice’ and identify obstetric compliance with such knowledge as part of the solution to the problems identified in the surveys. As such, survey data are used to question the authority of doctors rather than to argue for a fundamental de-medicalisation of maternity care. By translating localised knowledge about the micro techniques of power experienced by women in Irish maternity units through the language of international knowledge about evidence-based practice, AIMS Ireland hopes to mount a challenge to prevailing practices, a strategy that is acknowledged in the conclusion of its most recent survey:

Finally, a greater challenge which can be seen to underpin the concerns raised by women in this survey, is to adopt and nurture a culture where **evidence-based practice** and the **support of normal birth** underpins every aspect of care. (*What Matters to You: A Maternity Care Experience Survey* AIMS Ireland, 2010. Bold in original)

The surveys play a crucial role in structuring AIMS Ireland activities and in constructing its network of influence. The data produced legitimate AIMS Ireland as a ‘consumer/users’ representative and as an actor with moral and cognitive authority. This authority is strengthened by combining survey data with other types of knowledge based on EBM and/or international guidelines. As such AIMS Ireland activists do not sit on the edge of the medical world waiting for professionals to respond to their preoccupations and to find solutions, but actively articulate women’s wishes in relation to obstetrics. Moreover, because the figures they produce are illuminated by testimonies, they maintain the personal and situated character of women’s experience while creating resonance with and deriving strength from international analyses. The specifics of the Irish case are made visible but are viewed against the backdrop of a global situation.

## Producing Evidence about Medical Practices and Making Lay Perspectives Count

Childbirth associations are also involved in the collection and the production of statistics about medical practices and the organisation of care. There are three rationales for undertaking this work: providing women with information on practices in maternity units so that they can make a choice about where they want to give birth; raising awareness of some aspects considered as ‘details’ by professionals but that might be important to women; and making these ‘details’ count in health policy. Evidence about practices occupies a very strategic place at the intersections between women and professionals’ worlds.

A good example in the French context is practices around tying women’s hands during C-sections and the length of time they have to wait after C-section to hold their baby. There is no official mechanism in France through which this information is collected and made available, it is not a recognised professional concern, but it is something of significance for women. For this reason Cesarine, a member organisation of CIANE, decided to collect data on this and other practices by means of a permanent web survey. Survey results are publicly available, providing data for each maternity service. The collection and publication of evidence about maternity practices and policies was also undertaken by the first Association of Improvements in Maternity Services (AIMS) group in Ireland, which produced survey-based consumer guides to maternity units in Ireland in 1992 and 1995. The surveys sought to collect details for each maternity unit in the country on the range of services and facilities available and the rate of various medical interventions and procedures. For its recent publication *Healthy Birth Directory for the West of Ireland* (2011), AIMSI compiled statistics on caesarean section rates for the maternity units in the west of Ireland region.

The NCT provides us with a striking example of how statistical evidence about practices elaborated by a childbirth organisation became the basis on which to ground and make operative a new professional standard.

### Translating ‘normal birth’ into statistics

Over recent decades, the NCT has become highly successful in achieving status within policy engines. In 1999, it was involved in establishing the Maternity Care Working Party (MCWP), an expert advisory group addressing the public health implications of the rising caesarean rate (MCWP, 2007, p. 1) and providing evidence to the All-party Parliamentary Group on Maternity, “a cross-party group of MPs and Peers with an interest in the maternity services ... [that] raises awareness of the important part that maternity provision has to play in improving women and babies’ health”. In 2007, chaired by the NCT, this group published a consensus statement on normal birth that has become a model across Europe.

The process of developing the consensus statement began in November 1999 with a national conference organised by the NCT, The Royal College of Midwives and The Royal College of Obstetricians and Gynaecologists, entitled “The Rising Caesarean Rate – a public health issue”. The proceedings of the conference included a statement from the MCWP about normal birth, claiming that “most women would prefer to give birth normally, provided that a normal birth is considered safe for them and their baby” (MCWP, quoted in *The Guardian*, 24 November 1999). Over the next 4 years, further conferences were held on the subject of the rising caesarean rate and then focusing on normal birth. In 2006 the NCT, represented by

Mary Newburn, Head of Research and Information, led the MCWP in a collaborative drafting and redrafting process culminating in the consensus statement. The significance of collaboration with individuals and organisations in the UK context, analysed by Baggott *et al* (2005), is notable here.

