Anthropology & Medicine

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/canm20

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To cite this article: K. Eliza Williamson (2021) The iatrogenesis of obstetric racism in Brazil: beyond the body, beyond the clinic, Anthropology & Medicine, 28:2, 172-187, DOI: 10.1080/13648470.2021.1932416

To link to this article: https://doi.org/10.1080/13648470.2021.1932416

Published online: 28 Jun 2021.

ANTHROPOLOGY & MEDICINE
2021, VOL. 28, NO. 2, 172–187
https://doi.org/10.1080/13648470.2021.1932416

Routledge
Taylor & Francis Group

The iatrogenesis of obstetric racism in Brazil: beyond the body, beyond the clinic

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ABSTRACT

In Brazil, Black women are disproportionately denied access to timely care and are made vulnerable to death by avoidable obstetric causes. However, they have not been at the center of recent initiatives to improve maternal health. This paper contends that the effectiveness of Brazilian maternal and infant health policy is limited by failures to robustly address racial health inequities. Multi-sited ethnographic research on the implementation of the Rede Cegonha program in Bahia, Brazil between 2012 and 2017 reveals how anti-Blackness structures iatrogenic harms for Black women as well as their kin in maternal healthcare. Building on the work of Black Brazilian feminists, the paper shows how Afro-Brazilian women experience anti-Black racism in obstetric care, which the paper argues can be better understood through Dána-Ain Davis' concept of *obstetric racism*. The paper suggests that such forms of violence reveal the necropolitical facets of reproductive governance and that the framing of obstetric violence broadens the scales and temporalities of iatrogenesis.

ARTICLE HISTORY
Received 15 April 2020
Accepted 18 May 2021

KEYWORDS
Obstetric violence; racism; childbirth; health policy; Brazil

Introduction

I was observing in the waiting area of Public Maternity Hospital (PMH)[1] in Salvador da Bahia, Brazil one Monday morning in December 2016, when I witnessed the following scene unfold. After months of taking on far more than its share of patients in Bahia's maternal and infant health service network, PMH had another critical problem: the day shift's only anesthesiologist had abruptly quit, citing a failure in salary raise negotiations with the state government. In response, PMH's director had halted all admissions of women in labor since there would be no one to administer an epidural in cesarean section births. The receptionist was instructing people to seek care elsewhere. Women and their kin had begun shuffling out, off to try their luck at other hospitals. Around mid-morning, an Afro-Brazilian man in his mid-thirties began complaining loudly to the receptionist behind the metal-barred glass window: his wife was in labor, in pain, and they had struggled to get to PMH. How could the hospital tell him they now had to go elsewhere? Shaking his head, he said: 'I'm revolted with the public [health] system. I have a right [to care]! I pay taxes!' He paced

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the floor angrily as his wife, also Afro-Brazilian, sat in silence on the concrete bench in the waiting area, wincing through contractions.

I later found out that the couple, Marcos and Bia, had lost their first child two years prior, at a different public hospital. Their daughter had been born prematurely and had died just days after delivery because that hospital had no working incubator and was unable to transfer her to another hospital in time. The couple had come to PMH attempting to avoid repeating that traumatic experience. It was no wonder Marcos was so upset.

Marcos was still pacing the floor in front of the reception when a police officer barged into the waiting area. The officer was dressed in the khaki uniform and brown beret, a large gun hanging conspicuously from his belt. He was military police—the same police that terrorise Black communities in cities across Brazil (Alves 2018; Smith 2016a, 2016b, 2016c).[2] Without asking questions, the officer strode up to Marcos and began chastising him for making a scene. Marcos protested, saying he was going to file a lawsuit against the hospital for its negligence. The officer barked that if Marcos continued talking, he'd have him 'forcibly removed'. The officer stepped forward menacingly, but Marcos didn't budge from his seat, boldly telling the officer he had no legal justification to take him into custody. 'I'm going to stay right here', he asserted firmly. The officer bellowed back: 'Aren't you going to shut up?!' (*'Cê não vai calar a boca não?!*). Despite his assertive words, Marcos' demeanor had softened. The threat of him ending up in handcuffs, or worse, was very real. The confrontation eventually de-escalated when the officer received a call on his cellphone. Marcos remained on the concrete bench next to his wife, seething but silenced. An ambulance was eventually called, and the couple was carted off to another maternity hospital across town.

