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Translation in maternal and neonatal health

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1 Introduction

Conception, pregnancy, birth, labour and postpartum periods are crucial life events which have a bearing on the future health of individuals, as well as the collective health of families and societies. How one begins life or becomes a parent can have a lasting impact on their physical, mental and emotional health for the rest of their lives. Strictly speaking, pregnancy, labour, birth and postnatal period are not ‘medical’ events or processes per se. They are normal physiological processes with deep-rooted social, cultural, psychological, emotional, historical, spiritual and familial dimensions.

Practices surrounding childbirth vary from one culture to another. ‘Although the common aim is to maintain the well-being and safety of mother and child,’ there are great variations between the ‘notions of human reproduction, care of the expectant mother and the unborn child, methods of giving birth and postnatal care […] according to cultural beliefs and traditional practices’ (Hoang, Le and Kilpatrick 2009: 2). Regardless of these variations, there has been a gradual and global shift from a midwifery-led and woman-centred approach focused on normality in pregnancy and birth, to obstetric dominance, led by physicians and focused on the foetus. The latter perspective is mostly on the lookout for problems in birth and treating women’s bodies as factories/containers and mothers as patients/consumers.¹ This shift took place in tandem with the move of births from home to hospital, transforming birth from a social event shared within female circles to a medical event overseen by (male) physicians (for a succinct summary, see Colton 2004: 697–699; see also Arms 1975; Davis-Floyd 1992; Hensley Owens 2015; Wolf 2001; for a history of the development of obstetrics vis-à-vis midwifery, see Rich 1976: 128–155; for the control of reproduction, see Federici 2004). Especially in countries where healthcare systems are financially and technologically driven, birth has become ‘a complexly negotiated minefield of litigation, politics, vested interests, money, and beliefs about who holds the power over the delivery room’ (Wolf 2001: 18).²

We, the authors of this chapter, come from countries with high intervention rates. Caesarean section rates, for instance, are 53.1/100 live births in Turkey (first in the world among OECD countries in 2017)³ and 52/100 in Brazil (Oswaldo Cruz Foundation 2014).
A life-saving operation has become the ‘normal’ way of giving birth in both countries. We have both worked as translators, interpreters, editors and translation scholars in maternal and neonatal health (Fonseca is also a publisher in this field; Susam-Saraeva works as a doula) and we both self-identify as birth activists. We believe that empowerment of mothers is crucial not only for the physical, but also emotional and social wellbeing of the whole family. Our main theoretical perspective in this contribution is therefore a feminist approach to women’s health and to translation, and the next section will provide an overview of what such an approach entails.

2 A feminist approach to women’s health and to translation

This chapter approaches women’s health from the perspective of women’s health movements, which are part of the feminist struggle against patriarchal domination and capitalist exploitation. Although we are addressing translation in pregnancy and childbirth, we acknowledge that these are but two of the many areas in women’s health (e.g. reproductive rights, menstruation, abortion, menopause, domestic violence, birth control, genital mutilation, etc.). Translating women’s health, therefore, involves a translator’s agency that is aware of the various oppressions of women. The foci of the interpreting contexts and translated materials discussed in this chapter are: promoting wellbeing and women-centeredness during childbirth, strengthening the role of professionals who ensure the former (such as interpreters, doulas and midwives), and challenging the factors and infrastructures which account for the high intervention rates worldwide.

In the case of Brazil, for instance, c-section rates have increased by 400 per cent in 40 years. The rates for women in the highest income bracket is 88 per cent and there are high-income maternity hospitals in São Paulo with rates of over 90 per cent (Fonseca 2015: 84). This could imply that educated women with financial means are ‘choosing’ c-section: According to a study of medical narratives, Brazilian doctors claim that women ‘pressure’ them into performing c-sections (Hopkins 2000). However, the Nascer no Brazil (Born in Brazil) survey (Oswaldo Cruz Foundation 2014) tells a different story, revealing that when women start their antenatal care, 84.6 per cent of them in public healthcare and 63.9 per cent in private healthcare prefer a vaginal birth. During antenatal care – which in Brazil is carried out by obstetricians/gynaecologists (OBGYNs) – the c-section preference rate for women in the public healthcare remains unaltered; however, the rate for women who access the private healthcare goes up, indicating that they ‘change their mind’. This group’s c-section ‘preference’ rate rises from 36.1 per cent before the start of antenatal care to 63 per cent during the antenatal care. It is worth noting that this rate is still lower than the group’s actual c-section rate of 88 per cent mentioned above. This mismatch between what pregnant women desire and what they actually experience is not exclusive to Brazil; birth movements worldwide have been fighting for women’s rights to experience birth as they choose, on their own terms, and based on informed decisions.

Because a feminist approach to women’s health means placing women at the centre and in control of their own decisions, a feminist approach to translation in relation to pregnancy and childbirth entails choosing and translating texts that circulate within global women’s health movements and introducing these texts into target systems where they challenge hegemonic discourses and practices of exploitation; build collective memories of women’s embodied experiences; empower expecting women to achieve a more satisfying and liberating birth experience; and, contribute to transforming the contexts of reception.
In feminist studies, culture is seen as a field of conflict between oppressors and oppressed, and language as a domination tool (Ballestrin 2017: 1037). This conflict can take place on/in/over women’s bodies, which are both a source of identity and a ‘prison’ (Federici 2004: 15) and a ‘territory’ to be conquered (Ballestrin 2017: 1038). Women’s bodies are not only vulnerable in prototypical situations of violence and conflict which threaten them from the outside, such as urban violence and war. Because the driving force of capitalist exploitation and patriarchal domination have waged ‘a war against our body, making it a signifier for all that is limited, material, and opposed to reason’ (Federici 2019: 190), many women believe their bodies are dysfunctional and need to be fixed. This signification of women’s bodies becomes most apparent in pregnancy and childbirth.

In this context, translation can be a powerful discursive, ideological and cultural tool to foster feminist causes through numerous genres. In this chapter, we first address linguistic and cultural issues in interpreting for immigrant women during perinatal care. Then, we move on to the translation of childbirth narratives, which lie between oral and written genres. Finally, we focus on written genres, such as books for expecting families and midwifery textbooks.