In 1997 the World Health Organisation had defined normal birth as:

Spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and baby are in good condition. (WHO, 1997)

In the same year, Beverley Beech of the AIMS (another British childbirth organisation, mainly oriented towards advocacy and defending midwifery) argued that the WHO definition included a variety of often unnecessary medical interventions and that routine hospitalisation meant that most practitioners did not understand normal birth (Beech, 1997). Beech proposed that hospital case notes should record interventions and if procedures such as artificial rupture of membranes, induction of labour, acceleration of labour, epidural anaesthesia or episiotomy were carried out, the birth should be recorded as ‘technological’ rather than ‘normal’.

Reacting to this article, Soo Downe (now Professor of Midwifery Studies, University of Central Lancashire) worked with Beech to design joint research on ‘normal birth’, conducting a retrospective analysis of case notes in five consultant units (Downe *et al*, 2001). Using the 1997 AIMS criteria, they found that barely one in three women had a normal birth, even when women who had an epidural, electronic fetal heart monitoring and syntometrine for the third stage of labour were included in the ‘normal’ group. Downe *et al* queried both the Department of Health and obstetric definition of normal as “without intervention” and challenged the assumption that normal birth was “the most common experience of women”, arguing that obstetrically managed birth was statistically ‘normal’. Discussing the variation in definitions of normality used in reports from official bodies, they concluded both that many births recorded as ‘normal’ involve medical interventions and that a great majority of women experience some kind of intervention during labour.

Both Downe and Beech contributed to developing the consensus statement. Perhaps the most significant contribution, however, was the publication by BirthChoiceUK of statistics on normal birth. Established by NCT antenatal teacher Miranda Dodwell and her colleague Rod Gibson in 2001, this organisation published 1998 statistics (the most recent available at the time) gleaned from the Department of Health. Dodwell described this in an interview with us:

I phoned up this person [indicated on a document] ... and said “Can I have a copy of this?” They said, “Sure, we’ll send it to you in the post”. It arrived and to my amazement it included the caesarean rate from every hospital in the country! I hadn’t known it existed and nobody else I talked to had known it existed. It seemed to have been produced and then just put into some dusty cupboard at the Department of Health!

(Interview, 2010)

These statistics were based on hospital records of births and the information included records of key medical procedures (such as induction or caesarean), which had taken place.

Without these data it was not possible to ascertain how many women had had major interventions, in different hospitals. They led the way towards being able to calculate the rates of normal birth for different units, which showed wide variation in practice. This comparative evidence could be used to inform the public and as a potential lever for change.

Dodwell explains how this work developed, becoming critical to defining ‘normal birth’:

We were using statistics on intervention rates when I became aware of the agenda on measuring normal birth. It really came from Soo Downe and AIMS – around 2001. (...). The basis of our definition at BirthChoiceUK for measuring normal birth using routinely collected data was what we could get from the Department of Health. The DH collected induction data but they didn’t have any data about augmentation, so we couldn’t exclude that from normal birth. They had data about epidurals but they didn’t have anything about pethidine. So we were basically limited by what they collected – our definition was as “normal” as we could get given what the Department of Health could give us and this was what we put on our website. (...). We originally called it the ‘BirthChoiceUK Definition of Normal Birth’. (...) It’s now being used in Europe as well – the Peristat Report for Europe references BirthChoiceUK as being the original source for their definition of birth without obstetric intervention. (Interview 2010)

Dodwell quickly became seen as having expertise in maternity statistics and was invited to join various influential policy groups. She describes the power of ‘having numbers’:

I think having numbers allowed that shift to think about how you normalise birth. Soo Downe and AIMS were already looking at it, and I think beginning to have routine data on normal birth also helped give you something real. It wasn’t some nebulous concept any more, it was something you could measure and I think that was really important. (Interview, 2010)

