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"Mix of Races, Bad Uterus": Obstetric Violence in the Experiences of Afro-Brazilian Migrants in Portugal

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Abstract: In this article, I address the issues of obstetric violence and racism in the Portuguese setting of obstetric care. Based on data collected through interviews and participatory artistic creation, I analyze the perception of three Afro-Brazilian migrants about their perinatal experiences of obstetric care in the Portuguese public sector between 2013 and 2019. These women's experiences have much in common with experiences of obstetric violence as narrated by Portuguese, non-racialized women. Despite this, certain aspects of their experience are related to their particular identification as Brazilian, migrant, and Black, such as xenophobic discrimination and their placement in systems of stratified reproduction, including a supposed tendency for birth by caesarean section, as well as self-policing behaviors because of the stereotype of Brazilian women as flirty. I consider a range of manifestations of obstetric violence and racism, from more overt forms to more covert ones, to analyze how, in a country where racism and obstetric violence are only slowly beginning to be recognized as the norm, multiple discriminations intersect and have an impact on the experiences of women of their bodies in pregnancy, birth, and postpartum, including breastfeeding.

Keywords: Portugal; obstetric violence; racism; Brazilian migrants; Black women; obstetric care; childbirth; stratified reproduction

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1. Obstetric Violence, Racism and Brazilian Migration in Portugal

Obstetric violence, or the mistreatment of women in the setting of obstetric care, has been framed as a type of gender violence and a violation of human rights, closely imbricated in processes of medicalization and imbued with gendered concepts that devalue of the female reproductive body [1,2]. It assumes many shapes, from overt verbal or physical abuse to subtle psychological abuse and forms of coercion [3]. In Western countries, the most widely discussed form of obstetric violence (OV) is the performance of medical interventions without clinical justification and/or informed consent, relating to highly interventive, technocratic models of care and a structural imbalance in power relations between healthcare personnel, considered authoritative, and the users of services (patients). However, other forms of mistreatment have also been expressed by victims, including abandonment of care or lack of appropriate intervention. Ultimately, what is at stake in OV is the violation of the integrity and autonomy of the woman or birthing person during obstetric care. The consequences of obstetric violence can be devastating, usually related to women feeling a loss of autonomy and of the ability to decide freely about their bodies and sexuality, negatively impacting their quality of life [4]. To date, studies of obstetric violence in Portugal have been scarce [5–7].

Feminist critiques have shown how reproductive medicine, science, and technologies are grounded in racist, gendered, capitalist, and patriarchal ideologies. Social hierarchies rooted in putative embodied racial-ethnic essentialism take different forms across diverse contexts, and they always affect reproduction in multiple ways. Racism functions within reproductive medicine, science, and technology as a mechanism for the perpetuation and mediation of social inequality [8] (p. 725). The consequences of racism in reproduction are

relevant not only for maternal and fetal health, but also for the reproduction of inequality across generations, and for how power and inequality are embodied and inherited [9] (pp. 555–556). The concept of stratified reproduction—how "physical and social reproductive tasks are accomplished differentially according to inequalities that are based on hierarchies of class, race, ethnicity, gender, place in a global economy, and migration status and that are structured by social, economic, and political forces" [10] (p. 78)—is helpful to understand social and conceptual arrangements whereby some bodies are deemed more legitimate to reproduce than others. In this article, recognizing the need to take into account in the study of reproduction its constant renewal of racialization, racial privilege, and racial discrimination [8] (p. 726), I consider the nuanced workings of race, racism, and racialization in its relation to preconceived ideas about national origin and stereotypes about Brazilian women migrants in the Portuguese setting.

Because the term obstetric violence does not adequately take into account the contours of racism that materialize during Black women's medical encounters, the term obstetric racism has been recently coined to address the issue of how racism manifests in the provision of obstetric care [11]. According to Davis, "medical racism occurs when the patient's race influences medical professionals' perceptions, treatments and/or diagnostic decisions, placing the patient at risk." [11] (p. 561). The most obvious and measurable consequence of obstetric racism is higher rates of perinatal mortality among racialized minority groups as compared to non-racialized ones, but there are other, more invisible, consequences. Obstetric racism and its most immediate consequences, such as worse perinatal outcomes, have been gradually acknowledged and researched in few countries, such as Canada, the UK, and the USA. Additionally, in Brazil, researchers have identified racial disparities in care during pregnancy and childbirth: when compared with white-skinned women, black-skinned women were more likely to have inadequate prenatal care, to not be linked to a maternity hospital for childbirth, to be without a companion, to seek more than one hospital for childbirth, and less likely to receive local anesthesia for an episiotomy [12]. In the country, health disparities cut across racial lines, the structural dimensions of racism in society thus echoing what happens in the clinical setting [13].

In Portugal, to date, research on racism in obstetric care is practically nonexistent. The few analyses focusing on maternal health care services and migrant populations who are often racialized have identified inequities in access and outcomes between migrants (who are often racialized) and non-migrant populations [14,15][1]. Acknowledging the need to scrutinize an issue that remains largely under-researched, the collective of antiracist activists and researchers SaMaNe has launched an online questionnaire on obstetric racism, the results of which have not been published to date [16].