The next morning, however, they were back at PMH, looking exhausted. Bia had been transferred back when, after spending the whole night in labor, it was finally determined that she needed a cesarean section. Today, PMH had an anesthesiologist on shift, while the other hospital did not. The doctors at the second hospital, Marcos told me, didn't give her a C-section because 'they want people to have normal [vaginal] birth … because cesarean is more expensive for the government, and they want to avoid the cost, even when a woman needs one'. He pulled out his cell phone and showed me a picture of his wife clothed in a teal-colored bed sheet, which she was given because they had run out of clean hospital gowns. Marcos hadn't slept all night, waiting and worrying about his wife and baby. 'Public health care is shit [*uma merda*]', he repeated several times. 'My daughter died because of this. We are dogs. They treat us like dogs'.

Several forms of violence converged upon Bia and Marcos during those 24 hours, and all of them, I contend, demonstrate the intersections of obstetric violence, iatrogenesis, and structural racism that remain deeply embedded in Brazil's health system, despite efforts to 'humanise' birth. In what follows, I read what happened to Bia and Marcos as what Dána-Ain Davis (2019a, 2019b) has termed *obstetric racism*: the various forms of harm to which Black women are exposed in pregnancy, birth, and postpartum as a result of racial injustice (see also Davis and Scott 2020). My ethnographic research invites us to reconsider the scales and temporalities of racialized iatrogenic harm that remain unaddressed by recent maternal and infant health policy in contemporary Brazil. The racist violence visited upon Black bodies in pregnancy and childbirth allows us to see how such violence draws on long histories of anti-Blackness that reverberate beyond the pregnant and birthing body and the time-space of the clinic.[3]

Rede Cegonha and the humanization of birth

I witnessed the preceding scene during my fieldwork on the implementation of a federal government program called Rede Cegonha (Stork Network) in Bahia. Launched in 2011, Rede Cegonha draws on evidence-based recommendations espoused by the World Health Organization to improve maternal and infant health outcomes in Brazil's universal public health system (the Sistema Único de Saúde, or SUS). It promotes low-intervention, evidence-based care for women and babies that priorities vaginal delivery over cesarean section whenever possible. Key objectives for Rede Cegonha include reducing both maternal mortality and the overuse of medical interventions in childbirth. Cesarean section deliveries account for over half of live births in Brazil, and vaginal deliveries are often rife with medical interventions that can make the experience painful and traumatic. By promoting 'good practises' in birth that priorities low-intervention vaginal delivery, Rede Cegonha aims for better birth outcomes *and* experiences. Inspired in part by birth activists' calls for 'humanisation' of birth, Rede Cegonha 'is a package of actions to guarantee quality, safe, and *humanised* care for all women' (Brasil 2013; my translation and emphasis; Williamson and Matsuoka 2019). 'Humanised' birth care centers women as protagonists rather than as passive patients and respects the physiological process of childbirth. Thus, key program strategies have revolved around investing in health system infrastructure, 'sensitising' (*sensibilizar*) healthcare professionals to the importance of a more 'hands-off' approach to birth, and incorporating non-pharmacological techniques for pain management and healthy delivery into routine care.

Rede Cegonha endeavors to reduce iatrogenic harm in childbirth, such as infant prematurity due to untimely cesarean sections, or physical injury or emotional trauma to mothers after excessive medical interventions.[4] In a preliminary review, Leal et al. (2019) note significant advances in birth care since Rede Cegonha's inauguration. Between 2011 and 2017, the number of births with beneficial practices backed by scientific evidence increased in proportion to non-beneficial practices (those considered not beneficial and/or potentially harmful). Almost 84% of women were permitted a labor companion in 2017, compared with only 31.8% in 2011. The percentage of births attended by nursing professionals (as opposed to strictly doctors), which have been shown to reduce intervention in birth and improve outcomes overall (e.g. Sandall et al. 2016), went up to 27.3% from 16.5%, and the rate of episiotomy in vaginal deliveries (a manual cut in perineal tissue that is not recommended for routine use) went from 47.3% to 27.7% (Leal et al. 2019, 6, Table 2). The authors conclude their paper by stating that 'an increase in satisfaction on behalf of women undergoing birth care [sic] in the country is also a likely result. The process of change of labour and birth care in Brazil is in full development' (10).