The promotion of normal birth in the consensus statement circulates both a technical definition of and statistical information about normal birth. These emerged out of, and were motivated by, reflection on women’s experiences of childbirth by key actors in birth politics and other MCWP members. The consensus statement renders ‘normal birth’ an operative notion. The definition of ‘normal birth’ accomplished here is neither that proposed by WHO nor AIMS’ definition but one framed by the pragmatics of possible statistics. Fitting the existing set of data made available to the public through BirthChoiceUK’s website, the definition also creates a common reference for discussions between consumers and professionals.

Achieving this definition has had important political results: although debate continues, the document helps the NCT to pursue research and actions to increase women’s chances of experiencing ‘normal birth’. Being measurable, the definition of “normal birth” can be translated into a set of clear and defined objectives, the fulfilment (or not) of which can be traced to evaluate the quality of care: in 2010, for example, the NCT produced a report entitled “Normal birth as a measure of the quality of care: evidence on safety, effectiveness and women’s experiences” (Dodwell and Newburn, 2010). More recently, Newburn has been a co-investigator in The Birthplace in England National Prospective Cohort Study, comparing maternal and perinatal outcomes for healthy women with a straight forward pregnancy

according to planned place of birth (Birthplace in England Collaborative Group, 2011). This was the first published research to use normal birth (as defined by the MCWP) as one of its outcomes. Newburn argued successfully within the collaborative group that comparing normal birth rates (that is the extent of interventions throughout the whole process of labour) was important, as well as measuring individual interventions: taken alone, measurement of individual interventions masks the small proportion of women – even women at low-risk of complications – who have a normal birth if they book for a hospital (obstetric unit) birth.

Work on evidence has played a major role in the NCT's activism since the 1970s. This work has also played a role in the significant shift in the definition of one of its key foci: 'normal birth' now no longer refers to a spontaneous process in which there should be no medical intervention nor to a 'good enough' birth (Darra, 2009), but to a process described by the measurable absence of particular medical interventions. Of course, this does not mean that competing normative orientations are definitively out of the game. The statement operates as a frontier delimiting a space of consensus from a space of dissensus; groups such as the Birth Trauma Association and electivecearean.com vocally disagree with it and make visible the tension that it creates both with notions of a 'good' birth as seen from the mother's viewpoint and with the principle of 'informed choice'. The consensus statement is a tool for monitoring practices and provoking change that does not preclude the advent of what Beverley Beech (2008) of AIMS describes as 'more advanced' practices.

## Re-articulating Scientific Evidence as Matters of Concern

According to Homer and Broom (2012), EBM developed in response to the criticism formulated in 1972 by British medical researcher Archie Cochrane, who argued that obstetrics had been particularly resistant to the integration of scientific evidence within clinical practices. Together with Goer (2003), Homer and Broom argue that despite the development of EBM, controversies remain around issues such as homebirth, and activist midwives are faced with deliberate manipulation or mal-interpretation of data. Even though childbirth organisations' investments in science have been overlooked by social scientists – and the contrast with studies of other patient organisations in this regard is especially striking – some activists have highlighted the importance of such investment. Suzanne Arms, an American activist, recalls in an interview (Zwelling, 2002) the work done by Henci Goer who published two books, *Obstetric myths vs. research realities: A guide to the medical literature* (1995) and *The thinking woman's guide to a better birth* (1999); publications that attribute emancipatory power to knowledge acquisition.