1.1. Brazilian Migration in Portugal and Racism

Portugal and Brazil have a long history of migration flows in both directions, mainly due to their historical colonial connections [17]. From the 16th century onwards, Portugal colonized and exploited resources in what is nowadays Brazil. It was also a major contributor to the transatlantic market of enslaved people from Africa to the Americas, with massive contingents of people being forcibly dislocated from the coast of West Africa to Brazil. Brazil was the first colonized country to gain independence from the Portuguese colonial power in the 19th century and the two countries maintained privileged relationships throughout, in part due to their linguistic proximity. In the end of the 20th century, the way of the migration flow inverted and migration from Brazil started a constant influx to Portugal that persists. In the second decade of the 21st century, the "wave" of migration was mainly constituted by middle- and upper-class students and entrepreneurs [18]. Currently, Brazilian migrants are the largest foreign resident community in Portugal. In 2020, Brazilian residents accounted for 27,8% of total foreigners, the highest value since 2012 [19].

Several stereotypes accompany Brazilian migrants in Portugal, such as their outgoing ways and communicative capabilities, which have facilitated their insertion in the sectors of the labor market that require contact with customers [17]. Brazilian women have their

share of stereotyping in particular: they are seen as hypersexualized and are identified with prostitution, an idea partly shaped by the former colonial ties between the two countries and continuously fed by the media and entertainment industries [20–22]. In the context of obstetric care, health professionals sometimes imply that Brazilian women became pregnant with secondary intentions, such as securing a residence permit or for financial reasons, and ask about the father's nationality [15]. On the contrary, some women tell they felt more respected by the obstetricians when they became pregnant, as motherhood is considered an institution of respectability that contributes to distancing them from the stigma of prostitution [23]. Brazilian women have expressed a certain dissatisfaction regarding the quality of information provided by health professionals and the communication skills of these professionals, in addition to a perception of reduced access to medical specialties. Misinformation about legal rights and inappropriate clarification during medical appointments were frequently reported [24].

In Portugal, racism in institutions and everyday life, although pervasive in all spheres of society, remains largely unacknowledged [25–30]. Forms of "shy racism" prevail: nobody says he/she is racist, but then he/she behaves in ways that in practice have discriminatory consequences [27] (p. 91) [28]. The mainstream discourse on the nation's history perpetuates a narrative of good, exceptional colonization that denies the extreme violence of the foundations of such a sociopolitical and economic regime. Brazil's Gilberto Freyre's myth of "lusotropicalism," according to which the colonization by the Portuguese was founded on miscegenation and was thus less violent than that of other European countries, has its roots deep down in public opinion and discourse, fed by educational materials and public debate [25]. In Portugal, the debate about racism is even today an uneasy matter, because of the silence that has too long surrounded these issues, the lack of information and mental categories to discuss issues, the scarcity of empirical research, and the illusion that there never was and there is no racism in Portugal [29]. The construction of a modern nation-state relies heavily on the construction of corresponding authorized ethno-racial groups [30]. The nation-state, as a machine of production and management of identities, produces a space of belonging that is, at the same time, a place of exclusion. The immigrant is, in relation to that space of belonging to the nation, the "other" national and the "other" racial, the figure of the excluded par excellence [26] (p. 19). Adding to the division between "us" and "them," there is a hierarchical consideration about the value associated to each nationality or group racially defined, and its character more or less desired [26] (p. 22).

1.2. Obstetric Racism?

Analyses of obstetric racism have been absent from ethnographic accounts in the Portuguese setting of obstetric care, as has obstetric violence more generally. In this article, I tackle these issues by analyzing the perception and depiction of the experiences of three Afro-Brazilian women in the Portuguese obstetric care public system, with a special emphasis on birth, but also considering other episodes in their reproductive lives. I analyze the narratives of Diana, Maíra, and Rossana to reveal the racism inherent to reproductive health care. Their birth stories and narratives about obstetric care share many commonalities with the stories told by the average women giving birth in healthcare institutions in Portugal, regardless of their racial identity, class, sexual orientation, age, ability, or migration status. Several forms of mistreatment abound in their narratives, such as being depersonalized and objectified, not being informed or asked for permission, being subjected to painful interventions without clinical justification, being abused verbally, and others. However, there are some particularities to the experiences of these three women that can only be accounted for when race, as well as migration status (more than class), are included in the equation. Systems of stratified reproduction thus become clear: barriers to accessing healthcare, perceptions of xenophobia, ideas conveyed by healthcare professionals about miscegenation producing bodies unsuited for birth and some categories of people being more legitimate for reproducing than others, and condemnation of the exposure of the body for breastfeeding, among other subtleties. Multiple forms of

discrimination intersect in these women's experiences, in which racism seems to operate independently of class-based prejudice.

2. Researching Obstetric Violence in Portugal

Data were collected within the framework of a PhD research project in Anthropology. The bulk of research was carried out between 2017 and 2019, but conducting fieldwork "at home" and having an active role as an advocate for women's reproductive rights allowed for continuous observation until 2022. The COVID-19 pandemic declared in March 2020 in Portugal had a great impact on all spheres of society and in the healthcare provision, with several restrictions in place that strongly affected women's experiences of childbirth [31]. I underwent fieldwork in Portugal, with incursions to Catalonia, Croatia, and Slovenia, and maintained multiple virtual connections to other countries as well as continents, through online meetings, seminars, and courses.

I used classical ethnographic methods, such as interviews, participant observation, and focus groups, as well as more experimental ones, such as participatory artistic creation. In the tradition of activist or engaged research, my critical engagement with real-world problems informs my scholarly perspective and I often seek a direct intervention in the setting of the researched subject matter [32,33]. To this end, the project also uses participatory artistic methods for the collection of data and dissemination of results [34]. The artistic strand of the research, the Gallery of Obstetric Experiences, is online and continuously open for contributions[2]. The exploration of difficult birth experiences through artistic creation has proven valuable in accessing invisible dimensions of the lived experience that are often hard to convey through words. The process of creating a depiction provokes a self-reflexive attitude and demands an organization of the experience that often facilitates the identification of the core issues implied, engaging the interlocutor in the problematization of the subject matter at hand. This proves helpful for research, especially when dealing with sensitive matters, such as negative experiences. The participants have expressed how the creative process facilitates a certain therapeutic effect, and the viewers manifest how the materialization of the pieces makes an impactful impression upon them. These and other aspects, such as the potentials and shortcomings of the use of artistic methods in this research, are discussed elsewhere [35].

