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"Natural" and/or "Humanized" Childbirth? A Reflection from the Class Perspective

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Abstract: *The proposal for the "humanization" of childbirth care has gained ground in recent decades in Brazil, mainly in the middle-class urban strata. However, through its incorporation into the public health system, the proposal was also extended to women from the lower classes. This reality has posed some challenges and has raised questions about the format that "humanized" assistance has assumed in public institutions. Based on the analysis of two specific situations experienced by women from different social classes (one receiving care in the public sector and the other in the private sector), the article seeks to reflect on the notions of "natural" childbirth and "humanized" childbirth, pointing out, in each of these contexts, different perceptions of "humanization" and, consequently, considerations on what could be viewed as its opposite: "obstetric violence".*
Keywords: *Childbirth; Humanized care; Social class; Obstetric violence*

Introduction

The "humanization" proposal in childbirth care has gained ground in recent decades in Brazil, mainly in the urban middle-classes, a segment in which C-sections reached the alarming level of 85% in 2016. Nevertheless, through its incorporation into the public health system[1], the proposal has also been extended to women from the lower classes. This new reality has presented some new challenges and posed questions on the format that "humanized" care has taken in public institutions, as per studies by Carmen Susana Tornquist (2003), Sara Mendonça (2014), Rebeca de Cássia Daneluci (2016), and Rosamaria Carneiro (2017), among others. This scenario has enabled a privileged reflection on the different perceptions of childbirth and the identification of the difficulties and obstacles that can accompany proposals for "humanization", especially when they involve a transposition or replication of formats and models of one social universe to another, without considering differentiated institutional and social realities.

This article proposes a reflection on the "humanized" childbirth experience of women from different social classes. To this end, there is a need for a discussion on the uses and meanings attributed to the terms "natural" childbirth and "humanized" childbirth in the different contexts investigated. The question will be addressed through the analysis of two specific situations

[1] In 2000, the Ministry of Health implanted the Pre-Natal and Birth Humanization Program (*PHPN*), which sought to establish a minimum protocol of actions for obstetric care in the public network, in order to promote equal treatment all over Brazil. At the start of the 2000s, in addition to the PHPN, other actions and programs were spearheaded by the Ministry of Health, giving shape to what would be identified as the field of "humanization", permeated by the debate on the search for quality in the care provided. Although the word "humanization" did not appear in all of them, there was already a tenuous relation being established between "humanization", quality care and satisfaction. In 2011, as an effect of the PHPN, the *Programa Rede Cegonha* (Stork Network Program) was launched, aiming to improve access and quality of public network care.

experienced by women from different social classes – one receiving care in the public sector and another in the private.

These cases are part of the ethnographic material collected between 2011 and 2012,[2] monitoring two groups of women – one from a low income class and another from the middle class – in two contexts of childbirth care in a major Brazilian city. The empirical basis therefore involves two fields: the first consists of a group being prepared for "humanized" childbirth located in an affluent region of the city and which brought together women from the middle classes; the second is composed of pregnant and post-partum women in a public normal birthing center (CP),[3] situated in the periphery of the city where mainly low-income women received care.

The qualitative approach adopted entailed participant observation[4] and the holding of interviews in both research fields. In total, formal interviews were performed with 37 pregnant and post-partum women, who were giving birth for the first time or had other children. Twenty-five of these women were receiving pre-natal care from the CP, while the other 12 were from the middle-classes and were attending the birth preparation group. In addition, interviews were carried out with professionals whose expertise is directly involved in the project to "humanize" delivery and birth: an obstetrician (linked to the Network for the Humanization of Delivery and Birth), an obstetric nurse, coordinator of the CP at the time, and the doula who guided the birth preparation group where research was performed within the context of the middle-class strata.

The divergence in the number of women interviewed was due to the get-togethers that took place during the research. Participants from the middle-class sample generally gave longer interviews and had a greater interest and motivation in reporting on their experiences, which did not always happen with the low-income participants. While some were more open and interested, others limited themselves to the questions asked, demonstrating what was interpreted to be either shyness or a certain lack of interest in the subject matter, which led to the need to interview a greater number of women. Interviews for this group were held in reserved spaces in CP itself and subsequently counted on the participation of family members, who expressed an interest in collaborating with the research. For the other group, interviews took place mostly in the women's homes, but also in public parks. It should be mentioned that the research was approved by the Research Ethics Committee of the Municipal Health Department of the city where the research was carried out[5] and all of the women interviewed signed the Informed Consent Agreement they received.

Before analyzing the two specific situations – one observed during field work and the other based on the account of a postpartum woman[6] –, a brief review of the literature will be presented, with a view to mapping certain studies of a socio-anthropological slant that call attention to the interest in examining the relations between childbirth and class.

Childbirth and social class in contemporary socio-anthropological literature

In a pioneering study at the start of the 1980s, the sociologist Margaret Nelson (1983) investigated women from different social classes who gave birth in a teaching-hospital in New England, USA. The author found that while the middle-class women generally wanted more active births with more involvement in the process and fewer medical and pharmaceutical interventions, the working-class women wanted birth experiences that were more passive with more medical intervention – which was also noted in the women investigated for this research. The data collected by Nelson (1983) led to the assertion that "there is clearly more than one childbirth model among

[2] The material was gathered for the completion of a Doctoral thesis in the area of Social Sciences, submitted by the author under the supervision of the co-author.

[3] The institution is qualified as an autonomous Center for Normal Birth, that is, which is not physically connected to a hospital or maternity, and is defined as a primary health institution that provides care in "low-risk" pregnancies only. The infrastructure is set up to deal with lower complexity cases. The institution is part of a health system group that also includes the option of services and ambulance transfer to a hospital located in the surrounding area, in cases with complications. In the CP, all pre-natal, delivery and postpartum care is exclusively provided by obstetric nurses.

