Obstetric Violence: Inequalities and Vulnerabilities of Being a Racialised Brazilian Woman During Pregnancy in Portugal

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Abstract: This article presents issues related to obstetric violence (OV) during pregnancy, which affects women all over the world. This form of gender-based violence results in the subordination of women's access to sexual and reproductive health. OV can be defined as disrespect for women's rights during the pregnancy-puerperium cycle, manifesting itself in various ways, such as omission, neglect, physical and psychological violence, sexual abuse, the use of interventions and medications without scientific proof, and the deprivation of basic needs that generate suffering for women. It is a multifaceted practice, present in health institutions and rooted in power relations, which materialises through the manipulation of women's bodies, disrespectful forms of communication, inadequate provision of services and systematic violations of fundamental rights. This practice is often perpetuated by health professionals who exercise power over pregnant women, reflecting the inequality rooted in a patriarchal, monogamous and sexist society. It is thus an example of oppression and control over women, revealing a regime of domination and exploitation. In Portugal, this reality not only affects national women but also accentuates inequalities, especially among racialised Brazilian women. This topic is still invisibilized in the academic and social environment, and this exploratory qualitative study aims to fill this gap. Based on an intersectional feminist epistemology and the approach of social constructionism, the research examines the experiences of OV during pregnancy of these women in the Portuguese National Health System (NHS). The aim is to understand the reality of obstetric violence and its consequences for women, with attention to the intersections of migration and race that heighten their vulnerability. These women often have no social ties or support, and when they cross borders, they face realities marked by discrimination, which intensifies their vulnerability and makes it difficult for them to express their desires and intuitions in an environment that often makes their bodies invisible. This paper seeks to discuss the interrelationships between gender equality, race, and nationality, gathering information that can contribute to the formulation of health management strategies, especially in the care of migrant women during pregnancy in Portugal.

Keywords: Health Inequalities, Intersectionality, Maternal Healthcare, Obstetric Violence, Sexual and Reproductive Healthcare.

1. Introduction

The factors that lead a person to migrate are complex and multifaceted, motivated largely by the search for better living conditions, employment, health, and education (UNHCR, 2016). Migration involves moving away from familiar environments and adapting to a new and uncertain context in the host country (Daure & Reveyrand-Coulon, 2009). For this reason, the analysis of migratory flows must be interdisciplinary, with economic, social, psychological and demographic approaches contributing to a more complete understanding of this phenomenon.

In Portugal, the migrant population has grown in recent years, and Brazilians represent 35.3 percent of foreigners in the country, making them the largest migrant community (AIMA, 2023). According to the Brazilian Ministry of Foreign Affairs (2023), Portugal has the second-largest number of Brazilians outside Brazil. When studying migration, it is important to consider the gender perspective, as the experiences of men and women differ, and generic analyses do not capture the particularities of female migration (Sant'ana, 2008). Historically, gender has been little explored in migration theories, and the role of women in migration and in the social networks that sustain this process has only recently received due attention (Assis, 2003).

International migration is predominantly female, reflecting social and economic inequalities (Bertoldo, 2018). The growing presence of racialised Brazilian women in the labour market and their increased autonomy dispels the view of women as “”

The integration of migrant women is essential for strengthening social cohesion, equality and well-being, especially concerning rights, citizenship, and opportunities (Ramos, 2008). Racialised Brazilian women, when moving between distinct cultural and social contexts, become agents of change, but also face significant challenges, such as discrimination, isolation, and problems of identity and violence. Psychosocial and cultural difficulties, especially in the early years of migration, affect family life, health, education and social roles. This scenario makes the feminisation of migration a complex phenomenon, requiring inclusion policies (Ramos, 2008). In addition, the process of becoming a mother involves cultural and social learning, and far from family and cultural networks, these women face additional difficulties in motherhood, experiencing isolation and emotional challenges that impact the maternal role and family routines (Moro, 2017). In migratory contexts with limited support networks, the lack of familiar cultural values exacerbates the feeling of loneliness (Padilla et al., 2009).