3 Interpreting in maternal and neonatal health: linguistic and cultural issues

Research on linguistic and cultural issues in maternal and neonatal health has so far been conducted in disciplines such as midwifery, nursing, and perinatal healthcare improvement, and not in translation and interpreting studies. This is surprising given the high proportion of women giving birth in countries which are ‘foreign’ to them and the linguistic support they need throughout their pregnancies, births and postnatal recoveries. Within the last three to four decades, as a result of the increasing pressures of migration and globalisation, the number of foreign nationals giving birth abroad has steadily increased. Today, it is estimated that between 15–30 per cent of women giving birth in a given country were born elsewhere and more often than not, come from a different linguistic and cultural background from that of their host country (e.g. Akhavan and Lundgren 2012; Fredsted Villadsen, Ims and Nybo Andersen 2019: 2; Yelland et al. 2016: 2; Yelland et al. 2017: 500).

Migrant mothers in high-income countries are reported to experience considerable inequalities in healthcare provision (Hughson et al. 2018: 11) and more perinatal complications (Sami et al. 2019: 2). Multiple factors underlie this situation: a lack of social support in the host country, of cultural competence and health literacy, and, of course, language barriers (Sami et al. 2019: 2; Yelland et al. 2016:7). To complicate matters further, many of these women come from cultures where ‘the doctor knows best’; therefore, they do not necessarily ask questions or enquire about their options (Binder et al. 2012: 1178). They are often ‘reticent “in speaking out” as a result of ingrained unassertiveness and inhibition, cultivated from childhood in many cultures for all genders but especially for women’ and therefore, they may ‘have less access to resources and may not be able to receive the services they are entitled to’ (Hoang, Le and Kilpatrick 2009: 7). If parents do not know that interpreting services are available, for instance, they do not request them. They may not ‘feel that they had the right to ask for a professional interpreter or to request a different interpreter […]’ (Yelland et al. 2016: 6). Different solutions have been suggested to address this issue. For example, in a Melbourne hospital in Australia, notices
reminding staff about engaging interpreters were placed where midwives would regularly see them: on the doors of staff toilets. The notice said: ‘Offer interpreter early in labour; Gently insist if declined; Offer again’ (Yelland et al. 2017: 501).

There seems to be a strong correlation between being a foreigner and rating one’s intrapartum care experience as poor (Yelland et al. 2017: 500). Parents who experience communication difficulties tend to seek medical care rather late during their pregnancies; some are known to seek medical help only when labour begins (Igarashi, Horiuchi and Porter 2013: 782). They may have a poor understanding of treatment plans and may feel unable to participate in medical decision-making processes (Yelland et al. 2016: 1). This inability to seek help when needed reportedly contributes to maternal or neonatal deaths as a result of e.g. ectopic pregnancies or eclampsia (Yelland et al. 2017: 500). In the case of refugees, motherhood in a new country may take place against a complex backdrop of hardship, a history of torture and subsequent PTSD, loss of loved ones, ethnic and religious persecution, inadequate accommodation, lack of transport, poverty, racism, malnutrition, sexual slavery and female genital mutilation (Correa-Velez and Ryan 2012: 14; Fredsted Villadsen, Ims and Nybo Andersen 2019: 2; Hoang, Le and Kilpatrick 2009: 2; Sami et al. 2019: 6; Tobin, Murphy-Lawless and Tatano Beck 2014: 832–833). Healthcare providers, social workers and interpreters working with refugees in maternity settings need to be educated on the impact of this background on new parents.

Even in cases where women move to a foreign country as a result of a new job, relationship or other factors based on personal choice, the lack of a support network and familial role models may increase the new mothers’ sense of isolation (Sami et al. 2019: 4; Taniguchi and Baruffi 2007: 90), which is only exacerbated by linguistic barriers. In a study focusing on Japanese women living in Hawaii, ‘language barrier, the distance from family and friends, and different culture and healthcare attitudes’ emerged as key factors impacting on the mental and physical health of new mothers (Taniguchi and Baruffi 2007: 92). Childbirth in a foreign country thus emerges as a particularly stressful event, especially for those giving birth for the first time, in some cases multiplying postpartum depression rates six-fold (e.g. 31 per cent for Japanese women in the United States, compared to the Japan average of 5 per cent; Taniguchi and Baruffi 2007: 94). Furthermore, even if the women have high proficiency in the language of their new country, it is well-documented that people ‘tend to revert to their first language during times of stress, such as medical encounters’ (Maher, Crawford and Neidigh 2012–2013: 474), and especially during labour and birth, which necessitate the activation of ancient limbic parts of one’s brain.

While in translation and interpreting studies communication issues per se tend to dominate the discussion, in midwifery and healthcare ‘lack of connection, communication and cultural understanding’ are seen as interrelated issues, which exacerbate women’s experiences of alienation, loneliness, exhaustion, fear and vulnerability, ‘increasing their risk of mental health issues’ (Tobin, Murphy-Lawless and Tatano Beck 2014: 831, 837). Culturally appropriate and competent care, on the other hand, ensures that women will be treated with more respect and dignity (Tobin, Murphy-Lawless and Tatano Beck 2014: 837). However, it is also important to remember that healthcare providers belong to a culture of its own, i.e. the biomedical one (Fredsted Villadsen, Ims and Nybo Andersen 2019: 2), and this particular culture may need to be clearly explained to new parents. More often than not, ‘women have reported feeling that their intergenerational cultural knowledge was devalued or disregarded in the western maternity culture’ (Hughson et al. 2018: 11).
Interpreters have traditionally been the main link in the communication between healthcare providers and expectant women and their partners. The importance of using interpreters is widely recognised in maternity services and in research which focuses on remediating linguistic and cultural incongruence. However, a common pattern across countries is that interpreters are accessed less frequently during labour and birth (due to their unpredictability and protracted timeframe) compared to antenatal and postnatal care, which includes appointments with midwives, scans and tests at hospitals, ward stays or home visits (Yelland et al. 2017: 500). Even for routine antenatal appointments, it is common that interpreters are booked for the first appointment, but not for the subsequent ones (Yelland et al. 2016: 1, 4). There seems to be a general perception that appointments with an interpreter take twice or three times longer than appointments without (Binder et al. 2012: 1176; Hughson et al. 2018: 13), and this seems to hinder the booking of interpreters more widely. There are some common misconceptions amongst healthcare staff, such as ‘the perception that using interpreters for women in early labour would have unacceptable cost implications for the unit’s interpreting budget and that accessing an interpreter for a woman more than once in labour was not acceptable practice’ (Yelland et al. 2017: 502).

