Doulas as Agents of Reproductive Justice Who Promote of Women's International Human Rights: An Evidence-Based Review and Comparative Case Study Between Brazil and the United States

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The Status of Global Women's Health

While monitoring bodies such as the United Nations are publicly committed to the promotion of women's rights to empowerment and health, the international human rights community is failing women in several areas. A human rights approach to health dictates that quality healthcare should be available to all women (Miller et al. 2016). However, quality healthcare is routinely not available to everyone. Sex discrimination kills women, be it through the preference of male babies leading to infanticide of girl children, through preference for boys to receive healthcare and vaccinations compared to girls, or through poor-quality health services for women (Bunch 1990). As girls become adults, institutional challenges including poverty, racism, sexism, and ageism impact quality of and access to maternal healthcare for women globally (Bakken et al. 2015; Hayes et al. 2011; Almeida et al. 2013). Institutional poverty and discrimination impacts maternal health through costly maternal healthcare, lack of transportation options to receive care, and women's lack of awareness of maternal healthcare options (WHO 2017). Furthermore, inadequate numbers of trained women's healthcare providers and the lack of provision of goods and services related to women's health lead to poor health outcomes among women (WHO 2015a). As of 2015, only 73% of births were attended by a skilled attendant worldwide, with varying rates of 96% in the Region of the Americas to 59% in the Southeast Asia region (Boerma et al. 2015). Performance on indicators for women's health is also logically impacted by the quality of care delivered. Analysis of Millennium Development Goal (MDG) Target 5.A, which focused on reducing the maternal mortality ratio (MMR) by three-quarters between 1990 and 2015, indicated that women's health is improving but that much work is yet to be

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done. While only 44% of countries achieved the MDG, during this time frame, the actual MMR was halved (Boerma et al. 2015). Still, the rate of preventable maternal deaths remains staggeringly high in low- and middle-income countries (WHO 2014).

The reliance on medical technology and interventions can ignore the reality of many women's lived experiences. As Miller et al. (2016) indicate, "in many facilities, over-medicalization of childbirth is common practice and can include excessive or inappropriate use of interventions" (Miller et al. 2016). For example, while the World Health Organization (WHO) recommends a Cesarean delivery rate that does not exceed 10 to 15 per 100 live births to optimize maternal and neonatal outcomes and while a 2016 Lancet Editorial indicated that nonmedically indicated Cesarean sections are unnecessary for maternal health, the global Cesarean section rate has been steadily increasing since 1990 (WHO 2015b; Betrán et al. 2016; Miller et al. 2016). An analysis of the Cesarean delivery trends in 150 countries from 1990 to 2014 shows that the global Cesarean section rate increased 12% since 1990 to a final rate of 19.1% (Betrán et al. 2016). However, great discrepancies among regions were observed indicating both gaps to accessing of medical care and the over-medicalization of health systems with unnecessary interventions (Betrán et al. 2016). For example, the Cesarean section rate in Latin America and the Caribbean in 2014 was 42%, 25% in Europe, 32% in North America, 19% in Asia, and 7% in Africa (Betrán et al. 2016).

In addition to the physical health outcomes for women, women's autonomy and empowerment also contribute to good health. While it is often assumed that maternal and child health are interlinked, women have unique and specific health requirements separate from children's health needs (Rosenfield and Maine 1985). The quality of physical maternal health outcomes is crucial, but the personal experience of the mother undergoing medical procedures during pregnancy, labor, and childbirth are is equally important to consider. Respectful care is a key component of healthy birthing facilities (Lalonde and Miller 2015). In spite of this, women are subjected to disrespect and abuse in the form of physical violence, non-consented clinical care, non-confidential care, non-dignified care, discrimination, abandonment, and detention in health facilities during the birthing process (Bowser 2010). Women of lower socioeconomic status, those having children out of marriage, and women infected with HIV feel especially discriminated against (Miller and Lalonde 2015). A commitment to reducing discriminatory practices against women effectively contribute to reducing other forms of oppression, be it through class, race, or other forms (Bunch 1990). This is especially true because discriminatory practices resulting in inadequate care produce poor maternal health outcomes (WHO 2015a).

