sexes

MDPI

Article

Pregnancy, Childbirth, and Postpartum Experiences of Racialised Brazilian Women in Portugal: An Analysis of Obstetric Violence as Gender-Based Violence

Mariana Holanda Rusu [1,2], Conceição Nogueira [1,2] and Joana Topa [2,3,4,*]

1 Department of Psychology and Educational Sciences, University of Porto, 4200-135 Porto, Portugal
2 Center for Psychology, University of Porto, 4200-135 Porto, Portugal
3 Interdisciplinary Centre for Gender Studies, University of Lisbon, 1300-663 Lisbon, Portugal
4 Department of Social and Behavioral Sciences, University of Maia, 4475-690 Maia, Portugal
* Correspondence: jtopa@umaia.pt

Abstract: As gender-based violence, obstetric violence is a complex phenomenon that represents a matter for debate worldwide. The main objective of this exploratory study is to understand the experiences of obstetric violence during pregnancy, childbirth, and the postpartum period of racialised Brazilian women in the Portuguese National Health System. Using a qualitative case study research approach, semi-structured individual interviews were conducted with ten racialised Brazilian women who gave birth in Portugal. A thematic qualitative analysis was used. The findings reveal significant cases of obstetric violence, which include the complexities and lack of support, assistance and monitoring networks, structural inequalities, neglect, and intersectional discriminatory practices based on racial and cultural prejudices, as well as reflection. These experiences not only affect the physical health of mothers but also have profound psychological and emotional consequences. This study highlights the urgent need for culturally sensitive care and the implementation of policies to prevent obstetric violence, ensuring that the rights and dignity of migrant mothers are upheld. By highlighting these critical issues, this study aims to contribute to the broader discourse on maternal health care and promote social justice for these historically marginalised groups.

Keywords: gender-based violence; obstetric violence; structural inequality; racialised Brazilian women; intersectionality

Citation: Rusu, M.H.; Nogueira, C.; Topa, J. Pregnancy, Childbirth, and Postpartum Experiences of Racialised Brazilian Women in Portugal: An Analysis of Obstetric Violence as Gender-Based Violence. *Sexes* **2024**, *5*, 611–637. https://doi.org/10.3390/sexes5040040

Academic Editor: David L. Rowland

Received: 31 July 2024
Revised: 23 October 2024
Accepted: 25 October 2024
Published: 1 November 2024

Copyright: © 2024 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (https://creativecommons.org/licenses/by/4.0/).

1. Introduction

In recent years, the stimulus for the creation of health policies and reforms around the world, with the aim of increasing the number of births in health facilities, reducing maternal mortality rates, and offering patient safety and high-quality obstetric care [1] has come up against the persistently high incidence of adverse events (AEs), making their impact and the availability of efficient and practical preventive measures a constant challenge [2,3].

One of these major challenges is the prevention and eradication of obstetric violence (OV), a term coined by Latin American activists at the beginning of the 21st century, which refers to mistreatment and abuse that women can suffer in the care provided during pregnancy, childbirth, and the immediate postpartum period [4]. According to Sesia [5], OV is considered to be a form of gender-based violence experienced by parturients 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. Diaz-Tello et al. [4] reinforce that "obstetric violence is the intimidation and coercion of women during pregnancy, childbirth and the postpartum period by health professionals, [and]. . . a systemic problem of institutionalised gender-based violence" (p. 1).

Multiple aggravating factors increase the vulnerability of people who do not conform to the normative structures of Eurocentric and heteropatriarchal society. This includes migrants or refugees; individuals with non-normative gender identities, sexual or marital orientations, low socioeconomic status, and disabilities; and racialised people. These groups are more likely to experience racial and multiple oppressions and inequalities in obstetric care, which consequently puts them at greater risk of experiencing obstetric violence (OV) [6,7]. Some authors have recently expanded the term OV to emphasise these oppressions, coining, for example, the term "obstetric racism" [8,9].

The growing recognition of this form of violation of fundamental human rights by international institutions, such as the United Nations (UN) [10] or the Council of Europe (CE) [11], has contributed to the stabilisation of the concept and the visibility of the phenomenon. The World Health Organisation (WHO) has emphasised the importance of preventing and eliminating abuse, disrespect, and mistreatment during childbirth in health-care institutions, defending clinical practices based on scientific evidence, and promoting physiological childbirth based on respectful treatment [12].

In Portugal, assisted labour is not only a critical issue but also a controversial one. The study by Ref. [13] indicates that obstetric violence rates in Portugal are three times higher than the average of 11 other European countries. Ongoing studies underscore continuing to highlight this alarming trend [13–26], revealing several negative experiences within the health service. Notably, more than a fifth of Black women suffer OV, as highlighted by the Association for the Health of Black and Racialised Mothers in Portugal [14].

Despite these alarming findings and claims of victims, activists, and health professionals, there is significant pushback from the Portuguese Gynaecology/Obstetrics Specialty College [27], which claims that OV does not apply in the country, stating that the term obstetric violence is inappropriate in countries where excellent maternal and child health care is provided, as is the case in Portugal, and that "no situation of obstetric violence is proven in Portugal". This ongoing denial is exacerbated by the lack of a legal definition of OV in the Portuguese legislation, leaving it unresolved and unaddressed.

1.1. Obstetric Violence and Structural Inequality During Pregnancy, Childbirth, and the Postpartum Period: An Intersectional Overlook

OV is broadly defined as any action taken before, during, or after childbirth without the woman's consent or that restricts her decision-making power. This form of gender-based violence, including verbal, physical, and sexual abuse; social discrimination; neglect; and improper use of procedures, continues to occur globally [4,5].

OV involves any illegitimate and unjust form of coercion or mechanisms to uphold a power hierarchy defined by sexist culture, forcing women to comply with the demands and conditions imposed by the patriarchal system within the health system. It happens in both public and private healthcare facilities during obstetric care, causing physical or psychological consequences for women [6,10].

This behaviour distorts social relations, leading to abuses of power, violations, invasions, and transcendence of women's boundaries, all aimed at suppressing resistance and exerting control and domination over women to maintain a specific social position/order [28]. Power, therefore, is not an abstract concept; it is exercised, visualised, and demonstrated during social interactions [29]. It is legitimised by social norms and shapes new realities and existences, but at the same time, it allows for the exercise of control and domination over the lives of others, often demanding absolute obedience.

In the context of maternal care, the professionals may at times exert this power, leading to non-reciprocal interactions and subordinate women's identity. This is exemplified in the dichotomies between the feminine and the masculine and hierarchy, which create multiple social inequalities, especially within maternal health care.

The patriarchal foundations of this culture legitimise the authority of men or other women in power, denying the "other" women the rights of self-determination and dignity [6]. According to Foucault [30,31], power is not always evident at first glance but

often operates in subtle forms of coercion. For example, biopower includes mechanisms of population control, including the regulation of health habits and practices, women's reproductive behaviour, and sexuality. From this perspective, health facilities serve many times as institutions of discipline where power is exercised, illustrating how OV functions as a mechanism of biopower aimed to control women.

In this case, the female body is a strategic field, a place where biopower is exercised, where it undergoes a process of objectification and control by health professionals through their medical and psychological discourses. It represents a shift away from comprehensive, intersubjective care due to the use of technologies of power over the body. It represents the asymmetrical exercise of power relations between obstetricians, other health professionals, and women, which reveals inequalities and the deprivation of women's right to decide about their bodies [29].

This type of invisible violence is normalised by society and its institutions, restricting human rights and perpetuating patterns of submission to medical staff. Studies [28,29] highlight that these patterns are also maintained and aggravated by displacing the reflection, ethics, and human approach that specialists should apply when interacting with patients.

In this context, women are treated as a secondary element, with institutional protocols and guidelines, prioritising scientific and technical authority over their needs. Understanding these unequal power relations means entering the foundations that define society, its political discourses, interpersonal relationships, the sphere of sexuality, and social action. The exercise of power is not a mere concept, it is a mechanism that perpetuates dominant discourses, denies subjectivity and identities, and enforces repressive conditions [30].

The exercise of power in OV involves the intrusive and often coercive control over women's bodies, which is configured as gender-based violence [6–8]. The hegemonic model of care, which exacerbates existing inequalities [32], reflects the patriarchal, monogamous, and sexist nature of many societies. This model is an example of oppression and control, a regime of domination and exploitation of women by men [33]. Consequently, health professionals often appropriate women's bodies and their reproductive processes expressed through dehumanised treatment, the abuse of medicalisation, and the pathologisation of natural processes. This creates a loss of women's autonomy over their bodies and sexuality, negatively affecting their quality of life [13,14].

The abuses suffered by these women occur in contexts where their vulnerability is heightened, making the impact of these experiences particularly concerning. Some authors also state that this situation is intensified for doubly vulnerable women, such as those belonging to ethnic minorities, migrants, and pregnant or birthing women, among others, who may face the intensification of violence due to social conditioning [29]. For this reason, dialogue on the intersectionalities of the different perpetuations of OV as a form of gender-based violence is of the utmost importance.

Gender is not an isolated component of personal identity; identity is intersectional [32]. As a feminist theoretical framework, intersectionality posits that human experiences are shaped by several social positions simultaneously. This theory allows for the analysis of the unique and multifaceted experiences of racialised migrant women [33–36]. In this way, intersectionality conceptualises the problem, seeking to capture the structural and dynamic consequences of the interaction between two or more axes of subordination.

As a form of critical inquiry, intersectionality examines a variety of social phenomena through the lens of these intersecting structures [36]. It helps to reveal the magnitude of exclusion driven by patriarchal, sexist, racist, and xenophobic systems. This approach emphasises that the power relations shaped by these issues are not distinct or mutually exclusive categories; rather, they overlap and manifest in a unified way, affecting all aspects of social life.

Kimberlé Crenshaw [34] highlights that intersectionality provides a framework for understanding the unique experiences of racialised women. Gender, race, and nationality cannot be analysed in isolation, as they are interdependent in the social process. Racialised bodies serve as a critical lens to examine Eurocentric patterns that categorise people into

"us" and "them." This division supports hierarchical discourses, securing racial privileges for some while imposing violence on those excluded. Racialisation and compulsory heterosexuality reinforce these inequalities within obstetric and gynaecological practices.

Racism and violence are the acts that impose being the subject of one place on being the subject of another. It is not limited to aggression but results from the elimination of one of the individuals who are part of the relationship, modelling female subjectivities conditioned to make women a category of "Other" [37]. Thus, racism emerges because of the structure of society that normalises and conceives as truth the standards and rules based on discriminatory principles of race.

