Original Article

Repercussions of obstetric violence on the breastfeeding process: analysis from a racial perspective

Repercussões da violência obstétrica no processo de amamentação: análise sob a ótica racial

Repercusiones de la violencia obstétrica en el proceso de lactancia: análisis bajo una óptica racial

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Abstract

Objective: To analyze the association between exclusive breastfeeding and experience of obstetric violence according to self-reported race/color.

Methods: This was an observational, cross-sectional, descriptive and analytical study with online data collection from November 2020 to February 2021. For data analysis, the R software (v. 4.0.4) was used and a significance level of 5% was considered ($p<0.05$).

Results: The sample consisted of 241 women who met the inclusion criteria. Most of them (88.8%) suffered obstetric violence. Among them, 29.0% were black and 71.0% were non-black. When they answered the questionnaire, 70.1% of those who suffered obstetric violence stated that they were exclusively breastfeeding. The association between obstetric violence, exclusive breastfeeding and race/color variable did not present a statistically significant result ($p=0.822$).

Conclusion: No statistical association was found proving the repercussions of obstetric violence on the breastfeeding process. We suggested new research on the topic that considers racial perspectives and intersectionality. We also suggested continued and permanent education for professionals to improve practice and expand the knowledge acquired among women.

Resumo

Objetivo: Analisar a associação entre aleitamento materno exclusivo e experiência de violência obstétrica segundo raça/cor autorreferida.

Métodos: Este foi um estudo observacional, transversal, descritivo e analítico com coleta de dados *online* de novembro de 2020 a fevereiro de 2021. Para análise dos dados, foi usado o *software* R (v. 4.0.4) e considerado o nível de significância de 5% ($p<0,05$).

Resultados: A amostra foi composta por 241 mulheres que atenderam aos critérios de inclusão. A maioria delas (88,8%) sofreu violência obstétrica. Entre elas, 29,0% eram negras e 71,0% não negras. Quando responderam ao questionário, 70,1% daquelas que sofreram violência obstétrica afirmaram estar em aleitamento materno exclusivo. A associação entre violência obstétrica, aleitamento materno exclusivo e variável raça/cor não apresentou resultado estatisticamente significativo ($p=0,822$).

Conclusão: Não foi encontrada associação estatística comprovando as repercussões de violência obstétrica no processo de amamentação. Sugerimos novas pesquisas sobre o tema que considerem a ótica racial e a interseccionalidade. Sugerimos também educação continuada e permanente aos profissionais para melhorar a prática e ampliar o conhecimento adquirido entre as mulheres.

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Conflicts interest: nothing to declare.

Resumen

Objetivo: Analizar la relación entre la lactancia materna exclusiva y la experiencia de violencia obstétrica de acuerdo con la raza/color autopercibido.

Métodos: Se trata de un estudio observacional, transversal, descriptivo y analítico, cuya recopilación de datos en línea se realizó de noviembre de 2020 a febrero de 2021. Para el análisis de los datos, se utilizó el *software* R (v. 4.0.4) y se consideró el nivel de significación de 5 % (p<0,05).

Resultados: La muestra estuvo compuesta por 241 mujeres que cumplieron los criterios de inclusión. La mayoría de ellas (88,8 %) sufrió violencia obstétrica, entre las cuales el 29,0 % era negra y el 71,0 % no era negra. Cuando respondieron el cuestionario, el 70,1 % de las que sufrieron violencia obstétrica afirmó estar en lactancia materna exclusiva. La relación entre violencia obstétrica, lactancia materna exclusiva y la variable raza/color no presentó resultados estadísticamente significativos (p=0,822).

Conclusión: No se encontró relación estadística que compruebe repercusiones de la violencia obstétrica en el proceso de lactancia. Sugerimos nuevos estudios sobre el tema que consideren la óptica racial y la interseccionalidad. También sugerimos educación continua y permanente a los profesionales para mejorar la práctica y ampliar los conocimientos adquiridos entre las mujeres.