In labour and birth, there seems to be a tendency to ask for interpreting services only when consent for a procedure is sought or when there is an urgent need, such as in an emergency (Yelland et al. 2017: 503). However, enlisting an interpreter early on in labour is found to reassure the mothers and give them better support (Yelland et al. 2017: 502–503). In order to ensure this, language requirements could be noted on to the triage admissions or women could be informed about how to access the telephone interpreting service themselves (Yelland et al. 2017: 502). Targeted care for immigrant women can afford more flexibility for healthcare providers in, for instance, arranging the length of meetings and booking times. However, it also risks stigmatising immigrants by e.g. assigning interpreters based on the women’s names and surnames, rather than their actual need for interpreting services or assuming parents from a certain culture will have certain expectations, values, and belief systems, and thus homogenising a potentially heterogeneous group (Fredsted Villadsen, Ims and Nybo Andersen 2019: 1, 5). Furthermore, ‘emphasizing too much the culture behind a health issue might ultimately hand the problem over to the patient as a private matter’ (Binder et al. 2012: 1183).

In the surveys conducted, women who had interpreters were overall fairly positive about their experience, as they found it easier to ask questions, express themselves and share their concerns (Binder et al. 2012: 1176–1177; Yelland et al. 2017: 502). Some appreciated the distance, privacy and anonymity afforded by the use of remote interpreting (Yelland et al. 2016: 4), while others indicated a preference for face-to-face interpreters (Yelland et al. 2017: 502). Studies from Australia show that remote interpreting can be challenging for the midwives as well, due to issues such as delays in telephone connections, getting access on weekends and overnight, questionable quality of the ensuing communication and no provision for the languages required (Yelland et al. 2016: 4; Yelland et al. 2017: 503; Hughson et al. 2018: 13). In addition, amongst the maternity healthcare staff, skills and professionalism of interpreters appear to be a recurrent concern (Binder et al. 2012: 1180; Hughson et al. 2018: 14; Tobin, Murphy-Lawless and Tatano Beck 2014: 833). Many, for instance, are unsure about the interpreters’ grasp of medical terminology and professional training, which indicates that there are issues regarding accreditation and cooperation.

Reproductive health has its own characteristics when it comes to the use of interpreters. Given the intimate nature of labour and birth, women may decline offers of interpreting services. The presence of interpreters may be perceived as disruptive to the birth process,
causing embarrassment (Yelland et al. 2017: 502). Therefore, women may choose to rely on their partners or female members of their family, such as sisters, cousins, etc. (Yelland et al. 2017: 501). In other cases, it may be the partners who insist on interpreting; occasionally, they are known to request certain information not to be passed on to the mothers, presumably trying to protect them from worry and anxiety, acting as ‘gatekeepers’ (Yelland et al. 2016: 5). In fact, although bilingual or multilingual healthcare providers and hospital staff are occasionally called upon (Hughson et al. 2018: 13), it is often the partners and other family members interpreting for pregnant women, with varying degrees of success (Sami et al. 2019: 7; Yelland et al. 2016: 1, 5; Yelland et al. 2017: 500).

Some health professionals may also express a preference for the partners interpreting: ‘It’s not impartial or whatever but it’s superior (to telephone interpreting) in many ways’ says one midwife, especially when she has to show something to the women physically (Yelland et al. 2016: 5). However, the use of partners as non-professional interpreters within the context of maternal health inevitably discourages healthcare professionals from asking questions on domestic violence and may inhibit women from giving full and frank answers (Yelland et al. 2016: 6); it also endangers confidentiality (Sami et al. 2019: 7).

When professional interpreting services are available and called for, female interpreters are preferred overall (e.g. Binder et al. 2012: 1180; Yelland et al. 2017: 502), encouraging women to disclose ‘health or family concerns, asking questions and seeking clarification at pregnancy visits. [...] Several women noted that they were embarrassed to ask health professionals about “feminine issues” via a male interpreter’ (Yelland et al. 2016: 4). In the words of one mother: ‘I was unhappy when a male interpreter was called when I had a miscarriage [...] I didn’t like it and it took me a while to forget what happened’ (Correa-Velez and Ryan 2012: 16). A further complication arises when the mothers know that some accredited interpreters are members of the local and relatively small ethnic community. In such cases they are more reluctant to talk about sensitive issues, concerned that their personal information ‘could become “community gossip”’ (Yelland et al. 2016: 4).

In studies ranging from Australia to Sweden, Japan to Switzerland, researchers agree on similar solutions for ensuring optimum care for immigrant mothers (Binder et al. 2012: 1172, 1180; Hoang, Le and Kilpatrick 2009: 9; Hughson et al. 2018: 14; Sami et al. 2019: 7; Tobin, Murphy-Lawless and Tatano Beck 2014: 831):

- Dedicated community-based services
- Mandatory training for healthcare providers in cultural awareness and competence
- 24/7 access to professional interpreters during labour and birth (making sure that both the parents and healthcare providers are aware of the availability of interpreting services)
- Social assistance providers to guide parents through the local healthcare system and administrative procedures
- Use of technology, such as carefully screened or locally-developed eHealth resources (e.g. smartphone pregnancy apps in multiple languages)
- Training bi- or multilingual hospital staff so that they can interpret to a more professional standard
- Diversifying the healthcare workforce so that it is representative of the population it serves
- Information leaflets, videos or audio recordings in multiple languages

It is clear that in these research findings, interpreting is seen as only one, albeit a crucial and often underused, tool.
In the area of maternal health, it is well-known that continuity of carer, i.e. the consistency in healthcare providers who support a woman and her baby throughout pregnancy, labour and the postnatal period, increases women’s satisfaction, trust and confidence, ‘improves communication, and enhances women’s sense of control and ability to make informed decisions’ (Correa-Velez and Ryan 2012: 14). In the research surveyed, continuity of interpreters is highlighted for the same reason (Correa-Velez and Ryan 2012: 21), making sure that the same interpreter accompanies the mother in all antenatal appointments, as well as during labour and birth. In a project in Sweden, a further step was taken to train doula-interpreters who could provide such continuity of care. These were ‘foreign-born women (mainly non-European immigrants) who were interested in this project, had given birth, had their own child/children, could speak Swedish and could attend a birth at any time’; they were then ‘trained by midwives to become doulas and support their peers before, during and after childbirth’ (Akhavan and Lundgren 2012: 81). A similar project in the United States opted to work with trained medical interpreters and offered them additional doula training, with similarly successful results, increasing trust and cooperation between them and the healthcare providers (Maher, Crawford and Neidigh 2012–2013: 477, 479). Needless to say, an additional doulaing role blurs the professional boundaries of interpreters and can make any transition between these two roles rather tricky. It becomes vital for the doula-interpreter ‘to ensure that all involved understand exactly when she is interpreting and when she is speaking on her own behalf’ (Maher, Crawford and Neidigh 2012–2013: 478).