Oliveira [38] emphasises that racism is part of a social, historical, and political process that creates mechanisms for people or groups to be systematically discriminated against. A structural conception of racism is that it is intrinsically linked to institutional racism, which determines its rules based on an established social order.

According to the same author, institutional racism is considered a breakthrough for race studies, as it expands the existing idea of racism beyond individual behaviour. Institutional racism refers to the systemic effects caused by how institutions operate, granting privileges to certain groups based on race.

Institutions establish and regulate the norms and standards that should guide people's practices, shaping their behaviour, their ways of thinking, and their conceptions and preferences. Based on this idea, "institutions are the materialisation of formal determinations in social life" and derive from power relations, conflicts, and disputes between the groups that wish to gain control of the institution [38]. These power dynamics within institutions contribute to the hegemony of certain groups maintaining their social, political, and economic interests, naturalising specific rules and behaviours.

The domination that these groups exercise is produced through discriminatory principles based on race, establishing cultural and social norms that are transformed into a single civilising perspective of society. To demonstrate this concept of institutional racism, Oliveira [38] highlights the power structures that are dominated by white European men. These discriminatory principles are produced and disseminated in a powerful way, naturalising this hegemonisation and eliminating debate on the ethnic–racial, gender, and nationality inequalities within institutions such as health institutions.

Since OV does not fully address this specific kind of discrimination, the term "obstetric racism" has emerged. Dána-Ain Davis [8] states that it takes place at the intersection between OV and medical racism. Just as OV is a form of gender-based violence, obstetric racism represents violence that lies at the intersection of race and gender. The term suggests how institutional violence and violence against women merge with structural racism in the realm of women's reproductive health. According to Dána-Ain Davis [8], there are seven dimensions of obstetric racism: diagnostic lapses; negligence, disregard, and disrespect; intentional imposition of pain; coercion; degradation ceremonies; and medical abuse. This type of violence occurs when obstetric patients experience reproductive dominance by health professionals and staff, aggravated by race or historical ethnic–racial beliefs that influence treatment or diagnostic decisions.

An additional factor contributing to the discrimination faced by racialised migrant women is their status as migrants, and the stereotypes produced about this population naturalise the differences that highlight and create social consensus about ethnic–racial, national, gender, and sexual orientation categories that sustain and reproduce the inequalities to which these categories have historically been subjected [39]. According to the authors, the stereotyping of migrant women involves the problem of constructing a social imaginary that includes nationality, social identity, historical migrations, and the colonisation process.

For them, what is understood as a migrant woman was built from a historical process that has its roots in colonisation, in the exploitation and exercise of power over the bodies of the "pretty girls and pretty gentlewomen" [39], who became a colonial body to be exploited and dominated. This domination and exercise of power over bodies was not passive but marked by the continuous violence recorded first in the bodies of indigenous women, then

enslaved Black women, and later in the bodies of mulatto women—the fruit of the violent process of miscegenation.

This ends up being reinforced by the nation–state as an identity production and management machine, which, when faced with these bodies, produces a space of belonging that is, at the same time, a space of exclusion [40]. Studies show that racialised migrant women are often exposed to segregation, stigma, and violence, facing social, cultural, and economic restrictions that result in poor health indicators [41–46]. This situation can obviously be exacerbated in the case of these women during pregnancy, childbirth, and the postpartum period as they face constraints in terms of health and violence in their contact with the receiving countries [19].

From a social constructionist and intersectional perspective, these practices have been challenged. This analytical approach allows us to think about the intersection of the axes of systems of domination and their daily confrontations [34,35]. The feminisation of migration does not only involve factors such as gender, race, and nationality, as well as other identities, but also promotes the increased sharing of stories with a traumatic impact on OV, which raises the question of a lack of narratives.

When analysing OV experienced by racialised migrant women, it became evident that this violence is rooted in persistent gender inequalities. These inequalities are compounded and aggravated by intersecting factors such as gender, race, ethnicity, nationality, and sexuality [28].

1.2. Racialised Brazilian Women in Portugal: An Analysis of Health Disparities, Obstetric Violence, and Its Impact on Women's Health

Contemporary migrations highlight the complex and multifaceted factors driving human displacement, especially for the Brazilian communities. According to the Brazilian Ministry of Foreign Affairs' Secretariat for Brazilian Communities and Consular and Legal Affairs, Europe ranks second in terms of the Brazilian diaspora, accounting for 32.42% of the total population abroad. Within Europe, Portugal hosts the largest Brazilian community [46]. The Agency for Integration, Migration, and Asylum (AIMA) reports approximately 370,000 Brazilians living in Portugal, with women constituting 51% of this population [47].

The increasing participation of women in international migration has become a prominent topic in migration studies, particularly with the rise of feminist perspectives and advancements in the field. According to the International Organisation for Migration's World Migration Report (IOM), women now represent approximately 48% of the 281 million international migrants [48].

However, research highlights several specific impacts of women's migration, including challenges such as lack of support networks, difficulties in establishing professional connections, precarious and informal employment, issues with documentation, housing, education, and accessing healthcare services [41–46].

In fact, according to the European Commission [49], in their publication of the new Action Plan for Integration and Inclusion 2021–2027, a significant consequence of discrimination is restricted access to healthcare for migrants. They face persistent and specific barriers, such as administrative hurdles, fears about the uncertainty of their legal status, and discrimination. Additionally, they often struggle with insufficient information, unfamiliarity with the host country's health system, and linguistic and intercultural challenges, all of which further impede their ability to receive adequate healthcare.

Despite ranking third in Portugal in the Migration Integration Policy Index (MIPEX) in 2020 [50], deficiencies persist in the integration process, including difficulties in implementing legally defined rights, delays in procedural responses, and a lack of institutional knowledge among local officials and healthcare providers. Studies highlight challenges in navigating the healthcare system, where they face multiple forms of discrimination.

According to Oliveira, ensuring the health status of migrants and their access to and use of health services in host societies is crucial for their overall well-being [51]. This

supports not only their successful integration and inclusion but also promotes equity and upholds human rights in the destination countries. However, current data for Portugal reveal a concerning trend that contradicts this plan, showing a decline in the percentage of migrants reporting good or very good health care in recent years [51].

Brazilian women in Portugal face various stereotypes and prejudices, particularly those that are subtle yet equally damaging. One of the most pervasive stereotypes is the generalisation that all Brazilian women are associated with the stigma of "prostitute" and "easy access" [42,43]. This negative image affects their daily lives and impacts various social contexts, including health settings [41]. The prevailing narrative constructs Brazilian women as hypersexualised, promiscuous, and submissive, thereby confining their identities to these reductive stereotypes. Such exoticisation leads to adverse effects on their experiences with pregnancy, childbirth, and the postpartum period [20,22]. Consequently, these stereotypes of Brazilian women in Portugal are influenced by colonialism, racism, sexism, and heteronormativity, which serve to marginalise and stigmatise these women based on cultural, behavioural, or physical attributes, portraying them as hypersexual and readily available to Portuguese men [42].

When reproductive health issues are analysed, the situation becomes even more concerning. This is due to the compounded effects of migrant status, as well as the influence of gender stereotypes and cultural norms on how these women are treated in healthcare services [41]. In this way, research points to a higher rate of maternal morbidity and mortality among migrant women, lower adherence to prevention guidelines, and a lower rate of utilisation of health services when compared to Portuguese women [52,53].

When intersecting gender, nationality, and race, it becomes evident that the situation worsens for racialised Brazilian women. These women experience poorer health outcomes, particularly concerning reproductive and sexual health [20,21,54,55]. Pregnant Brazilian women face unique health challenges and elevated levels of violence [20,21]. Research highlights that these women encounter higher rates of maternal, perinatal, and infant morbidity [6,41]; increased complications during pregnancy, childbirth, and the postpartum period; a greater propensity for engaging in risky behaviours; and a lower likelihood of adopting preventive health measures [20].

According to the Portuguese National Institute of Statistics, there were 82,987 births in Portugal in 2022, where 17% were from migrant mothers [56]. Unfortunately, OV remains a significant public health issue in the country, profoundly affecting national and non-national women's experiences. A study by the European Commission's Directorate General for Justice and Consumers [57] revealed troubling statistics: 62.2% of women reported that their consent was not sought for the use of medical instruments (such as forceps and suction cups), 23.3% experienced verbal abuse, 38.1% did not receive emotional support, and 31.9% felt they were not treated with dignity.

Research by the Association for the Health of Black and Racialised Mothers in Portugal [17] further indicates that over 20% of Black women suffer from obstetric violence in Portugal. Their study also highlighted that migrant women experience obstetric violence at higher rates than non-migrant women, facing greater barriers to access (32.9% vs. 29.9%), delays in receiving care (14.7% vs. 13.0%), restrictions on bonding with their babies (7.8% vs. 6.9%), and increased likelihood of physical, verbal, and emotional abuse (14.5% vs. 12.7%).

According to the Portuguese Association for Women's Rights in Pregnancy and Childbirth [24], this violence includes refusal of treatment, neglect of women's needs and pain, verbal humiliation, physical violence, invasive practices, unnecessary use of medication, forced and non-consensual medical interventions, dehumanisation, or rough treatment. The results of two online surveys on women's experiences of childbirth across the country illustrate a highly interventionist context in which women often feel objectified, with their demands and preferences ignored [17,18].

To reinforce this theme, the results of studies with racialised women in Portugal reveal that these debates are mostly made up of white-European women and have this

same profile as their most prevalent audience [19,20]. In this sense, they understand that racialised women represent bodies that are sometimes more violated, but to the same extent are silenced and camouflaged in other bodies within the obstetric scenario. This confirms that racialised Brazilian women have less satisfactory experiences when accessing healthcare than white Portuguese women.

This highlights the role of race and nationality as critical factors in determining health outcomes and obstetric vulnerability. It underscores the need to understand that ethnicity, race, and gender are intricately linked to health inequalities and should therefore be considered key elements in the social determinants of health [22]. Barata [19] indicates that Afro–Brazilian women face multiple forms of discrimination based on their national origin, migration status, and racial categorisation, rather than merely their class. This intersection of gender, race, and nationality appears to be a central factor in the prejudice experienced by racialised Brazilian women in Portugal.

Recent studies in Portugal [13–26] report a range of negative experiences within health services. These include disrespect regarding sexual practices, lack of communication about bodily interventions, moral harassment, and various forms of violence—psychological, verbal, and physical—that constitute obstetric violence (OV).