All the organisations we studied recognise the power of knowledge. The NCT, for example, has a strong emphasis on engaging with scientific research. As well as producing their own 'in-house' (usually survey-based) reports and commissioning other research, the organisation collects, circulates and engages with published data, teaching members critical reading skills and conducting study groups on particular topics. A relatively small number of people are involved in such activities, most notably Mary Newburn, but they are highly energetic and productive, engaged not only in the preparation of evidence-based NCT statements, reports and policy briefings (for example Newburn and Singh, 2003; Dodwell and Newburn, 2010;

NCT, 2011) and preparing critical literature reviews or ‘evidence-based briefings’ (collected at [www.nct.org.uk/professional/research/reviews-evidence/nct-research-overviews](http://www.nct.org.uk/professional/research/reviews-evidence/nct-research-overviews)) but also publishing in leading medical and midwifery journals (for example Johannson and Newburn, 2001; Johanson *et al*, 2002; Newburn, 2012; Trickey and Newburn, 2014). The NCT’s attention to evidence in the current setting, as noted earlier, builds on a long history of making and intervening in knowledge about birth. Today, the NCT harnesses specific forms of expertise in garnering and producing knowledge and is strategic in its use of data: knowledge for the NCT is a political project closely tied to policy development and attempts to influence practice at every level (from individual birth plans and experiences to national clinical practice guidelines).

On a smaller scale, a core aspect of the epistemic work of AIMSI and HUMPAR has been the popularisation of specialised, credentialised, biomedical knowledge relating to clinical practices in maternity care: both organisations propose a selection of publications on their website, accompanied by summaries. AIMSI has created a Facebook page on which recent research is highlighted and discussed. AIMSI also calls for the creation of “National Guidelines for Clinical Practice in Maternity Care, including consent-related procedures” reflecting a strategy to effect a localised deployment of international standards to challenge practices in maternity units and among individual medical practitioners.

Since its creation in 2003, the CIANE has also invested a lot of effort in this type of work. Its orientation towards knowledge activities has been analysed by a CIANE activist. In a series of papers entitled “How perinatal care users call into question professional medical practice”, Phan (2010) argues that new kinds of mobilisation recently developed by maternity services users combine a challenging of professional practice with a critical analysis of scientific data made available by the development of the internet. She concludes that even though medical decisions should not be based on science only and should take into consideration the practitioners’ experience and individual preferences, discussions about evidence facilitate productive dialogue with professionals. The following discussion explores CIANE’s engagement with scientific knowledge in some detail.

Since its creation, the CIANE has participated in elaborating and/or evaluating more than 12 professional guidelines on varied topics. They have succeeded in influencing the HAS (High Health Authority, in charge of producing evaluations and guidelines) work programme, which is based on submissions from outside parties, professionals from the field, the state authorities and users. For several years, the CIANE has carefully prepared submissions, using a formalised process and mobilising scientific literature in order to build a convincing argument. The expertise of one of its member organisations has been decisive in this regard. The AFAR (Alliance francophone pour l’accouchement respecté) was founded by a few participants of the internet discussion list on childbirth who thought that the best strategy for changing childbirth care was to challenge what the professionals claim to be the source of their authority, namely science. They set up a public bibliographical database comprising more than 2300 scientific references with abstracts and comments in order to help activists and individuals to question the ‘evidence’ put forward by professionals who tended to impose medical interventions.

Drawing on AFAR’s expertise, the CIANE has produced submissions on topics like episiotomy, fundal pressure, induced labour and planned caesarean sections, which are all interventions that have become more or less routine in France. For a submission on prenatal

screening for Down's syndrome, they joined forces with other actors, who also believed that the gap between international and French practices was resulting in a much higher rate of amniocentesis, a practice that contributes to a higher rate of miscarriage. In 2011, they submitted a document on the calculation of due date, motivated by the influence due date yields in determining the date after which an induction will be proposed and/or imposed. As can be observed from these examples, the topics addressed reflect issues of direct concern to pregnant women.

### **Weaving different forms of expertise together**

Episiotomy was a recurring theme on the internet discussion list and was the first topic investigated by the AFAR shortly after its creation in 2003. In Autumn 2004, drawing on the AFAR's work, the CIANE suggested episiotomy as a theme for the development of clinical practice recommendations. The National College of French Gynaecologists and Obstetricians (CNGOF) decided to adopt this initiative and make it its own, developing recommendations in 2005 and then consulting the CIANE.