Despite this caveat, the midwives in the Swedish project note that they regard the doula-interpreters as ‘assets’, ‘facilitators’ and ‘part of the team’ (Akhavan and Lundgren 2012: 81). They appreciate the continuous physical presence and involvement of the doula-interpreters (as opposed to e.g. remote interpreters or interpreters sent from agencies), the support and assistance they offer to the midwives (e.g. in explaining cultural differences), the interaction and affinity between mothers and doulas (who had a chance to get to know each other throughout pregnancy), as well as doulas’ interest in and knowledge of childbirth and related terminology and procedures (Akhavan and Lundgren 2012: 82). According to the findings of this project, a doula-interpreter coming from the same linguistic and cultural background as the mother can also ‘create a sense of community’ (Akhavan and Lundgren 2012: 83), precisely what is demonstrated to be missing from the experience of women giving birth in foreign lands.

4 Translation of childbirth narratives

Regardless of any cultural or linguistic differences, what women most want during childbirth is respect, warmth, support, a sense of security and affirmation (Igarashi, Horiuchi and Porter 2013: 782). Within the medicalised model of birth, however, this is often rather difficult to achieve. As mothers have felt compelled to tell their birth stories, the term ‘obstetric violence’ has slowly gained ground. In the absence of stable and strong female communities and wisdom worldwide, and of familiarity with life transitions such as birth and death, women have turned to listen to each other’s birth stories, shared orally, in print, and online. ‘The shared birth story provides a vicariously learned experience’ for expectant mothers (Staton Savage 2001: 4). It partially fills the gap created by the lack of ‘significant observational and participatory experience with the process and with different women’s ways of handling different births’, compensating for ‘individual bodily experience and […]

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collective observational experience to draw on’ (Hensley Owens 2015: 95). Therefore, birth stories by women outside one’s own immediate circle can become a source of information and support.

Birth stories help the mothers to relive the events, incorporate them into their memory and sense of self (Nelson 2004: 803). Writing them down, sharing them publicly and reaching out to other women preparing for birth or grappling with their own birth-related emotions and memories help women avoid victimhood, censorship and silence (Hensley Owens 2010: 353). Especially in the case of traumatic events and their subsequent narration, birth stories may help turn disappointment into acceptance and reconciliation, which are crucial for mental health. This rewriting/rewiring of past events (Hensley Owens 2015: 137–138) enables women to gain more control over what has happened to them and to heal themselves, at least partially.

Second-wave feminism’s slogan ‘the personal is political’ resonates deeply in the writing and sharing of birth stories (Hensley Owens 2010: 356). While these stories are replete with emotional, physical, spiritual and psychological detail, and seem to solely focus on personal experiences and memories, they set off concrete social and political ramifications by presenting different choices in childbirth, critiquing societal and medical expectations, and advocating certain stances. They inspire resistance against standard practices and rigid social norms about where, how and with whom to give birth. As a social practice, birth stories are a way of being, because they express identities; a way of acting in the world, because they have the power to enact change in society; and, a way of representing birth, because they shape discourses and ideologies revolving around childbirth (Fonseca 2015: 29–32).

There is growing recognition within medical humanities that subjective experience can be a legitimate source of knowledge and that experiential information can complement, enhance, as well as challenge, the conventional wisdom disseminated by institutions and authorities. Medical humanities ‘attempts to bridge the gap between biologically based medical theory and reality-based human/patient experience’ (Hashish 2020: 165). Birth stories are noteworthy examples of such experiential, visceral and feminist experience and knowledge passed on from one person to another, one generation to the next, and, in the case of translation, one language and culture to another.

The significance of translating childbirth narratives is multi-fold. Infrastructures supporting maternity services vary considerably from country to country – and even within one and the same country – depending on socio-economic profiles, demographics and approaches to maternal healthcare. It is therefore important for parents to hear what is possible and available elsewhere. For instance, home-birth stories shared across languages and cultures have increased the interest in the possibility of giving birth at home, especially during the COVID-19 pandemic. Translating these stories also gives voice to parents who have taken unconventional decisions depending on their personal circumstances, education, research, convictions, etc. Being exposed to these decisions helps other parents question their own stance vis-à-vis the birthing choices presented to them by the medical establishment.

Despite the growing interest in childbirth narratives within diverse academic disciplines, such as rhetoric and discourse studies, comparative literature, motherhood/mothering studies, women studies, and midwifery (e.g. Akrich and Pasveer 2004; Colton 2004; Cossett 1994; Fonseca 2014; Hensley Owens 2015; Nelson 2009; Podnieks and O’Reilly 2010), there has been almost no research on the circulation of these narratives beyond their languages and cultures of origin from a translation studies point of view. To date,
the only research in this area is by Susam-Saraeva (2020), focusing on *Ina May’s Guide to Childbirth* (Gaskin 2003) and its Turkish translation (2015), which both include 44 birth stories. Her article compares and contrasts the US-American and Turkish maternity systems and cultural attitudes towards childbirth outside hospital settings by using the lens of translation. Adopting the framework of narrative theory, the article demonstrates that even though translational agents (translators, editors, revisers) may be open to new ideas and possibilities, they may still be unable to harness the full transformative power of personal narratives in translation. The public and meta-narratives about childbirth circulating in society exert their dominance in translational and editorial decisions both on macro- and micro-levels.

Stories of natural/positive births\(^1\) are part of a worldwide social movement enabling such births. Translating stories from countries with respectful, women-centred birthing practices can inspire expecting parents in target cultures and help transform interventionist medical institutions. Translated birth stories can also influence birth professionals who are open to challenging the status quo in their countries. Although stories, as well as personal observations, are considered ‘low-level’ evidence in medicine (as opposed to e.g. randomised controlled trials), the power of these stories should be acknowledged and taken into account.

**5 Translation of (text)books on pregnancy and childbirth**

This section explores translated books and textbooks aimed at birth professionals and expectant families within the natural/positive birth movement. The examples are taken from the work of Fonseca, as a translator and publisher. These books, translated from American English – and in one case, Mexican Spanish – into Brazilian Portuguese, are mostly written by birth professionals and relate to each other in terms of their common goal, i.e. reducing c-section rates in Brazil through materials that support informed decision making and reconnect women with their bodies and traditional knowledge on birthing.

