Experiences of Black Women in the Birth Process in Hospitals in the Extreme South of Brazil

Experiências de Mulheres Negras no Processo de Parto em Hospitais no Extremo Sul do Brasil
Experiencias de Mujeres Negras en el Proceso de Parto en Hospitales en el Extremo Sur de Brasil

RESUMO
Objetivo: Compreender a experiência de mulheres negras sobre o processo de parto em hospitais públicos e filantrópicos em uma cidade do extremo sul do Brasil. **Método:** Trata-se de um estudo qualitativo exploratório e descritivo realizado com 20 mulheres negras. Para o tratamento dos dados foi utilizado o software IRAMUTEQ e após realizada a análise de conteúdo de Bardin. **Resultados:** O software desenvolveu um dendograma contendo 4 classes, mantendo as classes 2 e 3, e 4 e 1 aproximadas. Foi possível observar que o racismo e o sexismo estão inseridos nas instituições de saúde e o quanto essas violências podem influenciar a vivência no parto e no ciclo gravídico-puerperal das mulheres negras. **Conclusão:** As experiências das mulheres negras no parto são prejudicadas pelos preconceitos dos profissionais de saúde, resultando em desassistência e violência nesses ambientes.
DESCRITORES: Saúde da mulher; Saúde das minorias étnicas; Parto.

ABSTRACT
Objective: To understand the experiences of Black women regarding the birth process in public and philanthropic hospitals in a city in the extreme south of Brazil. **Method:** This is an exploratory and descriptive qualitative study conducted with 20 Black women. The IRAMUTEQ software was used for data treatment, followed by content analysis according to Bardin. **Results:** The software developed a dendrogram containing 4 classes, keeping classes 2 and 3, and 4 and 1 close together. It was possible to observe that racism and sexism are present in healthcare institutions and how these forms of violence can influence the experience of childbirth and the pregnancy-puerperal cycle of Black women. **Conclusion:** The experiences of Black women during childbirth are negatively impacted by the prejudices of healthcare professionals, resulting in a lack of care and violence in these environments.
DESCRIPTORS: Women's health; Minority health; Childbirth.

RESUMEN
Objetivo: Comprender la experiencia de mujeres negras sobre el proceso de parto en hospitales públicos y filantrópicos en una ciudad del extremo sur de Brasil. Metodología: Se trata de un estudio cualitativo exploratorio y descriptivo realizado con 20 mujeres negras. Se utilizó el software IRAMUTEQ para el tratamiento de los datos y, posteriormente, se realizó el análisis de contenido de Bardin. Resultados y Discusión: El software desarrolló un dendrograma que contiene 4 clases, manteniendo las clases 2 y 3, y 4 y 1 aproximadas. Fue posible observar que el racismo y el sexismo están presentes en las instituciones de salud y cómo estas violencias pueden influir en la vivencia del parto y en el ciclo gravídico-puerperal de las mujeres negras.Conclusión: Las experiencias de las mujeres negras en el parto se ven perjudicadas por los prejuicios de los profesionales de la salud, resultando en desasistencia y violencia en estos entornos.
DESCRIPTORES: Salud de la mujer; Salud de las minorías étnicas; Parto.

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INTRODUCTION

Black women face multiple vulnerabilities in the Brazilian context—racism, sexism, social class, and the struggle for space in a Eurocentric and patriarchal society. These inequalities are directly related to barriers and insufficient public policies that guarantee access to health care and combat oppression [1-2].

Obstetric violence includes acts of institutional violence, medical abuse, and violations at any stage of pregnancy [3]. In Brazil, the Black population receives inadequate prenatal care, has less connection with maternity services, longer waiting times for care, reduced privacy and fewer companions, as well as less access to anesthesia for episiotomy [4].

According to Dána-Ain Davis, when obstetric violence intersects with racism, it constitutes obstetric racism. It manifests itself through negligence, neglect, intentional infliction of pain, coercion into procedures without consent, exposing black women and their children to risks of death and physical and psychological harm [3,4].

Intersectionality reveals how oppressive structures collide and act simultaneously on different identity markers. In Brazil, the reformulation of the Stork Network into the Alyne Network marks the understanding of the intersection of institutional and structural racism with obstetric violence that black women experience daily in health services and that can lead to their death [5].

This study aims to understand the childbirth experience of black women in public and philanthropic hospitals in a city in the extreme south of Brazil. It seeks to contribute to the discussion on how racism and sexism act in institutionalized childbirth and to indicate strategies for addressing these inequalities.