The numerous sequelae and traumas experienced by these women are likely to manifest during the puerperium, potentially increasing the risk of developing postpartum depression [58]. Additionally, maternal mortality rates are closely linked to both access to and the quality of health services. According to Diniz et al. [59], many of these fatalities could be prevented through the effective implementation of public policies. For instance, a study by Leite et al. [23] highlights the connection between traumatic events and difficulties during breastfeeding. These findings underscore the need for targeted interventions and improved support systems to address the specific challenges faced by these women during and after childbirth.

It is crucial to recognise that migrant women are not passive or subordinate; rather, their mobility reflects their role as active agents of transformation [60]. The female body, in its migratory context, serves as a critical document of these movements, whether voluntary or coerced (bodily document). Considering global commitments to uphold the human right to migrate, there is a pressing need for international cooperation to ensure that sexual and reproductive rights are accessible to all individuals, without discrimination [53].

1.3. The Current Research

Adopting a constructionist and critical social paradigm and an intersectional feminist epistemology, with a focus on prioritising the participants' subjectivities and unique perspectives, the qualitative methodological approach becomes fundamental to the progression of this case study research. This case study aims to explore a specific unit in-depth to gain insights that would not have been achievable through other approaches [61]. This study seeks to understand the experiences of OV during pregnancy, childbirth, and the postpartum period among racialised Brazilian women within the Portuguese NHS. According to Sadler et al. [9], this study interprets disrespect for women during childbirth as a manifestation of structural violence. The concept of OV is employed as a valuable analytical tool to address and understand these systemic issues in obstetric care.

According to the AIMA [47], the most representative non-national population in Portugal is Brazilian, accounting for 35.3%. Studies carried out in the country have shown high numbers of unplanned pregnancies among immigrants [62,63], and data from the Directorate-General for Health in 2022 reported that 28.9% of voluntary terminations of pregnancy that year were carried out among non-national women, with Brazilian women being one of the most frequent in this group [63]. Given the scarcity of research on racialised Brazilian women in Portugal, despite their significant contribution to national birth rates as the most prevalent migrant community [57], this exploratory qualitative study aims to fill this gap.

It is important to emphasise that the methodology is highly individualised, focusing on a specific segment of the population. Therefore, the findings cannot be generalised to the broader population.

2. Materials and Methods

2.1. Participants

A total of 10 interviews were carried out with racialised Brazilian migrant women. Participants' ages ranged between 31 and 41 years (M = 34.5; SD = 3.14). All participants self-identified as cis women, with nine identifying as heterosexual and one as bisexual. Participants had between one and three children (M = 1.5; SD = 0.67). In terms of educational qualifications, seven of the participants had a bachelor's degree, two had a master's degree, and one a PhD. The participants have lived in the country for between two and seven years (M = 4.6; SD = 1.68). In terms of employment status, nine are employed and one is unemployed. All participants perceived that they had experienced obstetric violence within the Portuguese National Health System (Cf. Table 1).

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	racialised	heterosexual	master's	cis woman	employed	1	6
P3	33	Brazilian	Black	heterosexual	graduated	cis woman	employed	1	5
P4	33	Brazilian	Black	heterosexual	graduated	cis woman	unemployed	3	2
P5	34	Brazilian	racialised	heterosexual	graduated	cis woman	employed	1	2
P6	34	Brazilian	racialised	heterosexual	graduated	cis woman	employed	1	4
P7	34	Brazilian	racialised	heterosexual	graduated	cis woman	employed	2	4
P8	41	Brazilian	Black	bisexual	doctorate	cis woman	employed	2	7
P9	31	Brazilian	racialised	heterosexual	master's	cis woman	employed	1	5
P10	40	Brazilian	racialised	heterosexual	graduated	cis woman	employed	2	7

2.2. Procedures

Participants were recruited through a convenience sampling method. This involved sharing the study on social media platforms (e.g., Instagram and Facebook). To be eligible, participants had to meet the following criteria: they needed to be Brazilian women residing in Portugal, aged 18 or older, identify as racialised, have given birth in the country within the past three years, and perceive that they had experienced obstetric violence within the Portuguese National Health System.

The selection process employed the snowball technique, relying on the contribution of some participants to suggest other candidates, thereby facilitating access to a broader pool of interviewees. As a result, there was no control over the age, marital status, sexual orientation, etc., of the participants in this study. The interviews were requested through direct telephone or email contact with the participants after obtaining their consent.

This study adhered to all ethical principles of research and personal data processing, including informed consent and debriefing, which covered the voluntary nature of participation, anonymity, data processing and storage, and the confidential treatment of information. It was approved by the Ethics Council of the Faculty of Psychology and Educational Sciences of the University of Porto.

In the first phase of this study and as support for the interviews, a theoretical review of the topic was carried out in order to understand the theoretical framework and methodology to be followed. Based on these definitions, the semi-structured interview was drawn up and then tested with a volunteer in order to realise the revisions needed to meet the objectives of this study.

At the beginning of each interview, the study's objectives were explained, ensuring the participants' anonymity and confidentiality and providing their prior and explicit permission for the recording and subsequent transcription of the interviews. All the

interviews took place online for the convenience of the participants through the ZOOM platform. Participation in this study was free and voluntary. Data collection took place between February and April 2024, lasting an average of 60 min.

The principle of saturation was reached in the tenth interview when the data collection was considered saturated and the sample was closed due to theoretical saturation. This means that the theoretical sampling had been defined, data had been collected and these data had been systematically analysed. No new facts emerged and all the concepts of the theory were well developed. The concepts and links between the concepts that form the theory were verified, and no additional data were required. No aspect of the theory remained hypothetical. This reveals that ten participants make the sample significant since there is quality in these data and no new categories emerged. All the conceptual boundaries were marked and the allied concepts were identified and delineated, showing that it did not alter the understanding of the phenomenon studied and the data were sufficient.

2.3. Instrument

A sociodemographic form and an individual semi-structured interview script were used to collect data with the aim of mapping and understanding the respondents' world of life, gathering basic data for a detailed understanding of beliefs, attitudes, values, and motivations about social actors and specific social contexts [64]. This approach was chosen because it facilitates a deeper understanding of women's experiences, attitudes, interactions, and behaviours in maternal health settings, thus more effectively addressing this study's objectives.

The interview script was developed through a comprehensive literature review and consisted of five distinct sections and the second composed of seven sections: (1) migratory journey (e.g., when you came to Portugal, did you have any information about how the national health service worked?), (2) being a pregnant migrant in Portugal (e.g., what has it meant to you to be a pregnant woman in Portugal?), (3) pregnancy (e.g., could you tell me about your pregnancy, especially your antenatal care monitoring? What was it like for you?), (4) childbirth (e.g., could you tell me about your labour? What was it like for you?), (5) postpartum (e.g., how do you describe your health care experiences in postpartum?), (6) obstetric violence (e.g., do you know what obstetric violence is?), and (7) final considerations (e.g., facing this experience, as a Brazilian, racialised woman, if you had the power to make changes to the NHS, what suggestions/changes would you make?).

As a way of following an instrument validation guideline, to show that the instrument really reflects what is intended, the Validation for Qualitative Research Instruments (Vali-Quali) by Torlig et al. [65] was developed. This proposal comprises two dimensions—content and semantic. To validate the content of the instrument, a scientific review of the topic was first carried out to determine the degree to which an instrument reflects the specific content domain of what is to be measured. Six integrated stages were outlined: the design of the initial script, validation by the reviewers, the overview of the results, a pre-test, a validated script, and a theoretical–empirical script.

In this specific case, validity was assessed in relation to all four attributes (alignment with objectives, adherence to constructs, clarity of language, and qualitative expectations). The experts were asked to evaluate the semi-structured interview with the items, taking into account the following aspects: (1) clarity of content: the questions are formulated clearly and precisely, which makes them easy to understand for people who suffer for different reasons; (2) clarity of wording: the wording and terminology used are appropriate for the target audience; (3) grouping of questions: correspondence between the content of the question and the category in which it is placed, as in, the logical order in which the questions are presented; (4) relevance of the data provided: the questions are relevant and provide the data needed to answer the objectives; (5) number of questions: the number of questions for each of the objectives is appropriate so that the interview does not get too long and the interviewee does not feel bored answering all the items. In addition, a

space was reserved for recommendations that they considered appropriate and suggested alternative ways of phrasing the questions that they considered inappropriate.

After all the analyses, considerations, and pre-tests, the instrument was considered valid because it covered each and every one of the elements related to the concept of the construct, based on the principle that the construction of the items was developed from the conceptualisation of the variable to be measured. The aim was to provide evidence that the semantic definition was included in the items constructed, that they were relevant to the construct, and that they adequately addressed each of the dimensions proposed in the semantic definition. It is therefore very important to quantify the degree of content validity of the instrument using indicators. Finally, the objective is to reflect the transparency of the process, the refinement of the instrument, as well as the maturity of the research and its methodological consistency. This reinforced that the qualitative research was reliable.

The team responsible for evaluating was made up of three people who have experience in qualitative research, specifically in Thematic Analysis: (1) PhD in Social Psychology, academic career since 1988, Full Professor; (2) PhD in Social Psychology, academic career since 2011, Assistant Professor; (3) PhD in Psychology, academic career since 1998, Associate Professor.

2.4. Data Analysis

To analyse the content of the case study's interviews, we employed the thematic analysis approach as outlined by Braun and Clarke [66,67]. The case study here seeks to delve deeper into a specific unit for greater understanding that would not have been possible by other means. This qualitative approach is a flexible and useful research tool that allows us to identify, analyse, and report patterns (themes) within the data, contributing to a deeper interpretation of the data [64,66,67].

The analytical procedures were undertaken by the two lead researchers, who followed the six stages defined by Braun and Clarke [66,67]. The first stage included familiarisation with the data, enabling the researcher to read and reread all the interviews conducted, noting down ideas for possible codes, to take a "deep dive" into each story. Stage 2 involved generating initial codes from the transcribed narratives, from which characteristics were identified in a central organiser that generated themes and sub-themes. Stage 3 was defined as a "search for themes", which made it possible to identify a single overarching theme, bringing together all the relevant data to give rise to a potential theme. In the stage 4, "theme review", refinement was carried out to confirm that the code extracts are descriptive of the theme, which clarifies the interpretation of the data set. This review was important to understand whether the themes were single or multiple, resulting in a thematic analysis map. Stage 5 involved "defining and naming themes" based on a satisfactory thematic map of the data, to generate clearer definitions. Finally, stage 6 consisted of "producing the report", in which a logical order was established for the presentation, thus constructing a coherent narrative of the data [67].