Despite these laudable goals and promising results, structural anti-Blackness in Brazil continues to shape experiences of birth care and complicates the 'humanisation' of birth. Rede Cegonha itself contains no specific language about race besides a stated commitment to 'respecting racial diversity' (Brasil 2011), though both international recommendations and federal guidelines emphasize the need for the program to address racial inequities (UNFPA 2016; Brasil 2014). During the years I spent tracking Rede Cegonha in Bahia, between 2013 and 2017 in total, the health effects of racism on Black women were not central to planning and implementation. Drawing on my research as well as the work of Black feminist scholars working on racial health justice in Brazil, I suggest that this elision

may ultimately hamper efforts to improve maternal and infant health outcomes and experiences. My research shows that the hoped-for 'increase in [women's] satisfaction' with their birth care may be more elusive than Leal et al. indicate. In particular, this has to do with what Rede Cegonha's focus on changing birth care practices leaves out—the structural racism in Brazilian society that drives up the numbers of maternal deaths and the incidence of obstetric violence especially for Black women. What follows is not an evaluation of Rede Cegonha's uses of best practices or medical technologies; rather, I bring my interlocutors' voices to bear on Black health activists' and scholars' longstanding call to bring racial equity to the center of maternal and infant health policymaking and program implementation. Recent research on Rede Cegonha's outcomes indicates that Black women still have unequal access to quality prenatal and birth care (Theophilo, Rattner, and Pereira 2018). My aim in this paper is to provide one account of how anti-Blackness impacts maternal and infant health on the ground in the context of Rede Cegonha's implementation, complementing epidemiological and survey data on Black women in pregnancy and childbirth. Ultimately, I hope to contribute to the ongoing efforts led by Black health scholars and activists to ensure that improvements in the delivery of perinatal care centers racial equity.

Fieldwork and methods

This analysis draws on eight years of research on maternal and infant healthcare in Brazil, including 24 months of multi-sited ethnographic fieldwork which tracked the implementation of Rede Cegonha in the majority Afro-Brazilian city of Salvador da Bahia. My research followed the program from the national Ministry of Health to local health secretariats, maternity care units, and communities in Salvador. Fieldwork involved participant observation in each of these sites, as well as 70 interviews with policymakers, government bureaucrats, health care professionals, birth activists, and women and their family members. I explored, in part, how racialised social inequalities in Bahia affected how Rede Cegonha was implemented and perceived by those Rede Cegonha is meant to help: pregnant women and their kin. In this paper, I center the experiences of pregnant and birthing people and their families to show how they understood the iatrogenic effects of racism in obstetric care.

Race and social class in Brazil are intimately bound together—75% of Brazilians living in extreme poverty are Black (Villas Bôas 2019). Both the numbers and the lived experiences of Black Brazilians attest to the persistence and pervasiveness of race-based discrimination in all areas of social life (e.g. Guimarães 1995; Hanchard 1994; Moura 1994; Perry 2013; Sheriff 2001; Telles 2004). despite the fact that Brazilian national identity has been founded on the myth of 'racial democracy'—the idea that Brazil is a color-blind nation characterised by racial harmony, anti-Black racism lies at the very foundations of Brazilian society (e.g. Perry 2020; Smith 2016a, 2016b; Vargas 2018). Christen Smith (2016a) proposes the concept of a 'paradox of Black citizenship' in a country that ostensibly celebrates Black culture as a symbol of national multiracial identity while, in practice, heavily polices, murders, and devalues Black bodies and lives.

Located in the Brazilian Northeast, a historically disadvantaged region compared to the wealthier South and Southeast, Salvador is Brazil's fourth largest city. With around 80% of its population identifying as *preta* (black, dark skin) or *parda* (mixed-race, brown), Salvador has a rich African diasporic culture. Social inequality there, however, follows the racialised pattern seen elsewhere in urban Brazil (Carvalho 2020). The vast majority of Bahia's elite

class, including physicians and health officials, are white or light-skinned. Preta and parda populations have higher rates of unemployment, are more likely to live in the city's poorly provisioned 'peripheral' districts (*periferias*), and earn on average less than half of what white Bahians make (Carvalho 2020).