Introduction

The attempt to prevent a woman from being a leading actor in her own pregnancy-puerperal cycle and/or abortion process is a form of obstetric violence, characterized by physical, verbal, emotional abuse, discrimination and suppression of information.[1-5] Obstetric violence can manifest itself in the following situations: negligence; deprivation of care and women's right to a companion in the maternity ward; unnecessary procedures and interventions; disrespect for culture, stigma and discrimination; imposition of procedures and positions during childbirth; lack of confidentiality and privacy; refusal to apply analgesia; and skin-to-skin contact with the baby in the first hours after birth.[1-5]

Obstetric violence can also be present during breastfeeding, which should be encouraged by healthcare professionals due to the numerous and proven benefits to children, women, families and society. However, this incentive does not always happen.[6] A North American study analyzed breastfeeding in black women and found that African-American women have greater difficulty breastfeeding, both when starting and maintaining breastfeeding for the recommended time, due to social factors such as racism and inequalities, individual factors related to the family support network and beliefs, in addition to structural factors related to service provision.[7] In Brazil, a study showed that black women may have better indicators of breastfeeding time, placing breast milk as an important source of nutrition for children (even after six months of age), although studies on breastfeeding in black women are still limited scarce.[8]

This study was developed based on the theoretical framework of intersectionality between gender, race/color and social class. This concept seeks to better understand the interaction and structural consequences of two or more axes of subordination, which are the structures that lead people to suffer violence because they are in a position considered to have less power.[9]

Considering the plurality of women and the need to intersect the identities of the roles they play in society (in addition to what was exposed above), this study was justified by the proposal to analyze obstetric violence in breastfeeding assistance from a racial perspective, as this relationship has not yet been identified in Brazilian literature. Thus, the following question was asked: Can obstetric violence interfere with breastfeeding? If this occurs, are these interferences related to women's self-reported race/color?

This study aimed to analyze the possible association between exclusive breastfeeding and the experience of obstetric violence according to self-reported race/color.

Methods

This was an observational, cross-sectional, descriptive and analytical study. Participants were recruited from Facebook and WhatsApp groups.

The reference population consisted of women with a postpartum period of up to six months. The

inclusion criteria included women over 18 years old, up to six months postpartum and with access to Facebook and/or WhatsApp. The exclusion criteria included women with a baby who required special care for breastfeeding and/or feeding, an impediment to breastfeeding and hearing, visual or cognitive impairment.

This study was carried out with a convenience sample consisting of 241 women with a postpartum period of up to six months at the time of data collection.

Three instruments were used for data collection. The first of them was prepared for this research based on previous studies developed on the topic, including identification data and participant sociodemographic and obstetric characteristics. The second instrument was the "*Questionário de Avaliação de Violência no Parto*" (Birth Violence Assessment Questionnaire). Its first part is related to women's profile, with nine specific questions about situations of violence experienced during hospitalization for childbirth and immediate postpartum care.[4] The instrument also assessed women regarding intensity of experiences and feelings related to situations of disrespect during care provided by healthcare team professionals.[4] For descriptive analysis of the frequency of this information, all women who mentioned any inappropriate or disrespectful procedure, situation or conduct were then considered to have suffered such violence.[4] The third instrument was adapted from the questionnaire developed by Silva (2007)[10] about the type of food offered to children at the time of data collection[11] and mothers' perception of breastfeeding. The three instruments were transcribed onto Google Forms.

To characterize the racial aspects mentioned by participants, the Brazilian Institute of Geography and Statistics (IBGE - *Instituto Brasileiro de Geografia e Estatística*) classification was adopted, which uses five categories of race/color (white, black, brown, yellow and indigenous). The black population is made up of all self-declared black and brown subjects.[12]

Data collection was carried out online using an electronic form from November 2020 to February 2021. This method of collecting data was necessary due to the social isolation imposed by the COVID-19 pandemic and in compliance with the recommendation of official national health bodies for the protection of the population.

Participants were recruited from Facebook and WhatsApp groups. Firstly, administrators of motherhood groups (or groups aimed at mothers) were contacted to present the research project and obtain permission for its dissemination in the groups. The groups were closed, with their own participation criteria established by the administrators. After administrators' agreement, the first author of this study published the research in the form of messages and invited participants to participate on Facebook (eight groups). On WhatsApp (two groups), disclosure and invitation were made by the administrators themselves. The messages contained an invitation to participate in the study and a link to the research presentation page, the Informed Consent Form (ICF) and the data collection form. Women who agreed to these terms electronically expressed their agreement through the ICF and answers to the form. Messages were sent biweekly to social media pages or administrators.

To expand research dissemination and reach, participants were asked to share the invitation with people they knew. Thus, 323 women answered the questionnaire. Among them, 82 were excluded, one for being a duplicate and 81 for having given birth more than six months ago.