Participant observation was carried out at birth-related conferences, seminars, and events, such as midwifery and birth conferences, academic seminars, public and political debates organized by political parties or by informal groups within feminist events, childbirth education classes, as well as informal groups and social media groups. I conducted twenty-two in-depth interviews. I interviewed eighteen women who gave birth in Portugal between 1993 and 2019 and self-identify as having suffered OV, initially recruited through an open call or further recruited through snowball sampling. I launched an open call on the Facebook page of the non-governmental organization (NGO) I collaborate with, APDMGP[3], the main birth rights NGO active in the country. I also interviewed a doula who was one of the first activists in Portugal, and three healthcare professionals: a midwife and two obstetricians who have adopted a "humanized" approach in their obstetric practice, and are active voices in the public arena. The midwife also identifies as having suffered OV in her first birth.

I visited two maternity wards in Portugal which are actively shifting to humanized approaches to birth, and in Slovenia to three maternity wards with different degrees of "humanization," where healthcare professionals guided me through and shared their experiences of the process. I organized a collaborative artistic workshop with victims of OV in Portugal, and two focus groups with childbirth activists: one with Portuguese activists of APDMGP, and one with activists from the ten countries[4] attending the European Network of Childbirth Associations (ENCA) meeting in Zagreb in 2019. I analyzed discourses on mass media and online social media. I also had countless informal conversations with mothers, fathers, couples, health professionals, activists, and doulas over a six-year period (2016–2021), mainly in Portugal. All participants have been given pseudonyms in order

to protect their identities, except one, who is an artist who signed an art piece for the Gallery and wished to be identified by her real name. Women's rights activism is both a middle-class phenomenon, like other types of activism, and a women-dominated arena, like other issues considered traditionally feminine. My interlocutors were mainly white, educated, middle-class women with liberal professions, with a few exceptions, including the few men who are either obstetricians or activists, and the even fewer women who are racialized.

This article is about the perceptions of obstetric violence of three migrant Brazilian women of mixed African, Indigenous, and European and/or Western Asian descent and is based on data from in-depth interviews and the artwork that one of them produced. They gave birth in five different public hospitals in the two bigger cities of Portugal (two births in Oporto and three in Lisbon) and self-identify as having experienced obstetric violence. One of them identifies as having suffered obstetric racism. They had five births in total: two women had two births and one had one, between 2013 and 2019. Two of these births were considered overall positive, as for their subsequent births the two women invested in getting information and looking for hospitals with a humanized approach. Two interlocutors were recruited through an open call. One of the interlocutors was recruited through snowball sampling. She contacted the researcher in order to contribute to the Gallery of Obstetric Experiences, about which she had learned through an informal group of parents in which a fellow activist of the researcher shared the call for the project. This particular contribution is detailed elsewhere [36].

3. Diana, Maíra and Rossana's Experiences of Obstetric Violence

Diana was employed at a café when I first interviewed her in 2019 and at a cleaning company when I followed up in 2021. She is from the São Paulo hinterland (Southeastern Brazil) and has completed middle education. In Brazil, she attended undergraduate studies in Education for two years, but when she moved to Portugal in 2003, at 19 years of age, she could not afford to pay for her studies and she quit. Her longtime partner and the father of her daughters is Brazilian, from the same hometown as herself. He was jobless in Brazil and they decided to move to Portugal together upon the invitation of his sister, who was married to a Portuguese man and was living in Portugal. This is a common pattern among Brazilian migrants in Portugal, a great percentage of who have friends or family members from their places of origin already living in the country [17] (p. 23) [20]. Diana and António's story fit in the so-called trajectory of couples "ready to go," young and childless couples leaving their country of origin to pursue their life projects elsewhere, with a long-term perspective (Wall et al. p. 616 in [15], p. 41).

Diana had two births in Lisbon, in two different public hospitals. The first was in 2016, when she was 32 years old and had Inês, who was born by vacuum extraction after induction, augmentation, several unconsented interventions, rude treatment by staff, episiotomy, and trial with forceps. The second was in 2019, when she was 35 and had Helena, an eutocic birth[5], after an induction at 40 weeks and five days, due to gestational diabetes in pregnancy. Although there were interventions involved in birth, such as induction, augmentation, and epidural, she felt respected throughout the process and recalls a very positive experience. Like we will see later with Rossana, Diana consciously looked for a different hospital for her second birth, because she wanted to avoid the mistreatment that she experienced in her first birth. Her partner, António, is a truck driver traveling all over Europe, staying away for long periods of time. He could not be present at the second birth because he was working in France, but Diana's best friend was present and filmed it. Diana says he is a very present father and was always very supportive in her pregnancies, in the first birth, and in postpartum. Additionally, his support was fundamental in her realization that she was suffering postpartum depression after her first traumatic birth.