[4] Together with the middle-class group, this meant the participation in weekly birth preparation group meetings as well as watching lectures, courses on "humanized" birth, breastfeeding, infant care, mother and baby sessions, trips to congresses on the theme, as well as participation in yoga classes for pregnant women. As such, it is important to mention that during one part of the research, from September 2011 and May 2012, the author was pregnant, which facilitated insertion in the field. In the context of the CP, research involved attendance at all the workshops that are mandatory for the pregnant women doing their pre-natal there (such as: labor, gender, breastfeeding, modifications, technologies, among others), as well as participation in Welcoming events, pre-natal consultations covering nutrition, delivery etc. over a period of 11 months, between June, 2011 and May, 2012.

[5] Cf. Research Protocol n. 59/11 – CAAE n. 0012.0.314.000-11.

[6] This differentiation is explained by the fact that, at least in the city where the research was conducted, the private maternities only offer their space and infrastructure, not having any commitment or interference in the type of assistance provided by the medical teams contracted by the woman. For this reason, it was not possible to complete research in a private health institution that called itself "humanized", as occurred in the other context studied. Nevertheless, this is already an important difference to be verified between the two fields researched, which reveals a wider range of possibilities for childbirth types open to middle-class women, that is, those who can gain access to private maternities.

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clients: not all women want the same type of birth experience". It is worth highlighting one point of convergence between the two groups: neither was fully satisfied with the care received in hospital, which Nelson (1983) attributed to the fact that the doctors apparently rejected certain aspects of each of the models, in favor of their own views on how the birth should transpire.

In her book *The Woman in the Body: A Cultural Analysis of Reproduction*, the anthropologist Emily Martin (2006) calls attention to the fact that the ideology of production, which became central to modern western society as a result of the growing industrialization process, influenced the form in which medical texts described female bodily experiences, including childbirth.

In the course of this discussion, the author addresses the question of social class and race, since, as she puts it, "the social origin of a woman, along with her race, profoundly affects the type of birth experience she will have in maternity" (Emily MARTIN, 2006, p. 233). Through contact with the "natural" birth movement in the USA, Martin observes differences among parturient women: while white middle-class women wanted birth experiences with fewer interventions and adopted certain strategies, such as delaying admission to the maternity to avoid being subjected to medical pharmacological procedures, for the white working-class women "deferment could be an issue, but behind it there was a greater problem, which was finding a way to pay for the pre-natal and obstetric care and the baby" (MARTIN, 2006, p. 243). Working-class black women, who shared the same financial concerns, had an added challenge: they had to deal with racism – and the subsequent mistreatment – by the medical staff.

In the Brazilian context, some socio-anthropological studies have also focused on the perspectives of different classes regarding reproduction, exploring the diversity of experiences and perceptions that this cross-section can offer.

In her book *O corpo da nação...*, the anthropologist Valeria Corossacz (2009) presents results from the research she carried out in two public hospitals in Rio de Janeiro, during which she employed interviews and participant observation with women, nurses, social workers and care assistants. The author addresses the phenomena of childbirth and sterilization of women to reflect on two aspects: the first refers to the racial classification process for newborns, which leads to a broader reflection on racism and the maintenance of the racial democracy ideology in Brazil; and the second refers to the social management of human reproduction.

Regarding the latter, in one of the chapters the author addresses the reproductive stories of male and female doctors (mostly white and middle-class) and their patients (predominantly black and brown-skinned, from low-income classes), with the aim of analyzing their reference models. It was found that there were "two models of procreation on the discursive and material plane" (Valeria COROSSACZ, 2009, p. 233). The author highlights that from the doctors' viewpoint, reproductive behaviors must be the result of a certain logic, a set of coherent rules, arising out of a calculated and planned choice. In this sense, other forms of life organization which do not correspond to this order – the ones observed among women from low-income classes – are perceived as disorder and even as instinctive or closer to the animal than to the human world. Nevertheless, in the author's assessment, the main difference between the two spheres (middle-class and low-income class) "lies more in the objective conditions of material life than in imagined or desired future projects" (COROSSACZ, 2009, p. 251). Refuting a discourse that sees an absence of rationality and projection into the future in the reproductive management of women from low-income classes, the author argues that it also involves the affective and economic investment represented by the presence of many children. According to the researcher, the limitation of the doctors' viewpoint is in the fact that they believe that "rationality is limited to the evaluation of that which the parents can give to their children, and not, for example, that which their children can give them" (COROSSACZ, 2009, p. 249).

Another relevant study in the area was that carried out by the anthropologist Tornquist (2003) in a teaching-maternity in Florianópolis recognized as "humanized". The institution provides care for women from low-income and middle-class backgrounds and the author sought to compare the two groups during the study. The most significant differences that were identified in this study refer mainly to the choice of birth type and companion. While the squatting position seemed to be central to the planning of the middle-class women, the other group did not appear overly concerned with the subject, even if they eventually accepted the suggestion from the medical team to adopt the vertical positions. With regard to the choice of companion, the author noted that middle-class women invariably chose the baby's father while the low-income class women opted for women from their family circle, such as their mothers, sisters-in-law and grandmothers. Tornquist (2003) also reflected on the procedures related to the promotion of breastfeeding and, particularly, the mandatory condition that it be well underway before the woman is released from hospital. Based on cases identified as problematic by the maternity ward, the anthropologist challenged the rigidity of this rule, pointing out the risk that the promotion of breastfeeding may "cease to be a woman's right, and become a normative and disciplinary duty" (TORNQUIST, 2003, p. S425).

As this brief review of the literature suggests, the social class to which a woman belongs often interferes in the birth experience that she will have, especially regarding her participation during

the process and the form she relates to the health professional, which constitute significant aspects in configuring the definite manner in which each parturient will undergo the "rite of passage" (Arnold VAN GENNEP, 1978) to becoming a mother. To sum up, social class mediates the form this biological experience takes for the different women. In this article, the aim is to explore the relation between childbirth and social class through the analysis of two cases of care provided within the "humanized" proposal.