The CIANE formed a work group and produced a proposal on these recommendations. On the basis of medical literature, the CNGOF text was almost exclusively technical, concluding with a number of general policy recommendations. In contrast, in addition to medical literature, the CIANE's text also cited women's testimonials gathered through a support list on episiotomy created by AFAR's members. It sought to reframe the problem, moving away from the 'prevention' of episiotomy towards discussion of perineal lacerations. This 'semantic shift', as it was described in the text, opened up other policy options. It led to recommendations relating to women's consent, professional training and medical protocols for the 'management of labour'. Furthermore it generated a severe critique of the 30 per cent rate of episiotomies stated as an objective by CNGOF, which, according to the CIANE, was not based on rational arguments and was too 'political' in its concern to avoid upsetting professionals.

### **Reframing issues**

As a major cause of avoidable maternal death, the issue of post-partum haemorrhage has been a focus of childbirth policies for 20 years. Compared to other European countries, France has a high maternal mortality rate and is the only country where haemorrhage is the first cause of death: thus the CNGOF prepared guidelines on the topic in 2004. The CIANE representative invited to assess these guidelines argued that they dealt entirely with treatment and did not envision any prevention policy. He suggested the hypothesis, established through internal discussions, that current medical practices – and especially the frequent use of oxytocin during the second stage of labour – could be the origin of the high haemorrhage rate. The CIANE subsequently endeavoured to find funds to commission the main research centre specialising in perinatal epidemiology to undertake a research project exploring this link. A paper describing this research published in the *BMJ Open* in December 2011 (Belghiti *et al*, 2011) confirmed this hypothesis. The CIANE issued a press release in March 2012 calling for a change of practices and a revision of guidelines. It recently submitted a proposal in response to a call issued by the French Medicines Agency that intends to support projects from patient organisations on the good use of medicines. This proposal is to develop a series of actions to improve women's information on oxytocin, its use and associated risks.

This example shows the progressive specification of CIANE's policy, starting from the evaluation of guidelines, moving through involvement in research and finally reorienting action towards users' information. A similar pattern can be observed in the case of prenatal screening, where the CIANE supported the elaboration of guidelines, which resulted in a drastic change in policy at the national level. The CIANE also supported the efforts of a French group of researchers trying to develop a non-invasive diagnostic technique and recently organised a training session for volunteers willing to help women encountering prenatal screening and seeking information, help and support on public internet forums.

The CIANE activities represent a loop from women's experience to scientific evidence and back to women; this loop is made possible through the articulation of experiential knowledge to formal knowledge and the elaboration of intermediate or hybrid forms of knowledge, as is experienced in many patient organisations (Epstein, 2011). At each step, a translation is necessary in which "matters of fact give way to their complicated entanglements and become matters of concern" (Latour, 2005, p. 31). All elements, from women's desires to medical practices and scientific knowledge, are reframed through this process; their articulation is put centre stage and defines an arena where concerned parties – professionals, administrations and users – are convened.

## **Establishing International Networks of Authority**

Although our discussion to this point may have given the impression that national borders define the 'natural space' of childbirth activism, this is not the case. While the existence of individual national health systems forces organisations to intervene at the level of state policy, the existence of international channels of communication and influence should not be overlooked. Evidence-based medicine itself, as a source of an international standardisation of practices, stimulates a 'synchronisation' of concerns among childbirth groups. For instance, the publication in 2010 of a meta-analysis in the *American Journal of Obstetrics and Gynecology* (Wax *et al*, 2010) stating that the risk of perinatal death was tripled in homebirth compared to hospital births, immediately provoked an intense and worldwide circulation of comments and counter-argumentations, involving among others the NCT, BirthChoiceUK, the CIANE, AIMS UK, the US Coalition for the Improvement of Maternity Services and other midwifery groups. The dynamics between the specificities of local organisations and contexts, together with the synchronising impact of international factors, account for the simultaneous deployment of original modes of action interlaced with common features. In addition, informal networks of exchanges exist: AIMS UK, CIANE and HUMPAR are members of European Network of Childbirth Associations, which has organised a yearly meeting since 1993. The first AIMS group in Ireland was founded in Dublin in 1979 by an English woman living in Ireland and from the outset was an affiliated branch of AIMS UK. Furthermore Beverley Beech, the chairwoman of AIMS UK attended the launch of the new AIMS in 2007. All of the childbirth organisations in this research at least know of the work of the US-based Coalition for Improving Maternity Services (CIMS) and most drew some inspiration from their activities: formal and informal links thus appear as crucial at the international level as at the national level (Baggott, 2005) in understanding childbirth activism.

