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Obstetric racism, a debate under construction in Brazil: perceptions of black women on obstetric violence

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Abstract *This article aims to know the perception of women on obstetric violence from a racial perspective. This was a qualitative study carried out in a public maternity hospital with 25 women in the city of Salvador, Bahia, Brazil. Data were collected through semi-structured interviews and participant observation from November 2021 to February 2022. Content analysis was used to organize the data obtained through the interviews. The results were analyzed through the theoretical contributions of intersectionality, focusing on the interaction between obstetric violence and obstetric racism. The narratives discuss issues of obstetric violence, institutional racism, and how these experiences are permeated by issues of race, gender, and class. Questions related to the feelings of these women regarding the experience of violence at the time of childbirth care were also highlighted. Obstetric racism denies reproductive rights and hinders access to respectful and equitable care for black women.*

Key words *Obstetric violence, Obstetric racism, Systemic racism, Intersectional framework, Reproductive Rights*

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Introduction

This article seeks to point out the contextual aspects of obstetric violence supported by race, or obstetric racism, based on the perceptions of black women, with the analysis focusing on the correlation with the main markers of social oppression. The theoretical-philosophical framework on the epistemology of intersectionality was used for this purpose.

It is important to highlight that ensuring a life free from violence and racial discrimination for all women and people with a uterus is a duty of the Brazilian State[1-3]. However, the State did not honor, when it did not guarantee Alyne da Silva Pimentel Teixeira, her right to dignified care, violating article 12, paragraph 2 of the Convention on the Elimination of All Forms of Discrimination against Women. The victim was a young woman of black origin, who died as a result of obstetric complications[4,5].

For the UN, violence against women in the field of sexual and reproductive health is a human rights issue and violates the provisions of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), of which Brazil is a signatory[5]. The Alyne Pimentel case is emblematic of racism, obstetric violence, negligence, and poor care, which makes Brazil the first country in the world to respond in an international court for a maternal death.

Obstetric violence affects women in different ways; however, black women suffer most from this type of violence in the country, according to data shown in the population-based study, "Born in Brazil". This study showed that black women have a 62% higher chance of having inadequate prenatal care, 23% of a lack of connection to maternity, 67% of an absence of a companion at birth, and 33% of antepartum pilgrimage[6].

However, episiotomy, epidural analgesia, and elective Cesarean section are procedures performed more frequently on highly educated, white women. It is important to mention that 49% of all episiotomies performed on black women were performed without local anesthesia. At first, it seems counterintuitive, but this in fact represents even further evidence of obstetric violence and racism, the result of racial disparities in care during pregnancy and childbirth, which black women often experience in the country's maternity wards[6].

The term obstetric racism was recently coined by the American researcher, Dána-Ain Davis[7], as her obstetric racism takes place at the intersection between obstetric violence and medical racism. She points out that, just as obstetric violence is gender-based violence, obstetric racism is violence that lies at the intersection of obstetric violence between race and gender. Thus, the term suggests that institutional violence and violence against women merge with structural racism in women's reproductive health, in addition to putting black women and their children at risk[7].

According to Davis, there are seven dimensions of obstetric racism: diagnostic lapses; negligence, disregard, or disrespect; intentionally causing pain; coercion; degradation ceremonies; and medical abuse. This violation characterizes situations in which obstetric patients experience reproductive dominance by healthcare professionals and staff, aggravated by the patient's race or history of racial beliefs that influence treatment or diagnostic decisions[7].

In Brazil, around 60% of all women who die from obstetric causes are black. It is important to note that deaths from obstetric causes can have been avoided in 90% of the cases if women and pregnant individuals had received adequate health care. It is extremely important that racism in health institutions be annihilated in order to enable and guarantee equity in the health of black and non-black women in the country[8].

According to the data presented by the "*Nascer no Brasil*" ("Born in Brazil") survey, even though obstetric violence affects all women without restrictions, black women are the most affected. Studies show that the quality indicators of childbirth care, when compared to the care received by white women, are more poorly evaluated by black women[9]. Therefore, the difficulties generated by institutional racism are significant, as black women are deprived of both decent living conditions and health by hindering their full access to services and comprehensive care focused on their true needs[8].

This study is highly relevant, as it seeks to address the gaps in the literature regarding an anti-racist approach to obstetric care, pointing out ways to achieve dignified, respectful, and equitable care. Furthermore, it highlights an invitation to institutions and professionals involved in obstetric care to reflect on the quality of care provided to women, especially black women.

To contribute to the discussion on providing dignified and differential care, this study aims to: Understand women's perception of obstetric violence from a racial perspective.