"Humanized" and/or "natural"?

As pointed out by Carmen Simone Diniz (2005), as the term "humanization" began to be divulged and used by different social players, it was possible to note a multiplicity of interpretations, with the term being applied to various forms of care. Along the same lines, Carneiro (2014) sought to map and explore the diverse meanings attributed to the terms "natural" birth and "humanized" birth among women, particularly from the middle-classes, who participated in two birthing preparation groups in São Paulo state.

In this text, the author suggests that it would be possible to define "humanized" childbirth not as a specific model to be replicated, but as one which "occurs in accordance with the expectations of the women" (CARNEIRO, 2014, p. 244). In other words, the "humanized" birth refers to the one where the wishes and rights of the woman are respected and she is treated in a personalized way by the medical team.[7] An important aspect observed during the research was that the term "humanized" often also encompasses the idea of "natural" birth, an expression that became popular in the 1980s and denotes the commitment to minimize medical and pharmaceutical intervention when possible.

It is worth mentioning that the expressions "humanized" birth and "natural" birth frequently appear as interchangeable in the discourses of the middle-class women studied, as well as among promoters of the ideology, as Carneiro (2011) also found. However, this does not preclude certain terminological preferences in other contexts: in relation to the low-income groups there was a preference noted among the women and the care provider professionals for the expression "natural" birth, to the detriment of "humanized", despite the birthing center where the study took place being considered a "humanization" model. This difference does not seem to be random and will be analyzed in the course of the article. Firstly, it must be noted that the terms "are close but also come undone depending on the circumstances" (CARNEIRO, 2011, p. 108), which became particularly evident in this study as it involved two groups.

The next section contains a description of a situation experienced by a low-income woman, reported during research in the CP. Further ahead, there will be a narrative of a middle-class woman from the "humanized" birth preparatory group upon which the other part of the study was carried out. As will become evident, their experiences are similar initially but they contain quite different outcomes, which arguably seems to be associated with differences in social class.

Carla's childbirth experience

The contact with Carla came about after she was admitted to the CP one afternoon, with dilation of 5 cm, to give birth to her first child. With her consent, the decision was made to spend the night there to watch the birth. She was alone, since her sister-in-law and niece who accompanied her on admission had left, and Carla was awaiting the arrival of two friends. She had changed clothes and was wearing a smock that she had been given in the CP.

Carla was working as a manicurist and hair-braider, which provided her with an income of approximately one monthly minimum wage. She is a tall, black, strong-willed woman. She had certain particularities that made her stand out among the women in pre-natal: Carla was 36 years old at the time, which was well above the average, especially for a first-timer, and she was living alone, unlike the other women present. She no longer had any ties to the baby's father, of whom she made only negative comments, and she did not get on with her mother either – which was uncommon in that context. On that day, she had not notified either of them that she had been admitted to the CP.

Her friends arrived a little later and meanwhile I kept her company. Agitated, Carla complained that there was no TV in the room and asked to walk in the garden. She spoke animatedly on the cell phone and seemed to be tolerating the contractions without great difficulty, merely holding herself up and remaining quiet whenever she felt them come on: nothing that would affect her good mood.

[7] According to the Ministry of Health's National Humanization Policy (PNH), which guides the actions promoted in this area, "humanization" is taken to mean: "an appreciation of the different subjects involved in the health production process (users, workers and managers), emphasizing: the autonomy and protagonism of these subjects, the co-responsibility between them, the establishment of supportive links and collective participation in the management process" (BRASIL, 2013). The definition is contained in the "Practical Manual for Implementing the *Cegonha* (Stork) Network", prepared by the Ministry of Health, available at www.saude.mt.gov.br/arquivo/3062 and in speaking of "autonomy" and "protagonism", seems to be aligned with the above proposed definition.

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A little later on, Carla returned to the room and the nurse who coordinated the CP began to create an ambiance by introducing an aromatizer and turning off the brighter lights. From then on, the room was in semi-darkness and there was soft music playing in the background.

Carla's friends arrived soon after. They had never visited the CP or participated in the workshops and were not really aware of the institution's proposal. After a few hours, one of the friends asked me if the nurse could provide a little "help", referring to the routine procedures and drugs given during "normal" deliveries in maternities.

From time to time a couple of night nurses came in to examine Carla, listen to the fetus' heartbeat, evaluate the dynamic of the contractions and perform the touch test. In one of these examinations, they got the impression there was meconium in the amniotic fluid – that is, the first contents of the baby's intestine, but which is not yet feces (DINIZ; Ana Cristina DUARTE, 2004).[8] Talking to Carla, they explained that given the context, there were two possibilities: transfer to the maternity of choice or take synthetic oxytocin to try to accelerate her labor. The parturient was no longer in good spirits and at each contraction seemed to feel a lot of pain, but she remained resolute and said she wanted to stay. "I'll go until the end, I'm not giving up".

Carla received an intravenous oxytocin solution for approximately 1 hour 30 minutes. After a while, she became very annoyed at the pain the contractions were causing. With her strong personality, she seemed to be more dominant than her friends, who were also showing signs of frayed nerves. At a certain moment, Carla said she no longer wanted the synthetic hormone since she could not stand the pain anymore. The nurses insisted that she keep it on, but she threatened to rip it off with her own hands. The nurses, who remained calm and unaffected by the agitation that took hold of the atmosphere, ended up granting her request.

One of the nurses suggested that Carla perform some walking and squatting exercises to help the baby's descent, which she did for a short while only, after claiming the exercises intensified the pain. Carla preferred to remain in bed in a prone position which, according to the nurses, reduces the rhythm of the labor. Between contractions, Carla began to have regrets and apologize. "I'd like a natural birth, but I can't manage it. Sorry, I'm ashamed... you treat me so well, I think it's great here, but I can't manage it. I don't want to scream and make a big scene, I'm so embarrassed...", she said, while occasionally trying to muffle her screams with a piece of cloth.

