Obstetric violence: socioeconomic and ethnics disparities in brazilian territory

Violência obstétrica: disparidades socioeconômicas e étnicas em território brasileiro

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ABSTRACT
As a country with a history of racial exploitation, aspects of colonial relationships persist in modern healthcare. The institutionalization of obstetric violence reflects structural racism, leading to the dehumanization of non-white women and the submission of birthing individuals to a paternalistic medical figure. The objective is to elucidate racial and social inequities in obstetric violence rates in Brazil. This literature review is restricted to the last five years, covering four databases, with the selection of 13 articles following exclusion criteria. There is a high maternal-fetal mortality rate due to direct obstetric causes, associated with increased rates of iatrogenic interventions and physical and verbal violence during childbirth. Resistance from the medical community, coupled with elitism in leadership positions of movements against obstetric violence and the normalization of abuses, makes it challenging for black women to recognize the violence. It is mandatory to implement legislation directly prohibiting obstetric violence.

Keywords: obstetric violence, Brazil, social inequity, ethnic inequity, racism.

RESUMO
Tratando-se de um país com histórico de exploração racial, aspectos das relações coloniais persistem nas relações modernas no sistema de saúde. A institucionalização da violência obstétrica é reflexo do racismo estrutural, com consequente desumanização de mulheres não brancas e submissão das parturientes à figura médica paternalista. Objetiva-se explicitar as inequidades raciais e sociais nos índices de violência obstétrica no Brasil. Trata-se de uma revisão de literatura com restrição dos últimos 5 anos, em 4 bases de dados, com seleção de 13 artigos após aplicados critérios de exclusão. Há alta mortalidade materna-fetal por causa obstétrica direta, associada a maiores índices de intervenções iatrogênicas e violência física e verbal durante o parto. A resistência da comunidade médica associada ao elitismo na liderança de movimentos contrários à violência obstétrica e à normalização dos abusos torna difícil o reconhecimento da violência por mulheres pretas. Faz-se necessário implementar legislações diretamente proibitivas à violência obstétrica.

Palavras-chave: violência obstétrica, Brasil, inequidade social, inequidade étnica, preconceito racial.

RESUMEN
Al ser un país con una historia de explotación racial, aspectos de las relaciones coloniales persisten en las relaciones modernas en el sistema de salud. La institucionalización de la violencia obstétrica es un reflejo del racismo estructural, con la consecuente deshumanización de las mujeres no blancas y el sometimiento de las parturientas a figuras médicas paternalistas. El objetivo es esclarecer las desigualdades raciales y sociales en los índices de violencia obstétrica en Brasil. Se trata de una revisión de la literatura restringida a los últimos 5 años, en 4 bases de datos, con una selección de 13 artículos tras aplicar criterios de exclusión. Existe una alta mortalidad materno-fetal por causas obstétricas directas, asociada a mayores tasas de intervenciones iatrogénicas y violencia física y verbal durante el parto. La resistencia de la comunidad médica asociada al elitismo a la hora de liderar movimientos contra la violencia obstétrica y la normalización del abuso dificulta que las mujeres negras reconozcan la violencia. Es necesario implementar legislación que prohíba directamente la violencia obstétrica.

Palabras clave: violencia obstétrica, Brasil, desigualdad social, desigualdad étnica, prejuicio racial.

1 INTRODUCTION

Feminist movements coined the term "obstetric violence" (OV), and it is currently used to describe and categorize various types of violence, assaults, and omissions that occur throughout the pregnancy, childbirth, and postpartum periods, as well as in situations of abortion.[1] Despite some questioning within the medical community regarding the term, it is legally accepted in Brazil as an official term, even though it has not been explicitly incorporated into legislation until now. OV encompasses both physical and psychological abuse, as well as the use of iatrogenic procedures and surgeries without indication. Additionally, the terms

"institutional violence" and "violence in childbirth" are often used interchangeably or as aggregators to express different aspects of the same general concept. There is significant variation in the terms applied based on the country of origin of the observed studies, but they all share the commonality of being a form of gender-based violence occurring during the pregnancy and postpartum cycles and are perpetrated by both healthcare teams and within the home.[2,3]