Race, racism and maternal health in Brazil

Unsurprisingly, health disparities in Brazil also cut along racial lines. Being Black puts one at a higher risk of state violence and daily discrimination (e.g. Paixão 2004; Perry 2020; Roth-Gordon 2017; Smith 2016a; Vargas 2018; Williams 2013). Access to health services and quality of care are unequally distributed, with Black and Indigenous Brazilians worse off than white Brazilians (Caldwell 2017; Edu 2018; Goes and Nascimento 2013). Brazil's overall maternal mortality rates are about 2.5 times higher for Black women than they are for white women (Bahia 2018; Brasil 2020; Leal et al. 2017; see also Martins 2006). Numerous studies have now shown that, when compared to white women, Black women are less likely to have the recommended number of prenatal visits, receive adequate prenatal consultations, get pain relief in labor, and have labor companions with them in birth. Black women are less likely than white women to deliver by cesarean section, but when they do, they are more likely to have untreated post-surgery complications (Diniz et al. 2016; Domingues et al. 2016; Leal et al. 2017; Viellas et al. 2014). These racial disparities in obstetric care reflect broader inequities in reproductive health for Black women (e.g. Edu 2018; Goes and Nascimento 2013; Falu 2019; Santos 2012).

The disparities go beyond mortality rates; given Rede Cegonha's insistence on reducing medical interventions in childbirth, it is necessary to understand how these interventions are racialised. Brazil has one of the highest cesarean section rates in the world.[5] In private hospitals, cesareans constitute 77% of all births, while they constitute 44% of births in public hospitals (Leal et al. 2019). Despite recent decreases in painful, potentially iatrogenic, and unscientific practices (e.g. routine episiotomy and fundal pressure) in public hospitals, these procedures are still widely used (Leal et al. 2012, 2019). Interventions now widely recognised as iatrogenic, such as routine episiotomy and the Kristeller maneuver, are difficult to eradicate in practice. Furthermore, women themselves often actively seek these interventions, understanding them as necessary for proper care (Béhague 2002; McCallum 2005a; Williamson and Matsuoka 2019).

Despite decades-long efforts of birth activists to shift the paradigm of care, change has been slow and uneven. Black feminist health scholars and activists denounce the Brazilian government's failure to account for and address racial disparities in reproductive health, including in childbirth (Goes and Nascimento 2013; Domingues et al. 2013; Goes, Ramos, and Ferreira 2020; Werneck 2016; Caldwell 2017). In an interview with Bahian nurse, Collective Health scholar, and Black feminist health activist Emanuelle Goes, she expressed frustration about Rede Cegonha's failure to center Black women's experiences and address racial inequities in maternal and infant health (personal interview, May 2014; see also Carneiro 2013). While they also critique the over-medicalisation that Rede Cegonha seeks to address, Black feminist health activists emphasize structural medical *neglect*, asserting that it is often a *lack* of timely intervention and quality care that Black women experience in pregnancy and childbirth (Caldwell 2017; Otovo 2016). In other words, Rede Cegonha's

emphasis on the iatrogenic effects of excessive intervention may fail to address the needs of those who have historically struggled to get *necessary*—or any—medical intervention (Otovo 2016, 211).[6]

These critiques point to the need for a wider framing of iatrogenesis that can account for the impacts of racism on Black women in birth. In many ways, Rede Cegonha's framing of iatrogenic childbirth practices mirrors Ivan Illich's (1982) notion of 'social iatrogenesis'—harm caused by forms of social and political organisation that promote ill health and dependence on medical institutions for care that fails to heal people. While this concept is a useful starting point for attending to social and political structures, Illich's rendering of social iatrogenesis has little to say about the harmful health effects of racism, and it fails to consider how certain groups of people are routinely denied access to its life-saving technologies. In contrast, I propose reframing iatrogenesis by centering the experiences of Black research interlocutors. Obstetric racism helps us see how iatrogenic harms exceed the birthing body and the maternity care clinic to encompass broader scales of structural and historical—and importantly, racist—violence that converge upon pregnant and birthing people as well as their kin. Examining how iatrogenesis is imbricated with structural racism allows us to better capture the specificities of iatrogenic harms to Black Brazilian women.

Anti-Blackness, necropolitics and obstetric racism in Brazil

Brazil's anti-Black, necropolitical social order is rooted in a history of chattel slavery. Brazil received more captured Africans than any other country in the world, and legal slavery lasted until 1888. As the first colonial capital, Salvador was a major port of entry for millions of enslaved people. Enslaved Black women were responsible for nurturing white children at the expense of their own, their reproductive bodies placed at the service of white-dominated Brazilian society (Edu 2018; Otovo 2016). Black women were also encouraged to racially lighten their family 'stock' by marrying and having children with white or lighter-skinned men (Skidmore 1992). Obstetric racism therefore draws from a deep temporal well, as it does as well for Black women in the United States (Davis 2019a, 2019b).