Outside the room, one of the nurses went through Carla's medical records looking for information on her background that might explain her irascibility and irritation, deemed by the team to be clearly disproportional. "Sooner or later her resistance will drop", they said, believing that the outlook for normal birth was positive.

Then came the moment that Carla's water broke spontaneously and the appearance and odor of the liquid discounted the nurses' suspicion about the presence of meconium. However, her labor continued to progress slowly, especially from Carla's perspective, who was showing clear signs of impatience and intolerance of pain.

Carla became increasingly upset, saying that she wanted to be transferred to the maternity of choice to undergo a C-section. The nurses told her that the transfer could not be made without a clinical justification – which was absent since the liquid was clear and had a normal odor – and even if she went to the maternity, this would not mean she'd be submitted to a C-section since the decision to perform the surgical procedure was not up to her, but the doctors.

Carla, in a great deal of pain, ripped the towel holder off the wall and began to punch the walls in reaction to her contractions. It was then she started calling her friends on her cell phone to ask for help, in the early hours of the morning, Between calls, Carla put on her own clothes again, saying she wanted to leave and go to a private hospital to have a C-section. At this stage, she had dilated to 9 cm: "I'll pay whatever it costs to have a C-section now! I'll pay with my credit card and work after to pay it off. I'm not afraid of work!". At a certain moment, she yelled: "If they [the nurses] respect that the birth be the way I want it, then they must respect that I want to go and have a C-section. I can't stand any more pain!"

Carla's companions oscillated between empathizing with their friend's pain – and pressuring me to intercede with the nurses – and rebuking her. One of them lowered her voice to tell me: "She's like this here because she feels as if she's at home. I doubt she'd behave like this in a public hospital... I never thought Carla would make a scene like this!". Carla's attitude was seen by her friends as an unexpected show of weakness, which became evident in a conversation between her and one of her companions: "A woman the size of you, people will laugh when they find out what happened!", to which Carla responded, between contractions: "Ah, I'm not falling for that! Better to be alive and weak than strong and dead!".

After receiving a call from Carla, one friend, who is a nursing technician and lives in the surrounding area, went with her mother to the CP. Carla insisted that her friend take her out of the CP and

[8] According to the authors, the discharge of meconium during pregnancy can be a sign of fetal maturity (which is not problematic) or fetal suffering, since when the fetus is poorly oxygenated the intestines contractility increases and the sphincters relax, leading to the release of the meconium. In this case, the situation requires care.

bring her to a private hospital to have a C-section, but her friend said she could not take responsibility for her. In a conversation, in the corridor outside the room, the friend's mother, who gave birth to twins when she was young, asked: "What? She didn't know she'd feel pain when having a baby?".

Carla's companions even rang her brother, who is in the army, to see if he could come there to deter her (or contain her?) but, according to them, he was in "service" in the barracks and could not leave. Early in the morning, the day-nurse team arrived and decided to transfer Carla to the maternity of choice. Around noon, having been fully "accommodated" in the maternity, as one of the nurses from the CP told me, Carla gave birth to a baby weighing approximately 4kg, in a "normal" delivery.

Carla's experience seems to reveal the expectations that the CP professionals, her friends and she herself had regarding what should happen there, an event in which Carla would ideally figure as the main protagonist and with a well-defined role. Preparation for the birth in that institution had provided her with a series of instructions and corporal techniques, a "training in levelheadedness" which, as Marcel Mauss highlighted (1974), ultimately constitutes something inseparable from the technique itself. It was expected that she would react as per the script, in which the parturient, by incorporating the techniques learned – and, in this sense, controlling her emotions –, is meant to be capable of directing and guiding the development of the birthing process in the predicted manner and towards the desired outcome. It presumes an implicit acceptance of a certain level of control in relation to pain and emotions making a "natural" birth possible and achievable in normal situations where the techniques have been taught and assimilated. In Carla's case, unlike an abstract parturient whose limits for controlling pain and emotions are presumed, her "lack of control" in fact indicates a capacity for control on a level that differs from that expected. It was acknowledged that Carla would feel pain, but not that she would lose control, which in contemporary western society constitutes a reason to feel ashamed and a sign of immaturity and/or inferiority, as stated by Norbert Elias (1994) when analyzing the nexus of what he called "the civilizing process".

The ideal of the self-regulating individual, who maintains strict control of bodily impulses and emotions, that is, the idealization of balanced emotions, is implicit. Hence the playful comment by her friend reminding her that she would be the butt of her friends' joke, and also the embarrassment and numerous apologies from Carla and the feeling of failure. All of this suggests the existence, in that context, of a birthing model that approves or rewards women who experience it as a rite of passage in which self-control is associated with personal development or self-betterment, as seems to occur with the middle-class women (Olívia HIRSCH, 2019; CARNEIRO, 2011, among others).

A study by Corossacz (2009) in two public hospitals indicates the existence of an acute perception of difference regarding low-income women, as suggested by the interview the author carried out with a doctor, identified as M in the transcription below:

> M: Our reasoning is more objective. Our class thinks like this: it's better to have two children eating first-grade meat than six children eating second-grade meat. [...] They are not as concerned as we are [...]
> V: In what way do you see them as being unconcerned?
> M: You see a woman with five, six kids; she isn't bothered [...] She is fulfilling a quasi biological function, and this [poor] woman's expression of pain is different from that which we see elsewhere [private hospital], from an economist or an anthropologist. When you have a baby, you'll have a different reaction.
> V: How do they react to pain?
> M: Either she is extremely resigned to the pain because her mother suffered, her sister suffered, or she is hysterical and wants to throw herself on the ground. Even when you suffer, you can do it with elegance, with manners and common sense; it's a question of education and attitude. A woman from a higher social class might not be able to stand the pain as she is not used to it, but she behaves a lot better. (COROSSACZ, 2009, p. 243)

If class difference is therefore evident – expressed in the use of "us", on one side, and "them", on the other –, it is also a culturally different manner of dealing with emotions and pain: this woman is unbalanced, oscillating from one extreme to the other – from resignation to hysteria –, that is, she represents a "problem", as do her unplanned children.