The target audience of these translations are women in the upper-middle class bracket. Although this group is statistically the best-read and has full access to relevant information, it also has the highest c-section rate in Brazil, due to the association of c-sections with economic status and of medicalisation with ‘risk avoidance’ and ‘state-of-the-art technology’. Other demographic groups in the society, in turn, try to imitate the choices of the upper-middle class whenever they can.

Among the discourses operated to encourage c-sections for the women in this group is the claim that their body cannot cope with a vaginal birth. This is part of a global discourse observed in diverse areas of medicine which represents women’s bodies as dysfunctional (Martin 2001). In the case of Brazil, however, it is further boosted by structural racism rooted in coloniality. White European women have historically been represented as fragile in contrast to non-white women, who, in turn, have been considered strong enough to cope with any kind of work (Lugones 2008: 95). As a result, the present-day upper-middle class woman in Brazil, who defines herself as white, perceives her inability to give birth due to her allegedly frail constitution as a means to come closer to the idealised notion of whiteness. Moreover, many women in the targeted group think they have control over their body and sexuality, and that oppression is reserved for poor black women (Martin 2001: 202).

To reach this group, a feminist translation approach should necessarily use a variety of genres. Women in this group are surrounded by birth professionals, their social peers
and family. When a woman considers swimming against the c-section current, she has to be able to find materials not only to educate herself and make informed decisions, but also to educate those around her. In her study of birth stories, Fonseca found that Brazilian VBAC (Vaginal Birth after Caesarean) stories represent partners as key allies in achieving a vaginal birth; without their support it was more difficult, if not impossible, to have a VBAC (2015: 123–125). Moreover, birth professionals who challenge the dominant c-section culture also require resources to educate themselves and their clients, and to show that their profession is ‘written about’, and therefore, ‘exists’. The birth professionals targeted by these translations are first, Brazilian doulas and midwives, and second, OBGYNs and nurse-midwives.

What the translated books have in common is their focus on the normalcy of childbirth, the celebration of women’s bodies, their power and ability to give birth, and women controlling time-space. Thus, although many of the books are targeted at professionals, they depict them in a supporting role in the pregnancy and birthing process. From a feminist translation perspective, the woman-centred birthing ideology these books convey deliberately antagonises the Brazilian c-section culture; and, from a marketing perspective, it targets an audience too small to attract mainstream publishers. As a result, only feminist translators and independent publishers take on this work, largely supported by the community of birth activists.

The work and encouragement of leading birth activists have been crucial to these feminist translation projects. Brazilian movement’s leadership is very active in São Paulo, and among other activities, holds the main annual humanised birth conference in Brazil (Simpósio Internacional de Assistência ao Parto, SIAPARTO) and promotes international exchange of birth professionals and activists. Three of the authors of the translations discussed in this section have been regular speakers at SIAPARTO. The birth movement’s role in promoting the authors is essential to the circulation of their books in translation. Because the authors, local birth professionals and activists frequently work together, their books circulate through word-of-mouth. As for the production of these translations, the movement’s role is equally crucial. Translations of all the books in this section have been carried out by birth activists who are professional or non-professional translators. Revision is also supported by birth professionals (doulas, midwives, nurses, doctors, and birth photographers), activists and/or graduate students and academics in Public Health at the University of São Paulo and other public universities. The networked and collective effort that goes into activist translation and publishing, especially of non-hegemonic women’s health texts, is a phenomenon widely researched (see, Davis 2009; Rosas et al. 2020; Sánchez 2020; Shapiro 2013; Susam-Saraeva 2020; Tymoczko 2007).

Having touched upon the complex networked endeavour of translating in the field of pregnancy and childbirth, we will now discuss specific feminist goals and rationale of each translation, and explicate translational strategies.

5.1 Heart and hands: a midwife’s guide to pregnancy and birth – new front cover and neologisms

Heart and Hands is a textbook by the American midwife, educator and consultant Elizabeth Davis (2012). The title was translated as Com as mãos e o coração: manual de parteria (With the Hands and the Heart: Midwifery Manual, Davis forthcoming). This 320-page textbook is targeted mainly at midwives, but also at doulas and expectant families. It was
translated by a team of three translators, with different specialisms. The revision of each chapter was carried out by activists who are also professionals and/or researchers in the topic of the relevant chapter.

Studies show that gender bias is rife in textbooks across all levels of education and disciplines (Baldwin and Baldwin 1992; Blumberg 2007). In medicine, it has been found that gender bias not only affects how women are represented (Martin 2001) but also the diagnosis and treatment of common ailments (Blumberg 2007; Dijkstra, Verdonk and Lagro-Janssen 2008). This is also the case in translated textbooks. Leonardi (2017) studied gender and ideology in original and translated anatomy textbooks in English and Italian to assess whether sexism is maintained or omitted linguistically and semiotically. She found that the ‘textbooks analysed show a disproportionate use of male-centred anatomy’ and that ‘sexism in both language and imagery helps reinforce the sexist social structure’, concluding that ‘it is important to rethink language used in all medical publications, including textbooks, and rethink visual language, even in translation’ (Leonardi 2017: 27; emphasis added). Accordingly, it is important to look at the packaging of and illustrations in translations, as well as any bias in the language used.

A midwifery textbook such as Heart and Hands, which focuses on the normalcy of childbirth, is inherently feminist and woman-centred. Yet, the front covers of the five editions in English to date have become increasingly baby-centred. Up until and including the 3rd edition, the front cover had a coloured photo of a dark-skinned baby’s head being born vaginally into the waiting hands of a midwife. In the 4th edition, the same photo was used for the cover, but this time in close-up and black and white, therefore not as clear as in the former editions. In the 5th edition, a different photo was chosen, showing a rosy-pink baby asleep on its white mother’s chest on top of a white blanket. The mother is out of focus, only the contours of her shoulder and chin are identifiable, and the baby is wearing a white bonnet hat.

Judging by the covers of the later editions, in addition to the characters having been whitened, the midwife has progressively left the scene. On the cover of the 5th edition, a tranquil baby, well past the moment of birth, was brought to the foreground and the mother was placed in fuzzy background in a much more conventional, restful position. The latest edition of this textbook on midwifery has thus completed the phasing out of the midwife from the front cover, as well as blurring the mother and her bodily powers. This is in accordance with the worldwide marginalisation of the midwife that started the process in which

[...] Women lost the control they had exercised over procreation, and were reduced to a passive role in child delivery, while male doctors came to be seen as the true ‘givers of life’ (as in the alchemical dreams of the Renaissance magicians). With this shift, a new medical practice also prevailed, one that in the case of a medical emergency prioritized the life of the fetus over that of the mother. This was in contrast to the customary birthing process which women had controlled; and indeed, for it to happen, the community of women that had gathered around the bed of the future mother had to be first expelled from the delivery room, and midwives had to be placed under the surveillance of the doctor, or had to be recruited to police women.