On top of this, these women face discrimination and vulnerabilities, which influence their experience at different stages of the migration process (Assis, 2003). This expands when these women become pregnant, which makes this issue complex, as it is affected by social, cultural and economic factors that impact maternal health and family well-being (Rusu et al., 2024). Many of these women face unique challenges, such as limited access to health services, language barriers, and possible economic constraints, which can result in inadequate prenatal care and complications in childbirth. In host countries, housing and working conditions often also influence maternal and child health, exacerbating the psychosocial and emotional vulnerability of racialised Brazilian pregnant women (Rusu et al., 2024).

As a result, these women end up suffering violence during prenatal care in the Portuguese National Health System (SNS), which impacts the development of other phases of this event because, in addition to cultural issues that can affect the experience of pregnancy, discriminatory and stereotyped practices in healthcare and beliefs about pregnancy are surrounded by violence that can be called obstetric violence (OV). OV is considered to be a form of gender-based violence experienced by parturient who are subjected to acts of violence that result in subordination, naming a multifaceted and diffuse phenomenon that can occur during contact with sexual and reproductive health care, as well as the specific practices of some health professionals, often exacerbated in the exercise of power with women who become pregnant (Sesia, 2020).

With this, there is an urgent invitation to look at these issues since this event passes through the bodies of racialised Brazilian women from an intersectional perspective. This perspective implies that the concept of gender cannot be dissociated from the political and cultural intersections that produce and sustain it (Butler, 1990). Especially when they are subjected to a colonial relationship between Brazil and Portugal, where gender is inscribed in racialised bodies (Akotirene, 2019), invoking somatic characteristics used to differentiate groups of common origin. These characteristics are shaped by hierarchical and colonial discourses (Kilomba, 2019). The process of racialisation legitimises Eurocentric standards that produce differences and perpetuate racial privileges, which imposes oppression on those considered 'Others' (Kilomba, 2019).

Violence as the imposition of a 'self' on the 'other' is not limited to physical aggression but cancels out identities, conditioning female subjectivities to mould women as the 'Other' (Akotirene, 2019). For Barros (2020), race is a historical construct mediated by colonialism. Lélia Gonzalez (1980) notes that the belief in racial harmony in modern societies can perpetuate violent effects for racialised women, including obstetric racism, a concept proposed by Dána-Ain Davis (2019) to describe the intersection between obstetric violence and medical racism. Obstetric racism emerges as a fusion of institutional and structural violence, characterised by diagnostic lapses, negligence, intentional pain, coercion and medical abuse. These practices of reproductive dominance are aggravated by racial factors, affecting the treatment of patients based on stereotypes.

In addition, studies by Wall et al. (2005) and Padilla (2007) highlight the vulnerability of Brazilian migrant women, who are subject to discrimination and stereotypes of sensuality and submission. For racialised Brazilian women, these processes of dehumanisation are articulated by gender, race and sexuality and reveal a structure of exclusion promoted by the state (Dia & Dias, 2011; Lugones, 2014, 2020), resulting in segregation, stigma and social and economic restrictions (Nwoke & Leung, 2021). In addition to the inequalities and violence faced by racialised Brazilian women, these migrants are vulnerable due to the lack of support networks and the difficulties inherent in the migration process, which can generate trauma, stress and depression, especially for mothers who face the challenge of raising children in a different culture (Ramos, 2010).

In Portugal, which is home to around 1,044,606 non-national citizens, the majority of whom are Brazilians, women account for more than half of this population (50.9%) (AIMA, 2023), which means that there has been an increase in the inclusion of immigrants in the National Health System (SNS). Despite access policies,

unfortunately, racial and nationality disparities persist in the use of health services (Costa et al., 2022). These services must adapt to cultural diversity to promote equity (Oliveira, 2023), given that the invisibility of migrant women's experiences is still a challenge, especially in the context of obstetric violence.

With this in mind, this work is based on an intersectional feminist epistemology and the social constructionism approach, and this research examines the experiences of obstetric violence (OV) during pregnancy of these women in the Portuguese National Health System (SNS). The aim is to understand the reality of obstetric violence and the main consequences of this violation for women, considering the intersections with situations of migration and race, which increase their vulnerability.

2. Methodology

This study adopted a qualitative approach, using semi-structured individual interviews as the main data collection method. The choice of this approach allowed for a more detailed understanding of the experiences lived by racialised Brazilian women in maternal health settings during pregnancy, seeking an in-depth analysis of their beliefs, attitudes, values and motivations about the different contexts and social actors involved, effectively addressing the objectives of the study.