OV leads to various adverse outcomes for both the postpartum woman and the baby, ranging from difficulties in forming emotional bonds to challenges in breastfeeding during the first six months after birth. The likelihood of postpartum depression and psychological traumas is directly linked to the experiences throughout pregnancy, childbirth, and postpartum.[4,5] Furthermore, OV contributes to an increased maternal mortality rate, estimated at 59 maternal deaths per 100,000 live births in Brazil in 2017, three times higher than the maximum rate of 20 maternal deaths per 100,000 live births recommended by the World Health Organization (WHO). This data raises discussions about the scientific framework supporting or questioning techniques frequently employed in medical practice.[1] The prevalence of these practices in Brazil exceeds global standards, with a cesarean section rate of 56.9% in 2015, while the WHO recommends a maximum rate of 15%. The incidence of labor induction was 40%, and 37% experienced the Kristeller maneuver.[6]

Among the significant medical interventions considered violent are both surgical procedures and medical maneuvers, such as the use of medications to accelerate labor, premature rupture of membranes, and the use of medical tools like forceps and episiotomy. While most of these techniques have scientific merit when used to ensure maternal-fetal survival in emergencies, they are often employed unrestrictedly and electively to expedite the labor process or follow unjustifiable protocols.[2,3] The commodification of medicine, the workload burden on obstetricians, and insufficient training of healthcare teams, combined with a backdrop of structural bias, contribute to the devaluation of women as the primary subjects in the childbirth process.[2]

Regarding the incidence of OV in different population groups, it is evident that the risks are higher for black women, those in poverty, drug users, or those who are socioeconomically vulnerable in some way. The reproduction of social hierarchies within hospitals under an interventionist medical logic normalizes the relationship between the obstetrician and the parturient's body, perpetuating broader societal inequalities.[2] The worst indicators in the country regarding good practices during childbirth, such as allowing the intake of food and drinks during labor, using non-pharmacological methods for pain relief, evaluating uterine

mobility, and employing the partogram, were found in the North and Northeast regions, where there is a lower human development index, a considerable population facing socio-economic vulnerability, and a scarcity of healthcare professionals, leading to a workload burden and low infrastructure.(1)

Maternal obstetric deaths among non-white women are 3.55 times higher compared to white women. One of the leading causes of these deaths is eclampsia, possibly due to the lower number of prenatal visits by this population despite being at a higher risk for hypertension. Additionally, black women have a higher risk of incomplete prenatal care and lack of accompaniment during childbirth. Concerning labor itself, women from these ethnic groups are more likely to undergo episiotomy without local anesthesia, experience a higher percentile of verbal, physical, or psychological violence during care, and face more significant risks of infection after cesarean section.(7)

Therefore, only a meticulous study of this phenomenon and identification of the factors responsible for such disparities in the incidence of OV in the Brazilian population can elucidate these issues and lay the groundwork for their correction. This study aims to clarify the most recent evidence regarding ethnic and social disparities during pregnancy and childbirth.

2 METHODS

This article is a bibliographic review with a selection from databases with all descriptors in English, 'Obstetric Violence,' 'Brazil,' 'Social,' and 'Racial,' using the conjunction 'AND' to associate all descriptors. Thus, the search was conducted following this pattern: (Obstetric Violence) AND (Brazil) AND ((social) OR (racial)). Preference was given to searching only for such descriptors in the specified form due to the relative scarcity of articles on this theme in the last five years and to better delimit the topic.