Structural anti-Blackness continues in the persistent and violent forms of policing of Black communities, the banalised deaths of Black people (often at the hands of the state), and the consistently worse health outcomes of Black Brazilians. As Black Brazilian physician, public health scholar, and anti-racist activist Jurema Werneck writes, 'Despite the intensity and depth of its deleterious effects, racism produces the naturalisation of the inequalities produced, which helps to explain the way in which many describe [racism], as subtle or invisible' (2016, 541; my translation). For Dána-Ain Davis, the guileful nature of racism permeates Black women's experiences of obstetric care, where they experience racism 'in the crevices and creases of a conversation, in the space between a comment and a pause' (2019a, 203). It is this aspect that makes obstetric racism a particularly useful analytic, given that racism is built into the hierarchical structure of society, usually unspoken but normalised in everyday social interactions (e.g. Domingues et al. 2013; McCallum 2005b). In my ethnography, such unspoken cues included the absence of healthcare professionals to accompany women in painful labor, the unhurried movement or inaction of

health workers in the hospital, or the chaotic shuffling of patients from hospital to hospital (see also Berry 2008; Andaya 2019).

In my clinical fieldwork, while racial disparities in treatment and quality of care were generally not verbalized, I noted that poor but lighter-skinned women questioned and made requests of health care professionals more often than darker-skinned women. Hospital workers themselves presented a skin color gradient that replicated the racial hierarchy of Bahian society, with doctors being mainly white and low-paid nursing auxiliaries (*técnicas de enfermagem*) largely Black. That few patients or providers spontaneously brought up race and racism as factors in care is consonant with what other researchers have identified as a common hesitancy among many Brazilians to talk about health inequities in terms of racial difference, a legacy of the myth of racial democracy that has so profoundly shaped Brazil (Pagano 2014).

However, Black patients were forthcoming about their experiences of negligence and abuse in public maternity hospitals, and occasionally they framed these experiences specifically in racial terms, for example, when I suggested their mistreatment may be linked to racial prejudice (*preconceito racial*), Black women often agreed. A few health care professionals I interviewed also referred explicitly to racial dynamics. Germana, a young nurse working at PMH who was one of the few personnel I interviewed who explicitly identified as *negra*, was adamant that racism was a key factor in the lesser treatment of Black women. She could clearly see anti-Black discrimination at work, especially when compared to the treatment that white women received. When a white patient arrived at the public hospital where she worked, which was a rare occurrence:

> … she's treated so differently that it's blatant. I just can't [watch this happen]; I stop what I'm doing, because I can't watch it. They [healthcare workers] finish the consultation, let the woman go, and look at each other and say, 'Wow, she's so well informed [*esclarecida*].' [Healthcare professionals] orienting [patients] differently… It's blatant, Eliza. I get enraged at the disparity. And the Black woman [*mulher preta*], who suffers in the doctor's care, who suffers because she doesn't have prenatal care, because she's from those peripheral [low-income] neighborhoods….[7]

Germana's observations point to the various forms of violence Black women are subjected to in birth. These include being scolded for being 'uncooperative' and/or reproducing 'too much', undergoing multiple cervical examinations during labor without their full consent and having to 'peregrinate' (*peregrinar*) from hospital to hospital to find an available bed are all common (Aguiar and d'Oliveira 2010; Leal et al. 2012; Parto do Princípio 2012). Scholars classify verbal, psychological, and physical abuse in pregnancy and birth, as well as medical neglect and denial of care as obstetric violence (e.g. Belli 2013; Castro and Savage 2019; d'Gregorio 2010; Diniz et al. 2015; Smith-Oka 2013; Vacaflor 2016). While a quarter of Brazilian women has experienced some form of obstetric violence (Fundação Perseu Abramo 2010), most existing data is not disaggregated by race.

Dána-Ain Davis (2019a, 2019b) has suggested that the term 'obstetric violence' is inadequate to understand the racialized contours of this violence. In her analysis of premature births of Black babies in the northeastern United States, Davis shows how the high rate of premature births and violence Black women experience in obstetric care must be understood as an iatrogenic instantiation of longstanding, systemic racism that leaves painful marks on bodies as well as psyches (see also K.A. Oliveira et al. 2018). Davis dubs this phenomenon

obstetric racism, an analytic that allows us to examine structural racism as it surfaces in Black women's reproductive lives. '[O]bstetric racism', she asserts, 'includes, but is not limited to, critical lapses in diagnosis; being neglectful, dismissive, or disrespectful; causing pain; and engaging in medical abuse through coercion to perform procedures or performing procedures without consent'. Obstetric racism 'is a threat to maternal life and neonatal outcomes' and Black 'women's interpretations of those encounters is a fluency of historically constituted racism, segregation and policing' (Davis 2019b, 561–62). Similarly, Brazilian scholars are increasingly framing obstetric violence against Black women as a manifestation of intersecting misogyny and anti-Blackness (Assis 2018; Lima, Pimentel, and Lyra 2019). My work contributes to this body of scholarship by offering an ethnographically grounded account of racism's manifestations and effects in childbirth in Bahia.