To guarantee the validity of the instrument used, a scientific review of the subject was initially carried out to assess the extent to which the collection instrument adequately represented the content it was intended to measure. The interview consisted of two parts, the first collecting sociodemographic data and the second made up of seven sections: 1) migratory journey (e.g., What changes have taken place since immigrating? (explore identity, family, personal, social, cultural), 2) being a pregnant migrant in Portugal (e.g., What has it meant for you to be a pregnant woman in Portugal?) 3) pregnancy (e.g., Could you tell me about your pregnancy, especially your prenatal care? What was it like for you?), 4) childbirth (e.g., Did you feel that your fundamental rights were guaranteed during labour?), 5) postpartum (e.g. Could you tell me a little about what changed in your life before and after giving birth?), 6) obstetric violence (e.g. Do you think you have been the target of obstetric violence? If so, what elements facilitate these situations?) and 7) final considerations (e.g., How satisfied are you with maternal care (perinatal, childbirth, puerperium), considering the conditions of being a racialised Brazilian woman in Portugal?)

The development of the instrument followed six main stages: drafting the initial script, validation by the reviewers, preliminary evaluation of the results, pre-testing, final validation of the script and construction of a theoretical-empirical version. The validation process included the assessment of four attributes: alignment with the objectives, relevance to the constructs, clarity of language and adherence to qualitative expectations. The instrument was considered valid, covering the essential elements of the concept investigated based on the definition of the variables.

The research was submitted to and approved by the Ethics Committee of the Faculty of Psychology and Educational Sciences of the University of Porto, respecting all ethical principles, including informed consent, anonymity and protection of the participants' data. Participation was voluntary, and the data was treated confidentially.

Participants were recruited through convenience sampling, using social networks such as Instagram and Facebook to publicise the study. The inclusion criteria required the participants to be Brazilian women, living in Portugal, aged 18 or over, identified as racialised, who had given birth in the last three years in the country and reported experiences of obstetric violence in the Portuguese NHS. In addition, the snowball sampling technique was used, in which the participants indicated other women who met the criteria, broadening access to potential interviewees. The interviews were scheduled by direct contact, telephone, or e-mail and carried out via ZOOM, ensuring greater convenience for the participants. The meetings took place between February and April 2024 and lasted an average of 60 minutes each.

Ten racialised Brazilian women took part in the study, aged between 31 and 44. All identified as cisgender; nine declared themselves heterosexual and one was bisexual. In terms of education, four had a bachelor's degree, four had a master's degree and two had a doctorate. The length of residence in Portugal ranged from two to eight years.

Braun and Clarke's Thematic Analysis (2006, 2013, 2020) was used to analyse the data, going through six stages: familiarisation with the data, generation of initial codes, search for themes, review, definition and naming of themes, and production of the final report. This approach allowed for an in-depth exploration of the narratives, resulting in a detailed mapping of the patterns in the data collected.

Table 1: Sociodemographic characteristics of participants.

Participant	Age	Nationality	Ethnic-racial identity	Sexual orientation	Academic qualifications	Gender identity	Employment situation	Number of kids	Time living in Portugal (years)
P1	31	Brazilian	black	heterosexual	graduated	cis woman	employed	1	4
P2	34	Brazilian	racialized	heterosexual	master	cis woman	employed	1	6
P3	33	Brazilian	black	heterosexual	graduated	cis woman	employed	1	5
P4	35	Brazilian	racialized	heterosexual	master	cis woman	employed	1	6
P5	34	Brazilian	racialized	heterosexual	graduated	cis woman	employed	1	2
P6	41	Brazilian	black	bisexual	doctorate	cis woman	employed	2	7
P7	31	Brazilian	racialized	heterosexual	master	cis woman	employed	1	5
P8	40	Brazilian	racialized	heterosexual	graduated	cis woman	employed	2	7
P9	42	Brazilian	racialized	heterosexual	doctorate	cis woman	employed	2	8
P10	44	Brazilian	racialized	heterosexual	master	Cis woman	employed	1	5

3. Presentation and Discussion of Results

This study sought to analyse experiences of obstetric violence and understand the motivations behind this practice. Three main types of violence were identified: physical, verbal and psychological. In addition to presenting these types, the study applied an intersectional analysis to highlight the multiple identities of the women involved, exposing the discrimination and stereotypes that emerge from the combination of factors such as gender, race and nationality. Understanding women's perceptions of this reality and views on obstetric violence is an essential step towards transforming this practice and ensuring that it does not become part of other women's reality in the future.