Maíra was raised in Rio de Janeiro state (southeastern Brazil). She holds a PhD in Sociology and is a teacher, educator, performer, and feminist activist. Maíra arrived in

Portugal in 2015 for one year, as a mobility student within her PhD studies program between one university in Central Brazil and one in Lisbon. Later that year, she met her future husband, a Cape Verdean man who has been living in Portugal for two decades and works as a general coordinator at an NGO. The following year, when she was 34 years old, Maíra moved to Portugal to stay. She is part of a very recent "wave" of Brazilian migration to Portugal within the so-called "migration system" between Portugal and Brazil [18], in part constituted by middle and upper-class students, specialized workers, and investors with higher education.

Maíra had one birth in a public hospital in Lisbon in 2018, at 36 years of age. It was an induction at around 41 weeks. Maíra expressed her wish to have a "natural" birth to the team, but synthetic oxytocin was administered intravenously without her consent. Other unconsented interventions followed, such as membrane sweeping (known as *toque maldoso* or "evil touch")[6] performed by the OB/GYN, who was accompanied by a group of students who did not introduce themselves. She later refused to let them perform cervical dilation assessments on her. As Maíra used foul language to express her pain and discomfort because of the intervention that was performed on her without any notice, the OB/GYN threatened to sue her and they exchanged some harsh accusations between each other. Maíra was in labor for four days, before her daughter was born by caesarean section (CS). I detail her story elsewhere, as she produced a piece for the Gallery of Obstetric Experiences [36].

Rossana is from a main city in Piauí state (Northeastern Brazil). She graduated with a degree in Journalism and is a postpartum doula[7], a professional path she chose after becoming a mother. Rossana moved to Oporto in 2012, when she was 23 years old, to marry a Portuguese man from Oporto whom she had met in 2011 on the Internet and who later visited her in Brazil. She enrolled in a Master's degree in Image Design, which she did not complete, as two pregnancies followed (her first daughter Mel was born in 2013 and the second, Aline, in 2016) and she did not find the opportunity to finish her degree. Rossana's trajectory fits in the pattern of migration of young women "long-term new life" (Wall et al. p. 608 in [15], p. 41).

Rossana had two births in two different public hospitals in Oporto. The first one was in 2013, when she was 24 years old. It was a birth with induction at 39 weeks and three days, and it involved a so-called "cascade of interventions"[8] [37], including multiple forms of mistreatment, such as many interventions without information or consent and depersonalized treatment, with health professionals not introducing themselves or "seeing" her, as she describes. She had an unconsented episiotomy and "husband's stitch."[9] After stitching her through a painful procedure, because the effect of the epidural had waned and she could feel everything (but nobody paid attention to her complaints), the physician showed her husband that she had stitched a bit tighter. The second was in 2016, when she was 27. Like Diana, Rossana chose another hospital for the birth of her second daughter. At 40 weeks and one day, she was pressured to be hospitalized for induction, but she negotiated a membrane sweeping with the obstetrician instead. She asked the doctor for a membrane sweeping instead of being immediately admitted and chemically induced, and was able to start labor at home, returning to the hospital for birth one day later. Apart from an OB/GYN who talked disrespectfully when she refused epidural anesthetic (saying "these women come here saying they do not want the epidural, but when it starts hurting, they cry for it"), she describes the whole birth as being very respectful. She handed out her birth plan to the team and it was fully respected. The few interventions there were (two cervical assessments, intermittent fetal monitoring, antibiotics for Streptococcus B) were all done with information, consent, and respect.

In the birth stories of Diana (D), Maíra (M), and Rossana (R), we encounter manifestations of obstetric violence that do not differ from what I have heard from my interlocutors of Portuguese origin and who are racially identified with the normative "white." All three women complained about feeling objectified and subjected to an excess of interventions, detailing their birth processes as pervaded by lack of information, rude treatment by staff,

interventions without consent, and other unpleasant features. The topics that came up in the interviews were: induction, augmentation, verbal abuse, lack of privacy, lack of information, lack of consent, threatening and culpabilization, unauthorized manipulations of the newborn (D; M; R); amniotomy, lithotomy, birth companion told to leave the room, Kristeller maneuver, continuous fetal monitoring, frequent vaginal examinations, episiotomy, suturing without anesthetic (D; R); painful vaginal examinations (M; R); discrimination based on personal attributes (being overweight), immediate cord clamping (M; D); undervaluing complaints, refusal to give anesthetic during labor with induction, physical restriction during birth (D); unconsented membrane sweeping, separation from newborn, lack of support in breastfeeding (M); enema, abandonment of care, catheterization, food or drink intake restriction, coercion to take anesthetic during labor, cord traction, "husband's stitch" (R).

Details of these interventions are beyond the scope of this manuscript. All the features enumerated correspond to forms of obstetric violence as classified in the literature [1,3–5]. Any intervention in birth that does not respect the right to self-determination or the integrity and autonomy of the woman, performed without consent or for valid clinical reasons, is considered obstetric violence, which is a form of human rights violation. Some of these interventions are advised against under all circumstances, such as the Kristeller maneuver or the "husband's stitch," and some others are fallback solutions that should only be employed in emergency situations to save lives, and are rarely needed, such as cord traction or episiotomy. All women said that their negative birth experience affected their well-being, perception of self, self-esteem, and sexual life. Rossana said it affected her bonding with the baby and Diana developed postpartum depression that was later diagnosed as being associated with the trauma she suffered during birth.

Apart from all these aspects, which we commonly find in a great amount of facility-based birth stories, there are also particular details in the narratives told by these women that can be considered specific to the situation of Brazilian migrants, informed by racial and national stereotypes.