Regarding the inability to control pain and emotions in a social context in which self-control is highly valued, there is another aspect that arises from Carla's childbirth experience, namely, the possibility for the parturient to interfere in the course the childbirth takes, whereby her wishes are respected, which broadly speaking corresponds to the definition of "humanized" birth (cf. CARNEIRO, 2014). Starting from this premise, Carla certainly did not experience this, despite receiving care in a unit considered to be a "humanization" model.

As shown, Carla took on-board the childbirth proposal and the team consulted her on the execution of procedures, giving her the option to choose between staying there or being transferred to the maternity. Up until that moment, the nurses collaborated with her decisions on the direction of the labor. However, once Carla gave up on that proposal and began to want a C-section, the professionals no longer accepted her choices, refusing any possibility of negotiation.

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As demonstrated throughout the article, this is an important difference between women from different social classes since the decision on the course of the birthing is not presented in the same manner, namely, as irrevocable, in the other context investigated. As Carla's case suggests, for women admitted to the public system, this choice is not theirs but the medical team's. In that context, the parturients who do not follow the desired behavioral and self-control norms and ask for a C-section, as Carla did, generally know beforehand that their request will most likely be denied, given that, as a rule, the public system health professional makes the decisions about the course of the labor and delivery, rejecting dialogue with the parturient.

In research conducted by Alessandra Chacham (2004), in which women from different social segments participated, a small part of the interviewees, from both groups, reported that they had sought C-sections during their pregnancies. However, while practically all the middle-class women had their wishes respected, the same did not happen for the women from low-income backgrounds, which led the author to state:

> For [middle class women] it is easier to obtain a cesarean when they wish one. In the case of poor and working class women delivering in public hospitals, even when they want a cesarean they do not get one unless a doctor decides they need them. Most of the time they do not know who is going to assist their birth or they even have the chance to express their wishes. (CHACHAM, 2004, p. 09)

Daneluci (2016), who carried out research in a teaching-maternity-hospital recognized as a "center of reference for women's health" with a focus on "humanized" birth, came to similar conclusions when stating that in the study context,

> it is not they [the parturients] who decide and determine what is necessary nor do they participate in this decision: they are there in body, but without the right to make themselves heard. It is as if they have no knowledge or control over their bodies and it is up to the doctor and to biology to decipher and decide (DANELUCI, 2016, p. 174).

It is worth adding that in public maternities and hospitals the definition for surgical birth cannot be exclusively attributed to a question of "necessity", that is, to a clinical recommendation. In some situations, the C-section can be performed as a means of fulfilling a tacit agreement between doctors, providing for the "pre-delivery" to be "clear" before a change in shifts, so that all parturients who are in labor should give birth, in order for the incoming professional to be unencumbered by those women who were admitted earlier, as shown in a study by Marcos Augusto Dias (2006).

The fact that the Brazilian public health system provides care to women from almost exclusively low-income classes should not be ignored, bearing in mind that, as Luc Boltanski (1979) stated, "the patient-doctor relationship is a class relation and the doctor adopts different behavior depending on the patient's social class" (p. 39). The experience of Elena, described below, seems to corroborate this affirmation.

Elena's childbirth experience

Elena initially planned to have a C-section but changed her mind when she discovered the "natural" and "humanized" birth proposal in her birth preparation and yoga classes in a private institution in an affluent area of city. She swapped doctors during her pregnancy and even hired a team recognized by this group as "humanized".

When she learned about the "natural" and "humanized" birth proposal, at the start of her pregnancy, Elena imagined that during labor she would feel pains similar to menstrual cramps, which would intensify at the end when the baby was ready to be born. She would be squatting or in water, "like they said" – referring to the accounts she heard from other women in the group which served as an inspiration to her – and her baby would be born in "really peaceful" environment.

It was a Friday and Elena, who was 37 weeks and 5 days along in her pregnancy, had not gone to work since she had made some purchases and there were people coming from the shop to assemble furniture in the baby's room. She went to bed late, at about 11 at night and, around midnight, she went to the toilet whereupon she noticed a liquid that was not urine running down her legs. She quickly realized her water had broken and called her husband. They rang the obstetric nurse, her doctor's assistant,[9] as previously arranged.

She was told to monitor the intervals of the contractions and, when they were regular and approximately 5 minutes apart, call back. The nurse also told her to try to relax and go to sleep, adding that she would probably go into labor in the morning. Her husband followed the instructions and Elena, who was tossing and turning, started to watch TV. At 5 in the morning, she woke him up, as she was tired of being alone and, shortly after, rang the nurse again: "Look, it [the contraction] is

[9] Elena's doctor, who is recognized and identifies with the ideology of "humanization", normally works with an obstetric nurse on her team who accompanies the initial labor and, in a sense, acts as a doula. This is an increasingly common practice among the obstetricians working in the city.

already strong. I think there is a sequence so you can come and accompany me", she said on the phone. "I thought I would already be able to go the hospital in the morning", she commented during the interview.

When the nurse arrived at Elena's house, she examined her and merely said "there was a way to go", adding that it was better to stay there and "work". Elena began to do exercises, put a hot compress on her back, and also tried to relax in the shower but the pain she was feeling at that point was "horrible": "A pain that seemed to be ripping through my back. My intestines hurt, my abdomen, down below; nothing was having any effect".

Time passed by and, in the early afternoon, Elena started to say she wanted to go to the hospital to take an anesthetic. The nurse examined her again and tried to dissuade her, saying that it was still better to stay at home. "At that time, my husband later told me, I was dilated to 1 cm and she didn't tell me so as not to upset me further. I thought I was dilated to 5 cm and that it was time to go to the hospital". After much insistence, Elena went to the maternity, accompanied by her husband and the obstetric nurse. Wary of causing a scene in the reception, she waited in the car until her admission process was completed.