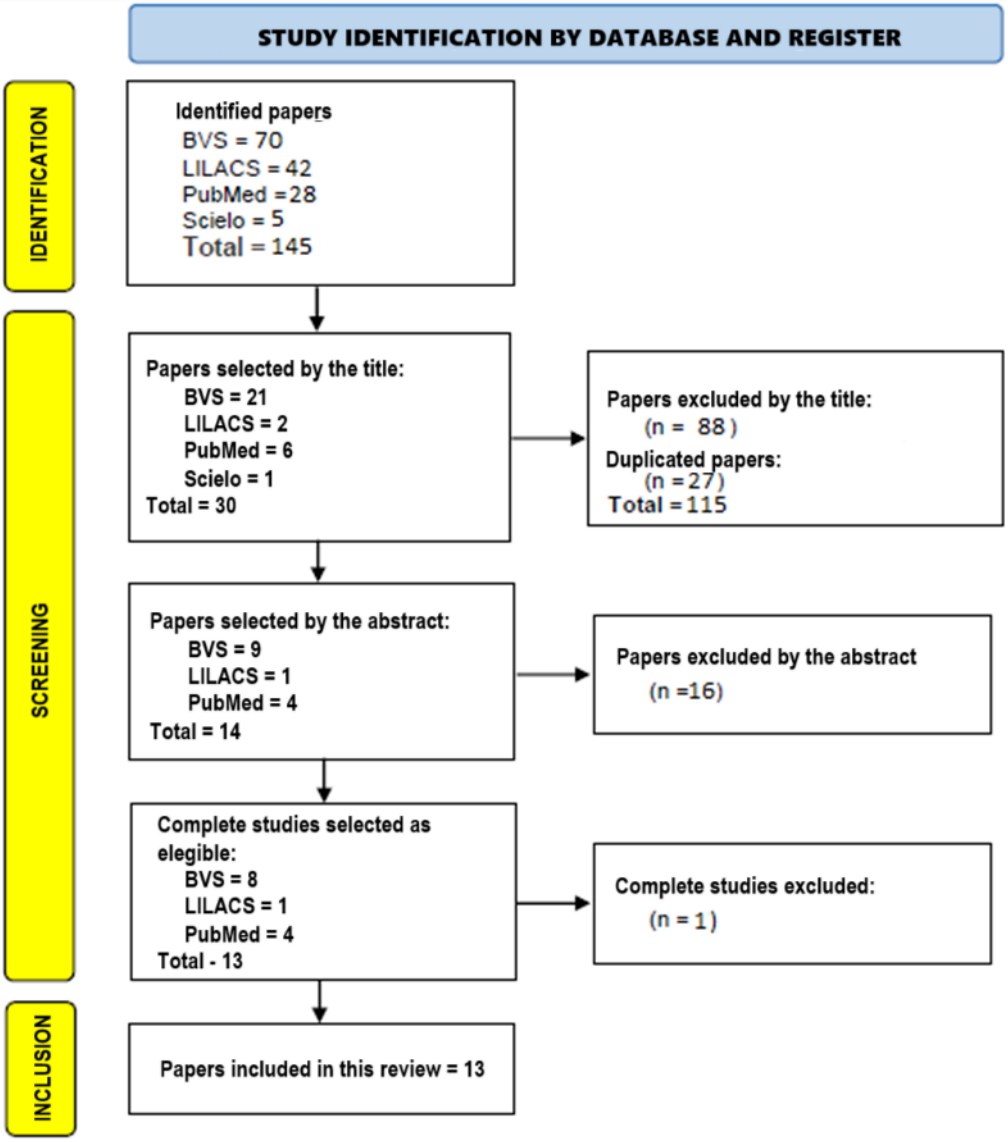
Searches were made with filters for complete Portuguese, English, and Spanish texts, with a time window from 2018 to 2023. A total of 70 articles were obtained from the Virtual Health Library (BVS), 42 articles from the Latin American and Caribbean Literature in Health Sciences (LILACS), 28 from PubMed, and five articles from the Scientific Electronic Library Online (Scielo), totaling 145 articles.

Given the above, in the first stage of article selection based on titles, it was determined as an inclusion factor that the article presents, in its title, ideas directly related to Obstetric Violence in Brazil, preferably addressing aspects related to ethnic and social disparity in the title. Articles that mention other types of violence, such as domestic or sexual violence, were

excluded, as well as articles dealing with countries other than Brazil. Duplicate articles from search platforms were also excluded. Thus, in this first stage of screening, 30 articles were selected.

In the second stage of screening, the abstracts of the articles from the first stage were read to select those most relevant to the proposed theme. In this way, 14 articles were selected for full reading. Finally, the entire reading of the articles resulted in selecting 13 to compose the present study. The process of study identification is described in Figure 1.

Figure 1: Methodological flowchart.



Source (ADAPTED): Page MJ, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n7.

3 DEVELOPMENT

After careful data collection, the main aspects of the studies analyzed were displayed in the Table 1, containing the name of the main author, objective, results, and conclusion.