Women also complain that they are not treated with the respect they expect during the maternal time period. Women report that they are not always asked for consent for medical procedures during delivery (Human Rights Watch 2011; Redshaw and Hockley 2010). Furthermore, even when women are asked to provide consent, some feel that information about risks and benefits for procedures is not always adequately explained (Human Rights Watch 2011). In general, the birth experience leaves many women feeling disempowered (Bohren et al. 2015).

The state of global maternal health is impacted by many intersecting factors that result in both poor physical maternal health outcomes and disempowerment because of poor care and discriminatory practices. Reproductive justice aims to overcome reproductive oppression with relation to reproductive health (including reproductive health services) and reproductive rights (legal rights to reproductive health) (Ross 2006). Equally, Forward Together, a social justice organization in the United States, set the definition as "the complete physical, mental, spiritual, political, economic, and social well-being of women and girls, and will be achieved when women and girls have the economic, social, and political power and resources to make healthy decisions about our bodies, sexuality, and reproduction for ourselves, our families, and our communities in all areas of our lives" (Asian Communities for Reproductive Justice 2005). This definition was later adopted by the United Nations Population Fund in 1994. In this way, reproductive justice can be used as a framework through which progress related to women's reproductive health and reproductive rights may be measured. The goals of reproductive justice may be realized through the provision of quality women's healthcare and through the promotion of women's control over their health.

Doulas are maternal healthcare professionals who engage in reproductive justice. Strauss et al. (2015) argue that doula care encourages reproductive justice because it results in better maternal and child health outcomes; improvements on the experience of pregnancy, childbirth, and the postpartum period by women; and lower medical costs (Strauss et al. 2015). John Kennell, the reputable pediatrician and researcher, is famously quoted saying "if a doula were a drug, it would be malpractice not to use it" (Maher et al. 2012).

Traditionally, doula is claimed as a Greek word, meaning "woman caregiver of another woman," "servant to the mother," and "mothering the mother" (DONA International 2017). Today, doulas are paraprofessionals who provide skilled care throughout a woman's childbearing years in the form of support during pregnancy, labor, and birth, as well as assistance during the transition to parenthood in the initial postpartum period (Kane Low et al. 2006). In this way, a doula can be compared to a community health worker who does not provide medical services but works alongside healthcare providers (DONA International 2017). The doulas' role is sometimes described as a bridge between mothers and medical providers, using their verbal and nonverbal communication skills to help fulfill the gap between the mother's desires and dreams and the reality of the medical care needed. Strategies and techniques used by doulas should accomplish the therapeutic goals to provide comfort, accelerate labor, aid fetal descent or position, and help mothers cope (Gruber et al. 2013).

We use a reproductive justice lens to understand the ways in which doula work supports women's health and the goals of the international human rights community through various human rights declarations and goals of the United Nations. We also provide a cross-cultural comparison of how doula work is promoted and challenged through national policies and programs in two case example countries representing different health systems, cultures, and stages of development: Brazil and the United States.

Doulas Improve Health Outcomes

Doulas support reproductive justice's goal of improving women's reproductive health. A 2008 study addressing evidence-based delivery, published in the *American Journal of Obstetrics and Gynecology*, concluded that a support person, including in the form of a doula, was among the most effective of the 41 birth practices reviewed—one of only three to receive an "A" grade (Berghella et al. 2008). Doulas support six evidence-based birth practices including allowing labor to begin on its own; walking, moving around, and changing positions throughout labor; bringing a loved one, friend, or doula for continuous support; avoiding interventions that are not medically necessary; avoiding giving birth on the back and following the body's urges to push; and keeping mother and baby together (Berghella et al. 2008).