In contrast to her nervousness and anxiety, the doctor arrived to the maternity "totally calm", about 2 hours later. After another examination, Elena was told she was dilated to 6 cm. She was then transferred to the delivery room where, at her request, she received epidural anesthesia. Despite the "acute" pain, Elena was satisfied, relaxed and managed to sleep. "I was completely relaxed because I didn't feel it anymore." The doctor said the effect of the anesthetic would wear off after 2 hours and, according to Elena, that is exactly what happened.

When she again began to feel the pain of the contractions, the doctor repeated the manual examination and told her she was dilated to 9 cm. Elena was sure: "I want more anesthetic", she stated. The obstetric nurse explained that during labor a lower dosage would have to be applied so that she could feel the contractions and expend the force necessary to give birth in the birthing period. "Said and done", Elena commented, and even under anesthetic she managed to change positions and feel the contractions.

Dilated to 10 cm, the parturient tried several times, without success, to push the baby out. The team then got together briefly before telling her the fetus was probably not in the correct position, which was impeding the descent. For this reason, they told her it would be necessary to perform certain maneuvers to facilitate the birth. Elena agreed initially. "But then I felt terrible pain because she [the doctor] stuck her hand inside me and turned it". In one of these maneuvers, she reflexively pushed the obstetric nurse with her foot. At this point she categorically stated: "Listen, I want have a C-section. I wanted the birth to be truly normal, not with these maneuvers. I don't want to go through this".

Within 15 minutes, Elena was transferred to the surgical center. She was given a higher dose of anesthesia and the baby was born shortly after, at 22h45min. He was brought to the nursery, accompanied by the father. Elena, who despite not feeling pain, had been distressed during the birth when she felt her skin being cut and the handling of the baby inside her body, asked the anesthetist to give her another shot to "knock her out". "I want to sleep and wake up once I've been sewn up and everything". She was back to herself about an hour later.

Despite supporting and routinely practicing "natural" birth,[10] that is, ideally without medical or pharmaceutical intervention, the "humanized" team that cared for Elena ended up acting in a manner that respected her wishes. The parturient, as was evident, directly intervened in the course of the birth experience, which would probably have taken a different course if it had depended exclusively on the team responsible for her care.

Elena's experience seems to reflect an important precept of "humanization", namely: that "the birth is the woman's" not the doctor's. This precept overrides demedicalization, as show by certain interviewees from the middle-class group – even though almost all of them initially wanted to have a childbirth experience simultaneously "humanized" and free of interventions, that is, "natural", to reproduce the term used by them.

> *Natural childbirth is one without any intervention, whether synthetic oxytocin or anesthesia, for example. It is a totally physiological birth. It is a humanized birth where the woman's protagonism is respected, where all the decisions or interventions are informed and consented to by the woman. A birth may be humanized even with the use of anesthesia, if that decision comes from the woman. In that case, it would be a humanized birth but not a natural one. The contrary may also occur: a woman may have a natural birth and be disrespected in the care she receives or suffer some type of obstetric violence, which may not necessarily mean an intervention.* (Vanessa)

> *I think the humanized birth is the one where your wishes are respected. So if you want a C-section, you can have one. If your wish is respected and you feel happy with it, I think you've had a humanized birth, you know what I mean? But if you take into account that the humanized birth entails the minimum of interventions possible, it's another concept. It can be, though I think it*

[10] In this sense, the fact that the nurse did not inform Elena that she was dilated to 1 cm only can be interpreted as a strategy consistent with this practice.

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> *would be more of a natural birth concept. A natural birth is the one with the least possible intervention. And I would define the humanized version as the birth where your wishes are respected. I think the ideal would be a natural and humanized birth.* (Alice)

As the testimony shows, the categories of "natural" childbirth and "humanized" childbirth are clearly defined here, although they were used interchangeably in the discourse of the middle-class interviewees. As such, the "humanized" birth, which often encompasses the "natural" birth, namely, demedicalization, is not limited to it, whereby a delivery with inventions or even surgery could be considered "humanized", provided it meets the demands of a parturient who is informed of its risks and benefits. In other words, the idea of "humanization", according to this reading, places emphasis on the rights of the woman regarding her body and the delivery. On the other hand, it is interesting to note that neither is "natural" childbirth necessarily "humanized", since the absence of intervention does not mean that the parturient's choices are respected. This is a relevant distinction when analyzing the topic at hand, the relation between childbirth and class in the "humanization" proposals, or in other words, how the "humanization" of the delivery is configured according to the parturient's social class.

Unlike what happened to Elena, Carla's request to have a C-section, which she expressed several times, was ignored by the team. It is true that the CP is limited in terms of infrastructure and because the professionals working there (obstetric nurses) are not trained in performing surgical deliveries of the type she was requesting. Neither are the nurses qualified to administer anesthetics, which Carla would possibly have accepted if it was offered – which is also the case in maternities and public hospitals. As shown by the study "Being born in Brazil: National Inquiry into Delivery and Childbirth", the application of anesthesia in the public health system occurs in only 27.1% of deliveries, a rate that falls to 21.5% when the patient's level of formal education drops (*apud* Maria do Carmo LEAL *et al*., 2014),[11] where there is practically no provision for it. In addition, Carla's transfer to the maternity, where theoretically she could have had a C-section, was flatly rejected by the team, under the claim that there would need to be a clinical justification for it, which did not exist: it "only" involved the patient's wish. In effect, the transfer took place the following day and only then because there was a shift change, despite Carla requesting it throughout the previous night.