Table 1: Details of the studies.

AUTHORS	OBJECTIVES	RESULTS	CONCLUSION
LIMA KD.[1]	Analyze the subjective experiences of black women during prenatal, childbirth, and postpartum, with a focus on understanding the ethnosocial influences in this process.	The intersection of oppression levels, class, race, and gender is crucial for the prevalence of OV and abusive practices from pregnancy to postnatal. Narratives reveal institutional racism, dehumanization of care, and perpetuation of female oppression.	Structural racism hinders black women's access to their reproductive rights. Urgent changes in pregnancy and childbirth care practices are needed, especially due to high maternal mortality and discrepancies between Brazilian and global practices.
JARDIM DMB.[2]	Examine the scientific production on OV, discussing its main characteristics in routine care for the gravid-puerperal cycle.	Studies on OV have intensified since 2015, covering the concept of OV, its ethnosocial interfaces, institutionalization, invisibility, and trivialization of the subject.	OV is a serious public health problem, manifested through institutionalized and legitimized negligent, reckless, and discriminatory acts, driven by hierarchical power relations and subjugation. Understanding this process is necessary to advocate for pregnant women subjected to such practices.
LEITE TH. (2022)[3]	Discuss the definition, measurement, and public policies in Brazil that hinder research on OV during pregnancy, childbirth, and postpartum.	Lack of consensus on terminology and definition complicates the use of validation instruments, resulting in imprecision and a lack of comparability between studies. There is a scarcity of studies on the consequences of OV on maternal-child health.	The lack of consensus, measurement difficulty, and absence of causal studies are obstacles to research in the field.
LEITE TH. (2023)[4]	Investigate the causal association between OV during childbirth and breastfeeding.	OV during childbirth reduces the likelihood of exclusive breastfeeding, especially in vaginal deliveries. Exposure to OV affects the ability to breastfeed 43-180 days after birth. The prevalence of mistreatment found was 44%.	OV is a risk factor for breastfeeding discontinuation and difficulty. Public policies mitigating OV in hospitals are necessary, given the impact on the health of mothers and babies.
PAIZ JC.[5]	Check for the existence of an association	Women who experienced OV had a higher prevalence	Postpartum depression symptoms are more

	between OV and suggestive signs of postpartum depression 4 weeks after childbirth.	of symptoms suggestive of postpartum depression (PR 1.55; 95% CI 1.07-2.25). Women with a history of mental health problems and low socioeconomic status also had a higher prevalence (PR 1.69; 95% CI 1.16-2.47).	prevalent in women with low socioeconomic status, a history of mental disorders, and those who experienced OV. Therefore, it is necessary to qualify care for this social stratum to reduce the occurrence of postpartum depression and its consequences.
LANSKY S.[6]	Analyze the profile and childbirth experience of 555 women after visiting the "Sentidos do Nascer" exhibition, focusing on perception of OV.	OV was reported by 12.6% of women as being associated with factors such as marital status, lower income, and the absence of a partner. Consequences included a higher rate of lithotomy position during childbirth, Kristeller maneuver, and early baby separation in the postpartum period.	The exhibition contributed to increased awareness of OV but did not assist pregnant women in recognizing outdated and harmful practices.
CARMO CBC.[7]	Evaluate the difficulty of access and healthcare for black women, as well as discrimination.	Black women have a higher risk of complications during pregnancy due to physiological causes but also have a higher chance of maternal death due to obstetric causes. Their babies have a 2 times higher chance of dying before the age of 1. Socioeconomic indicators are worse in this population, as well as the rate of prenatal care attendance.	Black women make greater use of the public healthcare system (SUS) and are more subject to peripheral hospitals. Historical inequalities and racism influence the development and outcome of pregnancy, with a higher risk of maternal-child death, deprivation of rights, and poor care. Additionally, they have a higher chance of physiological complications, aggravating their health situation.
IRVINE LC.[8]	Understand the legitimization process of the humanization of childbirth movement in São Paulo.	The movement uses scientific evidence and rights-based language. There is rejection from pro-cesarean doctors and influence from the medical lobby.	In Brazil, the movement presents itself as evidence-based advocacy, seeking optimization of obstetric interventions and reduction of iatrogenesis.
ALMINO MAFB.[9]	Discuss the consequences of racism and Brazil's slave past on black pregnant women. Assess the impacts of sexism and racism as tools of governance, especially during the SARS-CoV-2 pandemic.	The black population is more prone to die from COVID-19, with women being more affected than men in this population. Gender and social inequalities have led to a higher rate of infectivity and death in this population.	Black women remain vulnerable to social inequalities, requiring an anti-racist social transformation to promote social justice and equality, especially in a context of a global health crisis.