Furthermore, doula care is associated with good health outcomes for mother and child. A systematic Cochrane review of 23 randomized controlled trial studies, from 16 countries, involving 15,288 women concluded that women who had used a doula during labor were 28% more likely to have a spontaneous vaginal birth compared to a Cesarean section delivery and that they were more likely to have a shorter labor time compared to women who did not use doulas (Hodnett et al. 2013). Randomized controlled trials have supported the finding that Cesarean section delivery occurs less frequently among doula-assisted births compared to women in a control group, not using a doula (McGrath and Kennell 2008; Kennell et al. 1991; Campbell et al. 2006). In the United States, findings from research following Medicaid-funded births suggest that doula care is associated with lower odds of preterm birth, controlling for maternal race-ethnicity, age, hypertension, and diabetes (Kozhimannil et al. 2013a, 2016). Apgar scores are higher for infants born to mothers who were supported by doulas (Hodnett et al. 2013; Sauls 2002), and mother-child bonding is reported to occur quicker with doula-assisted care (McGrath and Kennell 2008; Sosa et al. 1980).

Doulas Promote Women's Empowerment

Doulas improve women's experience during pregnancy, childbirth, and the postpartum period. Women who are assisted by doulas report more satisfaction with the birth process compared to women who are not, and this may be due to the fact that women feel that they have more control over the birth process when assisted by a doula (Sauls 2002). It has been argued that the birthing process can be disempowering to women, especially in a hospital setting (Cheyney 2008). Because the average woman is, understandably, less educated about medical procedures compared to her medical provider, she may feel that her opinion about her care is less valuable compared to that of her health provider (Cheyney 2008). Furthermore, some women report feeling that they were not provided with adequate information about the medical interventions that they are about to undergo by their medical providers (Cheyney 2008).

Knowledge is power, and this lack of knowledge regarding one's rights to health, an understanding of the health system, and familiarity with evidence-based practices can result in women feeling like they have less control over their care. Doulas strive to re-balance the knowledge gap between birthing women and providers by providing information about the birth process (Cheyney 2008). Research from Mexico found that women who used doulas described their birth experience in very different ways compared to women who did not use a doula (Campero et al. 1998). Women who used doulas expressed the "feeling of having some rights," when speaking to medical professionals about the quality of their care, while women who did not use doulas did not express these feelings (Campero et al. 1998).

Research indicates that doulas "ensure that informed consent is accomplished and that the woman's personal birth choices are respected" (Meyer et al. 2001). Informed consent serves as a form of information sharing, and this plays a significant role in the degree to which a woman feels empowered to make decisions about her healthcare. Because doulas promote informed consent, they facilitate women's control over the medical care that they receive. They promote equity because they assist women to make informed decisions about their health (Koblinsky et al. 2016).

In addition, doulas help clients navigate the maternity care health system and locating resources (Strauss et al. 2015). Doulas may assist women living in areas where medical care is scarce (Kozhimannil et al. 2016). Their provision of prenatal and postpartum care can reduce the burden of these women to travel to health centers and hospitals. Additionally, Strauss et al. (2015) argue that doulas can reduce health disparities by assisting women who are most vulnerable (Strauss et al. 2015). Doulas are by nature community-based health practitioners, and they may be more able to reach women through culturally appropriate means compared to traditional hospital professionals (Strauss et al. 2015).

Doulas Reduce Healthcare Cost

Doula care is linked to lower healthcare costs for a variety of reasons. Because doula services are associated with lower Cesarean sections, which are expensive, and because women who use doula services are less likely to suffer from medical complications, costs related to childbirth are lessened (Kozhimannil et al. 2013a). Furthermore, because epidural use and analgesia use are less common with doula-assisted births, expenses related to these medications are also reduced (Kozhimannil et al. 2013a, b, 2016).

In the United States, the Institute of Medicine estimates that each avoided Cesarean section saves $4459, and each avoided epidural saves $607 (Kozhimannil et al. 2013b; Kozhimannil and Hardeman 2016). Hayes et al. (2011) estimated that on average, doula-supported deliveries among Medicaid beneficiaries regionally would save $58.4 million and avert 3288 preterm births each year (Hayes et al. 2011). Of 10,000 simulated scenarios comparing Medicaid-funded deliveries with

doula support to Medicaid-funded births, 73% resulted in cost savings, and 25% were cost-effective (Kozhimannil et al. 2013b; Kozhimannil and Hardeman 2016).