As demonstrated, Carla's choice to have a medicalized delivery or be transferred to the maternity, changing her initial intention to give birth in the CP, was not respected. In fact, once admitted to the CP and going into labor, the parturient was given no opportunity to interfere in the decisions relating to medicalization, which were based on strictly clinical criteria and taken unilaterally by the team, which clashes somewhat with the concept of "humanization", that is, respecting the choices and rights of the parturient. In this sense, the woman's freedom to choose is quite restricted compared to the other group, being limited to aspects involving birthing position, movement, the use of non-pharmacological means to alleviate pain, mood music etc. To sum up, it does not go beyond the range of possibilities presented by the team and is considered to favor "natural" birth, therefore not including decisions relating to medical or pharmacological procedures, which remain exclusively in the hands of the health professionals. Camila Amaral (2016), who performed research in the CP a few years after the research analyzed here, states that this information began to be transmitted to women during the childbirth preparation workshops – which did not take place at the time the investigation that resulted in this article was undertaken.[12] As such, it may not be claimed that the nurses who were caring for Carla during her labor were unprepared, since they approached it in the manner they were trained. What appears to have been added to the training or preparation for birth in the version accompanied by Amaral (2016) is a more explicit questioning of what could be viewed as a conflict between the woman's wishes and necessity, an issue that seems to be exemplified in Carla's childbirth experience.

In this context, it is comprehensible that the professionals in the CP would avoid using the expression "humanized" childbirth, preferring the term "natural" birth. It is not that there is no chance to have a "humanized" delivery there, but it entails a commitment to the demedicalization proposal that was not always observed among women from the low-income classes studied.[13] As stressed by

[11] Research was conducted by Fiocruz and heard from 23,894 women who gave birth in public and private maternities in 2011 and 2012.

[12] According to Amaral (2016), two situations tend to be referenced in these encounters: that in which "the body does not require intervention, but the woman wishes it" (p. 48), and another in which the woman fears interventions, but they are deemed necessary by the team. According to the author, the women were alerted beforehand that in both situations the decisions were not theirs to make, but rather the medical team's. In the first case, the justification was that the execution of these procedures without any "real" necessity could harm the parturient and, in the second, because the women did not possess the technical knowledge for this, whereby their prior consent was not required. It is worth noting that this stance is in conflict with the demands of activists and, in the evaluation of Amaral (2016), "an asymmetric relation emerges even in a humanized context, since the authority resides with the medical team" (p. 48).

[13] It must be taken into consideration the fact that in most of the cases monitored, the proposal of "natural" childbirth was not what motivated the parturient to be admitted there. The majority of interviewees reported mainly appreciating the care provided at the venue and the customized relation established with the professionals there, unlike what usually occurs in public maternities.

Carneiro (2017), who carried out ethnography in a public normal birthing center in the peripheral region of the Federal District,

> childbirth as event comprises numerous semantics and [that] the particularities experienced by women who are young, poor, single, black and residents of rural areas may create another assumption of care, beyond the physiology or absence of technical and pharmacological interventions (p. 397).

Final reflections

Carla's childbirth experience gives us the opportunity to discuss and challenge the subject of "obstetric violence", which is currently popular and on which there are ongoing Draft Bills in the Chamber of Representatives. The crux of the issue seems to be in the direct relation with the dissemination of the "humanization" ideology in recent years. In this sense, it is important to highlight that the definition of the term "obstetric violence" generally includes aspects directly related to the demands of the movement, as may be seen based on the definition proposed by Charles Tesser *et al*. (2015):

> The expression "obstetric violence" is used to describe and group different forms of violence (and damages) during professional obstetric care. It includes physical, psychological and verbal mistreatment, as well as unnecessary and harmful procedures – episiotomy; confinement to bed in pre-natal period; enema; clipping; and oxytocin (almost) routinely; absence of companion – among which are an excess of C-sections, on the rise in Brazil for decades, in spite of some government sponsored initiatives. (p. 02)

As we can see, the term classifies as "violence" the execution of certain medical and pharmaceutical procedures which, until recently, were considered "standard". The perception of these acts as "violent" implies a prior contact with the ideology of "humanization", which is contemporary and at the same time bears witness to and drives the various changes in the perception threshold of what violence and rights are, particularly regarding women, their bodies and their reproductive practices. The notion of "obstetric violence" is part of a debate and is far from being universalized. On the contrary, for a section of the women studied from low-income classes, such procedures – considered violent and invasive mainly for supporters of the movement for "humanization" – far from being challenged, are in fact described as a "help". This is because these technologies frequently reduce labor time, an experience that is generally held to be extremely painful and which they want to be free of as soon as possible.

Certain contemporary authors, such as David Le Breton (1999), have called attention to the error in "naturalizing" limits of tolerance and/or perception of pain by situating them in a determined time or place, and also the risks of generalizing when not taking into account that pain is always an interpretation, that is, it is always dependent on the meaning attributed to it. This led him to develop a very significant distinction regarding pain, which is of direct interest here: the fact that what we call pain consists of qualitatively different experiences whether involving a "chosen" pain or an "imposed" pain. In the former, there is a type of context, a "shield of meaning" whereby the suffering is relative. Distinct from this experience, there is that where the pain is "imposed", that is, it is not "chosen", wherein it may be considered a form of violence.

Carla's experience appears to be very significant in this regard. Feeling a pain that was not "chosen", unlike the middle-class parturients who decide not to receive an anesthetic when opting for a "natural" birth, may in fact be considered violence. Carla's experience broadly subverts the concept of "natural" birth, in so far as all her anguish and suffering derived from her wish to have access to technology, in the form of a C-section, which was not respected. As such, regardless of the implication of pain and of its interpretation in the birthing context as mentioned previously, we must accept Mariana Pulhez' (2013) assertion that "not being anesthetized or being brought to deliver normally, when the expressed wish is a C-section, may also be viewed as a violent act. Therefore, the acceptance of what constitutes violence must also be put in context [...]" (p. 560).

Thus, this article suggests that there may be different interpretations of what constitutes "obstetric violence", which seem to be associated with the manner in which women view the world. And in this sense, there is no doubt that their lenses are also filtered by the social class to which they belong.