3.1. System's Constraints—Barriers to Accessing Healthcare

When Rossana found out that she was pregnant, she went to the public health care center of her area of residence, like most women do. Rossana did not have an assigned general practitioner (GP), as she had only recently moved to Portugal, and having a consultation to be seen by a doctor was not straightforward. The administrative assistant at the healthcare center said she was not allowed to have a consultation there, as she was not enrolled in the system. As Rossana declared that she might be pregnant, the assistant became more flexible. Rossana managed to have the first consultation, but she was then told that she could not be assigned a GP there. Instead, she was referred to the hospital, where was assisted by an obstetrician-gynecologist (OB/GYN).

Maternal and infant healthcare in Portugal is a legal, universal right, and every pregnant woman in the country is entitled to full perinatal care for free, regardless of her legal status [15,24]. In the National Health Service (SNS[10]), low-risk pregnancies are attended to at the healthcare center, where a general practitioner (GP) is assigned to pregnant women (and remains her GP afterwards) and prescribes the diagnostic methods, which are done at private clinics at no cost to the patient (paid for by the state). The care is complemented by a nurse, who takes measurements before consultations with the doctor. Hospital care is for high-risk pregnancies and for monitoring the last few weeks of pregnancy, when low-risk pregnant women are referred to the hospital, and is more directed to intervention in pathologies (by OB/GYNs). Whereas at the healthcare center the woman is assisted by the GP assigned to her throughout, continuity of carer is rarely provided for her at the hospital, depending in great measure on the internal policies of each hospital. There is a parallel private sector, in which women are always assisted by the same obstetrician (that they often consciously choose). The intricacies of these two sectors are

complex and at many times have had detrimental consequences for the care that women receive at birth [7].

Rossana's case is contrary to what has been identified in the literature as dissatisfaction arising from Brazilian women's concerning lack of access to medical specialties in Portugal [24]. Although Rossana was never refused care, having prenatal care at the hospital, which is for high-risk pregnancies, instead of at the healthcare center, which is for low-risk pregnancies as was her case, could have consequently contributed to her being treated as high-risk. Obstetrical models of care have been associated with a higher risk of interventions and are not considered the golden standard for low-risk pregnancies [38–40]. A discussion about models of care and the need to restructure the Portuguese obstetric care system is beyond the scope of this manuscript. Relevant to our discussion is the fact that Rossana's access to the type of care as it is outlined in the *SNS* was possibly complicated by her legal status as a migrant woman. Although the public sector in Portugal is structurally understaffed, and the system's failure to provide for an assigned GP affects a large part of the population, studies have found that inequalities in access to healthcare exist, and that migrant women are sometimes refused care or demands for payment are made [13,14]. Despite the law, disparities in access to healthcare persist, based on race, socioeconomic status, migration status, and other sociopolitical markers.

3.2. Brazilian Women and the Caesarean Section (CS)

3.2.1. "How Strange, a Brazilian Wanting a Normal Birth!"

At a prenatal appointment, a female obstetrician told Diana that everything seemed on track for a normal birth[11], as she already had a bit of dilation. When Diana showed her enthusiasm for "natural" birth, the obstetrician commented "How strange! A Brazilian wanting a normal birth! They all come here wanting a caesarean!" As Diana confirmed that she wished for a normal birth, the OB/GYN reiterated how rare that is and how Brazilian women always want CSs. Diana quoted the physician: "Ah, that's very rare, because you already come in here demanding a caesarean section." Diana emphasized the employment of the plural of the pronoun (*vocês*) by the physician to underline the fact that she treated her as part of a homogeneous group.

3.2.2. "Mix of Races, Bad Uterus . . . That's Why There Are So Many Caesareans in Brazil"

Maíra describes a midwife as being very affectionate and gentle coming into the room at dawn, on her first day at the hospital. In a very quiet tone and while stroking her head, she said: "Ah, another Brazilian! You are a mix of races; you won't be able to birth your baby. Surrender to the fact that you are having a caesarean section." She added: "Don't you see how many caesareans there are in Brazil? That's because you are a mix of races, your uterus is very bad, because you are a mix of races . . . " On the second day, the nice midwife came back and once again gently repeated how a mix of races make a bad uterus that prevents a woman from having a normal birth, saying that that was the reason why Maíra was still there. She was very nice throughout the interaction. Apparently, the midwife wanted to offer some comfort to Maíra, and she expressed those racist tropes to console her.

3.3. Xenophobia and Stratified Reproduction

Diana said about the birth of her first daughter that she was the most mistreated when she was alone. Her partner was present during labor, except when told to leave in order for the health professionals to carry out interventions, and when Diana had to move to the birth room. Diana says she felt a difference in treatment when she was alone, as if her husband acted as a protective shield, and she thought this happened because she is Brazilian. She told an episode to illustrate the kind of mistreatment she received when her partner was not by her side. When moving from the dilation room to the birth room, she was told to walk on her own feet, and was accompanied by a male midwife. Upon feeling a very strong contraction, she was incapable of moving and abruptly stopped in the middle of the corridor. The midwife "almost hit" her, reproaching her with harsh manners "You

have to tell me when you're going to stop, because I'm carrying your drip!" Diana replied that she became breathless on every contraction and was not able to talk.

Diana was convinced that this kind of abuse only happened because she was alone, as the health professionals were more polite to her while her partner was present. She thought this to be connected with her being Brazilian. Two and a half years later, when I asked her to elaborate on this idea, she told me that she had changed her mind and was not so sure whether that was the case. Having heard many awful birth stories in the meantime, she realized the kind of mistreatment she suffered was actually the norm in Portuguese facilities, and she now thinks that this happens regardless of nationality. However, Diana went on to talk about other situations in her life in Portugal when she felt discriminated against for being a Brazilian, especially in the workplace. As for the concept of obstetric violence, she expressed she was familiar with it already in Brazil, but she thought she would never go through it, because in Portugal things were surely different, she thought, "more advanced." Rossana expressed a similar idea, that Portugal being a European country would be expected to be better than Brazil in this regard.