GONZAGA PRB.[10]	Problematize motherhood and the maintenance of the colonial perspective on the female body.	The concept of motherhood is sacralized while becoming an instrument of subjugation. Ethnical disparity corresponds to the dehumanization of non-white women.	The institution of motherhood is an integral part of femininity, even for non-mothers. A critical perspective is necessary to understand its social importance.
WILLIAMSON KE.[11]	Understand how obstetric racism sustains iatrogenesis against black women in Brazil.	Black women are disproportionately denied access to care and are more vulnerable to death from avoidable obstetric causes.	The observed forms of violence reveal the policy of reproductive governance and obstetric racism as a reflection of structural racism.
DALENOGARE G.[12]	Understand the experiences of pregnancy and childbirth for women in prison, considering race, gender, and social class.	Pregnancy in prison can intensify power relations and mechanisms of inequality in caring for women and children. Reports reveal situations of OV from the first police approach, being institutionalized. The childbirth experience was permeated by feelings of loneliness and helplessness.	Pregnancy in prison deepens existing inequalities and vulnerabilities in the Brazilian territory, with an amplification of inequalities and institutionally applied OV along with dehumanization in care. Urgent policies and practices are needed to ensure dignity for pregnant women in prison.
SUPIMPA.[13]	Describing the experience of immigrant women in the process of childbirth and delivery.	Fluency in the local language, adaptation to culture and laws, separation from family, and exposure to stress during the migration process make the gravid-puerperal cycle challenging, increasing the chances of experiencing OV.	Cross-cultural training for nurses is essential in a world with a growing migratory flow. Prenatal care is crucial to understanding the specific needs and risks of migrants.

Source: made by the authors, 2023.

Black women have a higher proportion of teenage pregnancies (18.8% - 15.1%), lower educational levels (27.2% - 21.1%), and income below the minimum wage (31% - 21%). Studies indicate a SUS (Unified Health System) utilization rate of 80.3% to 93.1% within this population, and their deliveries are concentrated in hospitals of lower quality than the average hospitals attended by white women (73.7% of deliveries to black women occurred in hospitals that account for only 17.8% of white women's deliveries). Regarding mental health, there is a 2-fold higher chance among black women of starting treatment for postpartum depression. There are also lower rates of initiating prenatal care in the first trimester (64.7% - 71.6%), a smaller proportion of prenatal consultations (73.2% - 82.3%), longer waiting times for care, a smaller proportion of companions during childbirth (68% of women did not have this right), and a higher frequency of repetitive vaginal examinations (26% more common in brown women

than in white women). Thus, it is possible to perceive the violation of the bodies of black women as reflected by their greater socioeconomic vulnerability. Furthermore, among deaths of children under one year, 61.8% are of black and brown children, with the maternal mortality ratio being two and a half times higher in black women than in white women. Non-white women have a 3.55 times higher chance of dying from direct obstetric maternal mortality compared to white women, in addition to an 80% risk of readmission in the postpartum period.(7)

It is evident that, despite the scarcity of studies on ethnic and socioeconomic disparities in the occurrence of OV the identified works present a unique reality in which black women and those from less affluent social strata end up becoming victims of institutionalized violence. There are discrepancies in the incidence of OV among various studies, despite the overall conclusion of the urgent need to implement policies aimed at mitigating the processes of dehumanization in maternal care.