METHOD

A qualitative, exploratory, and descriptive study was conducted in a municipality in the extreme south of Brazil between September and November 2023. Twenty women over the age of 18, who self-identified as black and had given birth in local public or philanthropic hospitals, participated in the study. Pregnant women and women who had recently suffered a miscarriage were excluded.

Participants were selected using the snowball technique, starting with a black mother and nursing student as the seed participant. After the interview, she indicated three possible participants who were contacted by telephone and invited to participate in the study. Three attempts were made, and there were four refusals to participate. Data were collected by a nursing student previously trained by the principal investigator, using a semi-structured instrument with questions about the childbirth experience, previously approved in a pilot test with a profile similar to that of the initial participant. Data collection took place in a protected environment that could be chosen by the participant, such as her own home or a room on the university campus.

The project was approved by the Research Ethics Committee, under registration number 71732423.6.0000.5317, upon submission to the Brazil Platform. Data collection began after approval, with audio recordings ranging from 30 to 60 minutes, and the signing of the Free and Informed Consent Form. Anonymity was preserved through the use of pseudonyms identified by "P" followed by a number (e.g., P1, P2).

The transcribed interviews constituted the corpus analyzed by the IRAMUTEQ software, which enables text management and statistical analysis [6]. The software performs Descending Hierarchical Classification in three stages: textual preparation and coding, data processing, and class interpretation. The qualitative analysis was based on classes obtained from statistically significant words, using Bardin's Content Analysis [7-8].

The corpus achieved a utilization rate of 79.23%, exceeding the minimum of 75% required for analysis. The content analysis was developed based on the statements associated with the dendrogram generated by the software.

RESULTS

Twenty black women who had given birth in public and philanthropic hospitals in the municipality participated in the study. The profile of the participants is detailed in Table 1 below.

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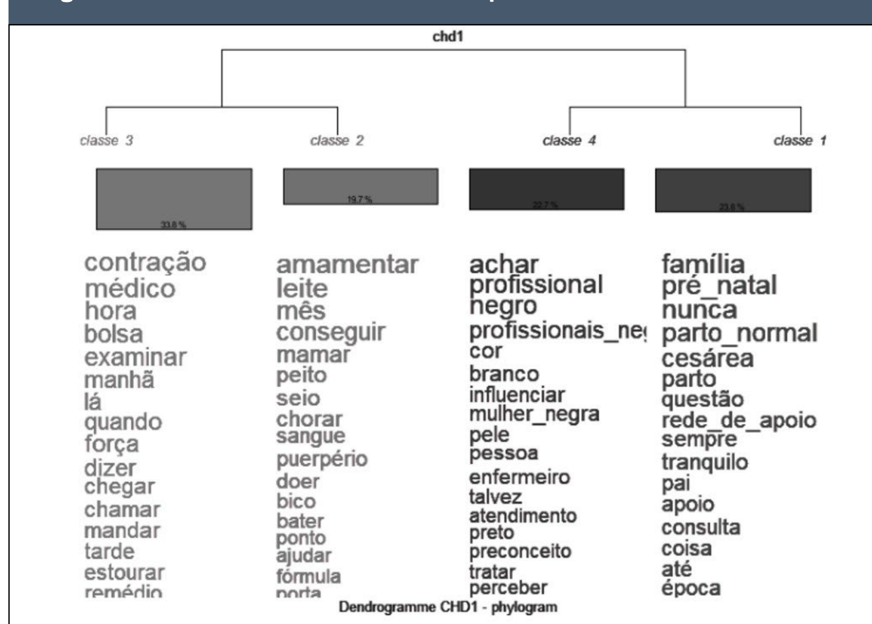
Table 1. (Profile of study participants)

Total number of participants	20 black women
Age	24 to 64 years
Education	Incomplete elementary school = 1 Complete elementary school = 1 High school = 5 Incomplete higher education = 4 Complete higher education = 9
Occupation	Craftswoman = 1 Registration assistant = 1 General services assistant = 1 Pastry chef = 1 Housekeeper = 2 Intern = 1 Student = 5 Cashier = 1 Manager = 1 Meteorologist = 1 Pediatrician = 1 Religious Leader = 1 Civil Servant = 2 Nursing Technician = 1
Marital status	Married = 7 Divorced = 1 Single = 12
Number of children	1 to 5 children
Age of children	2 to 32 years
Number of births	1 to 4 births
Type of delivery	Cesarean section = 13 Vaginal delivery = 11
Pregnancy loss	3 women with 1 loss each
Births	Births 23 full-term 4 premature
Prenatal consultations	None = 1 1 to 13 consultations = 19

(Prepared by the main author)

The CHD generated a dendrogram (Figure 1) with 4 classes, which should be read from left to right. The words presented in the dendrogram allow us to understand the similarities between the classes, highlighting the proximity between classes 3 and 2 and between classes 4 and 1.