3.3.1. "Control It Now, Alright?"

When asked about discrimination due to her being a foreigner and a Brazilian, Rossana answered that she heard a discriminatory comment from the physician who discharged her from the hospital, after her second birth. The OB/GYN told her, as she performed the physical exam before discharging her, "Now, let's see if you control that, alright?" Rossana interprets that comment as a disciplinary attitude by the doctor, who felt she had the right to tell Rossana how to lead her reproductive choices: it was implicit that she had already "made her contribution to the country's natality rate," Rossana says, and that she should behave now, refrain from "overpopulating" it. She added that she is not sure whether this was because she is a foreigner or because of her age, probably because of both. She was 27 and had two daughters, a pattern not consonant with the national average, with women becoming mothers at 30.7 years of age and having on average 1,4 children[12]. Either way, it conveys ideas of stratified reproduction of which bodies are legitimate to reproduce and which are not [9].

3.3.2. "Beware Not to Have More Children"

Like Rossana, Diana also heard a discriminatory comment from a health professional, after the birth of her first daughter. An older midwife came into the room, bringing the newborn to breastfeed, and asked the mother how the birth had been. Diana answered that it had been awful. The midwife, apparently angry about her honesty, harshly told her, "Well, I also don't want to see you here ever again, beware not to have more children!" This power display was like a punishment for Diana's wrong answer. It was actually a rhetorical question, Diana was not entitled to have an opinion, even more so one that did not fit the inquirer's expectations. The question remains whether the midwife would feel the same right to intrude in Diana's reproductive choices were she a non-racialized, Portuguese woman.

3.4. Ashamed to Breastfeed in Public: The Brazilian Woman as "Piriguete"

Once, at a shopping mall, Diana took her breast out to nurse her four-month-old baby Inês. She heard a Portuguese young woman say out loud, "How awful, that's disgusting!" The woman was alone, so Diana knows she clearly meant her to hear this. Diana immediately felt embarrassed, but she decided not to stop breastfeeding her daughter. She told me that she felt ashamed, because of the stereotype of Brazilian women being *piriguete* (a flirty, promiscuous woman who offers herself sexually): "I get this way, because I'm Brazilian, and there's that stereotype of the Brazilian woman being *piriguete*, that she likes to expose herself, so, in my head, the less I expose myself the better for me." Diana breastfed her first daughter for one year and four months and her second daughter for nine months.

4. Obstetric Violence and Multiple Discriminations

In the birth stories of Diana, Maíra, and Rossana, several elements of what has been defined as obstetric violence abound [3,4]. Their birth stories share many commonalities with the stories told by the average women giving birth in healthcare institutions in Portugal [5–7,35], regardless of their racial identity, class belonging, sexual orientation, age, migration, or ability status. Several forms of mistreatment, such as lack of information, unconsented interventions, objectification of the body, and even verbal abuse concur to make these women's birth experiences paradigmatic of what has been termed and defined as obstetric violence.

Adding to this, these women suffered multiple discriminations based on their national origin, migration status, and categorization of race, more than their class belonging. Ranging from declared forms of racism, such as a midwife telling Maíra that being of "mixed races" meant having as a consequence a "bad uterus" that would make vaginal birth impossible, to more subtle, covert forms of racism, such as disciplinary comments about reproductive choices and preconceived ideas about Brazilian women and their sexual and reproductive habits, informed the clinical encounters of these women with health personnel. All women identified as having suffered obstetric violence. Maíra was the only one to clearly identify having been subjected to racism, because of the racist tropes expressed by the midwife, but the different vignettes discussed before reveal a subtle and covert racism inherent to reproductive health care and policies. In relation to their specific status as migrant Brazilian women, three main themes emerge, related to stereotypes about Brazilian women:

- Identification with caesarean section, either by personal preference or by physical incapacity;
- Being undisciplined breeders;
- Being flirty (*piriguete*).

4.1. Identification of Brazilian Women with Caesarean Section

Multiple stereotypes about Brazilian women pervade public opinion and public discourse in Portugal [20–22] and they also manifest in obstetric care [15,23]. Both Diana and Maíra heard health professionals normalize Brazilian women as naturally prone to deliver by caesarean section, an idea mainly shaped by the high CS rates in Brazil and by the fact that some Brazilian women in Portugal express their wish for an elective caesarean. Brazil stands out among countries with the highest caesarean section rates in the world [41]. According to Morais, Padilla, Rossetto, and Almeida [23], Brazilian women demanding CSs can be seen as an effect of the dominant "caesarean culture" internalized by women in Brazil, who bring these perceptions to their host countries. In highly medicalized systems, the caesarean section as state-of-the-art technology is highly valued. It can also be a strategy they use to avoid not only the fear of vaginal birth, but also the possibility of mistreatment during labor, as they have the perception that their vulnerability as migrants and potential for discrimination as Brazilian is more prone to happen in vaginal birth rather than in CSs [23].

In Diana's case, an OB/GYN takes the woman's preference for CS for granted, and expresses her surprise when Diana tells her otherwise. Diana's individuality is eroded as she is placed within a group, generalized as a Brazilian migrant who is expected to behave in a certain manner. Brazilian women want caesarean sections, or else why would there be so many CSs in Brazil? When discussing the issue of the global rise of CS rates, a common explanation introduced by health professionals is women demanding caesarean sections as a driver for the substantial rise in CS rates globally. However, this thesis has been called into question, as studies show that only a minority of women in a wide variety of countries express a preference for caesarean delivery [42,43]. Additionally, women's choices and preferences do not exist in a void, they are instead embedded in and influenced by sociopolitical contexts [6], and the option for caesarean sections has been shown to be greatly influenced by medical opinion [41,43]. The significant differences in CS rates

in public and private sectors also hint at cultural and economic factors influencing this decision, rather than clinical ones [7,43].