4 DISCUSSION

The existence of a history of ethnic disparities in Brazil, linked to the country's high social inequality and the presence of a hierarchical healthcare structure, leads to the institutionalization of OV as a standard instrument of care in many maternity units.(5) Practices that are globally discouraged continue to be used in the national territory, while rates of iatrogenesis and mistreatment during childbirth are exceptionally high in regions known for social vulnerability, such as the North and Northeast.(1)

The primary observed forms of violence include an excessive number of pelvic exams, the Kristeller maneuver, and episiotomy, procedurally, as well as verbal oppression and punishment or abandonment of women labeled as "insubordinate".(8) It is expected to hear reports of verbal oppression and delegitimization of pain during invasive procedures, with statements such as "You enjoyed it when it was happening, now endure it" or "Do not make a scene," especially when it involves women in greater social vulnerability.(1) The hierarchical position in the doctor-patient relationship causes the former, by adopting a superior posture, to reproduce discourses of subjugation of birthing women, reaffirming prejudices and belittling women as human beings. The view of women as fragile beings in need of patriarchal care transforms the figure of the doctor into the central subject of childbirth, allowing free action according to their whims.(2)

Since motherhood is considered an integral part of the female entity and an example of femininity, the process of pregnancy, childbirth, and postpartum becomes delicate.

Expectations are imposed on the parturient's body, norms are enforced, and instructions on how the childbirth should proceed are dictated.[2] The historical construction of motherhood as a social function of women dates to the colonial history of Brazil, where a clear distinction was made between two groups of women based on their ethnicities: white and non-white. In this context, non-white women, despite being seen as potential mothers, are not treated as human beings but rather as animals.[9] Consequently, their pregnancy is not viewed with the same sacred character as that of white women. The pregnant enslaved woman was expected to meet the same production targets as other women, regardless of her health condition. This colonial perspective of viewing women from different ethnicities and social strata persists in the propagation of racist discourses and the application of iatrogenic practices with false scientific backing. The saying "black women are more resistant to pain and diseases" is merely a reflection of a racist discourse of dehumanization stemming from Brazil's colonial history. It is precisely this logic that facilitates dehumanization during childbirth and can justify unequal treatment of non-white or socially vulnerable women.[10]

The country's history of slavery has thus shaped the foundations of the current structural racism prevalent in both social structures and government policies. Despite representing the majority of the country, black and brown individuals continue to exhibit lower health indices, higher mortality rates, and greater overall socioeconomic vulnerability. The scarcity of public policies aiming to mitigate harm to this population reflects institutionalized racism as the norm, as observed in the application of OV.[11]

These inequalities become even more pronounced for pregnant women in prison. Reports demonstrate complete disrespect and dehumanization, with violence reaching even higher thresholds, including physical violence, precarious accommodation situations, minimal access to healthcare and prenatal care, disdain from the hospital's health team during childbirth, loneliness throughout the process, and early separation of babies. Thus, since women in prison often have lower levels of education, higher rates of family abandonment, a greater incidence of illicit substance use, and, above all, greater socioeconomic vulnerability, the practice of OV becomes mandatory. Reports show violence and disdain as an apparent indirect form of punishment for women's crimes, both by prison officers and the health team itself. Some pregnant individuals report receiving differentiated care as their pregnancy becomes apparent, demonstrating a prioritization of fetal life and well-being over maternal concerns.[12]

Regarding immigrants, like black women, they exhibit a higher incidence of cesarean sections and medical interventions. Considering the overall vulnerability of these women, with a social context of the need for social integration, language difficulties, and challenges in

comprehension, childbirth becomes an even more delicate experience. When questioned about parallels between childbirth in Brazil and their home countries, reports point to a greater dependence on the healthcare team to ensure positive outcomes in Brazil, given that many Latin American countries have home childbirth as a cultural norm. Cultural sensitivity and the actions of healthcare professionals are essential to facilitate the integration of these women into a new culture and ensure the best outcome for both the parturient and the baby. There are reports from Bolivian women who claim to be often seen as "submissive" by healthcare teams in Brazil, reflecting a position of superiority towards pregnant individuals and enabling the use of violent practices during childbirth.[13]

Furthermore, regarding the practices of obstetricians, it becomes evident that the preference for cesarean sections serves to manage private patients better, given that it is not possible to predict the timing and duration of a vaginal delivery. Thus, the medical community itself is encouraging the increase in the number of cesarean sections. When present in public healthcare settings, these same cesarean doctors often are unfamiliar with non-invasive childbirth procedures and employ techniques to expedite the process, resulting in harm to pregnant individuals. Rates of episiotomy of up to 56% among socially vulnerable women, minimal use of anesthesia, and high use of oxytocin for labor induction are observed. The goal is to increase the number of deliveries within the same period, regardless of patient outcomes.[8]