Method

This work is a descriptive-exploratory study with a qualitative approach. The chosen study setting was a public maternity hospital in the city of Salvador, Bahia, Brazil. This selection occurred due to the unit providing obstetric care to the population of the Liberdade district, which has the largest number of black people in the city of Salvador, as shown by data from the Brazilian Institute of Statistics and Geography (IBGE)[10]. Furthermore, the choice of this institution was motivated by the fact that it is a reference center for obstetric care for high-risk births in the state health network. As for the preference of the municipality to be studied, this was influenced by the fact that Salvador is considered the city with the largest number of black people in Brazil[10].

The empirical universe of this study consisted of 25 women admitted to the maternity ward at the time of delivery care, which included pregnant and/or postpartum women, by classifying two or more variables (e.g. presence of a companion, free, Kristeller maneuver, episiotomy, among others) corresponding to obstetric violence. These variables were described in an instrument, also used for data collection, created by the main author of this study. Participants were contacted by identifying two or more variables of obstetric violence in their medical records. After this selection, the women were located in the wards and invited to participate in the study. No problems were faced to carry out this study. This study excluded women who did not have the physical and emotional conditions to participate in the study due to a hindrance that made it impossible to provide the necessary technical responses to the data production instrument.

The data were produced from interviews guided by a semi-structured instrument between November 2021 and February 2022, using the technique of participant observation and guided interviews. Regarding participant observation, the main researcher of this study was allowed to move freely throughout all obstetric care spaces (surgical center, obstetric room, and wards) during administrative hours. The instrument contained sociodemographic and obstetric data guided by open guided questions aimed at women's experiences regarding episodes of obstetric violence, in addition to the variables that characterize this type of violence.

The interviews were carried out in a private institutional space, by the main researcher, who was duly trained, with the support of a member of the Research Group, called the Study Group on Women's Health in the Pregnancy-Postpartum Period (*Grupo de Pesquisa denominado Grupo de Estudos sobre saúde da mulher no período gravídico-puerperal* – GESTAR). These lasted an average of 30 minutes and were recorded using a telephone audio recorder and transcribed in full, using the Microsoft Word tool. The interviews were archived on the computer belonging to GESTAR and will be discarded after five years.

To analyze the results, the Thematic Content Analysis, as proposed by Laurence Bardin[11], was used, which results from the following steps: organization of the analysis, codification, categorization, treatment of results, inference, and interpretation of results.

Thematic categories were created and incorporated theoretical contributions on the concepts of intersectionality, which provides epistemic support for understanding how race, gender, and class contribute as structuring markers to the health conditions of black women.

Regarding ethical aspects, the principles of bioethics were respected, which guarantee anonymity. Thus, the participants in this study were identified with the names of black women who stood out in the history of the Brazilian struggle and resistance against racism. This study was included in Plataforma Brasil and was evaluated by the Research Ethics Committee, obtaining a favorable opinion number 4,447,699/2020.

Results

In this study, 25 women, aged 16 to 34 years, participated, 100% of whom declared themselves to be black. Regarding the level of education, 80% of the women reported a primary and secondary level of education (incomplete or complete), while 20% reported only an incomplete or complete higher education. In relation to occupation, the majority of the population (60%) has activities related to invisible and marginalized work (housewife, nanny, general services, farm worker, and cashier). Furthermore, around 52% of the women did not carry out paid work.

The content analysis revealed two thematic categories: black women's perception of obstetric violence from the perspective of the intersectionality of race, gender, and social class, as well as black women's perception of the feelings generated by the experience of obstetric violence. These categories demonstrate how much obstetric racism is inserted into the scenarios of health prac-

tices, which are institutionalized in professional care, felt and perceived in the experiences of women who receive medical care. This configuration highlights the perspective of obstetric violence permeated by raciality in the health system and, above all, the oppression experienced by women at such a vulnerable moment as childbirth.

Through participant observation, situations of institutional racism were recognized, regarding the body esthetics of black women, with a special emphasis on women who were wearing synthetic braids when they entered the surgical center. Discriminatory speeches and behaviors from medical professionals towards these patients were witnessed.

Black women's perception of obstetric violence from the perspective of the intersectionality of race, gender, and social class

According to the narratives below, we learn how women perceive that the determinants of race, gender, and social class are established as a system of oppression in an obstetric care environment.

[...] neglect, because of the color? Why was there so much support with some, but nothing with me? Why am I probably colored? The question remains, you know? (Elsa Soares).

Yes, my husband is black [...] brown. He came to see his son, they didn't let him in, when they called the social worker, they let him in, it's the fact of his color, because of his color, because the same thing happened to another father of a child here (Adelina).