In Maíra's case, the midwife offers a simplistic explanation for the high caesarean section rates in Brazil based on race: most Brazilian population is miscegenated, and a "mix of races" produces a "bad uterus"—that is why there are so many CSs in Brazil, she says. She condescendingly urges Maíra to accept her fate as a woman who has no alternative but to have her child via caesarean section, as she is of mixed race. The midwife invokes Maíra's racial status and forces an association between her nationality and the CS to prove the evidence of the outcome she foresees. The surgery is then a "natural" and consequential solution to address a biological problem that "mixing races" brings to women. As a mixed-race woman, Maíra is declared unfit for birth by the healthcare professional, who overlooks all sociological explanations and presents a faulty argument.

As with other processes of stereotyping, the selection of a random characteristic to compose an idea about a whole group is always partial in the information it picks and depending on a generalization whereby heterogeneous groups get reduced to a homogeneous mass of similarity. The identification of Brazilian women with birth by caesarean section is a generalization that, like all generalizations, is based on a detail and simplification from reality, operated through an essentialization. The prejudice according to which Brazilian women are naturally more prone to birthing by CS offers a simplistic explanation of a complex reality, deliberately ignoring all the historical, social, economic, and political reasons that overlap to contribute to the phenomenon. It is also an exercise of stratified reproduction [9], as it classifies a certain category of bodies as being more unsuited for birthing their offspring, in opposition to another kind of body that is able to do so. This adds another layer to the conception of the female body as defective and requiring technological assistance in order to perform reproductive tasks [44].

The so-called "epidemic" of caesarean sections worldwide has been recognized as a public health problem and several reasons have been appointed to explain it, from medical cultures highly reliant on interventionism, financial incentives, personal convenience motivations, and fear of litigation to lead to the practice of defensive obstetrics [45]. The midwife chooses to ignore all this and, by blaming the woman's characteristics instead, puts the onus for what might go wrong on her, exerting a power that has the potential to undermine the laboring woman's confidence. Blaming and culpabilization are common expressions of obstetric violence, with women being coerced into interventions and/or blamed for negative outcomes (potential or real) because of their physical characteristics, their behavior in labor and birth, and not complying to orders by the staff.

4.2. Brazilian Women as Undisciplined Breeders

The concept of stratified reproduction helps us see the arrangements by which some reproductive futures are valued while others are despised, as the inequalities based on hierarchies of class, race, ethnicity, gender, place in a global economy, and migration status deem some human groups more eligible for reproducing than others [10] (p. 78). Both Diana and Rossana were subjected to comments by healthcare professionals, with the assumption that they should be disciplined about their reproductive life choices. In Rossana's case, her class status was overshadowed by her racial status, and her national origin most likely contributed to the shaping of the healthcare provider's framing of Rossana as an undisciplined breeder, as ideas about the Brazilian women as eroticized and disruptive of traditional familiar patterns in the country are conveyed in public opinion [20]. Brazilian women are often confronted with gender and class discriminatory situations that evoke the idea of pregnancy for secondary interests (such as legal regularization) and being questioned about the father's nationality [15] (p. 172, 199, 236), as are other racialized women [16]. Diana also heard comments on her need to refrain from further reproducing after her first birth. The comment proffered sounded like a punishment for Diana being critical of the care that she received during birth.

4.3. Brazilian Women as Flirty

The impact of the stereotypes about Brazilian women extend well beyond the event of childbirth. Diana's self-awareness about her condition as a Brazilian woman leads her to self-police her behavior, to avoid adopting behaviors usually identified with the group she is supposed to belong to. The reproaching comment she heard from a stranger when she exposed her breast to nurse her baby daughter immediately evoked in her mind the stereotype of Brazilian women being flirty and liking to expose themselves, and inhibited her from being at ease breastfeeding in public.

The exotization and erotization of the Brazilian woman is fostered by the media and publicity and entertainment industries, in Portugal but also in Brazil, where certain racialized groups of Black or *mestiças*[13] women are especially subject to these processes of erotization [20]. Brazilian Black feminism has argued that the ideology of *mestiçagem*, associated with the hyper sexualization of Black women, conceals the oppression and sexual violence suffered by enslaved Black women and perpetuates their subaltern condition, linking it to sexuality [21,22]. When arriving in Portugal, Brazilian women are confronted with these preconceptions about themselves as sexually available and as bearers of an exotic and exaggerated sexuality, easily associated with prostitution.

The intersection between gender and race/coloniality seems to be the main intersection to explain the prejudice against Brazilian women in Portugal. Other articulations, such as class, add to the difficulties, but what all the Brazilian women seem to have in common is the stigma of hypersexuality [21] (p.186).

5. Concluding Remarks

In the cases discussed, it is hard to determine whether race or national origin have a stronger bearing on the discriminations that the women have suffered. Apparently, being a Brazilian has predominance over being Black, but the question remains whether it is easier for those involved and for us hearing the stories to identify these situations as xenophobia, because the discourse about Brazilian women is more established and assumed in public opinion and public discourse, rather than the debate about racism.