The analysis of the data, including coding and categorisation, was based on the intersubjective consensus of the research team. Themes were identified using a blended approach of both deductive and inductive methods. Initially, deductive analysis was guided by theoretical frameworks such as intersectionality, and then this was complemented by an inductive approach, allowing for the modification and refinement of themes and sub-themes as new insights emerged during the data coding process, as allowed by Braun and Clarke [64].

3. Results

In Portugal, the percentage of unnecessary obstetric interventions that are frequently carried out in various hospitals and health centres is quite high [15,19,20,22,26,27]. Combating the countless violent and traumatic acts that affect the majority of women is a driving force behind this research, and an aggravating factor is the issue of immigration, a reality that is still scientifically scarce and more invisible to women, particularly racialised

Brazilian women living in Portugal who, during pregnancy, childbirth, and the postpartum period, are faced with a lack of respect for their autonomy, dignity, and rights.

Unfortunately, these women's experiences during pregnancy, childbirth, and the postpartum period were not positive. OV is a term that is gaining familiarity among women who seek access to information from the moment they choose to reproduce. As a result, the women in this study realised that OV was presented at all stages (pregnancy, childbirth, and postpartum) from a set of definitions that describe various practices of invisibility, subjectivization, and polyphony. Knowing women's perceptions of this reality, exploring their views and opinions, as well as the level of information women have about OV, is a start towards change so that it is not seen as "acceptable" in the future.

Based on the theoretical support, in this case study, it was possible to develop a data collection instrument that yielded significant results, thus providing answers to the questions that will be presented. According to this reality, the thematic analysis allowed us to identify a set of themes and sub-themes in the discourses of the 10 interviewees that we entitled and set out in Table 2.

Table 2. Themes and subthemes.

Themes	Subthemes
From dream to nightmare: experiences of pregnancy, childbirth, postpartum in Portuguese NHS	Challenges faced by racialised Brazilian women: social inclusion, maternal health, and universal right. Intersectional inequalities at stake.
Obstetric violence: another form of violence against racialised Brazilian women in Portugal	Naming the types of violence experienced. Obstetric violence definitions: when practices became a clear concept. Repercussions of OV in racialised Brazilian bodies.

3.1. From Dream to Nightmare: Experiences of Pregnancy, Childbirth, and Postpartum in Portuguese NHS

3.1.1. Challenges Faced by Racialised Brazilian Women: Social Inclusion, Maternal Health, and Universal Rights

As mentioned earlier, in light of the global process of globalisation, migratory flows are currently one of the most visible and discussed dimensions. For this reason, we sought to understand the migratory journeys of the interviewees to understand their choice of Portugal and their expectations, difficulties, and facilities. Among the different answers, there was a certain recurrence of motivations: work, familiarity with the language, the search for quality of life, education, and free public healthcare. However, one of the biggest challenges linked to migratory phenomena has been the universal and equitable provision of health care, with accessibility and quality of services being central, regardless of gender, race, ethnicity, or country of origin—health is a universal right. It is well known that health and guaranteed access to health care are pillars for the social inclusion of migrants, consisting of one of the main routes to participatory citisenship and civil rights. The idea of accessible, public, and free health ends up promoting the idea that they will be able to have quality care during maternity care. According to the study presented, in the reality faced by immigrants, as confirmed in the reports, the NHS was not so welcoming, inclusive, empathetic, and respectful during pregnancy, childbirth, and the postpartum period for these women. The participants felt very alone and helpless. They did not feel supported in this time of life where they felt more vulnerable and sensitive.

> *"I felt very alone, especially at those times. I needed so much support and there was no one, so it wasn't easy" (P1).*

> *"I think everything is more difficult because I'm an immigrant, being alone appears more often at all stages, from pregnancy to childbirth and postpartum" (P2).*

> *". . . I think this thing, that you're alone in your vulnerability here, is one of the worst things for me. . ." (P3).*

"I felt very fragile as an immigrant during my pregnancy" (P9).

It was possible to notice that the psychological and social conditions of these women were not considered. All the interviewees expressed loneliness, lack of support, the vulnerability of being a migrant, lack of information, lack of social support, lack of family members, and lack of specialised multidisciplinary care for the migrant population.

During pregnancy, women undergo a period of adaptation and preparation for childbirth in anticipation of the arrival of a new being. During this period, women should be informed about the anticipated course of events throughout the entire process, from conception to the postpartum period. Prenatal care is the optimal time to address a multitude of concerns and guidance essential for women to make informed decisions about their bodies and childbirth, as well as to have literacy for their rights (e.g., report situations of abuse). However, from the onset of pregnancy onwards, a significant proportion of these women are not adequately informed about their rights and the autonomy of their bodies.

This lack of awareness and guidance extends from prenatal care to childbirth. The dearth of assistance, welcome and information in maternal care can be attributed to the prevailing approach to care, known as OV, practiced by professionals working in the maternal health context. Unfortunately, this scarcity is normalised by society and ends up shaping new realities and existences, while at the same time promoting an exercise of control and dominance over the lives of others, stripping away essential rights during this phase of these women's lives.

The participants reveal that one of the primary aspects of negligence felt in care during these phases was the difficulty in making appointments and/or long waits for care during prenatal consultations at health centres and gynaecological emergency consultations at NHS hospitals. Additionally, they indicate a lack of information about the rights offered by the NHS during pregnancy, as evidenced by their discourses.

"I didn't know that pregnant women were entitled to exemption from the emergency fee. The health centre should have given me a document, I didn't know that information" (P1).

"I wasted a lot of time because I couldn't call and say: I need to make an appointment. You have to go there, get a ticket, you have to wait all morning" (P1).

A policy of humanising care takes welcoming as an ethical and practical stance in the care and management of health units, which favours building a relationship of trust and commitment between users and the teams and services, contributing to the promotion of a culture of solidarity and the legitimisation of the NHS. However, in this study, the service presented itself in the opposite way to these women. There is a lack of sufficient information and communication, which also emerges as a practice of OV that is often not perceived and criticised because it is perceived as a body that does not belong in that territory, without rights, which generates silencing, invisibility, and vulnerabilities.

Another factor that reinforces the above-mentioned issues is the centrality of the practices of health professionals, eliminating the role of women. Another factor that reinforces the aforementioned issues is the centrality of health professionals' practices, eliminating the role that would naturally belong to women. By granting them the highest authority to intervene in these bodies, these procedures are seen as a necessary or even acceptable practice by these women. By giving them the ultimate authority to intervene in these bodies, these procedures are seen as a necessary or even acceptable practice by these women.

"(. . .) at this appointment with the same obstetrician who accompanied me throughout my pregnancy, she asked to examine me. She didn't tell me and did a touch, without asking me, without telling me" (P2).

"(. . .) there was obstetric violence because they did a touch test at every appointment (. . .)" (P5).

"I asked him to take his finger out of me and he didn't" (P7).

"The doctor was unfriendly, she was the boss, she didn't listen, she just wanted to impose" (P10).

The power exercised is not evident at first glance, as there are more subtle forms of coercion, where, through biopower, it can lead to population control, employing various mechanisms. This type of care reinforces inequalities and exposes these women to significant risks. It results in uncomfortable and undesirable experiences, shaping their perceptions of the event, the professionals involved, and the country in which they were supposed to feel welcomed and cared for on a basic human level. In the light of the discourse collected, maternal care confirms the disrespectful and inhumane practices towards these women.

"(. . .) they put me with a doctor who was available, but I didn't like it, it was the first one, I didn't like her, her approach, I thought she was very rude. Me, a pregnant woman, right? I was all sensitive (. . .)" (P3).

"(. . .) I was scolded because the baby didn't kick during the exam" (P5).

"They have a rude manner" (P7).

"The way they communicate is as harsh and cruel as possible" (P8).

These narratives show a notable lack of a support and reception network in NHS health centres and hospitals. The neglect of health professionals in their care during pregnancy, childbirth, and the postpartum period is evident in these women's testimonies. The participants did not feel welcomed, as they should have been in a system that takes responsibility for comprehensive care by providing qualified listening, fostering a bond, and assessing vulnerabilities according to their social context. Instead, their experiences resulted in uncomfortable and undesirable perceptions of the event, the professionals involved, and the country in which they are supposed to feel welcomed and cared for on a basic human level.

Another issue presented was that the absence of a support network was reinforced when these women, on arriving at hospitals for the birth, were prevented from being accompanied by their partners, going against Law nos. 14/85, July 6, Art. 1 and 2, which state, respectively, that: (1) a pregnant woman admitted to a public health establishment may, at her request, be accompanied during labour by the father-to-be and even, if she so wishes, during the expulsive period; (2) the companion referred to in the previous paragraph may, at the express wish of the pregnant woman, be replaced by a relative indicated by her; (3) the right to accompaniment may be exercised regardless of the time of day or night during which labour occurs [68]. On the contrary, these women are prevented from being accompanied, which has ended up promoting more insecurity for the parturient woman at a time when she is vulnerable.

"(. . .) we got there, I went to reception. P couldn't accompany me, he couldn't go in with me, I went in alone" (P2).

"(. . .) he has to go, these are the hospital rules and you can't stay with him, so I was left alone at the worst moment of my labour (. . .)" (P5).

"When we arrived at the hospital, the father was stopped at the door" (P9).

During the prenatal period, childbirth, and the postpartum period, which are unique moments in life, the participants felt they needed to receive support from trained health professionals and services. For them, it was crucial that these professionals be committed to the physiology, psychology, and sociology of birth, and should respect pregnancy, childbirth, and breastfeeding as social, physiological, psychological, and emotional processes that should be a process of learning and continuous monitoring to deal with any difficulties.

For many of the participants in this study, this period of their lives is often remembered as a series of traumatic moments in which they felt attacked, disrespected, and maltreated by those who should have been caring for them.

3.1.2. Intersectional Inequalities at Stake

As can be seen above, the care protocols practised with these women during pregnancy, childbirth, and the postpartum period are marked by noticeable discrimination. This inadequate and unequal treatment is a significant problem for them. The participants reveal the structural inequalities that health systems operate on them, mainly in the face of the challenges of racialisation processes.

During the prenatal period, childbirth, and the postpartum period, nine participants revealed the perception of experiencing OV during pregnancy; all reported OV practices during childbirth, and seven suffered in the postpartum period.