3.1 Physical, Verbal and Psychological Violence, Intersectional Discrimination and Vulnerability

Delving into the interviews confirmed that the consequences of disrespectful care are profound, resulting in physical and psychological complications for women. This violence involves acts that cause physical harm, whether accidental or not, generating pain and injuries. The women reported repetitive vaginal examinations and touches, constituting a violation of their right to information and autonomy in harmful practices. In addition to this, the reports include cases of verbal and psychological violence such as: mistreatment, rudeness, unpleasant comments, debauchery, threats, blackmail, humiliation, disregard and misinformation, exposing these women to physical and psychological risks. The interviewees' statements clearly reflect these practices, highlighting the need to carefully analyse care practices and how these interactions impact on women's health and well-being during obstetric care.

> *'She touched me with an absurd pain that I had never felt during my entire pregnancy' (P1).*
>
> *'The family doctor, during my antenatal care, started shouting at me wildly, calling me irresponsible because I had an ultrasound in a private hospital' (P4).*
>
> *'The doctors always treated me very badly' (P5).*
>
> *'The family doctor was unfriendly, she was the boss, she didn't listen, she just wanted to impose' (P8).*

The violence that women face during obstetric care during pregnancy manifests itself in various forms, with physical, verbal and psychological violence being particularly worrying. According to Sesia (2020), this violence causes physical harm, resulting in pain and injuries, with reports highlighting excessive examinations and vaginal touches, which violate women's right to information and autonomy, as well as being scientifically harmful practices.

These practices violate women's right not to be mistreated and reveal the inequality of power in relations with health professionals, who often perpetuate obstetric violence (Rusu et al., 2024). In addition to physical violence, many women also report verbal and psychological aggression, including slander and defamation, which impacts their psychological health and reputation (Sesia, 2020). These reports highlight a multifaceted pattern of violence, emphasising the urgency of interventions that promote respect, information and autonomy in obstetric practices.

In addition, because these women are racialised Brazilians, they end up suffering discrimination and stereotypes as a result of the production of non-national bodies. These practices have direct and indirect consequences on these women's daily lives. In the case of the participants, the stereotype of hypersexualised, promiscuous women is valued, as are practices of racism and xenophobia

> *'Several times I was recognised as a whore or a maid' (P6).*
>
> *'The nurses cursed the immigrants, called them smelly' (P7).*
>
> *'Also, you're too old to get pregnant' (P10).*

The text addresses the stigmatisation of Brazilian women, who are often associated with hypersexuality and promiscuity, with impacts on everyday life, including health (Padilla, 2007; Rusu et al., 2024). These perceptions are rooted in gender coloniality, a concept that Lugones (2014) uses to explain the animalisation of non-white women, who are seen as not belonging to the ideal of white European femininity. This modern-colonial gender system racialises and imposes gender norms, contributing to the historical abuse and dehumanisation of racialised bodies (Gonzalez, 1980). Furthermore, obstetric racism persists, manifesting itself in inequalities in access to services and opportunities, defined by ethnic-racial factors. Kilomba (2019) describes how racism is based on the creation of an 'Us' and an 'Other', hierarchised and maintained by power, which allows for institutional discrimination (Akotirene, 2019; Davis, 2019). Intersectionality is crucial to understanding these contexts of exclusion, silencing and discrimination (Akotirene, 2019). Adopting an intersectional perspective is key to developing effective interventions and protection mechanisms.

For Dias and Dias (2011), race and gender are also some of the most important principles of hierarchical division that do not fail to interact with the national principle in maternal care, reinforcing relations of domination, capturing how women in situations of vulnerability tend to face many more obstetric and gynaecological problems than other women. The interviewees are aware of these historical and social markers, which place them in a position of vulnerability, as can be clearly seen in their accounts.

> *'I was all sensitive... then the doctor: but have you done it? complained to me like that, she was rude, you know? don't you know you have to do it?' (P3).*
>
> *'I was treated at the health centre as if I didn't know anything' (P7).*

The consequences of the OV suffered by these women end up causing obvious damage in each report. Memories from prenatal care remain vivid, deeply affecting them on a cognitive and psychological level, with significant impacts on their experiences (Rusu et al., 2024). At this stage of life, the body becomes central, and any event can affect their emotional and psychological well-being.