Federici 2004: 89

The feminist translation project of this book revolves around birthing in Brazil, and the challenges of having a vaginal birth in this context. Therefore, a very different photo
A birthing woman and her partner in an upright position. The woman's right hand is on her pregnant belly, and her left hand is partially on top of her partner’s hand whose fingers are crossed over her breasts, at the height of their hearts, as he holds her. The choice of the photo was motivated by the lack of powerful imagery showing vaginal births in (text)books in Brazil, and due to the key role partners play in helping women achieve a respectful and midwife-assisted birth in the target culture. The semiotically translated cover photo is intended to enable couples to see themselves birthing and to build their individual representations and collective memory pool, in addition to subtly warn women that they seldom achieve a natural birth in Brazil unsupported.

The translation of the term midwifery throughout the book has been another issue. It is known that students learn 5,000 new words in the first year of medical school (Bordelois 2016: 14), but what is the dominant ideology behind the words they learn? If most textbooks are linguistically and semiotically gender biased, their vocabulary – or the lack thereof – would mirror this bias. In Brazilian Portuguese, there is no word for ‘midwifery’ – neither in medicine nor in nursing. There is, however, a term for midwife, parteira, but it is ideologically charged and stigmatised. Parteiras correspond to ‘self-taught or traditional midwives’ who attend births in rural areas. Trained midwives in Brazil are called obstetrizes, their field of knowledge being obstetricia (obstetrics), and ‘nurse-midwives’ are called enfermeiras-obstetras (nurse-obstetricians). Activist and trained birth professionals, on the other hand, make a point of being called parteiras and even parteiras urbanas (urban midwives).

Because our feminist translation approach aimed at raising the status of midwifery as a profession in order to challenge the interventionist birth culture, we wanted to create a counterpart for the word ‘midwifery’. After a number of exchanges with the reviewers, our attention was called to the fact that Spanish has the term partería (midwifery). This term is transparent to Brazilian readers. Therefore, it was decided that the translation would introduce the term parteria (without the accent) into the Brazilian birth culture. The need to use a Spanish neologism in a translation from English was clarified in the paratext, and the term was presented as a dictionary entry at the beginning of the book, as well as being used in the title.

Creating new words has always been part of a feminist agenda. Since language is a social phenomenon, new words that expurgate sexism in society must be created (Saffioti 2015: 51). In the discourse surrounding childbirth in Brazil, women have been masterfully excluded from the lexicon. There is no grammatical equivalent for ‘I give birth’ or ‘she gives birth’; the verb parir (to give birth) cannot be conjugated with first- or third-person singular. OBGYNs, on the other hand, systematically use the phrase fazer o parto, which literally means ‘to perform a (vaginal) birth’, rather than ‘to assist a birth’; and, maternity hospitals identify their operating rooms as sala de parto (vaginal birth room). The lexicon attached to those supporting the mothers can also be vague and misleading. Feminist translation can raise awareness about the biases reflected in such terms and phrases, as well as about the urgent need to create new ones.

5.2 The Belly Mapping Workbook – enlarging readership

The Belly Mapping Workbook: How Kicks and Wiggles Reveal Your Baby’s Position was written by the American midwife Gail Tully, who is also the author of the well-known book and website Spinning Babies (2010). The original was a 45-page-long A4
spiral-brochure targeted mainly at ‘pregnant women’, according to the title, but also at ‘maternity care providers’ (Tully 2010: 1). The workbook was translated as Guia prático de Belly Mapping: descobrindo a posição do bebê na barriga pelo tato (Practical Guide to Belly Mapping: Finding the Baby’s Position Through Touch; Tully 2015). The translation, in square back binding, 21 × 21cm, has 126 pages. This expansion is due to the objective of the translation project, which was to appeal to a wider audience in the target language. This was achieved by enlarging all the photos; rewording the title to address midwives as well as mothers; changing the front cover; adding an entire chapter on belly painting; and, whenever possible, replacing the photographs in the original with those of Brazilian women and birth professionals – not only doulas and midwives, but also physicians – so that they could see themselves represented in the book and thus perceive woman-centred pregnancy and birth as tangible and possible in their own culture.

As a result, the book has become popular among doulas and young or in-training nurses and doctors. Doulas use it to teach their clients how to feel their baby in the womb, and by doing this, they encourage expecting women to touch, feel and know their body. Mothers who use the Belly Mapping techniques become less alienated from their pregnancy, gain confidence in their ability to give birth, and begin to value women’s knowledge about their own bodies. Enabling women to (re)gain this knowledge about themselves is subversive because ‘science’ and the medicalisation of birth have undermined women’s knowledge for centuries (Federici 2004; Schiebinger 1999).

This translation project holds ‘translating and editing as a mutually implicated process whose points of divergence are also points of contact’ (Emmerich 2017: 13). The ‘original’ workbook was translated into an expanded version to fulfil the feminist agenda of both the original author and the editor in the target culture. By enlarging readership, the editor instrumentalised a wider range of birth professionals and activists, who can then attend to expecting women and empower them. At the same time, these professionals gain visibility in the process, through belly painting and birth photographing – two activities which celebrate women’s bodies.

Finally, in terms of the discourse of translation, which ‘has consistently served to express the difference in value between the original and its “reproduction”’ (von Flotow 1991: 81), this feminist approach to editing subverts traditional hierarchies and power relations by making the work of ‘reproduction’ fruitful and valuable. Feminist translation in women’s health challenges the static notion of the ‘original’; every interpretation is guided by the present context and its current struggles and challenges.

5.3 Un bebé nace naturalmente / Nasce um bebé… naturalmente/ A baby is born… naturally – memory in the making

The first edition of this multilingual book was written in Spanish and illustrated by the Mexican midwife Naoli Vinaver, translated into English and Brazilian Portuguese, and published in 2005 (retranslated in 2015). The book has also been published in another trilingual edition since then (Italian, German and French; Vinaver 2009).