Participants reveal that:

> *"While I was still in hospital, I needed a test, but the doctor said she wasn't going to see me and just left the room and didn't see me" (P1).*

> *"I had a birth plan, but it was completely ignored" (P5).*

> *"Everything was taken away from me, I couldn't choose the position or anything, I couldn't scream, I couldn't vocalise, I couldn't speak, I couldn't choose anything. I completely stopped being the protagonist and became a supporting player. I was just a piece of meat" (P6).*

> *"Superior and there it's always been like that, since my first touch, I'm the boss, I'm going to do it, it has to go through me, it's never been any different" (P6).*

> *"Open your legs now, because it's time for the residents, you're in a teaching hospital and you have to be available for the procedures" (P8).*

The violence suffered by these women explains the domination–exploitation determinations of a system that operates according to the needs of a patriarchal, sexist, racist, and xenophobic system. Because they are so intertwined, they constitute a single system, generating combined forms of oppression and subjectivisation, most acutely in racialised Brazilian women, reflecting on their quality of life, especially regarding sexual and reproductive issues.

Violence consists of imposing one person's position over another and goes beyond mere physical aggression. It occurs when one of the individuals in the relationship is eliminated or silenced, contributing to the construction of feminine subjectivities that place women in the condition of the other, subordinate, and devalued. As racialised Brazilian women, the participants were also forced to deal with stereotypes on the part of health professionals and assistants:

> *"the receptionist said: Brazilians only come here to have children and steal other people's children and husbands" (P9).*

> *"She didn't ask if I was married, she asked: is it the same father?" (P8).*

> *"The doctor said: you know that having many partners is not good (. . .) at the health centre I was immediately considered a woman with a promiscuous and vulnerable sex life" (P8).*

As can be seen, stereotypes naturalise the differences they highlight and create a social consensus about ethnic–racial, regional, gender, and sexual orientation categories that sustain and reproduce the inequalities to which these categories have historically been subjected. These are historically elaborated and pre-established conceptions of what the "others" are. As a result, these women experience segregation between national and non-national women during hospitalisation, mistreatment, and differentiated care in the NHS.

> *"She went into that room complaining, like: why did she receive this kind of care? What's the difference? Is it because she's a foreigner? (. . .) Why was she treated like that? This is wrong, is it because she's a foreigner?" (P1).*

> *"In the hospital, they divided Portuguese mothers and non-Portuguese mothers into rooms (. . .) they didn't mix them" (P9).*

There is the aggravating factor of being unprepared to deal with sociocultural differences, clearly ignoring the social markers of difference, erasing their networks around identity, and the result of pre-judgment by healthcare professionals because they are not Portuguese. This discriminatory treatment (gender, race, class, nationality) during prenatal care appointments, ultrasound examinations, and hospital admissions by all those who make up the maternal health care context reveals that OV is not enough to structure the contours that materialise in the racism practised towards these women during pregnancy, childbirth, and the postpartum period.

The obstetric racism experienced by these women is what best defines the violence that occurs in contexts where obstetric patients face reproductive domination by health professionals and teams, intensified by racial factors or the influence of ethnic–racial beliefs. These beliefs affect both treatment and diagnostic decisions, perpetuating inequalities and discrimination in obstetric care. In the encounter between institutional violence and the racism of health professionals, the treatment and/or decisions regarding maternal care put their integrity at risk, and they are physically, psychologically, morally, and/or sexually violated.

"the doctor was calling me a savage, a monkey" (P6).

"it's impossible to deal with these savages" (P8).

"you know you're not going to have a normal childbirth, Brazilian, mixed race, there all the women have bad uteruses, because you're mixed race" (P8).

The structural racism orchestrated in these bodies presents difficulties that end up violating them physically, psychologically, morally, and socially since this reality contributes to the current scenario of social inequality, which for Nogueira [38] means the transformation of racism into a dominant social practice in which it ideologically links white Europeans, maintaining their privileges, while racialised women are denied citisenship. These structures of inequality place racialised Brazilian women in a position where their human rights are particularly violated

3.2. Obstetric Violence: Another Form of Violence Against Racialised Brazilian Women in Portugal

3.2.1. Naming the Types of Violence Experienced

The protocols practised with these women have been marked by interventions where OV is quite discernible. In this context, it is evident that racialised women often represent bodies more susceptible to violence, being recurrently silenced and hidden compared to other bodies within the obstetric landscape.

In these experiences, the participants describe different types of obstetric violence suffered: physical, sexual, institutional, moral, verbal, and psychological. Women highlighted the high occurrence of repetitive vaginal examinations and touching, which can be seen as a violation of the right to information and autonomy, based on practices considered scientifically harmful.

"And then she touched me, an absurd pain that throughout my pregnancy, I had never felt that way, it hurt a lot, but it hurt a lot and then when she removed her fingers, she lifted it like this, it was full of blood, I was desperate" (P1).

"(. . .) there was already such a thing as obstetric violence because they did a digital examination in every consultation (. . .)" (P4).

"He made a touch that was one of the biggest pains I felt in my life (. . .) he was aggressive" (P7).

"(. . .) they did the episiotomy, at no point did they ask me if I authorised it or not. . . I had my scar, the three cuts I suffered (. . .)" (P5).

"And then he said: I'm going up. If no one goes up, I'll go up, he came with his elbow, pushing my stomach, hurting me (. . .)" (P5).

"(. . .) they did the forceps" (P5).

"There were a few suction cups and spatula. The suction cup would burst, like, it would burst, it would burst, it would burst, it would burst. And they used a spatula (. . .)" (P6).

". . .He said: I'm sorry, but I'm going to have to do one more bad thing, I'm going to have to remove your placenta. He stuck his hand inside the vagina, inside the uterus, to pull out my placenta. And in this process it hurts, it hurts and he: but it has to be like this. He pushed my belly like this, on top. I felt him pull inside, I felt him pull out the placenta. He took it off, sewed it up and left" (P2).

". . .my first ultrasound was super violent, I started to suffer violence during my first ultrasound. The doctor took the probe, I don't know the name, and she pressed my belly, and I oh, oh, oh (. . .) it was horrible, horrible (. . .)" (P6).

As confirmed in the interviewees' reports, the practice of touch exams, episiotomies, Kristeller manoeuvres, and the use of forceps, suction cups, and spatula, in addition to physical strength, were justifications for the good care and monitoring of pregnant women and women in labour. All practices occurred without any authorisation or consent. These situations are identified as physical abuse and the imposition of unapproved interventions that violate the right of these women to be free from mistreatment and the right to information.

Another physical violence that appears here is medicalisation. According to the reports of the interviewees, the use became increasingly present in their bodies, under the justification of the need for a healthy birth and reduction of suffering.

"(. . .) my doctor arrived, did the touch and said: you're only 2 cm, even so, you're not going to leave here, woman, let's induce, let's induce" (P2).

"(. . .) she said it was necessary to increase oxytocin. And it increased oxytocin absurdly" (P2).

"And then they gave me oxytocin, they gave me an intravaginal pill" (P5).

"oxytocin increased, and it hurt a lot after that, it wasn't from God" (P8).

In the statements above, the predominant medicalisation is the use of oxytocin, considered by some experts as generating serious undesirable effects, resulting in adverse perinatal events, and its use must be selective and restricted to situations where there are indications; indiscriminate use may cause harm to the mother and the baby.

Related to this violation, resulting from the use of frequent touching, episiotomy, and exposure of the body, among other situations, we are faced with sexual obstetric violence. The data show that three women suffered this violence, which can be understood as any action imposed on a woman that violates her intimacy, delegitimises her sense of sexual and reproductive integrity, and may or may not directly affect the sexual organs and intimate parts of her body. Being extremely harmful, it materialises symbolically at the level of the body and behaviour.

"I was feeling my body stopping, you know? Locking up because it's a strange person touching me (. . .)" (P4).

"(. . .) I felt pushing for my daughter to be born, at the same time he was stretching the lower and left part of my vagina, you know, pulling it (. . .)" (P4).

"(. . .) what affected me most is my sexuality. At this moment, she is torn apart, torn apart, that's the word. I don't want to touch myself, I don't want to have sex. I don't want anything like that (. . .)" (P4).

"(. . .) to this day I feel the consequences of my sex life not returning normally, because I no longer have the same lubrication" (P5).

"sexual relations, yes, I was dying of shame, I was dying of shame, I was dying of disgust, I couldn't look" (P6).

In some cases, consequences for their sexual life were also reported, as the interviewees had their self-esteem and psychological well-being affected. Women also report that their trust in health professionals diminished, leaving them only able to view them as rapists.

What was supposed to be a humanised relationship, where dialogue, information, and trust permeate, in this case, resulted in institutional violence, which presents itself as one in which there is the reproduction of inequalities in power relations present in the social space for the hospital environment. In this case, all participants revealed that they suffered institutional violence.

> *"(. . .) when we got there, I checked into reception and X was unable to accompany me. I think it was one of the first acts of violence" (P2).*

> *"Nurse H was the one who raped me. He immediately put on the glove and wanted to do the touch (. . .)" (P4).*

> *"the doctor said: you are in the hospital environment, we are the ones who have the voice here, we know what is best for your daughter" (P5).*

> *"The medical approach contributed to preventing further labour" (P7).*

> *"the receptionist at the Health Center said: today we received 300 people, only 1 Portuguese. Exposing their discomfort at having many immigrants there" (P8).*

> *"the doctor cannot do everything, but in the public sphere we are more susceptible to the doctor's power" (P10).*

The statements reveal how institutions behave as instruments of social control created by society within its own structure, with the aim of maintaining the supremacy of certain groups as they are legitimised by the State. The interviewees' statements provide an understanding of the abuses committed due to unequal power relations between users and professionals within institutions (health teams and administrative staff).

When detailing the violence experienced, the interviewees' reports also reveal that within these institutions, there is conduct designed to slander, defame, or insult honour or reputation. Configured as moral violence, the quantitative data reveal that the 10 women interviewed suffered this violence, reflected in a set of practices offensive to sexual and reproductive health, to offend them in front of third parties, with the aim of damaging their reputation and undermining their mental health. Inevitably, it is possible to notice this practice in the reports of the women interviewed.