International Human Rights and Reproductive Justice

The goals of reproductive justice are admirable, but without support in the form of legislation, public backing, government collaboration, and routine evaluation, it can be both difficult to realize the goals and quantify success. In many ways, the goals of reproductive justice align with the objectives of international human rights. While human rights support people's autonomy over themselves and promote the idea of self-determination, certain human rights clauses and conventions specifically speak to women's access to healthcare service, women's control over healthcare, and health equity. The promotion of reproductive justice therefore serves as a key component of the goals of many human rights declarations. It is through these conventions that we can understand the power of doulas to promote human rights. Likewise, we argue that it is possible to assess the success of the goals of reproductive justice through some international human rights.

Because doulas may serve as agents of reproductive justice, their services may be used to complement and supplement activities targeting women's rights through the establishment of declarations and covenants for international human rights. This paper focuses on the ways in which doulas may support the promotion of international human rights through the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Sustainable Development Goals (SDG).

Universal Declaration of Human Rights

The Universal Declaration of Human Rights was signed in 1948 and serves as the first signed declaration developed by the United Nations (UN). As the first signed document, equality and equity were key components throughout. Article 25 is especially in line with the aspirations of reproductive justice, and it states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including [...] medical care and necessary social services, and the right to security in the event of unemployment, [...] or other lack of livelihood in circumstances beyond his control" (UN General Assembly 1948). Doulas promote the standard of living highlighted in this Declaration because they are focused on ensuring that pregnant women experience good quality physical and emotional health. Furthermore, this article also details "Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection." Because doula care is associated with better

health outcomes in the form of shorter delivery time, lower odds of preterm delivery, better Apgar scores, and better mother-child bonding, doula care may serve as a kind of special care and assistance.

Within the Declaration, Article 2 states that "everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." Doulas contribute to this article through providing health knowledge to all women in the hopes of improving the birth experience.

CEDAW

The Convention on the Elimination of All Forms of Discrimination Against Women, formally signed in 1979, defines discrimination against women and provides a framework for action to eliminate this discrimination by nations. Within CEDAW, Article 12 obligates that "parties shall take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure […] access to healthcare services, including those related to family planning," as well as "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation" (UN General Assembly 1979). Doula services support evidence-based prenatal, birth, and postpartum practices and, as a result, reduce the risk of discrimination against all women.

Sustainable Development Goals

The Sustainable Development Goals of the United Nations were established in 2015 to enable progress with regard to all forms of development including with regard to women's health and rights. Goal 3: Good health and well-being aims to "reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030" and to "end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births" (UN 2015). Because doula care reduces the odds of preterm birth and is associated with a lower rate of Cesarean sections as well as with better Apgar scores and maternal-child bonding, doula support should be considered as a strategy to help nations achieve Goal 3. Furthermore, Goal 5: Gender equality focuses on ensuring "universal access to sexual and reproductive health and reproductive rights." Doula support empowers women to make healthy decisions about their bodies during the pregnancy and labor and delivery.

A Practical Analysis of Doulas, Reproductive Justice, and International Human Rights

Doula care may be implemented and supported through various means. Depending on the cultural, political, and social context in a country, doula care can be valued differently, and this difference in principles can affect how successful doulas are at completing their work. We argue that these same differences can also play a role in how international human rights that support reproductive justice may be defended. We provide a cross-comparison of two distinct case examples of countries where doula care is provided, the United States and Brazil. This comparison provides a practical application of our hypothesis that countries adopting doula-friendly policies may better promote reproductive justice.