HUMPAR, the Portuguese childbirth organisation studied in this research emerged out of an encounter between Portuguese women and this international network and still draws strength from it. Unlike the other organisations which had a long history as in the UK case or were rooted in previous organisations as in the case of France and Ireland, HUMPAR is relatively new, being founded in 2006 by a group of people involved in an organisation of doulas. The Doulas of Portugal Association (DPA) was established in 2005 on the initiative of two women who went to London in 2004 for training with Michel Odent, a French obstetrician and Liliana Hammers, a doula. Doulas support women during their pregnancy and childbirth and they emerged in the United States in a context very similar to the current Portuguese one, that is where childbirth was taking place in a highly medicalised environment and where the profession of midwife had almost disappeared. Therefore, from its inception, the Portuguese childbirth movement borrowed its mode of expression and action from foreign activities.

HUMPAR is part of an informal network of organisations, which, apart from DPA, comprises Bionascimento, an organisation also founded by DPA members that provides services to doulas and midwives, and Maternar, a self-help group founded by HUMPAR members. These organisations have developed actions in relation to two key objectives. They are as follows:

- The promotion of a childbirth model that would recognise both the physiological and familial character of the event, resulting in a significant decrease in medical interventions and a more respectful attitude by health professionals and institutions towards parents.
- Advocating for change in the Portuguese legal framework that defines childbirth as a medical event to be carried out in duly authorised medical establishments, with no recognition of midwifery as a profession.

In all their actions, these organisations have drawn extensively on a web of international reference points including institutions, other activist organisations, prominent figures and scientific literature or international recommendations.

WHO recommendations are cited in HUMPAR's charter as a reference for the improvement of maternity services and figure prominently on the Bionascimento website. They stand as a mandatory reference to which doulas must adhere and as the basis for the expression of public concern over caesarean section rates in the country. European legislation and 'other European countries' are also cited as sources of inspiration for changing childbirth in Portugal. The websites of HUMPAR, Doulas of Portugal and Bionascimento provide links to those of Brazilian, French, Spanish, British and International organisations. Some of these links correspond to actual contacts made through Portuguese participation in international meetings, such as a yearly doulas' meeting in Paris or the meeting of the US-based CIMS. A number of prominent international birth activists feature in all the websites either via quotations or papers, some of them translated into Portuguese. These include figures such as Michel Odent, Ricardo Jones (a Brazilian obstetrician), Laura Gutman (an Argentine writer on maternity), Suzanne Arms (an American activist) or Marsden Wagner (an American perinatologist who has headed the Women's and Children's Health programme in the WHO for 15 years and has reflected upon the use of technology in birth (Wagner, 1994)). References to scientific papers or international recommendations appear on the websites but mostly in official documents such as the "10 Steps of Viana" and the "Right to normal birth consensus", which constitute the most visible achievements of the childbirth movement in Portugal.

The 10 steps of Viana were the outcome of a conference held in 2009 in northern Portugal involving a heterogeneous group including mothers, obstetricians, general practitioners, nurses, maternal health professionals, psychologists, journalists, consumer groups, doulas, teaching staff of medical and nursing schools, and HUMPAR representatives. The aim of this meeting was to define 10 basic principles in order to improve childbirth in public hospitals. The principles were then presented to the general public and made available online: in 2013, organisations were still working to disseminate them in maternity services and more widely.