Obstetric racism both contributes to iatrogenesis and extends its temporality. Thinking obstetric racism and iatrogenesis together allows us to see the *necropolitical,* rather than only the biopolitical, logics of reproductive governance at work (cf. Morgan and Roberts 2012). Necropolitics refers to the ways sovereign power not only conditions the reproduction of life and the way people live, but also actively or passively brings about 'the material destruction of human bodies and populations' (Mbembe 2003, 14). Life is subjugated to the power of death. As nurse and Collective Health scholar Elaine Soares Oliveira puts it, the necropolitical Brazilian state manages the Black population by making their lives 'subject to the constant risk of death'. This includes the conditions of Brazil's healthcare system, which, Oliveira insists, 'tends to operate necropolitically in that it produces fatal conditions in certain [health] services and equipment … with the purpose of making it so that [the Black] population does not survive, or that it lives in such limit conditions that the space between life and death is very small' (24 July 2020). Black Brazilian women are indeed 'subject to the constant risk of death'—a risk structured by the institutional racism that denies appropriate, timely care to Brazil's Black population. Thus producing, monitoring, and controlling *bios* is only one part of how reproductive lives are governed; another, equally important dynamic—particularly for racialised populations—is the exposure to untimely death.

The case of Bia and Marcos, described at the beginning of this paper, illuminates the necropolitical logics embedded in maternal health care in Brazil. It evinces the violence—both passive (structural neglect) and active (lethal policing)—of the state's presence in the lives of Black Brazilians, thereby allowing us to perceive multiple scales of racial injustice and iatrogenesis at work. Marcos' frustrations were linked to the couple's previous maternity hospital experience, where their infant daughter died for lack of adequate equipment and a failure to transfer in time. The rage in his voice reflected the painful knowledge that his wife and child were once again at the mercy of a healthcare system that treated people like them with disregard and routinely allowed Black babies to die. In the encounter with military police, the lethal arm of the state was deployed to 'pacify' Marcos' unrest. In this instance, Marcos was reminded that not only could the racist state allow his loved ones to die, it could also actively kill him. Thus, what may at first appear as two very separate institutions—public healthcare and the military police—converged in the hospital waiting area, highlighting the necropolitics of the Brazilian state. For the hospital, the police, and the Brazilian state more broadly, the couple's Blackness ultimately marked them and their child as disposable subjects.

'He simply decreed that I had to have a cesarean section': Vanessa

While Blackness and class are in many ways linked in Brazil, the analytic of obstetric racism also allows us to disentangle them, showing how racism operates independently of class-based prejudice. One of my interlocutors, a Black birth doula and activist named Vanessa was in her late 20 s at the time of our interview and was the adopted daughter of a light-skinned, upper-middle-class family of Roma origin. She had had an unplanned pregnancy a few years earlier and had given birth by cesarean section in a public hospital. In the hospital, her higher socioeconomic status than the other patients was irrelevant; she was read as a Black woman and treated accordingly.

At the hospital, she was in labor for several hours in the waiting area before being called into the intake unit, and then waited in triage while the doctors on shift attended to other matters. At no point was her husband or any other family member allowed to accompany her. When a doctor finally came to see her, Vanessa told me,

> He came in, didn't say 'good evening,' didn't ask my name, didn't say anything. He barely looked at my chart, I think. And he said, 'Lie down, I'm going to do the *toque* [cervical examination to determine extent of dilation].' I lay down. I thought he was going to rip the baby out. Because he—that wasn't a toque; that was something, like, that was very brutal. He stuck his whole hand in and pulled all at once. I said, 'My God, he's going to rip out my baby now.'[8] Then he looked at me, looked at the nurse, and said to the nurse, 'She's already at 10 centimeters [cervical dilation]. You can send her for a cesarean.' And I was in the middle of a contraction; I couldn't even ask him why [cesarean]. In that moment I said to myself, 'You know what? I'm not going to even ask. Let's just get this thing over with. […] He didn't take my blood pressure. He didn't do anything. Nothing. Didn't listen to the baby's heartbeat, nothing. He simply decreed that I had to have a cesarean section to make [the birth] go faster.