> *"(. . .) the woman can handle everything, she will have to leave" (P2).*

> *"I have 11 women to be born, right? I don't know what, unfortunately we can't wait for everyone's time, I don't know what, right?" (P3).*

> *"(. . .) the nurse fought with me because she said I was dirtying the floor. You're dirtying the floor, you're dirtying everything, you can't" (P5).*

> *"(. . .) I entered the room, and he said: what a huge belly, you are very small, this child will not come out from underneath" (P2).*

> *"(. . .) look, I'm going to have to cut you off. It was written in my birth plan that I did not want an episiotomy under any circumstances. Look, I know you wrote on that piece of toilet paper that you didn't want (. . .)" (P6).*

> *"the anaesthetist said I was hysterical, how poor this child has such a hysterical mother" (P7).*

The reports bring cases of insults, mistreatment, approaches, unpleasant comments, mockery, threats, blackmail, neglect, misinformation, and exposure to physical, psychological, and verbal risks, with humiliations that harm their privacy. However, despite being recurrent, these practices/situations often occur in a covert manner and are rarely questioned by patients, for fear of reprisals that they may suffer during contact with the health service.

The consequences, where violence is the result of disrespectful assistance, need to be carefully analysed, as such actions result in physical and psychological complications for

women. The psychological aspect of abuse is explained in cases of lies, humiliation, rudeness, blackmail, insults, omission of information or inaccessible language, disrespect, or disregard for cultural standards. This is also noticeable in the testimonies of the interviewees.

"Another girl, who I imagine was the assistant, started reading my birth plan with irony... I don't accept analgesia even if I ask for it during the active phase. Then, he looked like this to the anesthesiologist, then the anesthesiologist looked like this" (P4).

"I just didn't sign my discharge, because later they told me: if you sign, we won't prescribe the antibiotics, you can only do the antibiotics if it's here" (P1).

"even though I expressed my wishes, they didn't listen" (P10).

"Because the guy is always threatening a caesarean section (...)" (P4).

"At that moment, he climbed onto the bench, looked at me and says: I'm going to have to cut you, he says I'm going to have to cut you and if I don't do that, there's a risk that your daughter will die" (P6).

"And she was looking at the computer, there wasn't that human service, you know? Looking at the person—I spoke, and they were just pressing the buttons on the computer and filling in their things" (P3).

"Everything was summarily disregarded, it was as if you were exaggerating (...)" (P5).

"She bombarded me for induction" (P10).

Psychological violence translated into verbal or behavioural actions by the healthcare team and everyone who makes up the hospital environment amplified the view of gender inequality and the imposition of participants to endure any pain or situation during pregnancy, childbirth and postpartum.

The memories that span from prenatal to postpartum remain active both at the cognitive and psychological levels, causing a series of impacts on these women's experiences. This study identified that, in this delicate moment when women confront their identities in the face of medical positivism, the tactic of using fear and pain, often associated with the hospital environment, increases vulnerability. This results in subjective consequences, including traumatic experiences and health issues.

3.2.2. Obstetric Violence Definitions: When Practices Became a Clear Concept

Faced with their experiences during pregnancy, childbirth, and the postpartum period, the racialised Brazilian women interviewed had the opportunity to conceptualise obstetric violence since they now carry the scars of this violence on their bodies. For them, OV is defined as:

"It is inhumane and disrespectful service" (P1).

"It's everything that causes some discomfort, it's doing what the woman doesn't want or wasn't warned about (...) So it's doing it without asking, it's doing an act that causes discomfort (...)" (P2).

"It's not respecting the mother's wishes, it's not strengthening the mother in what she's capable of. It's you discrediting this mother, her strengths, her nature, you know?" (P3).

"For me, obstetric violence is not respecting, first of all, not respecting the pregnant woman's wishes, that alone for me is violence. Obstetric violence, for me, is also carrying out a procedure without explaining why it is being done. Interventions are also unnecessary, for me, it is violence against my body (...)" (P4).

"It's you not being heard, it's you not having the right to choose, it's you not having the right to express any choice that health professionals say" (P5).

"Obstetric violence for me is the use of power and the destruction of the power of protagonism, removing women from their protagonism and using the power of the hospital environment (P6).

> *"any violence that a woman suffers, not only during childbirth but throughout prenatal care"* (P7).

> *"Do anything I say no to"* (P8).

> *"to take away a little of your humanity (. . .) to take away my own nature"* (P9).

> *"It's when you feel violated, the person is forced into something"* (P10).

These women felt that their fundamental rights were not respected at times during this period of their lives, and they did not feel culturally sensitive care. In the context of obstetric violence, the body emerges as the subject of perception, despite contemporary scientific discourse often treating it as an indifferent matter or mere support for the person, ontologically distinct from the subject. This perspective reduces the body to an object to be acted upon and "improved".

It is crucial to emphasise that women in the migration process should be recognised as transformative agents, rather than as subordinate or dependent figures. In this way, the female body becomes the main document of the crossings, whether they are forced or not. Due to the global commitment to protecting the human right to migrate, nations must collaborate to ensure the sexual and reproductive rights of all people, without distinction.

3.2.3. Repercussions of OV in Racialised Brazilian Bodies

It is possible to verify that the experience of OV had multiple consequences for these women. Many reported difficulties and insecurities in bonding with their children and in breastfeeding. They also faced physical, mental, and emotional exhaustion due to the new dynamics, lack of sleep and rest, as well as lack of health support. These complications stemmed from the violence they endured during pregnancy, childbirth, and the postpartum period.

> *"I wanted to breastfeed. I felt guilty, I felt punished. It felt like it was a punishment that I couldn't"* (P1).

> *"(. . .) my milk came out green. The doctor said it could be psychological (. . .)"* (P2).

> *"So I felt like less of a mother. Because I said: I can't look after my son, I'm not physically able to look after him now. And so all of this was the result of a series of problems I had during my delivery, right?"* (P5).

These women, with traumatic histories, were especially vulnerable to the effects of low levels of health and social support directly related to the way the environment presented itself to them during pregnancy, childbirth, and the postpartum period. In this sense, the emotional effects that emerged in these women were feelings of guilt, loneliness, anger, hatred, sadness, mourning, frustration, and fragility.

> *". . . what is most present is anger and that makes me feel sad about myself because I've never been angry with anyone to this extent, you know?"* (P4).

> *". . .it was even a source of great stress for me, every time I went to the maternity ward I was sick the day before. . ."* (P5).

Unfortunately, this reality reinforces that the female body is understood as a strategic field where biopower is exercised, being subjected to a process of objectification and control. This occurs through the actions of health professionals and their medical and psychological discourses, which shape and regulate the woman's body, transforming it into a target for interventions and standardisations.

The OV suffered by these women led to changes in their emotional lives, such as the development of mental disorders that arise after childbirth, such as depression associated with the negative experiences of pregnant and parturient women during obstetric care. Postpartum depression, suicidal ideation, psychosis destruction of self-esteem, and loss of self-confidence were found. Many of them had to seek psychiatric help and were put on medication.

"I had postpartum psychosis (. . .) it was impacted by the care I received from that doctor and then, from then on, I had to take medication prescribed by the psychiatrist for a few months" (P1).

"I didn't feel capable of taking care of my daughter (. . .)" (P1).

"I started to have more symptoms of postpartum depression (. . .) I had suicidal ideation" (P2).

"I had a very strong postpartum depression, with suicidal ideation, a lot of frustration and recurring thoughts that I didn't recognize" (P8).

The participants of this study did not report positive experiences during pregnancy, childbirth, and postpartum care within the Portuguese NHS. Instead, they experienced various forms of obstetric violence from healthcare professionals and assistants in different health settings. This represents an unequal exercise of power relations between obstetricians and women, revealing the inequalities and the denial of women's right to make decisions about their own bodies. It is a form of invisible violence, normalised by society and its institutions, that limits the realisation of human rights and perpetuates patterns of submission towards medical personnel. The authors emphasise that, in this way, these standards are not only maintained but also exacerbated by neglecting the reflection, ethics, and humanisation that should be fundamental in patient care. This violence had a significant impact on their life as individuals, mothers, wives/partners, and in their sexual lives.

4. Discussion

From the beginning, pregnancy, childbirth, and the postpartum period have been seen by modern society as a prototype of happiness and well-being, with little value attributed to the practice of health assessment [52]. In theory, preparation for childbirth should begin with the first antenatal visit to ensure that women are well-informed and better prepared physically and psychologically for labour and delivery by the time they arrive at the hospital. This preparation includes understanding their rights and responsibilities and being familiar with the birth process [19]. It also includes the care team, including maternal health professionals, that must support pregnant and postpartum women in primary care. These professionals play a vital role in caregiving, education, and research, thereby contributing to the holistic care of both the individual and their family [29]. For Leite et al. [23] health professionals need to listen to the pregnant woman, listening to their fears and anxieties that arise at this stage. Creating spaces to meet other pregnant women promotes reflection on these feelings, and the pregnant woman realises that she is not alone.

However, based on the results of this study, this is also the beginning of a new cycle, a milestone, and a period of vulnerability for many women. According to the participants, the Portuguese NHS did not meet their expectations for inclusivity, cultural sensitivity, and respect. During this vulnerable and sensitive period of their lives, they felt unsupported, isolated, and helpless. They felt that their psychological and social conditions were not considered.

All the interviewees expressed loneliness, lack of information, lack of family members, lack of social support, and lack of specialised multidisciplinary care professionals with competence to deal with the migrant population. They were also denied the possibility of being accompanied during labour, which contradicts the Portuguese legislative regulations, which confirms that a hospitalised pregnant woman has the right to have someone of her choice accompany her during all stages of labour [68].

Most participants in this study reported experiencing OV during pregnancy, childbirth, and the postpartum period. Health professionals appear as one of the main ones responsible for the reproduction of OV in this study, confirming some of the references studied [18–20,25,26]. The hierarchy opens space for some unnecessary interventions and procedures to be carried out, which expose women to risks and cause them suffering [18,19]. Based on this, patients are ranked below healthcare professionals, especially doctors. This

structure often leads to the normalisation of viewing women as mere subjects of medical intervention, without questioning the impact of such treatment [29]. As a result, there is a significant impact on the perception of these events, which is often taken for granted. This violence encompasses a series of practices related to invisibility, subjectivisation, and various forms of abuse.

It also seems very clear that structural inequalities are imposed. Although the term "obstetric violence" may lack semantic precision, it proves to be a powerful tool for legal and political actions, as well as being useful in explaining a complex sociocultural phenomenon that frequently occurs in healthcare institutions [59]. As the same author states, unfortunately, they are embedded in sociocultural systems that reproduce and are immersed in asymmetries of social power. These systems also normalise and naturalise medical practices laden with ideology, although presented from the perspective of ideological neutrality, moral superiority, pragmatic effectiveness, and scientific rationality [41]. I also add the idea of an altruistic science that is free of values, supposedly dedicated exclusively to the benefit of humanity. Revealing that institutional obstetric care in Portugal faces a complex and multidimensional problem.