Figure 2: Educational brochure for companions (back cover)



Source: Iramuteq

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Classes 3 and 2 address women's experiences during the pre-delivery, delivery, and postpartum periods, highlighting their experiences in relation to the care provided by health professionals and the breastfeeding process. Classes 4 and 1 refer to the absence of Black professionals in the prenatal and delivery care of these Black women, the influence of racism in the delivery process, and the importance of the support network at this crucial moment in their lives.

Class 3 - between the humanized support of health professionals and the maintenance of violence

In class 3, the participants' statements highlight the role of healthcare professionals, especially doctors, during the active phase of labor. The care provided by these professionals can be a source of support when they guide and approach the woman in labor in a humanized manner. However, it can also be perceived as a source of violence when behaviors and practices are identified that cause discomfort or endanger the lives of black women and their babies.

[...] At the time of delivery, I was accompanied by my doctor, who performed my delivery, an excellent doctor... where she guided me through everything, so that I could stay calm and everything else [...]. (P4)

[...] The doctor, the nurse, and the resident who was there at the time told me exactly what was going to happen [...]. (P9)

[...] I was going to have a normal delivery, but my water hadn't broken. So the nurse took my water and broke it [...]. (P8)

[...] that thing of pushing on my belly to give birth, the doctor was getting a little impatient, I had been there a long time and my daughter wasn't coming out and he was losing patience [...]. (P1)

[...] Look, there were a lot of people in the delivery room. I think there were more than 10 [...]. (P10)

According to the participants' statements, childbirth is still seen as a medical act, with the health professional occupying the decision-making and autocratic center of the process. Another important point analyzed refers to the provision of analgesic drugs to black women during childbirth. It was found that the interviewees did not receive analgesia, even when requested. In addition, there was a disregard for reports of pain, exposing black women once again to obstetric racism.

[...] I asked if there was any medicine I could use, but the doctor said no, that it had to be natural [...]. (P18)

[...] And then I was in a lot of pain, and the lady [health professional] said that there are a lot of people in more pain than me and didn't want to give me any pain medication [...]. (P3)

[...] they didn't give me anything for the pain, no integrative practice, nothing for pain relief, nothing [...]. (P1)

Class 2 - The act of breastfeeding

Class 2 presents breastfeeding as one of the highlights of the postpartum period, both in positive aspects, as this moment fosters the bond between mother and baby, and in negative aspects, being related to the difficulty of breastfeeding, as it is often associated with pain. In cases of early lactation suppression, women end up offering artificial milk.

[...] I had milk, but it became blocked, so I couldn't express it, blood came out, I massaged, I put him to my breast, I tried, but there was no way. He was fed formula milk [...]. (P17)

[...] I didn't breastfeed much because of my nipple [...], it came off in pieces. It was the worst part [...] breastfeeding, I didn't have the courage to continue. I regret it, but the pain is so great that it feels like I'm sucking all the energy out of my nipple [...]. (P10)

Class 4 - Intersection between race and childbirth

Class 4 presents different perceptions about childbirth among the study participants. They point out that black professionals are still a minority at the time of childbirth.

[...] There were no black professionals assisting me during childbirth [...] there were none in any of my deliveries. [...] in the hygiene area, in the kitchen when they brought me meals, the professionals were practically all black, and I don't remember any on the team [...]. (P18)

[...] I see that a lot has changed, but I think there is still prejudice against having black professionals in the health field. It still exists, at least here [...] we have a lot of nurses, but few doctors [...]. (P17)

[...] And I think that when there are black professionals, we feel more at ease, more welcome at that moment [...]. (P6)

Black healthcare professionals are still scarce, especially when it comes to healthcare for women during pregnancy and the postpartum period, and racism is linked to this scarcity.

Class 1 - Family and support network

Class 1 features the word family in its structure, highlighting the importance of companions in providing support during childbirth. During childbirth, the companions commonly mentioned are the women's mothers, since they provide the necessary support for their daughters from the beginning of pregnancy, mainly because they have already gone through this experience. Health professionals were also identified as a support network by these black women, their care being intertwined with that of family members.