In the obstetric surgery unit, Vanessa was left with 'a bunch of women, wandering around' in white hospital gowns like hers, also in labor, reminding her of 'a horror film' or a 'hospice'. When her name was finally called, the anesthesiologist demanded she hoist herself up onto the high, narrow operating table, refusing to help her despite Vanessa's obvious difficulty. 'Hurry up, child [*minha filha*]! You think you're the only one here? Come on!' he chided, as Vanessa struggled. Once she had pulled herself onto the operating table, he berated her for lying down, since he needed to give her an epidural for which she had to be seated. Despite Vanessa crying and pleading to have a moment to wait out a contraction, he reiterated impatiently, 'I don't have all day! Can't you see it's full here? Hurry up!' After the birth, Vanessa didn't see her baby for several hours, until her sister-in-law was finally allowed to see her and advocated on her behalf. Her son had been taken for routine examination and a first bath while Vanessa was left on a gurney in the hallway, listening to his cries.

From Vanessa's perspective, despite her relative economic privilege, she was read as another Black woman having a baby. Her dark skin conveyed to hospital staff the stigmas of poverty, illiteracy, sexual licentiousness, and irresponsibility so often attached to it (De Zordo 2012). She became someone not worth looking in the eye, addressing directly, or helping onto the operating table, someone on whom procedures could be performed without consent, for whom decisions could be made without consulting or explaining. Vanessa's needs and desires were cast aside by doctors' intent on delivering her baby quickly rather than waiting for labor to progress toward a vaginal delivery. Vanessa's body became a barrier to the production of neonatal life under the control of hospital care professionals.

Vanessa's story shows the harm engendered by historically rooted anti-Black racism on birth care such that this 'care' generates harm. The iatrogenic effects of this experience left psychological and emotional wounds that Vanessa experiences as gendered and racialised trauma. As Vanessa became a racialized subject of the obstetric gaze, she experienced iatrogenic harm in the flesh but also beyond it, a harm she carried with her in her vivid memory of the mistreatment she experienced in her birth. However, Vanessa's experience of obstetric racism did not only make her a victim; after her traumatic birth experience, Vanessa decided to become a birth doula. In addition to working with paying clients, she volunteered weekly at a public maternity hospital, supporting other Black women through labor and delivery—the very support she herself had been denied. In our interview, she described this work as 'using my privilege in a way that eases someone else's life'. Through her volunteer doula work and activism, she fought for Black women's 'right … to give birth with dignity, to access care, [and] to not suffer obstetric violence'.

Vanessa is certainly not the only one doing this radical work. In Salvador, a collective of Black doulas has recently formed to address the specificities of Black women's concerns and experiences in pregnancy and childbirth (Correio 24 Horas 2020). Black feminist scholars have brought the term 'obstetric racism' into public discourse in Brazil (Ramos 2020), giving force to vital conversations around the need to attend to anti-Blackness in maternal and infant health care. While it is beyond the scope of this paper, further work might follow that of scholars who have addressed Black Brazilian women's resistance to reproductive injustice to investigate forms of agency in relation to obstetric racism.

Conclusion: the racial temporalities and scales of iatrogenesis

This paper has shown how an analytic of obstetric racism makes visible the longer *temporalities* and *scales* of iatrogenesis—not just the duration of harms themselves, but the longer histories that condition how it manifests for differently positioned subjects, their families and their communities (e.g. Cooper Owens and Fett 2019; Falu 2019; Otovo 2016; Santos 2012; Roberts 1997; Washington 2006). Obstetric racism's iatrogenic effects are deep, and its effects are long-lasting and wide-ranging. In Illich's analysis, iatrogenic harm is located on and in the body. Certainly, women's and babies' bodies bear the marks (literal and figurative) of too much or not enough medical intervention (see also Miller et al. 2016). However, in the cases I have presented, especially that of Bia and Marcos, we see that the 'marks' of obstetric racism are also left on the bodies of others: on parents, and, we can safely presume, on wider communities as deaths reverberate and medical horror stories circulate. For Bia and Marcos, the trauma of losing their first child fueled their anxieties about and experience of the birth of their second. Vanessa's birth experience left a C-section scar and also haunted her emotionally for years afterward (see also Varley and Varma 2018). Obstetric racism entails not just what happens between a doctor and patient, but also the broader sociopolitical conditions that produce harm, including the long histories of anti-Black violence that reverberate beyond birthing bodies and clinical spaces.[9]