From the spreadsheet generated in Google Forms, data were exported to a Microsoft Excel spreadsheet and analyzed descriptively and inferentially using the R software (v. 4.0.4). Chi-square and Fisher's exact tests were used to verify the possible association between variables. A significance level of 5% (α=0.05) was adopted.

For data analysis, considering the racial perspective, the race/color variable was condensed into the following two groups: black (including participants who self-referred to as black and brown) and non-black (including participants who self-referred to as white and yellow). In this sample, no participant declared themselves as indigenous.

The research project was approved by the *Escola de Enfermagem de Ribeirão Preto Universidade de*

São Paulo Research Ethics Committee linked to the Brazilian National Research Ethics Commission (CAAE (*Certificado de Apresentação para Apreciação Ética* - Certificate of Presentation for Ethical Consideration) 25950219.3.000.5393), under Opinion 4.152.952. The study complied with the Brazilian National Health Council (Resolution 466/12) and Guidelines and Regulatory Norms for Research Involving Human Beings Humans recommendations.[13] As racial and violence issues are sensitive and to avoid possible harm to participants, women were offered the possibility of welcoming and extended listening, with referral to a psychologist (if a professional was necessary) and then to the healthcare service with psychologists and professionals trained to care for these women as needed. No participant made such requests.

Results

The final sample was made up of 241 women who had given birth up to six months before data collection, with a mean age of 32 years (SD: 5.0 years; min.-max.: 20-45). They declared themselves as white (70.5%), black (black and brown; 27.4%) and yellow (2.1%). Regarding education, we highlight that 43.6% of participants attended graduate studies, 34.9% had higher education (complete or incomplete) and 21.6% had high school (complete or incomplete). Among the participants, 63.1% declared they had a religion, 74.7% declared they had paid work outside the home, 94.6% had a partner and 61.4% had their own home. Most of them (61.0%) lived in the Southeast region, and residents in the North region were not registered. The majority of them (59.3%) reported having an income of 4-20 minimum wages, and 88.0% reported receiving help with childcare.

As for obstetric characterization, the number of participants' children varied in the range of 1-4, with the majority (64.7%) reporting having one child. Among the participants, 60.6% reported having planned their last pregnancy. The start of the prenatal period ranged from 4 to 39 weeks. In the majority (93.7%), the onset was until the 12th week and the number of appointments ranged from 5 to 20. The majority (68.1%) reported having had no complications during pregnancy and childbirth (74.7%) or postpartum (87.1%).

Concerning the type of birth, 57.3% were cesarean sections and 42.7% were vaginal (with or without induction). Regarding the desire for the type of birth at the beginning of pregnancy, the majority (73.9%) of women stated that they wanted a vaginal birth. When they were asked about this desire at the end of pregnancy, the majority (72.6%) reported that they also wanted a vaginal birth. For women who had a cesarean section, the majority (44.3%) reported having wanted a vaginal birth but changed their mind during pregnancy (by their own choice or medical advice). Those who had a vaginal birth (96.1%) already wanted this type of birth from the beginning of pregnancy, and only 3.9% had wanted a cesarean section and changed their mind throughout the pregnancy (by their own choice or medical advice). Concerning the type of hospital, the majority (73.9%) reported having given birth in a private hospital. Most of women who had a vaginal birth (91.3%) were seen by obstetricians.

Participants stated that they had breastfed the baby in the first hour of life (63.5%). The majority stated that they were breastfeeding their babies (97.5%) and were exclusively breastfeeding at the time of data collection (71.4%). Of the 235 women who were breastfeeding, 83.4% considered that the baby was satisfied after breastfeeding.

When they were asked about milk production, 85.9% perceived their milk as good, strong and supporting their baby. More than half of women (56.0%) reported that the treatment given by healthcare professionals influenced their breastfeeding in some way. Among the 135 women who reported professionals' influence on their breastfeeding, only 123 answered how and more than half (61.8%) reported having been positively influenced.

Table 1 shows the procedures performed during the intrapartum period.