[...] I had a support network from everyone, I had my mother, husband, sister, I had help from everyone [...]. (P9)

[...] My mother helped me in the beginning for a few days, I remember she stayed with me a little, but my mother-in-law was there more during my first delivery [...]. (P1)

[...] My support network during those seven days was my family, my mother, my

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father, and my daughter's father too [...]. (P2)

[...] the only person who was there to tell me that it would all pass, to support me, and to help me manage the pain was a nurse [...], she massaged my back, she took me to the shower, she put me on the ball, she put me on the horse, even though I didn't want to do all that, it helped the dilation progress and I felt much calmer with her [...]. (P1)

The support network can consist of friends, family, neighbors, and also health professionals. This includes the nuclear family, consisting of the husband/partner and children, and the extended family, which are other relatives, who are a source of support, who bring meaning, and who are really present.

DISCUSSION

It is necessary to break with the biomedical model, which medicalizes childbirth and establishes an authoritarian power relationship, in order to understand it as a physiological, anthropological, psychological, and social event in which women are the protagonists. This change is essential to replace unsafe and dehumanizing practices with evidence-based, woman-centered care [9].

Nursing plays a crucial role in preventing obstetric violence and humanizing childbirth, acting directly to modulate environmental factors to avoid a traumatic experience. This includes ensuring a peaceful environment, with reduced noise, unnecessary interventions, and an excessive number of people at the birth scene.

Childbirth care requires the elimination of unnecessary and potentially violent practices. It is important to restrict vaginal examinations, avoiding their performance by multiple professionals on the same woman in labor. Furthermore, routine amniotomy lacks evidence of benefits, with its potential harms outweighing any gains. Furthermore, the Kristeller maneuver, a form of obstetric violence with clear racial disparity, was reported by 45% of black women in a study of 353 women in labor, compared to only 10% of white women.

The refusal of analgesia for black women shows negligence and obstetric violence. This deprivation extends to non-pharmacological methods, according to a study that showed access to pain relief techniques in only 39% of black women, compared to 58% of white women. As an option, Integrative and Complementary Practices (ICPs) during labor reduce pain and anxiety, promoting autonomy, self-esteem, and empowerment in women, who become aware of their own body's capabilities.

Self-efficacy in breastfeeding is related to the type of delivery, absence of postpartum complications, assistance in neonatal care, adequate guidance at the beginning of breastfeeding, and having a religion, factors that favor its prolonged maintenance. However, the obstetric landscape is still challenging in Brazil, as the Nascer no Brasil (Birth in Brazil) survey alerts us to the inadequacy of prenatal care for black women, who have fewer consultations and insufficient information[16] a fact that impacts their preparation for childbirth and breastfeeding. In order for adequate guidance to be provided during prenatal care, professionals need to be trained to address social inequalities and institutional and structural racism in health services[17].

Black healthcare professionals promote better care through representation and acceptance. However, institutional racism generates inequalities in the distribution of healthcare services and opportunities [18]. Structural racism naturalizes inequalities in healthcare institutions and professional training, making them invisible or subtle [19-20]. It is essential to fight for the training of non-white health professionals, ensuring their admission, retention, completion of their studies, and access to the job market, with promotion to decision-making positions[20], in addition to including racial equity as an indicator of service quality in the pursuit of social justice[16].

Another aspect concerns the support network that assists women in difficulties, collaborating with maternal and child care [21]. Pregnant women can (re)configure this network, identifying people who are truly present in the process, while lack of support leads to isolation and difficulty in sharing pregnancy anxieties. The support network is a protective factor in the pregnancy-puerperal cycle, reducing insecurity and loneliness, strengthening bonds, recognition, and belonging, and may include family members, friends, and health professionals. Nursing was cited as a support profession and is a fundamental part of advancing the quality of care through active listening, information sharing, and prevention of obstetric violence[23-24].

These women's experiences are intrinsically linked to their identity and how they are perceived in health services. Violence and inadequate care are consequences of racism rooted in the health care of this population. Intersectional public policies and non-violent practices value women's knowledge and critical thinking [25].

CONCLUSION

The analysis of the content and organization of the classes highlights the intersectionality between racism and sexism in the childbirth experience of black women. The scarcity of literature on the subject, which represented a limitation to this study, reinforces the urgent need for further research. Future investigations are essential to uncover the specific mechanisms of these oppressions and thus support the formulation of truly equitable and respectful care practices.

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