There is, therefore, a confluence between medical guidance and patient desire, as the former benefits from surgical deliveries, while the latter finds herself in an environment where vaginal childbirth is associated with pain and suffering, precisely due to institutionalized OV in the country.[8] Moreover, given that a significant portion of violent acts described in this article arise from practices occurring during vaginal childbirth, it can be observed that, although OV occurs in both cesarean and vaginal deliveries, its intensity is heightened in the latter, with worse repercussions for the parturient and her baby.[4,5]

The fight for more significant implementation of humane childbirth and awareness regarding OV primarily comes from wealthier white women, directly reflecting a higher level of education and awareness of their rights.[4] Reports from black birthing women reveal a high degree of experienced OV, even though many are unaware of the term and have difficulty identifying violent situations until they are educated about it, potentially leading to potentially underestimated OV rates found in some studies.[6] Social vulnerability, therefore, has created room for the autonomous action of the medical team over these women's bodies based on the social submission to which these women are accustomed. Ethnic and gender violence is

common in Brazilian society, and once OV becomes institutionalized, violent acts are accepted as commonplace by the victims.[5]

OV has long-term consequences for the mother-baby dynamic, with a considerable increase in cases of postpartum depression and difficulties in breastfeeding due to the stress experienced during childbirth. However, when comparing women who have experienced violence, a notable difference in socioeconomic levels is observed, with women from higher social strata having half the chance of developing postpartum depression, possibly justified by the lower intensity of violence in these cases or the better general conditions of the postpartum woman upon leaving the hospital environment.[5,8]

Finally, it is essential to highlight that the fact that most socially vulnerable women attend a minority of public hospitals leads to an overload of maternity units. This factor can directly impact outcomes for pregnant women, as the high workload of healthcare professionals may create a sense of neglect and affect the connection between the healthcare team and parturients. Additionally, the hospital structure itself may constitute institutional violence, as inadequate facilities can violate the dignity and privacy of women during childbirth and postpartum.[3]

5 CONCLUSION

It is possible to perceive that the impacts of OV encompass not only maternal health but also the health of their babies, with effects ranging from the mother-baby bond in the postpartum period to breastfeeding itself. In this aspect, the evident disparity in the type of care offered to Black and White mothers exposes the effects of structural racism, influencing medical attitudes toward an already vulnerable population. The greater the social vulnerability of the pregnant woman, the higher her risks of dehumanization, neglect, and mistreatment by the healthcare team, whether during prenatal care, childbirth, or the postpartum period. The risks of maternal death due to iatrogenesis are higher in this population, as are the risks of undergoing prescribed or not recommended procedures.

Despite vaginal delivery presenting better rates of postpartum recovery, lower maternal mortality rates, fewer complications, and a directly proportional relationship with breastfeeding rates, fears arising from a culture based on violence hinder women's adherence to this route. In Brazil, there is a preference for high-risk delivery among doctors due to various factors, especially the ease and speed of performing the surgery, turning vaginal delivery into the second option. As a result, many teaching hospitals do not employ intrapartum maneuvers for

complicated situations and dystocia, opting for the high-risk route to "facilitate" the process. However, this culture of cesarean section indications makes it difficult for students to learn functional obstetric techniques, fostering a cesarean culture.

Natural childbirth, as the term suggests, should be a process in which the healthcare team only assists the parturient in her needs to avoid major complications, contrary to what is observed in Brazil, where OV is an institutionalized instrument, depriving parturients of their reproductive and human rights. As unanimously pointed out by the authors in this study, it is necessary to guide public policies encompassing this already marginalized population to equalize their care with that of any other citizen.

Given the significant variability of terms associated with OV, this study's limitation is having restricted searches to "obstetric violence," which may have resulted in fewer articles for analysis than the actual quantity of studies on the subject. In future research, it may be interesting to conduct associated searches for terms such as "mistreatment," "childbirth," and "humanized childbirth" as alternatives in international and national literature, respectively.

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