Among the 241 women who made up the sample, 214 (88.8%) were identified as having suffered obstetric violence, i.e., they mentioned some procedure (or inappropriate conduct) considered as vi-

Table 1. Description of procedures performed during the intrapartum period considered as obstetric violence

	n(%)
Impediment of carrying out actions by postpartum women (n=170)	
Inability to walk	3(1.8)
Impossibility of adopting positions as needed	14(8.2)
The above activities were not prevented	146(85.9)
Did not go into labor	71(41.8)
More than one option	7(4.1)
Procedures without consent or explanation (n = 241)	
Trichotomy (hair shaving)	4(1.7)
Use of oxytocin (“serum” to speed up labor)	2(0.8)
Repetitive vaginal touching and/or performed by different people	7(2.9)
Fast	2(0.8)
Artificial water breaking (professional broke the water)	3(1.3)
Kristeller maneuver (they pressed or climbed on belly to “help” the baby be born)	2(0.8)
Episiotomy (cut in the perineum, “prick down there”)	4(1.7)
Cesarean section	9(3.7)
Immediate cutting of umbilical cord	15(6.2)
Not applicable	152(63.1)
More than one option	41(17.0)
Procedures during the expulsion period (n=103)	
She was deprived of the possibility of adopting the most comfortable posture to pull (force)	14(13.6)
She had “pushing” directed by a healthcare professional (they told the frequency and how women should push without respecting their own rhythm)	23(22.3)
More than one option	16(15.5)
Not applicable	50(48.6)
Procedures during cesarean birth (n=138)	
They pressed or climbed on belly to “help” the baby be born	7(5.1)
Parallel conversation between professionals about other topics	22(15.9)
They kept her hands tied, preventing her from touching the baby	4(2.9)
Carrying out procedures without consent or without explaining why they were necessary	2(1.5)
More than one option	42(30.4)
Not applicable	61(44.2)
Procedures right after the baby is born (n=241)	
Contact with baby was postponed	13(5.4)
Procedures right after the baby is born (n=241)	
Their baby was immediately taken to the procedure room, without any professional explaining what was happening to them	10(4.2)
She was forced to breastfeed or establish contact with her baby (hold, look at the baby, etc...) against her will	1(0.4)
Prevented or made breastfeeding difficult in the first hour of the baby’s life, with no reason to justify this attitude	8(3.3)
The situations mentioned above did not happen to me	176(73.0)
More than one option	33(13.7)

olence. Considering women’s race/color, we found that, among the 66 black women, 62 (93.9%) suffered obstetric violence and, among the 175 non-blacks, 152 (86.9%) suffered violence. Despite the significant number of women who suffered obstetric violence, there was no significant association between obstetric violence and race/color (Fisher’s exact test; p=0.8811). In addition to this analysis, it was descriptively verified that, of the total number of women who suffered obstetric violence (214), 29.0% were black and 71.0% were non-black. It is interesting to highlight that six women (2.5%) reported having perceived different treatment in a negative way due to the color of their skin.

For the 214 women who suffered obstetric violence, no association was observed between experience of intensity of experience and race and/or color (p=0.103) as well as between experience of intensity of feelings and race/color (p= 0.636). However, when analyzing the responses to experience of intensity of experience, we highlighted that black women experienced more situations of violence (45.2%) than non-black women (32.2%). In experience of intensity of feelings, we can visualize the conversely: situations that aroused feelings related to violence were experienced less by black women (47.0%) than by non-black women (51.4%). Table 2 presents these data are.

Table 2. Association between experience variables of intensity of experience and feeling and race/color for women who suffered obstetric violence

Color or race	Black n(%)	Non-black n(%)	Total n(%)	p-value*
Experience of intensity of experience				
Yes	28(45.2)	49(32.2)	77(36.0)	0.103
No	34(54.8)	103(67.8)	137(64.0)	
Total	62	152	214(100)	
Experience of intensity of feeling				
Yes	31(47.0)	90(51.4)	77(36.0)	0,636
No	35(53.0)	85(48.6)	137(64.0)	
Total	66	175	214(100)	

*Chi-square test.

For women who suffered obstetric violence (n=214), the analysis of the association between exclusive breastfeeding and self-declared race/color indicated that this result is not statistically significant, i.e., these variables are not associated (p=0.822) considering the data from this sample (Table 3).

Table 3. Association between exclusive breastfeeding and race/color for women who suffered obstetric violence

Color or race	Black n(%)	Non-black n(%)	Total n(%)	p-value*
Exclusive breastfeeding				
Yes	44(71.0)	106(69.7)	150(70.1)	0.822
No	17(27.4)	41(27.0)	58(27.1)	
I am not breastfeeding	1(1.6)	5(3.3)	6(2.8)	
Total	62	152	214(100)	

*Chi-square test.