We chose to analyze Brazil and the United States for specific reasons. According to Elias and Cohn (2003), while American analysts typically choose to look at European systems for the comparison of public policies on health with the United States, Brazil may also be used for comparison because of its high relevance to the American context (Elias and Cohn 2003). Brazil is similar to the United States in terms of its diverse racial and ethnic makeup, its vast geographic differences, and its situation of social inequality (Elias and Cohn 2003). Brazil also faces similar challenges to the inclusion of certain people in public health policies, considering that, historically, a large portion of the population was excluded from public health coverage leading to the preference for participation in private health plans (Elias and Cohn 2003). Because the United States and Brazil experience similar social and public health challenges but incorporate doula care into public health policies and health provision practice differently, these countries serve as an excellent comparison for understanding how doulas facilitate reproductive justice, depending on context. Table 1 describes the comparison of healthcare system and doula services available in the two countries.

Recently, both countries have adopted legislation that strengthens the provision of maternal and child healthcare. In Brazil, the Stork Network was established in 2011 to improve communication between local health systems and the federal level to strengthen quality of care through the incorporation of best practices for maternal and child health, increase value-based payments, and decrease fee-for-service payments for Cesarean section deliveries (Sartori Fernandes and de Gouveia Vilela 2014). In the United States, the passing of the Affordable Care Act in 2015 created an unprecedented opportunity to discuss the maternal care model because of its goals to improve health outcomes, increase satisfaction with the care experience, and reduce costs align with evidence-based childbirth practices (Strauss et al. 2015).

Brazil employs a national universal public health system known as Unified Health System or "SUS" (Macinko and Harris 2015). Through the public health system, universal access and coverage is available at primary, secondary, tertiary, and surveillance levels (Macinko and Harris 2015). This system coexists with a private system that is primarily comprised of private insurance companies as well as direct payment care services. Currently, 86% of the population depends exclusively

on SUS, and 24% use private health insurance (Fertonani et al. 2015), with the total expenses for healthcare of 8.3% of the GDP or $947 per person (World Bank 2017a). In Brazil, 80% of births are paid for by the government, with the average cost of delivery in a hospital being $160 for vaginal deliveries and $224 for Cesarean section deliveries (da Gama et al. 2016; Cavassini et al. 2012; Le et al. 2014).

In contrast, the United States employs a largely private system, comprised of different private health insurance companies, and two publicly funded programs: Medicare which covers people older than 65 years and people with disabilities and Medicaid which provides care for anyone under 133% of the poverty line and all pregnant women (Centers for Medicare and Medicaid Services 2013). After the Affordable Care Act (ACA) was enacted in 2015, millions of American gained health coverage, but as of September 2016, 12.3% of adults ages 18–64 years and 5% of children 0–17 years old remained uninsured (Martinez et al. 2017). The total healthcare expenditure with healthcare is considerably higher than Brazil, achieving 17.1% of GDP, which can be translated to $9403 per person (World Bank 2017a). In the United States, the government pays for about half of all births, with an average cost of $3500 per delivery (Childbirth Connection 2016; Agency for Healthcare Research and Quality 2017).

Doulas in Brazil

In Brazil, two different groups of doulas can be identified in the country: doulas who work as autonomous professionals in the private sector and the community doulas who volunteer at public birth homes and hospitals. Private doulas are paid out of pocket by women, and their services are costly. They provide support during pregnancy, labor, and after delivery. Community volunteer doulas are commonly members of the community who are served by the hospital themselves (Silva et al. 2016). They support women during labor after women are admitted to the hospital or birth home. The first registered community volunteer doula program was implemented at the Hospital Sofia Feldman in 1997. This program was later expanded to all the other public hospitals in the town of Belo Horizonte (de Castro Leão and Bastos 2001). In spite of the comprehensive training for community volunteer doulas, no standardized training for doula care exists in Brazil. Healthcare professionals and pregnant women themselves may not be aware of how to work with doulas, and a lack of structure in hospitals facilitating doula care can result in the devaluation of doula care (Silva et al. 2016).

In 2006, the Brazilian Ministry of Health and National Policy on Integrative and Complementary Practices included doulas as traditional medicine and alternative and complementary medicine professionals (Brasil Ministério da Saúde 2006). In 2013, doula work was recognized as a formal occupation, under the group "technologists and technicians in complementary and aesthetic therapies" (Brasil Ministério do Trabalho e Emprego 2013). This recognition granted doulas a professional status, allowing them to be included on payrolls and tax returns, and it guaranteed their rights as workers (Brazil 2017).