[...] my partner has dreadlocks in his hair [...] we were ignored, especially in the surgical center and they didn't let him in [...]. In addition, most of the people in this scenario are women, and many of them were insensitive to my care. These women should be strengthening other women to experience the protagonism of their births and not helping to put women in a position of submission [...] (Aqualtune).

Women are able to perceive the violence they experience. Color is a determining standard of care, as one of the participants pointed out in her speech. We also observed how gender relates to race, generating an idea of a body resistant to pain. The body that supports and that no one cares about.

This observation can also be confirmed by the researcher, where once when a patient was being treated for hemorrhagic shock, one of the doctors who was providing medical care mocked the patient's situation.

I think they expect us to be Wonder Woman and handle everything, but it's not like that. Each woman feels differently (Dandara de Palmares).

We are short on money, that's why they do this mistreatment, they think we can't do anything (Adelina).

I feel angry at this place, because I couldn't do anything and it's something that we have to go through, because we are from a lower class and have no resources, unfortunately we have to stay, swallow it, and do nothing [...] (Carolina de Jesus).

This violence happens because we are poor, no one cares about us [...] (Ruth de Souza).

These discourses are permeated by feelings of invisibility that, anchored in the bias of class and race, bring with them the primary belonging of race and gender. Here we can observe how social markers are related in an oppressive structure that promotes and perpetuates obstetric violence, through the subjugation and vulnerability of black women.

Black women's perception of the feelings generated by the experience of obstetric violence

This second category is related to these women's perception of the feelings generated and experienced by the experience of obstetric violence, when related to abusive, humiliating, disrespectful, negligence and negligent procedures, which were experienced by them during obstetric care.

I felt oppressed, desperate, coerced, and treated inhumanely in that place (Aqualtune).

It was horrible, feeling attacked. I couldn't speak [...] my mother only made me cry. What was the point of her asking if she could take my baby out of me? [...] (Zeferina).

I feel angry. There are some doctors who for them are just another person, another mother, another baby. But for us, it's a unique moment, and we want it to be special. So, for me it was a very painful moment, I just wanted it to go away, that's what I wanted that (Dandara de Palmares).

[...] After everything they did to me [...] if I had the power, I would go ahead and sue the hospital, but I don't have the finances, I don't have the intelligence to do these things (Carolina de Jesus).

I simply had no autonomy over my body and no role in the birth of my son. I felt like a piece of meat, lifeless, with no dignity on a stretcher [...] (Aqualtune).

We infer, through the speeches, how obstetric violence generates negative feelings for women who experience the birth process. Although the multiple reports bring their stories in a unique way, about their perceptions of obstetric violence, we identified negative feelings when remembering their birth stories.

Discussion

The results demonstrated that women perceived obstetric violence, permeated by structural and structuring markers of social oppression, as instruments of the perpetuation of power and corporeal coloniality. Thus, intersectionality reveals itself as a transdisciplinary theory that achieves the analytical potential to understand the identities present in the social inequalities of the major axes of oppression, which are found in the categories of race, gender, and class[12]. To understand how these markers of oppression operate in our society, we need to look at the biological component present in the categories of race and gender. And how these differences are used for subjugation and to obtain power over time by the oppressor.

Racism finds its origins in colonialism and the slave system, but the end of the regime of racial exploitation was not enough to abolish the social construction of the sense of inferiority of black people. In this way, racism is a structural effect of society, which regulates and establishes standards and rules as truth based on discriminatory principles of race. Thus, racism is part of a social, historical, and political process, which forges structures so that people or groups are systematically discriminated against[13].

Historically, in Brazil, poverty occupies a racial status. It continues to impose its colonial effects of exploiting poverty, resulting from the expropriation of enslaved people. Even though all women are subject to obstetric violence, it was observed, through the results of this study, that black women perceive themselves to be more affected by violence and subjected to greater vulnerability when this point is analyzed from an intersectional perspective.

This situation is reinforced by the sociodemographic profile presented in the study, corroborating data from the Applied Economic Research Institute (Ipea), demonstrating that, in recent years, the remuneration scale has remained unchanged throughout the historical series, where: white men have the best income, followed by white women, black men, and black women[14]. This situation of economic vulnerability is a major example of various situations of violence against women in public and private spaces, due to their race and gender condition.

It is important to reflect that, although many current debates address race and gender as parallel issues, it is necessary to say that these are not categories that are equivalent. The reality of black women is a hybrid phenomenon, crossed by racial and gender experiences[14]. The black woman is the other of the other, that is, she is neither white nor male, an antithesis, occupying a very difficult position in white supremacist society. Thus, we can understand that race and gender are articulated dialectically in the expressions provided by patriarchy.