Discussion

The results of this study show the significant percentage of women who suffered obstetric violence in healthcare provision (regardless of race/color). We, therefore, suggest that there be continued and continuing education for professionals who provide assistance to women in clinical practice. This is important so that they have access to reliable information and can recognize practices considered as obstetric violence (including gender-based violence, racism and any other violence) during care provision.

Online data collection (due to restrictions imposed by the COVID-19 pandemic in the years 2020-2021) was a limitation of the study. The sample was then composed by convenience, including participants from different regions of Brazil, but without a representative number per region, which could make it difficult to generalize the conclusions. Furthermore, the research reached a part of the population in Brazil with easy access to the internet, also influencing the differentiated profile of the sample. Despite these limitations, the wealth of data collected contributed to expanding the discussion on this very important topic for maternal health.

The sample had a high level of education and high salary income. This confirms the scientific literature, which shows that the level of education is closely linked to individuals' income.[14] Considering the demographic profile of this sample and the data collection carried out online, we highlight the Brazilian population's access to the internet. In the latest survey of Information and Communication Technologies in Brazilian Households (2021), people without internet access are those with a lower salary income. A drop in access to computers in classes C, D and E was also noted, although there was an increase in internet access compared to the previous year.[15] Therefore, the profile of participants identified in the present study is consistent with data from the most economically advantaged Brazilian population.

Regarding obstetric characterization, the results of this research confirm two national studies, in which more than half of women had their births in private hospitals and the most frequent care was provided by obstetricians.[3,4] Analyzing the type of birth and care (public or private), among women who gave birth in private hospitals, the majority had a cesarean section. Among women treated in public hospitals, more than half of them had a natural birth. Although the majority of natural births were carried out in public hospitals, the number of cesarean deliveries in these hospitals exceeds the 10% recommended by the World Health Organization (WHO).[16] These data confirm studies, suggesting that the higher the education and income, the greater the access to private care and the greater the chances of having a cesarean section.[17]

Still regarding the types of birth, most women in the present study wanted a natural birth at the beginning and end of pregnancy. Among women who had a cesarean section, the initial desire was a natural birth, but they changed their minds throughout the pregnancy (alone or under medical advice). Similar results were obtained in a national study and in studies carried out in Norway and China where natural birth was the desire of most women.[4,18,19] The study carried out in China states that the number of women who preferred a natural birth but underwent a cesarean section was greater than the number of women who preferred a cesarean section but underwent a natural birth.[19]

Analyzing data on breastfeeding, 63.5% of participants breastfed their babies in the first hour of life. This is similar to the national percentage (62.4%) for children under two years of age (Brazilian National Child Food and Nutrition Study (ENANI - *Estudo Nacional de Alimentação e Nutrição Infantil*); 2019).[20] Data on breastfeeding in the first hour of life in this research and in Brazil have higher percentages when compared to global data (47.0%; 2021).[21]

The benefits of breastfeeding are already consolidated in the literature. Among the study participants, the majority were breastfeeding; among them, 71.4% were exclusively breastfeeding. According to ENANI (2019), the national percentage of women exclusively breastfeeding was 59.7% for children under four months and 45.8% for children under six months. The global percentage reached

48.0% in 2021.[20,21] Thus, the percentage found in the present study was higher than the national and world averages for women who were breastfeeding only with breast milk.

In the present research, the comprehensive collection of data on breastfeeding allowed us to identify that the majority of women considered their milk positively, and the way healthcare professionals approach women during guidance on starting breastfeeding positively influenced breastfeeding. It is important to highlight that protecting women through qualified care, avoiding complications during childbirth and postpartum, can result in improved self-confidence, making them more positive about their ability to breastfeed, consequently influencing the breastfeeding process to be more effective.[6]

During intrapartum, women may be exposed to procedures considered obstetric violence.[1-5] Comparing the procedures performed during labor (normal or cesarean section) in the present study with national[3,4] and international studies (Guinea, Ghana, Myanmar and Nigeria),[22] we noted that procedures considered violent (or carried out without women's consent) are still widely carried out in the present study as well as among women in these countries, although with different percentages. Procedures characterized as obstetric violence in the literature[1-5] can be an aggravation of the situation of violence experienced by women during childbirth, especially those that occur during cesarean birth, as this type of birth (as mentioned previously) can put the lives of mothers and babies at risk when carried out without indication, constituting in itself a violent act against women.