The Portuguese consensus document, entitled “The Right to Normal Birth – A shared vision”, was proposed by a group of obstetric and maternal health nurses and was intended as a formal recommendation to the Ministry of Health on the procedures taking place in public and private maternal care and childbirth services. This document draws on the same literature base as the 10 steps of Viana, namely 13 references mostly from the Cochrane Database Systematic Reviews, plus a number of academic papers and publications from international organisations such as the WHO, International Confederation of Midwives (ICM) and International Federation of Gynaecology and Obstetrics (FIGO). Moreover, it mentions no less than seven documents (out of 31) related to the elaboration of the British normal birth consensus statement discussed previously.

### **Setting up the Portuguese ‘matters of concern’**

Referral to this international literature in documents addressing the general public, professionals and political and governmental authorities, constitutes a key strategy of legitimisation for HUMPAR. The mobilisation of international frameworks for analysis and action has played a central role in constructing a programme for engaging diverse publics in childbirth-related issues. The ‘humanisation’ vocabulary borrowed from Brazilian birth movements and associated by HUMPAR’s president with the French notion of ‘respectful birth’, for example, puts the idea of empowering women on the agenda, emphasising that women are capable of making choices (although this in turn raises the question of which choices are possible within the current organisation of care related to childbirth).

The ‘normal birth’ agenda, associated with the British example, appears in Portugal to be directed towards health authorities and professionals, providing guidelines for the establishment of a set of rules for practice and the allocation of competencies and responsibilities to different kinds of professionals. It emerged in response to a policy-making initiative by the Portuguese General Health Directorate who was interested in the elaboration of a consensus document. This Portuguese consensus document differs from the British one on significant points. While the British document was the outcome of a long process that gave it its operative character – discernible in its title “Making normal birth a reality” – the Portuguese one may be regarded as a starting point for such a process. First, it was negotiated expeditiously by organisations and individuals without a mandate from their members but rather in response to pressure from the General Health Directorate. As a result, the professional organisation of gynaecologists and obstetricians has not yet signed the text, despite its being available on a governmental website devoted to the National Health Plan 2012–2016. Second, the statistical apparatus that would make the consensus document operative is still only partially built: at one point HUMPAR sought collaboration from a research centre to collect data on maternal and infant perinatal mortality, thus

demonstrating willingness to engage in knowledge production. Third, the legal situation in Portugal is very different to the United Kingdom: midwifery has no official status in Portugal and homebirth is illegal. The title of the Portuguese document “The Right to Normal Birth” evokes this situation and echoes the legal amendment initiative promoted by HUMPAR, the aim of which is to change the current definition of childbirth as a medical act. In a similar vein, “The Right to Normal Birth” document adds an interesting category to that of ‘normal birth’: *natural birth*, whose spontaneous beginning and progression culminates in birth with no intervention, which can be either *assisted* or *not assisted* by a health professional. This distinction, which legitimises a non-interventionist stance, generates what is regarded by many as a threat (the expansion of non-assisted births) and the response to that threat (the recognition of a special body of professionals – midwives and/or obstetrical nurses – dedicated to this non-interventionist approach to birth).

The mobilisation by the Portuguese childbirth movement of foreign references is a powerful device to promote change, offering readily available strategies for action that can be adapted to the national situation. The articulation of local specificities to general frameworks is thus achieved in a quite different way than in the Irish case discussed above.

## Conclusion

Evidence-based activism in the childbirth organisations we studied has several key features. First, large parts of the organisations’ activities are devoted to what we call evidential work, that is the collection, the production and the mobilisation of various forms of knowledge. Through these activities, organisations build representations of the people and the concerns they are supposed to voice, describe practices from a user’s point of view, translate and articulate this viewpoint in and with the language of science and position themselves in an international space that gives more weight to their arguments. This articulation of various forms of evidence is crucial to their activism. We saw for example how the CIANE combined various forms of knowledge in its critique of the guidelines on episiotomy and how the collection of statistics on British obstetrical practices simultaneously served to define ‘normal birth’ and to generate a mechanism whereby information on hospital-specific practices was made available to women. Similarly the Irish surveys, which were designed to inform the organisation’s agenda and shape its campaign work, also underpinned the design of an information resource for women. Through this articulation work, the clear-cut distinction between experiential expertise and scientific expertise that appears in the literature on lay expertise is partly erased. This reflects the reality that women’s experiences of maternity care cannot be separated from medicine, not only because the experience of childbirth as well as the illness experience (Anglin, 1997) involves the intervention of medical procedures, but also because women’s bodily experience is informed by medical knowledge and technologies (Akrich and Pasveer, 2004; Akrich, 2010). Knowledge and evidence thus play a pivotal role in creating an interface for engagements between users and professionals. They provide the language through which a negotiation is set up between the organisation, professionals and health policy makers. This is also true at an individual level: organisations consider that giving women access to knowledge and evidence can help to open up spaces for self-determination and for meaningful discussion with professionals.