Despite long standing action by anti-racist activists and work by scholars, the debate about racism in Portuguese society has only very recently received more widespread attention and it is still subject to a lot of disputes in the public arena. Several historical events conspire to make the racist debate difficult in Portugal [25,29]. The myth of lusotropicalism is deeply ingrained in Portuguese society, as is in Brazil the myth of racial democracy, influenced by the ideas of sociologist Gilberto Freyre in the mid-20th century, that has found a fertile ground in both countries [25]. In Portugal, the fascist regime embraced the ideas of lusotropicalism as a way to legitimate colonial power, as it served the purpose of denying the brutality of the colonial power in the domination of native populations. Unlike what happened in other European countries that suffered World War II and started the debate around the inequalities based on the idea of race much earlier, Portugal managed to remain removed from the debate, as its status as a neutral country in the war provided the illusion of not having aligned with state racism [29]. Recently, the debate about everyday racism pervading all spheres of society has been gaining momentum, with the exposure of the ways through which racialized communities are discriminated, excluded, and subjected to stereotypes that are detrimental to their achieving the same educational, housing, professional, material, and symbolic status as other majority, non-racialized communities [27,28]. As the conflation of a national identity with an ethno-racial identity is a central process in the building of modern nation-states, racist ideologies, even if not openly assumed as such, help the hegemonic group maintain its privileges while perpetuating the lack of access of minority groups to de facto equality in society [26,30].

Maíra affirmed that all types of violence are pretty much intertwined, and one cannot be eradicated without eradicating the others. According to her intersectional approach, it is useless to look at racism without looking at gender, at class, and all the categories that work in people's minds and are mirrored in society to hierarchically differentiate

and classify people and human groups. As is happening with the debate about racism in Portuguese society, the debate about obstetric violence is finally gaining momentum in the country, after long years of work by both anti-racist and childbirth activists in denouncing the structural dimensions of these phenomena. As the public debates about racism and gender violence provoke discomfort among the groups that benefit from these types of inequality, generating reactions of denial and backlash, it becomes ever clearer that tackling difficult issues requires knowledge about them. The need for research on obstetric violence as well as obstetric racism is crucial to disclose how multiple discriminations intertwine in reproductive healthcare and how so often these forms of violence operate in subtle, disguised, and concealed ways.

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Institutional Review Board Statement: Ethical review and approval were waived for this study, due to the study being conducted within the framework of the program of PhD studies in Anthropology at the Institute of Social Sciences of the University of Lisbon (Portugal), under the supervision of Chiara Pussetti PhD. All studies developed within the Institute are according to the national legislation and fundamental ethical principles of scientific studies.

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Data from the research was recorded in handwritten form and as such avoids the need for online data protection. Demographic data was anonymized and stored separately from the qualitative data. Identification codes and personal data will be stored in an encrypted file. References to interlocutors in the outputs will be given through codes of identification. Data will not be used for any other purpose other than that purpose for which it was obtained.

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Notes

1 I thank Carolina Coimbra and Laura Brito from SaMaNe collective for bringing these two works to my attention.

2 Galeria das Experiências Obstétricas: <https://galeriadasexperienciasobstetricas.wordpress.com/>. (accessed on 6 March 2022).

3 Associação Portuguesa pelos Direitos da Mulher na Gravidez e Parto (APDMGP).

4 Austria, the Czech Republic, Croatia, Germany, Hungary, Ireland, the Netherlands, Portugal, Spain, and the UK.

5 Vaginal birth without recourse to instrumental extraction, either by vacuum or forceps.

6 Health professionals asking women to open their legs in order to do the *toque*—digital vaginal examination to assess cervical dilation—and, with the fingers inside the vagina, sweeping the membranes either to provoke or accelerate labor, without further notice, without asking for permission and without explaining the reasons and risks. It can be a painful procedure and women many times are surprised by the pain it causes, only retrospectively realizing that they were subjected to this procedure and not to the *toque* (which is supposed to be painless) they were expecting.

7 A doula is a person who provides informational and emotional support regarding perinatal matters. It is a paid service. She is not entitled to perform obstetric interventions.

8 When one medical intervention leads to another one to contravene the iatrogenic consequences of the previous one and so forth in an endless chain.

9 An extra stitch done after vaginal delivery to repair a natural tear during childbirth or a cut by an episiotomy. The supposed purpose of the husband's stitch is to tighten the vagina to its pre delivery state, and is done with the idea that it might increase the frequency of the woman's orgasms or enhance a man's pleasure in intercourse. It is neither an accepted practice nor an approved medical procedure and it can lead to painful sex for both partners.

10 *Serviço Nacional de Saúde*.

11 "Normal birth" is the emic term for eutocic birth (vaginal, non-instrumental birth), in opposition to dystocic birth either by vacuum extraction, forceps or caesarean section.

[12] Data for 2020, which does not differ from the pattern in the last years: https://www.pordata.pt/Portugal/Idade+m%C3%A9dia+da+m%C3%A3e+ao+nascimento+do+primeiro+filho-805; https://www.pordata.pt/Portugal/Indicadores+de+fecundidade+%C3%8Dndice+sint%C3%A9tico+de+fecundidade+e+taxa+bruta+de+reprodu%C3%A7%C3%A3o-416 (accessed on 9 February 2022)

[13] Terms such as *mestiça*, *mulata* and *cabrita* (crossbred) have their origins in animal reproduction to define the crossing of two different breeds or species, originating a type of animal considered inferior and impure. They are anchored in a historical colonial project that functions to affirm the inferiority of one identity through its attribution to the animal condition. At the same time, the romantization of such terms transforms the relations of power and sexual abuse in glorious sexual conquests, that have resulted in an even more exotic body [28] (pp.12–14).

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