Doulas in the United States

In the United States, an estimated 6% of births are attended by a doula, and 27% of women who did not use a doula during birth say they would have liked to have had been assisted by a doula (Declercq et al. 2013). The majority of doulas who work in the United States are paid out of pocket. The exception is in two states, where Medicaid funding for doula care exists. In 2013, the Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and CHIP Services (CMCS), and Provider Resources, Inc., recommended providing coverage for continuous doula support during labor among its recommendations (Kozhimannil et al.

Table 1 Comparison of healthcare, maternal health, and doula care systems in the United States and Brazil

	Brazil	United States
Healthcare system	Universal coverage, 100% have health insurance	87.7% Adults have health insurance
	Healthcare GDP, $947/person	Healthcare GDP, $9403/person
	Stork Network (2011) strengthens maternal care	Affordable Care Act (2015) strengthens maternal care
Doula services available	Private doula: paid out of pocket Public hospital volunteer doulas: since 1997	Private doula: paid out of pocket in all states except Oregon and Minnesota
	No standard training for private doulas but formal training for public hospital volunteer doulas	No standard training, but DONA training often used
	No national data about births attended by doulas	An estimated 6% of births are attended by a doula
Policies supporting doulas	Right to Companionship During Birth Act (2005) guarantees women's right to have a companion of her choice during labor	ACOG Committee Opinion (2014): "The continuous presence of supported personnel, such as a doula, is among the most effective tools to improve labor and delivery outcomes"
	Since 2014, 5 states and 17 cities legally grant women the right to companionship allowing doulas to enter public and private hospital as part of birth team, not substituting family members	
	National Policy on Integrative and Complementary Practices (2006) recognizes doulas as a member of a birth team Stork Network (2011) funds doula training using federal resources Doulas are incorporated in the Brazilian classification of occupations (2013)	Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and CHIP services (CMCS) and Provider Resources, Inc., recommended providing coverage for continuous doula support during labor Oregon (2013) and Minnesota (2015) started covering doula service through Medicaid

2013a). Additionally, the CMS Preventive Services Rule (42 CFR §440.130(c)) in 2013 expanded the definition of professionals eligible for reimbursement of preventive services to include doulas (Minnesota State Senate 2013). In 2013, Minnesota introduced legislation to provide Medicaid funding for doula services including childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and postpartum (Oregon Health Authority 2015). Additionally, Oregon began reimbursing for doula services maternity case management services and labor and delivery services using Medicaid funding in 2015 (ACOG 2017). In the United States, several doula training options exist, but most are included in the umbrella of trainings offered by the Doulas of North America (DONA) International, a nonprofit organization that was founded in 1992 to professionalize the work of doulas (Berghella et al. 2008). Since its inception, DONA has certified doulas in all states of the United States (Berghella et al. 2008).

Comparison of Embodiment of International Human Rights

As previously discussed, doula care may be supported and even promoted through international human rights that promote women's right to health and empowerment. A comparison of the status of Brazil and the United States in relation to these women-specific international human rights declarations and covenants can help to illustrate the ways in which doula care may be facilitated. Brazil and the United States are both member states of the United Nations and as such have the power to promote efforts to guarantee women's reproductive justice through specific international human rights conventions and declarations. Furthermore, a comparison of scores on maternal and child health indicators provides concrete examples of the maternal health situation in both countries. The international community is focused on improving three maternal and child health indicators: the infant mortality rate (IMR), the maternal mortality rate (MMR), and the Cesarean section rate.

Both countries signed the Universal Declaration of Human Rights in 1948 (UN General Assembly 1948). Through signing, they publicly declared that they were committed to the statements included in the Declaration.