> *'I felt afraid' (P2).*
>
> *'I cried a lot, I never imagined they would touch me without consent' (P9).*

The experiences of violence reported by migrant women during obstetric care in Portugal reveal a painful distancing between body and subjectivity, where the body, in becoming 'sensitive to the other', is the target of practices that sever ties with the special event of motherhood. This violence, resulting from a lack of sensitivity and preparation to deal with socio-cultural differences, generates a feeling of helplessness and loneliness, marked by feelings of guilt, sadness, fear and frustration. Rusu et al. (2024) emphasise the importance of understanding the experiential dimension of the body in the subjective constitution, which is essential for psychology, while studies indicate that such traumas can increase the risk of postpartum depression, affecting the mother (Sesia, 2020). The lack of adequate public policies accentuates the negative impacts, especially for migrant women, who have less access to quality care due to prejudice and a lack of preparation on the part of professionals (Fernandes and Miguel, 2009; Padilla and Miguel, 2009; Padilla et al., 2009).

4. Conclusion

From the analysis presented, it is clear that female migration, especially of racialised Brazilian women in Portugal, reveals a complex scenario of intersectional inequalities. This study highlights the challenges and vulnerabilities faced by racialised Brazilian women during pregnancy in Portugal, highlighting social isolation, the absence of support networks and barriers to accessing health services. These barriers can aggravate mental health issues and contribute to increasing the inequalities faced by these women. 'Gender vulnerability' manifests itself even more intensely when it intersects with other social markers, such as race and nationality, deepening structural inequalities and revealing the need for an intersectional approach to these experiences.

OV emerges as a pressing issue in the Portuguese National Health System (SNS), where a lack of understanding of cultural dynamics and a shortage of psychological support limit the quality of care. The research points to the prevalence of OV among racialised Brazilian women, who often suffer from stigmatisation and discrimination due to social constructs involving race and gender. In particular, the concept of 'obstetric resistance' suggests that some women, based on their racial or class belonging, are perceived as being able to endure more pain, perpetuating practices of dehumanisation and neglect.

Added to this, obstetric racism, as a specific form of intersection between institutional violence and medical racism, highlights the inequalities of gender, race and nationality that permeate the Portuguese health system. In Portugal, racialised Brazilian women face systematic discrimination during pregnancy, reflecting a profound disrespect for fundamental human rights. This issue is not limited to prejudiced individual practices but is the result of deep-rooted historical and cultural structures that perpetuate the subordination of racialised bodies and compromise access to sexual and reproductive health that values equity and well-being.

Dialogue between policymakers, health professionals, migrant women and organisations is key to promoting change and tackling this urgent problem, especially in the face of the country's demographic challenges. Understanding these specific needs and adopting intersectional practices in care are fundamental steps towards building a health system that promotes equity, respect and protection, reducing obstetric violence and guaranteeing the well-being of these women.

5. Limitations and Future Directions

This study has some limitations that should be considered. The small sample size limited the ability to capture the diversity of experiences among racialised Brazilian migrant women in Portugal's SNS, considering variables such as gender, nationality, age, education, geographical location, citizenship and migration status. A larger sample could provide a more comprehensive understanding of the processes, dynamics and types of obstetric violence (OV). Accessing migrant women who identify as survivors of OV was particularly challenging, probably due to the sensitive nature of the topic, which can lead to reluctance to participate in research.

Future research could expand on these findings with several approaches: (1) conducting broader studies to better understand the intersections of class, nationality and other forms of discrimination; (2) establishing studies to determine the prevalence of VO; (3) longitudinal studies examining complaints and the long-term impacts of VO; (4) comparative studies between different nationalities to gain broader perspectives; (5) promoting the recognition of OV in policies as a preventive measure; (6) exploring how institutions respond to OV complaints in different healthcare settings; (7) analysing the role of support networks in mitigating the effects of OV; (8) assessing awareness of OV among healthcare professionals; and (9) developing targeted training programmes to reduce OV in healthcare facilities. These efforts could provide valuable information and guide policies and practices that protect the rights, dignity and well-being of migrant women in the context of health services.

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