It was found that obstetric violence was the reality of the majority in the present study (88.8%). In the literature, varying percentages of women reported having suffered obstetric violence were found both nationally (Belo Horizonte, Rio de Janeiro, Niterói, Ceilândia and Brasília; (13%)) and internationally, such as in Ethiopia (75.1%), Netherlands (54.4%), African countries (41.6%), Spain (38.3%), Mexico (33.3%), and USA (17.3%).[3,5,22-26] Among the authors cited, it is a recurring statement that the variation between percentages is due to the fact that there is no consensus on the nomenclature or what exactly characterizes obstetric violence. Therefore, the way data is collected and the time of collection may vary between studies, generating different percentages. Furthermore, the sample size also varied between studies, in addition to factors intrinsic to each culture that may influence the occurrence of violence.[5,22-26]

In the present study, the association between obstetric violence and participants' race/color did not present a statistically significant result. It is worth remembering that the sample profile is compatible with that of the most economically advantaged population. However, the literature indicates that obstetric violence is more likely to occur in groups with more vulnerability factors, e.g., race/color or ethnicity.[26,27]

According to the concept of intersectionality pointed out by Crenshaw, (2002),[9] when considering obstetric violence as gender-based violence, women who suffer violence have other subordinate axes that lead to greater chances of suffering and experiencing obstetric violence in institutional spaces, e.g., race/color.[28] Thus, even though the sample studied in this research did not show an association between obstetric violence and race/color, it is important that healthcare professionals who assist women and their families know that this can happen in other settings and in other population segments. In many cases, factors that may be protective for white women, such as higher social class and higher levels of education, may not play the same role for black women. This is because racism and discrimination can generate negative obstetric results, with greater chances of maternal morbidity and mortality for black women when compared to white women, even if black women have these favorable conditions.[27]

In the present study, the association between exclusive breastfeeding and race/color for women who suffered obstetric violence was not associated. Although similar studies were not found in the literature to establish comparisons, some studies point to violence against women as a factor that makes it difficult to initiate and continue breastfeeding.[29] Therefore, the interpretation and understanding of

obstetric institutional violence is essential for proposing safe and beneficial care for the mother and child dyad,[30] because especially when obstetric violence related to race/color is considered, the data point to the fact that racism can be strongly linked to populations' health, with harmful consequences in the pregnancy-puerperal cycle, including increasing morbidity and mortality in the mother-child dyad, making access to healthcare services and adequate prenatal care difficult.[27,31]

Among health system users, it is difficult to recognize that discrimination in care can occur due to race, not just gender and class. This may be related to veiled racism, but present in the services and attitudes that generate and worsen inequalities among the black population, especially among black women.[8,31] Black women have higher morbidity and mortality rates and suffer more practices that can be characterized as obstetric violence. In the nationwide study "Born in Brazil", it was identified that black and brown women are more likely to have inadequate prenatal care, including lack of basic guidance, receiving less labor analgesia, in addition to the lack of connection with the maternity ward, not having the presence of a companion and having a post-term baby. This study also highlights that black women receive fewer interventions, such as vaginal examinations, episiotomies and cesarean sections, but that this indicator must be critically analyzed. In Brazil, obstetric practice is markedly interventionist and the procedures mentioned above are considered as defining good care by the lay public. The smaller number of these interventions may indicate racism and discrimination against black women.[31]

Conclusion

Association between obstetric violence, exclusive breastfeeding and race/color did not prove to be statistically significant. However, breastfeeding is known as a protective factor for women, children and society, and the obstetric violence observed in the present study has a deleterious influence on maternal health and safety regardless of race/color. Despite the increased number of international studies, discrimination, racism and their influence on black women's reproductive, maternal and breastfeeding health are topics that require further investigation in Brazil, as the few Brazilian studies show that this population faces greater inequities in access to healthcare services during the pregnancy and puerperal cycle.

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Collaborations

Azevedo-Pereira HA, Lettiere-Viana A, Gomes-Sponholz F and Monteiro JCS contributed to study design, data analysis and interpretation, article writing, relevant critical review of intellectual content and approval of the final version to be published.

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