Examining obstetric racism in Brazil sheds light on the necessity for even innovative policies like Rede Cegonha to focus more attention on racial equity. Given that anti-Black racism undergirds the iatrogenic effects vividly illustrated in my interlocutors' narratives, anti-racism must be placed at the center of efforts to improve maternal and infant health. Fortunately, some of this work is already underway. In 2014, in partnership with the United

Nations Population Fund, Brazil's Secretariat of Policies for the Promotion of Racial Equality (SEPPIR) launched the 'Rede Cegonha e Mulheres Negras' initiative, which has been collecting survey data specifically on Black women's prenatal and birth experiences in the context of Rede Cegonha (UNFPA 2014). This is a positive step forward. While my research is not directly linked to this ongoing initiative, my ethnographic analysis supports the overall effort to place racial equity at the center of policymaking and program implementation.

I am writing this at a time when Brazil's public healthcare system is under attack and at risk of collapsing under the weight of the Covid-19 pandemic and the necropolitical governance of the Bolsonaro administration. It is now as important as ever to defend the SUS. Public healthcare must be a primary funding priority for the Brazilian federal government. In the United States, where I write now, the lack of universal health care is a major driving factor in the country's profound health inequities. Brazil is, in this sense, far more advanced than the U.S. in establishing healthcare as a constitutional right. However, neoliberal economic logics have led to the chronic underfunding of the SUS since its beginnings, and recent austerity measures have guaranteed that it will remain so for decades to come (e.g. Paim et al. 2011). Without robust public healthcare, racial health inequities will remain stark. However, as Black scholars and activists have repeatedly argued, universal health care is not enough; targeted action is necessary. Maternal and infant health policies in Brazil and around the world should center the experiences of Black and other racially and ethnically marginalized women in order to formulate policies that work for those most impacted by maternal morbidity, maternal mortality, and obstetric violence. I write in co-conspiration with Rede Cegonha's proponents, SUS defenders, and Black scholar-activists toward good birth for all.

Notes

1. All names of people and institutions have been changed to protect confidentiality.
2. Both civil and military police have a history of violence committed against Black communities in Brazil, but the military police is particularly feared (see Amnesty International 2018; Smith 2016c).
3. This paper focuses on anti-Black racism; however, racist violence in pregnancy and birth also profoundly affects Brazil's Indigenous population (see Inter-American Commission on Human Rights 2017; Lima 2016).
4. Rede Cegonha also works to strengthen the articulations between maternal and infant healthcare services and increases funding for reproductive planning programs. Here, however, I focus primarily on the program's promotion of low-intervention vaginal delivery.
5. As of 2018, according to the latest data available from DataSUS (http://tabnet.datasus.gov.br/cgi/deftohtm.exe?sinasc/cnv/nvuf.def; accessed 7/29/20).
6. Here Otovo refers to what Robbie Davis-Floyd (2001) has influentially termed the 'technocratic model' of birth, wherein labor and delivery is doctor-centered and heavy on medical technologies and interventions.
7. "Peripheral neighborhoods," *bairros periféricos*, refers to low-income districts racialized as Black.
8. What the doctor did here was likely not a cervical examination but 'membrane stripping', a painful procedure sometimes used to induce labor. I thank an anonymous reviewer for this observation.
9. I thank Saiba Varma for this phrasing of my intervention.

Acknowledgments

I thank Saiba Varma and Emma Varley for organizing this special issue. I also thank them, Dána-Ain Davis, Nia Georges, and two anonymous reviewers for their generous feedback and encouragement. My deepest thanks go to the women, healthcare professionals, and activists who shared their stories with me and who continue to fight for racial health justice.

Ethical approvals

This research was approved by the Rice University Institutional Review Board (Project 702001-2) and the Comissão Nacional de Ética em Pesquisa-CONEP (CAAE 56582116.2.0000.5030).

Disclosure statement

No potential conflict of interest was reported by the author.

Funding

This research was supported by the Wenner-Gren Foundation and the Fulbright-Hays program as well as the Association for Feminist Anthropology, the Brazilian Studies Association, and Rice University.

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