In 1979, both the United States and Brazil were present for the creation of CEDAW and signed the covenant as present member states. Protocol dictates that United Nations conventions be ratified by a country's legislative structure in order to become a policy guideline for the country. Brazil ratified CEDAW in 1984 (UN 2017), and this ratification occurred immediately after 20 years of military dictatorship. In spite of the fact that the United States sponsored CEDAW, to date, the United States has not yet ratified it (United Nations 2017). This has effectively limited the influence of the covenant on women's health policy in the United States (UN 2017; United Nations 2017).

In 1995 both countries were present at the Fourth World Congress on Women in Beijing, where women's rights were internationally recognized and a platform for engagement with women's empowerment was established (United Nations). After the 1995 conference, the platform for action has been periodically monitored at subsequent meetings, including the last one, Beijing +15 (United Nations). Both Brazil and the United States attended Beijing +15, and Brazil has diligently published follow-up reports related to women's empowerment and health, but the United States has not presented reports about their plan of action for women's equality, development, and peace (United Nations 2010). Finally, following the conclusion of the Millennium Development Goals, in 2015, both the United States and Brazil endorsed the Sustainable Development Goals. Brazil has joined the High-Level Group, alongside with eight other countries, to provide political leadership, guidance, and recommendations for the 17 Sustainable Development Goals (Swedish Government Initiative 2017).

Maternal and Child Health Indicators

The infant mortality rate (IMR), the maternal mortality rate (MMR), and the Cesarean section rate guide our understanding of how each country is implementing policies related to women's health and women's rights. In Brazil, the IMR decreased from 129 deaths/1000 live births in 1960 to 15 deaths/1000 live births in 2015 (World Bank 2017b). The United States had a lower baseline IMR in 1990 compared to Brazil, at 26 deaths per 1000 live births, and successfully decreased this rate to 6 deaths per 1000 live births in 2015 (World Bank 2017b).

In Brazil, the MMR was halved from 1990 to 2015, from 109 deaths/100,000 live births in 1990 to 44 deaths per 100,000 live births (World Bank 2017c; Dias et al. 2016). In spite of this, the maternal mortality Millennium Development Goal of reducing maternal mortality by 75% was not achieved. Again, the United States started with a lower baseline rate compared to Brazil, with 12 deaths/100,000 live births in 1990. However, compared to Brazil, the United States did not successfully reduce MMR in the same way as Brazil. While the United States started with a MMR of 12 deaths/100,000 live births in 1990, MMR increased slightly to 14 deaths/100,000 live births in 2015 (World Bank 2017c). In fact, of the high-income countries, the United States changed from having one of the lowest MMR in 1990 to having the highest in these 25 years (Shaw et al. 2016).

The Cesarean section rate in Brazil is high at 57% across the country in 2014 (Nakamura-Pereira et al. 2016). In the United States, an estimated 32% of women delivering deliver by Cesarean section, a significant increase from 4.5% in 1965 (CDC 2015; Gregory et al. 2012).

Implication for Practice and Policy

We argue that doulas are key stakeholders in women's reproductive rights and reproductive justice and systematically including doulas in health systems could facilitate the achievement of the goals of reproductive justice and international human rights. Our cross-cultural comparison between Brazil and the United States illustrates that there are several means to implement doula care.

While both the United States and Brazil have successfully lowered IMR, MMR continues to challenge both countries. While Brazil successfully significantly reduced MMR, MMR is still considered to be exceptionally high by international standards. The United States has a relatively low MMR compared to Brazil, but no progress has been made to reduce MMR since 1990, as indicated through documented MMR. Furthermore, while the United States has a lower Cesarean section rate compared to Brazil, both countries have higher rates than is recommended by the WHO (2015b).

While Brazil has actively participated in international human rights goals to promote women's rights, the United States has participated less actively. We believe that Brazil's faster adoption of women's human rights agreements compared to the United States could be one of the factors contributing to the progress the country has made in relation to MMR. Whereas the United States has been willing to develop human rights treaties and covenants for other countries to sign, it has been less willing to sign those same documents itself. It is our understanding that this commitment to engagement in international human rights has a direct impact on prioritization and direction to health policies that contributed to lowering the MMR. Furthermore, the difference in dedication to women's rights in particular may help to explain the significant improvements in both countries' IMR. Meanwhile, IMR has significantly decreased in the United States and Brazil. This suggests that both countries are focused on infant health, and the disparity in improvement between maternal and infant health in the United States reflects the fact that infant care may be more of a priority compared to maternal care in the United States (Rosenfield and Maine 1985).