A Baby is Born… Naturally is a birth story told by Aleli, the older sister of a soon-to-be-born baby. Although the book is primarily for older siblings in families planning a home birth and conveys Vinaver’s experience as a midwife, it is a book Brazilian doulas and midwives carry with them to show to pregnant women, due to the lack of available home-birth imagery. It is lavishly illustrated by the author in bright colours and in marked Latin American aesthetics. The drawings depict scenes which may be considered taboo in...
children’s books, such as the baby crowning, Aleli kneeling facing her mother’s open legs, and the naked mother catching her baby. In the story, Aleli learns to wait, helps the midwife prepare the house for the birth, watches her mother labour, witnesses the intimacy and cooperation between her parents, and more: ‘she looks in wonder as her mother’s vagina opens, widens, and slowly makes room for the baby’s head’ (Vinaver 2015: 14).

As stated in the section on birth stories, this story in the form of a children’s book aims at building and strengthening individual and collective memory pools, for both children and adults. These memories will be accessed by older siblings, partners and birthing women when the time comes. The book goes against the countless images inflicted by the mainstream media, which feed into the interventionist and medicalised birth culture. By making the imagery in Vinaver’s book available to its target readers, the feminist translation aims at compensating for the lack of observational experience related to childbirth.

In the book and its translation, the term ‘naturally’ takes on two meanings: the natural birth of Aleli’s brother is not only free from intervention, but is also experienced as a natural part of life, with ease and without fear. ‘Just as birth should be: a remarkable event, but at the same time common and constant in any growing family. Some may think it is a miracle, but it is simply life as it is’ (Vinaver 2015: 15).

This book, seemingly addressing children, is intertextually connected to the previously discussed translations. As in Heart and Hands, it depicts the work and role of midwives, the bodily expressions of women during birth, and the process of childbirth. It is linked to the Belly Mapping book, as the midwife feels the baby to determine the foetal position and draws the baby on the mother’s belly. The three translations discussed in this section so far reinforce each other, value the birth attendants, and encourage the mother so that she can find material support to educate those in her social and family circles, who, in turn, will be key supporters for her to birth on her own terms.

5.4 A Bun in the Oven: how the food and birth movements resist industrialization – connecting the dots

Unlike the authors above – all midwives – Barbara Katz Rothman is Professor of Sociology at the City University of New York. Having penned a number of other books about birth (Katz Rothman 1986, 1991, 2000), in A Bun in the Oven (2016) Katz Rothman takes the leap and provides women with the opportunity to connect the dots, encouraging them to identify – and fight – patriarchal domination and capitalist exploitation beyond birth:

[…].] Birth and food are a lot alike: they became institutionalized, industrialized. As did pretty much everything else in America. Prisons, schools, childcare, disease, dinner (and maybe especially breakfast), transportation, housing, clothing production – you name it. It all came under the rational, systematic gaze of science. […] Things that used to be in the realm of the lay world become subject to medical definition […] in a world that recognizes only medical knowledge about the body as legitimate knowledge.  

Katz Rothman 2016: 75

Because Katz Rothman writes about the United States in particular, to achieve the same eye-opening effect in the target culture, the myriad of both evidence-based and anecdotal examples of scientification and medicalisation of both food and birth were adapted
whenever possible, with the agreement of the author. Adaptation took place first in the title. Translated as *Comer, parir e pensar: como os movimentos do parto humanizado e da alimentação saudável resistem à industrialização* (*Eat, Birth and Think: How the Humanised Birth and Healthy Food Movements Resist Industrialization*), the title replaces the culturally-marked idiom of the source language – ‘a bun in the oven’ – with the trinomial ‘Eat, Birth and Think’, which intertextually resonates with Elizabeth Gilbert’s bestseller *Eat Pray Love* (2006) and its Brazilian Portuguese translation. Further adaptations were introduced, for instance, when food brands unknown to the target audience were referred to (brands were replaced with local examples) or scientific studies by government agencies were mentioned (similar Brazilian studies were included). Adaptation is a common – and necessary – practice in feminist translation, especially in women’s health (Davis 2009; Sánchez 2020; see also Bessaïh in this volume), which is a culturally marked area affected by local laws and policies. In the case of *A Bun in the Oven*, adaptation provides a continuum with the previously discussed translations and attempts to create a sinuous path towards emancipation. It offers readers quality information so that they can establish connections, identify implications, deconstruct the ideologies behind both modern food and birth processes, and subsequently, transfer this knowledge to other aspects of their lives.

6 Future research

As is hopefully demonstrated in this chapter, translation and interpreting within maternal and neonatal health is a complex and dynamic field. It comprises a range of outputs and situations: from oral to written genres; from offering support to the most marginalised groups in society to those who are better educated and well-off; and, from a close rendition of the words of an asylum-seeking mother in labour to extended adaptations of (text)books aiming at birth professionals. Translations can introduce a more favourable approach to disparaged practices (e.g. in *parteria*/midwifery), improve women’s lives in the countries they immigrate to (e.g. integrated interpreting services), and help parents-to-be gain their own voices and challenge ingrained attitudes and existing customs (e.g. birth stories).

More research in this area is definitely called for, particularly from within translation and interpreting studies, complementing, and possibly contrasting and challenging, the existing body of research produced in other disciplines. Especially in the case of interpreting, the existing research regards interpreters as ‘outsiders’ – a profession deemed necessary but only partially understood and accepted by healthcare professionals. Another fruitful area of research is non-professional interpreting within this context, teasing out its advantages and disadvantages, as well as comparing it to the more recent trials with multilingual doulas.

Translation in the area of women’s health in general, and maternal and neonatal health in particular, is a highly networked, feminist, collective and intersectional endeavour. Future research could examine these endeavours from the perspective of sociological approaches to translation, highlighting the embeddedness of translational activities in the transformation of societies and the infrastructures that sustain them. Furthermore, such research could focus not only on the North to South flows, as we have done so far in our own research, but also on South to North, as well as South to South ones.

Given that translations carried out within maternal health form a continuum of activist endeavours, studies focusing on a body of work, rather than individual translations, would...
shed light on wider translational and editorial patterns. Such research could also feed into actual practices of feminist translation which resist coercive systems of oppression, and not only in the field of maternal and neonatal health.

Notes

1 Although this chapter generally uses the term ‘women’ to refer to those who go through pregnancy and childbirth as a reflection of our experiences as well as of the available literature on the topic, the authors would also like to recognise that not all pregnant people identify as women.