The American sociologist Margaret Nelson (1983) makes some telling comments when reflecting on the reality researched. According to her, "[t]hat class of women who have always had access to the most sophisticated medical technology may make the decision to reject some aspects of that class privilege" (NELSON, 1983, p. 295) – and, moreover, come to classify them as acts of violence. Nevertheless, the author adds, "those who have not yet consistently received these benefits may not be ready to abandon them" (NELSON, 1983, p. 296).

References

AMARAL, Camila Manni Dias. *"Aqui a gente é tratada como pessoa, no hospital é como corpo": motivações e trajetórias de gestantes em uma casa de parto pública no Rio de Janeiro*. 2016.

Dissertação (Mestrado) – Programa de Pós-Graduação em Ciências Sociais, Departamento de Ciências Sociais da Universidade do Estado do Rio de Janeiro, Universidade do Estado do Rio de Janeiro, Rio de Janeiro, RJ, Brasil.

BOLTANSKI, Luc. *As classes sociais e o corpo*. Rio de Janeiro: Edições Graal, 1979.

CARNEIRO, Rosamaria Giatti. *Cenas de parto e políticas do corpo: uma etnografia de práticas femininas de parto humanizado*. 2011. Tese (Doutorado) – Programa de Pós-Graduação em Ciências Sociais, Departamento de Ciências Sociais da Universidade Estadual de Campinas, Universidade Estadual de Campinas, Campinas, SP, Brasil.

CARNEIRO, Rosamaria Giatti. "De perto e de longe do que seria natural, mais natural e/ou humanizado: uma etnografia de grupos de preparo para o parto". *In*: FLEISCHER, Soraya; FERREIRA, Jaqueline (Orgs.). *Etnografias em serviços de saúde*. Rio de Janeiro: Editora Garamond, 2014. p. 243-266.

CARNEIRO, Rosamaria Giatti. "O peso do corpo negro feminino no mercado da saúde: mulheres, profissionais e feministas em suas perspectivas". *Mediações*, Londrina, v. 21, n. 2, p. 394-424, jul./dez. 2017.

CHACHAM, Alessandra Sampaio. "Doctors, Women and Cesareans: The construction of normal birth as risky and the medicalization of birth in Brazil". *In*: ANNUAL MEETING OF THE POPULATION ASSOCIATION OF AMERICA, 7, 2004, Boston, Population Association of America. Book of Abstracts, 2004, p. 1-19.

COROSSACZ, Valeria Ribeiro. *O corpo da nação: classificação racial e gestão social da reprodução em hospitais da rede pública do Rio de Janeiro.* Rio de Janeiro: EDUFRJ, 2009.

DANELUCI, Rebeca de Cássia. *Instituições públicas de saúde e mulheres gestantes: (im)possibilidades de escolhas?* 2016. Tese (Doutorado) – Programa de Pós-Graduação em Psicologia, Instituto de Psicologia da Universidade de São Paulo, Universidade de São Paulo, São Paulo, SP, Brasil.

DIAS, Marcos Augusto Bastos. *Humanização da assistência ao parto. Conceitos, lógicas e práticas no cotidiano de uma maternidade pública*. 2006. Tese (Doutorado) – Departamento de Ensino e Pós-Graduação em Saúde da Mulher e da Criança, Instituto Fernandes Figueira/FIOCRUZ, Rio de Janeiro, RJ, Brasil.

DINIZ, Carmen Simone Grilo. "Humanização da assistência ao parto no Brasil: os muitos sentidos de um movimento". *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 10, n. 3, p. 627-637, jul./set. 2005.

DINIZ, Carmen Simone Grilo; DUARTE, Ana Cristina. *Parto normal ou cesárea? O que toda mulher deve saber (e todo homem também)*. São Paulo: EDUNESP, 2004.

ELIAS, Norbert. *O processo civilizador: uma história dos costumes*. Rio de Janeiro: Jorge Zahar, 1994.

HIRSCH, Olívia Nogueira. *Parto natural, parto humanizado: perspectivas de mulheres das camadas populares e médias*. Rio de Janeiro: Fiocruz, 2019.

LEAL, Maria do Carmo *et al*. "Intervenções obstétricas durante trabalho de parto e parto em mulheres brasileiras de risco habitual". *Cadernos de Saúde Pública*, Rio de Janeiro, v. 30, Sup. 1, p. S17-S47, jan. 2014.

LE BRETON, David. *Antropología del dolor.* Barcelona: Editorial Six Barral, 1999.

MARTIN, Emily. *A mulher no corpo: uma análise cultural da reprodução*. Rio de Janeiro: Garamond, 2006.

MAUSS, Marcel. "As técnicas corporais". *In:* MAUSS, Marcel. *Sociologia e Antropologia*. São Paulo: EPU/EDUSP, 1974. p. 209-233.

MENDONÇA, Sara Sousa. "Uma análise das denúncias a uma maternidade pública humanizada: dilemas da humanização". *Revista de Ciências Sociais*, v. 4, n. 2, p. 217-241, jul./dez. 2014.

NELSON, Margaret K. "Working-class women, middle class women, and models of childbirth". *Social problems*, Knoxville, v. 30, n. 3, p. 284-297, feb. 1983.

PULHEZ, Mariana Marques. "Parem a violência obstétrica: a construção das noções de 'violência' e 'vítima' nas experiências de parto". *RBSE – Revista Brasileira de Sociologia da Emoção*, João Pessoa, v. 12, n. 35, p. 544-564, agosto 2013.

TESSER, Charles Dalcanale *et al*. "Violência obstétrica e prevenção quaternária: o que é e o que fazer". *Revista Brasileira de Medicina de Família e Comunidade*, Rio de Janeiro, v. 10, n. 35, p. 01-12, jun. 2015.

TORNQUIST, Carmen Susana. "Paradoxos da humanização em uma maternidade no Brasil". *Cadernos de Saúde Pública*, Rio de Janeiro, v. 19, n. 2, p. S419-S427, 2003.

VAN GENNEP, Arnold. *Os ritos de passagem*. Petrópolis: Vozes, 1978.

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