We argue that perhaps this same disparity in dedication to women's rights may play a role in how doula care services are provided in each country. Whereas doula care is facilitated through the public health system in public hospitals in Brazil, doula care is less easily included in the formal healthcare infrastructure in the United States. We have argued that doulas improve women's lived birth experience, and by Brazil incorporating doula care into public healthcare, Brazil has visibly made improving women's experience of healthcare a priority through this facilitation of doula care services.

However, while Brazil shows a high commitment to international human rights, Brazil must commit to the United Nation call for action "Too much, too soon, too late, too little," to improve quality of maternal health (Miller et al. 2016). This call to action describes the two realities that occur within the field of maternal health impacting quality and safety. On one side, there are low-income countries that cannot offer sufficient care and intervention and timely to all women. On the other

side, there is an excess of unnecessary maternal medical interventions conducted too soon, which results in additional complications and costly provision of services. This over-medicalization of childbirth can lead to services that are not medically necessary including Cesarean sections (Miller et al. 2016). By committing to this call to action, Brazil may address its excessive Cesarean section rate. Incorporating doula care services into all regions of the country may assist in this task, as doula care is associated with fewer Cesarean sections (Hodnett et al. 2013).

The United States must demonstrate higher commitment to reproductive justice and international women's rights. Through ratifying covenants such as CEDAW or providing routine reports about efforts undertaken to promote women's rights, the United States will remain accountable for its actions to the global community and will fight to improve the status of women. An expansion of coverage for doula care through Medicaid would improve women's birth experiences and improve overall health outcomes (Hodnett et al. 2013). Incorporating doula services into routine maternal care could also assist the United States in reducing its MMR, since doula care is associated with good maternal health (Berghella et al. 2008).

Both countries should adopt standardized trainings. In order to continue to promote doulas as agents to reduce health disparities, Strauss et al. (2015) recommend "training and hiring doulas who are trusted members of the communities most at risk for poor health outcomes, with attention to racial, ethnic, geographic, socioeconomic, cultural, and linguistic factors" and "ensuring that doulas are trained in cultural competency, trauma-based care, and support services that are available for low-income pregnant and postpartum women" (Lothian 2009; Strauss et al. 2015). An agreement of the minimum criteria for doulas training, incorporating each country and/or region cultural perspective, would not only be beneficial to women and doulas but also help to overcome one of the barriers for doulas being integrated in the birth team, the lack of understanding by other professionals of the doula's role.

We recommend that both countries invest in research to identify the impact of doulas on the public health system, especially considering quality of care and cost-benefit analysis. Little research about doulas exists in Brazil, and this does a significant disservice to both Brazil's public health system and stakeholders in global health. By understanding how doulas impact public health in Brazil, Brazil may develop strategies to facilitate their work, and other countries may look to Brazil for guidance related to promotion of doula care. Public health societies and private societies invested in health including physician society organizations would be able to use analysis about doula care to support the use of doulas. Furthermore, analysis of doula care should facilitate evidence-based practices during labor and childbirth.

Conclusion

Doulas are important stakeholders in international human rights promoting women's rights and women's empowerment. Their promotion of maternal health through improving health outcomes, promoting women's control over their health, and

reducing cost-related health disparities embodies the goals of several United Nations goals and declarations including the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, and the Sustainable Development Goals. Incorporating doula services into health systems may serve as an important strategy to improve maternal health. While doula care is provided in both the United States and Brazil, services vary, and each country faces different challenges to its doula services due to the unique cultural and political norms. Both countries have areas for improvement, but they are committed to women's health and the goals of reproductive justice. We argue that strengthening doula care services should be promoted as a practical approach to realizing better maternal health.

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