These findings align with other studies in Portugal [13–26], which have also highlighted that obstetric violence is a routine issue, particularly affecting migrant women. Considering the issues raised in this study, it was observed how much migration status and nationality appeared before any other social marker. This implies that migration constitutes one of the most important determinants of global health and social development and that we must accept and act on this challenge [43].

Additionally, they also face stereotypes and discrimination in the context of obstetric care. Professionals who work in the health context sometimes insinuate that Brazilian women become pregnant with ulterior motives, such as obtaining a residence permit or for financial reasons, as well as repeatedly asking about the father's nationality, which meets other studies' results [55].

Furthermore, these racialised bodies face disparities in maternal healthcare, resulting from both racism and medicalisation, which manifests differently in these bodies [59]. These disparities are deeply intertwined with histories that continue to influence contemporary expressions of medical racism directed at racialised Brazilian women. The way these women are demonised, stereotyped, violated, and surveilled reflects the current medical interactions, serving as a constant reminder of these stories.

This population suffers from these non-white European bodies, which are targets of the concept of racism as a technology of power that, according to Foucault [30,31], constructs the category of biopower to refer to the disciplinary and controlling forms of exercising power, capturing the bodies of racialised Brazilian women during pregnancy, childbirth, and the postpartum period. Unfortunately, the integration of biopower and racism as an essential device of power in the Portuguese NHS classifies these women as subjects according to phenotypic characteristics, as well as defining a line that divides superior and inferior groups [38]. This same author presents the relationship between law and race through a synthesis of definitions of law and its articulations with the structural process of racism, as can be seen in the assistance of maternal care with these women.

For this, Western categories of gender, race, and nationality are intertwined by global dynamics, presented as inherent in nature (of bodies), and operate in a dichotomous duality [37]. These racialised Brazilian women are made secondary, seen by Western eyes as others, with stereotypes of hypersexualised, promiscuous, submissive, and inferior sexual athletes and opportunists. In this case, intersectionality, together with social constructionism, proposes tackling these cases of OV, dealing with the interconnection of structures towards racialised Brazilian women during pregnancy, childbirth, and postpartum in Portugal or outside home, to verify identities produced by sexism, racism, and xenophobia, helping to see oppressions and fight them and recognising these painful and traumatic oppressions.

In this study, OV is seen as an intersectional continuum that overcomes pregnancy, childbirth, and the postpartum period. A period where these women face a lack of respect for their autonomy, dignity, and rights, such as physical, emotional, and psychological violence. These results are consistent with a study carried out by the European Commission, Directorate General for Justice and Consumers, et al. [57], that showed that in Portugal, 62.2% of women did not have their consent requested for the use of instruments (forceps, suction cup, spatula, among others). It reports that, in Portugal, 23.3% of women were victims of verbal violence. This study is in line with research carried out by SaMaNe [14] in Portugal on the experiences of Black and Afro-descendant women. A total of 23.4% reported feeling neglected, 19.7% felt disrespected, and 17% were humiliated.

The participants define OV as an inhumane and disrespectful practice when the body suffers some violation and desires are ignored. In terms of impacts, the findings reinforce other studies that reveal that there can be numerous sequelae and traumas reflected in the postpartum period, increasing the risk of developing postpartum depression, for example [38,58], both for the baby and the mother. They also point out that maternal mortality rates are related to access and quality of health services offered and, according to Diniz et al. [8], much of it could be avoided through the appropriate application of public policies. Another example comes from another study by Leite et al. [23] in the journal Lancet Regional Health–Americas, which shows the relationship between the occurrence of a traumatic event and difficulties during breastfeeding.

These problems are deeper than mere ignorance; they are deficiencies in the management of the system. They reflect systematic and structural issues of over-medicalisation and the pathologisation of natural physiological processes, as well as the abuse and "dehumanising" treatment of patients; in other words, the problem of institutional obstetric violence [18]. This points to a systemic phenomenon, especially in the NHS that serves women who are marginalised, immigrants, and/or racialised. The system frequently fails to address this violence, offering instead inadequate, unqualified, and impersonal care.

To address this issue effectively, it is crucial to raise awareness among women about the types of obstetric violence they may encounter at each stage of the process. The results confirm the need for a holistic, cultural sensitive, human rights-based approach to address maternal health challenges. This is only possible when it includes indicators of physical and psychological integrity, the right to information, and freedom of choice. Individualised care practices, with the help of an interdisciplinary health team, inform women about safe obstetric practices from prenatal care onwards to empower women and help them face the moment of labour.

Thus, the more women understand exactly what actions characterise OV and, consequently, demand dignified care, the lower the prevalence of violent episodes against pregnant women in the future [18,19]. To truly ensure that no one is left behind, it is crucial to consider the broader impact of pregnancy and childbirth on women throughout their lives and across generations. This involves recognising and addressing the adverse contexts that shape their experiences during pregnancy, childbirth, and the postpartum period, as well as addressing maternal complications beyond the typical postpartum period.

It is important to note that women increasingly play a leading role in the migration process, which characterises the feminisation of migration. In Portugal, it is important to note that this trend has been observed since 2012 [44]. Therefore, it is essential to address this issue, as gender inequality—rooted in stereotypes affecting all women, including Brazilian women—and the national stereotypes highlighted in this study, exacerbate the inequality experienced by these women when interacting with professionals in the Portuguese healthcare context. [45].

For Crenshaw [40], intersectionality, together with the issues of the feminisation of migration, aims to increase dialogues with the episteme of racialised Brazilian women that encompass body theory, ethnicity, memories, and polysemic culture, breaking through the imaginary horizon lines that produce fixed demarcations, making it necessary to draw on gender, race, and nationality. This shows the importance and need to understand the

impact of migration on health, both from the perspective of the health systems in the countries that receive migrants and from the perspective of the migrant and non-migrant populations living in these contexts [51].

It is essential to consider that the training of healthcare professionals, especially doctors, plays a fundamental role in the current configuration of care and in the resistance to change [6]. Today, access to better and updated evidence is more facilitated, but unfortunately, students are rarely guided on how to search for, evaluate, and review recent studies on a particular topic. As a result, graduates have limited knowledge about evidence-based practice, often treating best practices as matters of "opinion" or "philosophy," rather than recognising them as the gold standard of care. With this, women feel that they are being objectified for the training of interns [18].

Welcoming pregnant and parturient women in primary care implies taking responsibility for the integrity of care by welcoming the user with qualified listening, fostering a bond, and assessing vulnerabilities according to their social context, among other precautions. This makes it necessary to adapt the protocols regarding obstetric care, as well as the urgent need to humanise the services provided by health professionals through awareness and attitudes that provide women with respectful care [18,19,54,55], which reflects on female immigration, relating the experience of pregnancy and childbirth among migrant women, with knowledge of cultural competences among the health team in maternal care.

5. Conclusions

Racialised Brazilian women have the right to experience pregnancy, childbirth, and the postpartum period in safe and dignified conditions, incorporated as one of the pillars of reproductive justice. However, this study reveals that the practice of OV occurred in different forms and stages—pregnancy, labour, and postpartum—as an intersectional matter.

This research highlights how OV, migration, racism, and structural inequalities intersect with women's experiences and their interactions with Portuguese health systems and society. These experiences of violence—physical, psychological, moral, and sexual—are embedded in a system marked by dehumanising treatment and institutional constraints. Structural inequalities exacerbate these issues, particularly for these women, who face additional challenges due to their intersecting identities as women, migrants, and Brazilian and racial minorities.

Historically, gynaecology's advances have been linked to the accumulation of power and exploitation of racialised women's bodies, reflecting a broader pattern of reproductive control. Women with these identities could see an increase in the risk of experiencing this type of gender-based violence.

The violence suffered can manifest itself as trauma for these patients, ultimately resulting in the development of puerperal depression or other physical and emotional problems. It is therefore essential that women's knowledge of their rights as pregnant women are increased and that they understand what characterises OV, so that they can take a stand when they deem it necessary, reducing the rates of childbirth-related trauma and, consequently, depression in the puerperium.

Given the limited research on racialised migrant women's experiences of OV in Portugal, this exploratory study encourages critical reflection on OV in the country. Although entities and associations have played a crucial role in improving data on OV in Portugal and bringing the issue into public discussion, effective legislation is still needed to prevent and combat this form of gender-based violence. A deeper analysis is necessary to understand how systemic oppression increases vulnerability to OV for certain women. Institutional reforms are needed to recognise this problem and ensure that women's rights are upheld during critical moments in their lives. There must be a dialogue among policymakers, health professionals, migrant women, and relevant organisations to address this issue and advocate for legislative reforms. Given the country's challenges with demographic sustainability, addressing OV is an urgent and essential issue.

5.1. Limitations

This study presents some limitations that should be considered in its interpretation. First, the small number of participants (e.g., gender, nationality, age, education, geographical location, citizenship, and immigration status) did not allow us to capture the diversity of racialised Brazilian migrant women and their experiences in the Portuguese NHS. A deeper comprehension of OV processes, dynamics, and typologies would benefit from a larger sample. Accessing migrant women who identify as survivors of OV was particularly difficult. This shows an individualised methodology, being only a section of the population, and it is not possible to generalise. The reluctance to engage in scientific research could be explained by the sensitive nature of the issue.

5.2. Future Directions

In line with the research developed in this study, further research could be conducted considering several approaches: (1) a more extensive study would be pertinent, allowing for a better understanding of the connections between class, nationality, and other axes of discrimination; (2) more studies to determine the prevalence of obstetric violence; (3) longitudinal studies analyses of complaints and consequences of OV; (4) comparative studies on similar cases across different nationalities; (5) policy recognition of OV as a prevention mechanism; (6) policy implementation by examining institutional responses to OV complaints in different health settings; (7) analyses of the influence of support networks; (8) understanding the awareness of obstetric violence by health professionals; (7) development of training programmes to eliminate this type of violence against women in health facilities.

Author Contributions: Conceptualisation, M.H.R., C.N. and J.T.; methodology, M.H.R. and J.T.; investigation, M.H.R., formal analysis, M.H.R. and J.T.; writing—original draft preparation, M.H.R.; writing—review and editing, J.T., supervision, C.N. and J.T. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: This study was conducted in accordance with the Declaration of Helsinki and approved by the Ethics Committee of the Faculty of Psychology and Education Sciences of the University of Porto (Ref[a] 2023-09-07c, 5 January 2024).