In their narratives, the women in this study brought up the devaluation of their black bodies in the scenario of obstetric care. These also reflect gender-based violence practiced by health professionals as agents who operationalize asymmetric power relations, given that such health practices remain naturalized through cultural and stereotypical meanings, where there is devaluation and a submission of women horizontalized by a colonizing and patriarchal ideology[15].

The bodies of black women are seen as invisible, highlighted by the unimportance of life, according to raciality, which prints and determines neglect and a lack of attention towards these bodies. These are crossed by the zone of body dehumanization and stereotyped by the colonized gaze. The invisibility strategically used by whiteness is one that defines the terms of the relationship, a dialectic of everyday racial erasure. Therefore, it is important to highlight that obstetric racism makes it difficult to care for the reproductive health of black women, in addition to being a threat to satisfactory birth results[7,16].

It is important to understand that much of the medical knowledge in obstetrics acquired and practiced today was developed from experience with poor or enslaved women of the time. A well-known example is the American doctor James Marion Sims, considered the "father of modern gynecology". Sims performed surgeries on women without anesthesia, because, according to him, black women had an unusual physiological tolerance for pain[17]. The myth that black women are resistant to pain arises through these experiences of cruel and inhumane interventions. This theory is still used today to refute the execution of abusive and violent conduct when providing assistance to black women during childbirth.

It is worth highlighting that, in this scenario, in addition to experiencing obstetric racism and violence, women in general have lost space and autonomy, as childbirth becomes centered on the hegemonic medical figure.

The devaluation and inhumanity linked to black women is a racist and sexist construction of our colonial heritage, which is legitimized in biopower relations, widely seen in health practice, expressed through knowledge techniques and discursive procedures in the service of colonization, domestication , eugenics, and repression[18,19]. Not far from this relationship of subjugation of bodies with a focus on control, the care of women during the pregnancy and postpartum period is well supported.

Institutions are made up of hierarchies of domination, where this intrinsic relationship of power contributes to the hegemony of certain social groups to the detriment of others. Institutional racism produces and maintains these hierarchical structures of racial domination with a discriminatory matrix to maintain their social, political, and economic interests, defining rules and conduct that are naturalized. These discriminatory behaviors are produced and disseminated systematically to the point of eliminating the debate surrounding racial and gender inequalities present in institutions[13].

Black women have worse care results, less access to health services, and worse indicators of quality of care throughout their obstetric trajectory when compared to white women[9]. Feelings of despair, coercion, aggression, dehumanization, and anger are perceived by non-white women, through expressions that characterize feelings of oppression. The women in the study still perceive themselves as powerless, deprived of autonomy and dignity, and such feelings are mediated by power and class relations[20].

In Brazil, it is important to recognize racism as one of the central factors in the production of health inequities for black women, as structural determinants that shape the worst living and working conditions, as well as the lack of access to health and the lack of opportunities of the black population, particularly women. The structural organization of Brazilian society and the various forms of marginalization of black women continue to create access barriers and, consequently, limit these women to second or third order health services[21].

Final considerations

Race is a social category, not a biological condition that elevates the risk of certain diagnoses and health disparities. Racism has been, and continues to be, systematically incorporated into our society and healthcare practice, and represents a stature of pressure and subjugation by race. Thus, it is present in institutions of power, where the hospital environment is heavily represented. It is also reflected in the relations of social oppression through the logic of biopower and, consequently, reveals the practices of reproductive care in our society. This is reflected in the invisibility of black women's bodies, making them more vulnerable to the phenomenon of violence in obstetric care.

Inequality between race, gender, and class produces profound disparities in the health of women and people with uteruses in our country. These social markers, considered to be structuring, are directly related to the sexual and reproductive injustices experienced by this population. For this reason, it is essential to connect the struggles against institutional racism, gender violence, and obstetric violence in order to produce a more profound impact when combating these inequities in obstetric care.

It is essential to understand that a black woman's body is forged by an accumulation of intersecting pains, pains that are guided by gender and racial components. Therefore, it is necessary to think about strategies that include in health care, the perception of social determinants for comprehensive and respectful care. It is necessary to establish measures that facilitate rapprochement and access in order to overcome the barriers to the exercise of the right to health by black women, thus strengthening anti-racist public policies.

Collaborations

AT Santana and TM Couto contributed to the conception and interpretation of the data. ANA Bomfim, KTRS Lima, PS Oliveira, LCS Rusmando and LCG Almeida wrote the manuscript critically regarding intellectual content important. AT Santana and TM Couto approved the final version of the version to be published.

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