2 For some concrete examples of how financial considerations dictate the care offered, see e.g. Wolf (2001: 169, 178).


4 For risks associated with unnecessary c-sections, see WHO Recommendations (2018). For financial and health costs, see Gibbons et al. (2010).

5 A doula is a trained companion who offers physical, emotional, informational and advocacy support to women during their pregnancy, labour and birth, as well as postnatally.

6 Given their position of power in relation to patients, it is easy to villainise doctors. However, the current birth culture turns doctors into employees of hospitals and health insurance companies, working on the basis of maximum profit and control.

7 All glosses from Spanish and Portuguese are by Fonseca.

8 This strong push for c-sections in Brazil is a structural issue, which can, for instance, be observed in advertisements of private maternity hospitals showing blow-dried celebrities after ‘painless’ c-sections due to ‘large babies’ and high-tech ICU units for ‘small babies’. It results from the prevailing set up of an OBGYN practice. OBGYNs in Brazil usually have a private practice and any time away from consultations at the practice due to spontaneous labour and birth in the hospital means less income. Therefore, scheduling elective c-sections is the ‘most efficient’ way to run a one-person business.

9 Whereas in rich countries there is usually lack of information on the availability of interpreting services, in poor countries interpreters may simply not be available in the public healthcare system, even when there are laws in place ensuring the right to their services. There may also be differences in availability between public and private healthcare. In the city of São Paulo, the situation of immigrants is radically different from the situation of ‘expats’ and wealthy tourists serviced by upscale hospitals, which may have International Patient Centres where staff are bilingual and interpreters are a phone call away (e.g. www.einstein.br/en/international-patients-center. Accessed: 31 October 2020).

10 Having said that, cultural differences do have a profound impact on the parents’ expectations about pregnancy and childbirth. For instance, migrant Brazilian women in the UK have difficulty understanding why they cannot ‘simply’ have their c-section scheduled before they go into labour as they do in Brazil (Fonseca 2014: 106), and find it odd that the UK’s National Health System (NHS) ‘insists’ they have a vaginal birth. This is demonstrated in the numerous comments made by Brazilian women on the British birth culture in groups such as Brasileiras Poderosas na Europa (Powerful Women of Brazil in Europe) www.facebook.com/groups/256025137909432 and Mães Brasileiras na Inglaterra (Brazilian Mothers in the UK) www.facebook.com/groups/526163771057598.


12 It is important to note that ‘Unlike the traditional doula role, in which the doula is not affiliated with the hospital and is working solely for the birthing mother and her support persons, interpreter/doulas are hospital employees’ (Maher, Crawford and Neidigh 2012 2013: 477). This shifting allegiance can erode the doula’s advocacy role on behalf of the parents, defending the mothers’ rights in medical settings.


14 In Brazil, the term ‘obstetric violence’ has been defined and criminalised by statute in some states (Lei Estadual nº 17.097 2017). In 2019, the Federal Health Ministry attempted to ban the use of
the term due to pressure from medical associations. The attempt was unsuccessful; the Federal Prosecutor’s Office sued the Ministry, arguing that the term has been firmly established in scientific literature and is widely used by specialists and non-specialists alike. https://g1.globo.com/ciencia-e-saude/noticia/2019/05/07/ministerio-diz-que-termo-violencia-obstetrica-tem-conotacao-inadequada-e-deixara-de-ser-usado-pelo-governo.shtml (Accessed: 21 October 2020).

For the transformative power of birth stories in healing birth trauma, see Colton (2004).


It is difficult to give a single name to the movement that questions the dominance of the patriarchal/medical model of obstetrics. While ‘natural’ denotes that the births in question are mostly free from medical interventions and end with vaginal births, ‘positive’ implies that it is how supported and good parents feel during and after a birth that is crucial regardless of the type of birth they had.

Two of these translations have not yet been published due to the challenges faced by independent publishing, but they are forthcoming (Davis 2012; Katz Rothman 2016).

Ana Cristina Duarte, a Brazilian midwife based in São Paulo, not only organises marches and demonstrations, but also speaks at public legislative hearings.

Carla Finger, Eliana Herrman and Fonseca are all professional translators. Finger is a physician by training and Herrman a medical translator; both have almost 20 years of experience in translating medical texts but not in birth activism. Fonseca, on the other hand, is a birth activist but does not specialise in women’s health.

Reviewers were University of São Paulo graduate students in Public Health and members of the GEMAS group (Gender, Maternity and Health).


The English version is the work of professional translator Amanda Morris and Fonseca; the Brazilian Portuguese version is by co-editor Luciana Benatti and Fonseca.

The translation was carried out by doula and physiotherapist Lúcia Desideri and Fonseca. Revision was undertaken by a certified Spinning Babies professional, Tania de Filippis.

www.labeltrao.com/gael (Accessed: 21 October 2020). Gail Tully’s Spinning Babies (Tully 2016) and Spinning Babies: Breech Birth (Tully 2018) have also been translated into Brazilian Portuguese.

The translation was undertaken by certified Spinning Babies professional, Lucia de Filippis.


The English version is the work of professional translator Amanda Morris and Fonseca; the Brazilian Portuguese version is by co-editor Luciana Benatti and Fonseca.

Translation of the European edition was carried out by birth professionals and activists. The book was published by the School of Midwives in Florence, Italy.

The book was translated by anthropologist, doula and professional translator Clarissa Oliveira, social scientist and professional translator Maria Teresa Mhereb, and Fonseca.

Further reading


This is a systematic review of articles on migrant women’s experiences of pregnancy and maternity care in the European Union. According to the findings, migrant women report poor understanding of medical terminology and inadequate use of interpreters within the healthcare system, affecting their ability to choose care options, provide informed consent and establish relationships with providers.

The book focuses on the rhetorical analysis of birth plans and stories circulating online as part of blogs, opening up a personal space for mothers in the medicalised birthing culture of the United States.


This contribution examines the role of translation in the spread of natural birth movement in Turkey, particularly focusing on the diverse data that support the movement (e.g. translational data available online, official and amateur subtitles of audiovisual material, and translated key publications).


This technical guidance addresses interpretation services and provides recommendations, such as those for the use of remote and face-to-face professional interpreters and cultural mediators rather than family members.


The article reports on a project designed to improve the engagement of professional interpreters in maternity units in Australia, and provides a model for enhancing effective communication between healthcare providers and parents-to-be.

Related topics
Translation and Women’s Health, Community/Liaison Interpreting in Healthcare Settings, Medical Humanities and Translation

References


Maternal and neonatal health


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