Second, this evidential work results in the emergence of ‘matters of concern’ to be discussed between all parties involved. In contrast to the movements in the 1970s that have been more or less portrayed as new social movements (Buechler, 1995; Pichardo, 1997), these childbirth organisations clearly adopt a reformist perspective and do not definitively oppose obstetricians and medicalisation. Investing in medical science, they place themselves within the obstetrical collective that they seek to transform. Following accusations directed at some AIDS activists (Epstein, 2011), can it also be argued that birth organisations, by deploying ‘mainstream’ EBM to strategically oppose the routine use of certain interventions, have been trapped into a biomedical way of thinking or have lost or softened their radicalism? The critical engagement of such groups with EBM would suggest not: birth activists have developed critiques of EBM, pointing to its lack of rigour in some cases (Gyte *et al*, 2011) and to the inadequacy of EBM standards of proof in others (Bel, 2004; Loup, 2005; Gyte *et al*, 2010). Furthermore, our analysis suggests that while scientific evidence was one genre of evidence mobilised by the organisations, their evidence work was varied and expansive and was characterised by the production and articulation of different forms of evidence, as also identified by Hausman (2005). In many instances, their work consists of unpacking the assumptions supporting practice and of articulating a new form of knowing in which local experiential knowledge provided by service users is translated through or connected with, international, credentialised, EBM.

Third, the objectives and missions of the organisations are partly re-shaped through evidential work. In all our case studies knowledge activities perform a tentative definition of the issues at stake, the actors to be represented and the attribution of causal relations and thus responsibilities. These activities contribute to the definition and redefinition of the organisations’ strategies and causes and this clearly differentiates these organisations from Embodied Health Movements (Brown *et al*, 2004) in which the mobilisation of science is oriented towards the reinforcement of a politicised collective identity. The work on statistics in the UK case opened up a space for negotiation and action and resulted in a definition of ‘normal birth’ that epitomises an evolution of the organisation’s previous position; the Irish surveys contributed to the definition of a programme of actions for AIMSI and at the same time provided them with arguments and legitimacy that strengthened their capacities for action; the production of a critical review on post-partum haemorrhage led the CIANE to invest in research, the results of which opened a new field for action; and the mobilisation of foreign repertoires by Portuguese organisations prompted them to delineate the Portuguese situation as regards maternity care.

It would thus appear that the momentum generated through knowledge activities can potentially re-orient and indeed de-stabilise organisations. We have observed that in the self-descriptions of the organisations we studied, concepts such as ‘choice’, ‘normal birth’ and ‘evidence-based care’ underpin key objectives. However, these objectives do not always fit together and sometimes refer to different principles of justification, causing the organisations to live within a regime of permanent compromise (Boltanski and Thévenot, 2006). Although intrinsically linked to the organisations’ constitution, these principles may oppose one another when put under strain by certain actions: to give but one example, in the United Kingdom, the normal birth consensus affirmed divisions in the birth activism field, as the way normal birth was set up as a quality measure through the implementation of indicators based on statistics conflicted with the vision of organisations such as BirthTrauma or electivecaesarian.com.

Indeed, this regime of compromise is, we argue, reinforced by the knowledge orientation of childbirth organisations, which opens up spaces for public discussion around ‘matters of concern’, challenging the application of unique normative principles. It does not mean that all options are equivalent; rather it implies rather that each one is confronted with its own complexity.

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