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

Data Availability Statement: The data presented in this study are available from the corresponding author upon request.

Acknowledgments: We are grateful to all the women who have consented and shared their stories.

Conflicts of Interest: The authors declare no conflicts of interest.

References

1. The Sustainable Development Goals Report 2023: Special Edition. Available online: https://unstats.un.org/sdgs/report/2023/?_gl=1*1iepz*_ga*MTg4Njc4NjExLjE3MjIxODU4NTE.*_ga_TK9BQL5X7Z*MTcyMjE4NTg1MS4xLjEuMTcyMjE4NjA4NC4wLjAuMA (accessed on 23 June 2024).
2. Perera, D.; Lund, R.; Swahnberg, K.; Schei, B.; Infanti, J.J. 'When helpers hurt': Women's and midwives' stories of obstetric violence in state health institutions, Colombo district, Sri Lanka. *BMC Pregnancy Childbirth* **2018**, *18*, 211. [CrossRef] [PubMed]
3. Skoogh, A.; Hall-Lord, M.L.; Bååth, C.; Bojö, A.-K.S. Adverse events in women giving birth in a labor ward: A retrospective record review study. *BMC Health Serv. Res.* **2021**, *21*, 1093. [CrossRef]
4. Diaz-Tello, F. Invisible wounds: Obstetric violence in the United States. *Reprod. Health Matters* **2016**, *24*, 56–64. [CrossRef]
5. Sesia, P. Naming, framing, and shaming through obstetric violence: A critical approach to the judicialisation of maternal health rights violations in Mexico. In *Critical Medical Anthropology: Perspectives in and from Latin America*; Gamlin, J., Gibbon, S., Sesia, P., Berrio, L., Eds.; UCL Press: London, UK, 2020; pp. 222–247.
6. Barata, P. Violência obstétrica—Um termo recente para denominar um fenômeno antigo. *Rev. Misc.* **2023**, *19*, 11–17.
7. McLemore, M.R.; Altman, M.R.; Cooper, N.; Williams, S.; Rand, L.; Franck, L. Health care experiences of pregnant, birthing and postnatal women of color at risk for preterm birth. *Soc. Sci. Med.* **2018**, *201*, 127–135. [CrossRef] [PubMed]

8. Davis, D.-A. Obstetric racism: The racial politics of pregnancy, labor, and birthing. *Med. Anthropol.* **2018**, *38*, 560–573. [CrossRef] [PubMed]
9. van der Waal, R.; Mayra, K.; Horn, A.; Chadwick, R. Obstetric violence: An intersectional refraction through abolition feminism. *Fem. Anthropol.* **2022**, *4*, 91–114. [CrossRef]
10. Šimonović, D. A Human Rights-Based Approach to Mistreatment and Violence Against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence. Available online: https://digitallibrary.un.org/record/3823698?v=pdf#files (accessed on 13 May 2024).
11. Obstetrical and Gynecological Violence. Resolution n. 2306. Available online: https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=28236 (accessed on 23 July 2024).
12. Organização Mundial da Saúde (OMS). *WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience*; World Health Organization: Geneva, Switzerland, 2018.
13. Lazzerini, M.; Covi, B.; Mariani, I.; Drglin, Z.; Arendt, M.; Nedberg, I.H.; Elden, H.; Costa, R.; Drandić, D.; Radetić, J.; et al. Quality of facility-based maternal and newborn care around the time of childbirth during the COVID-19 pandemic: Online survey investigating maternal perspectives in 12 countries of the WHO European Region. *Lancet Reg. Health Eur.* **2022**, *13*, 100268. [CrossRef]
14. Experiências de Gravidez, Parto e Pós-Parto de Mulheres Negras e Afrodescendentes em Portugal—1º Relatório Técnico. Available online: https://drive.google.com/file/d/1Xos6n1GNtrFUFgtSfNDw2GQldsd4IMDM/view (accessed on 2 July 2024).
15. Aires, E. Violência Obstétrica: Estudo Qualitativo Sobre Conceções e Significados no Contexto Português. Master's Thesis, Universidade Lusófona do Porto, Porto, Portugal, 2023.
16. Experiências de Parto em Portugal: Inquérito às Mulheres Sobre as Suas Experiências de Parto. Available online: https://associacaogravidezeparto.pt/wp-content/uploads/2020/12/Experie%CC%82ncias-de-Parto-em-Portugal_2edicao_2015-19-1.pdf (accessed on 2 July 2024).
17. Inquérito Experiências de Parto em Portugal, 2ª ed. Available online: https://associacaogravidezeparto.pt/campanhas-e-eventos/inquerito-experiencias-de-parto-em-portugal-2-a-edicao/ (accessed on 2 June 2024).
18. Barata, C. "Mix of races, bad uterus": Obstetric violence in the experiences of Afro-Brazilian migrants in Portugal. *Societies* **2022**, *12*, 78. [CrossRef]
19. Barata, C. Body broken in half: Tackling an Afro-Brazilian migrant's experience of obstetric violence and racism in Portugal through art making. *Rev. D'Antropol. Investig. Soc. (Con)textos* **2022**, *10*, 65–84.
20. Barata, C.; Simões, V.; Soromenho, F. Obstetric violence as gender-based violence. In *The Emerald International Handbook of Feminist Perspectives on Women's Acts of Violence*; Banwell, S., Black, L., Cecil, D.K., Djamba, Y.K., Kimuna, S.R., Milne, E., Seal, L., Tenkorang, E.Y., Eds.; Emerald Publishing: Bingley, UK, 2023; pp. 203–217.
21. Costa, K.A.O.; Brito, L.E.F.; Coimbra, C.V.S.; Lopes, N.C.C.; Depuydt, D.O.S.; Correia, R.N. Racismo obstétrico em Portugal: Relato de experiência de um coletivo antirracista. *Forum Sociol.* **2022**, *41*, 7–14. [CrossRef]
22. Fedele, A.; White, J. Birthing matters in Portugal: Introduction. *Etnográfica* **2018**, *22*, 607–618. [CrossRef]
23. Leite, T.H.; Marques, E.S.; Mesenburgo, M.A.; Silveira, M.F.; Leal, M.C. The effect of obstetric violence during childbirth on breastfeeding: Findings from a perinatal cohort "Birth in Brazil". *Lancet Reg. Health Am.* **2023**, *19*, 100438. [CrossRef] [PubMed]
24. Rohde, A.M.B. A Outra Dor do Parto: Género, Relações de Poder e Violência Obstétrica na Assistência Hospitalar ao Parto. Ph.D. Thesis, Universidade Nova de Lisboa, Lisboa, Portugal, 2016.
25. Simões, V.A.S. *A Violência Obstétrica: A Violência Institucionalizada Contra o Género (Prémio Teresa Rosmaninho—Direitos Humanos, Direitos das Mulheres)*; Associação Portuguesa de Mulheres Juristas: Lisbon, Portugal, 2016; Available online: https://apmj.pt/premio-teresa-rosmaninho (accessed on 2 June 2024).
26. Simões, V.A.S. Violência Obstétrica, Direitos das Mulheres e Tutela Jurídica. Ph.D. Thesis, Universidade Nova de Lisboa, Lisboa, Portugal, 2023.
27. CE de Ginecologia/Obstetrícia. *The Lancet: Artigo Esclarece Mensagem Incorreta, Difundida pelos Media, Que Colocou Portugal como o Terceiro Pior País, em Alegadas Práticas de "Violência Obstétrica"*; Ordem dos Médicos: Lisbon, Portugal, 2022; Available online: https://ordemdosmedicos.pt/the-lancet-artigo-esclarece-mensagem-incorreta-difundida-pelos-media-que-colocou-portugal-como-o-terceiro-pior-pais-em-alegadas-praticas-de-violencia-obstetrica/ (accessed on 2 June 2024).
28. Medeiros, R.C.S.; Nascimento, E.G.C. "Na hora de fazer não chorou": A violência obstétrica e suas expressões. *Rev. Estud. Fem.* **2022**, *30*, 1–12. [CrossRef]
29. Iparraguirre, M.; Cóndor, M.; Muñoz, R.; Mendoza, J. La violencia obstétrica como biopoder: A propósito de la dignidad de la mujer. *Encuentros Rev. Cienc. Humanas Teoría Soc. Pens. Crítico* **2023**, *17*, 411–423.
30. Foucault, M. *Microfísica do Poder*, 16th ed.; Graal: Rio de Janeiro, Brazil, 2000.
31. Foucault, M. *O Nascimento da Biopolítica*; Martins Fontes: São Paulo, Brazil, 2007.
32. Nogueira, C. *Interseccionalidade e Psicologia Feminista*; Editora Devires: Bahia, Brazil, 2017.
33. Collins, P.H. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*; Routledge: New York, NY, USA, 2002.
34. Crenshaw, K.W. Documento para o encontro de especialistas em aspectos da discriminação racial relativos ao gênero. *Rev. Estud. Fem.* **2002**, *10*, 171–188. [CrossRef]
35. Crenshaw, K.W. *On Intersectionality: Essential Writings*; The New Press: New York, NY, USA, 2017.

36. Collins, P.H.; Bilge, S. *Interseccionalidade*, 1st ed.; Boitempo: São Paulo, Brazil, 2021.
37. Akotirene, C. *Interseccionalidade: Feminismos Plurais*; Polén: São Paulo, Brazil, 2019.
38. Oliveira, D.d. *Racismo Estrutural: Uma Perspectiva Histórico-Crítica*; Editora Dandara: São Paulo, Brazil, 2021.
39. Costa, A.R.P.; Ruviaro, L.G. Estereótipos e migração: A mulher brasileira em Portugal. *Rev. Interdiscip. Mobil. Hum.* **2020**, *28*, 101–120.
40. Dias, B.P.; Dias, N. *Imigração e Racismo em Portugal: O Lugar do Outro*; Edições 70 e Le Monde Diplomatique: Lisboa, Portugal, 2011.
41. Morais, M.S.; Padilla, B.; Rosseto, C.M.; Almeida, M.A.S. Migração: Saúde reprodutiva e estereótipo. *Cad. Saúde Colet.* **2021**, *29*, 86–91. [CrossRef]
42. Padilla, B. A imigrante brasileira em Portugal: Considerando o gênero na análise. In *Imigração Brasileira em Portugal*; Malheiros, J.M., Ed.; ACIDI: Lisboa, Portugal, 2007; pp. 113–134.
43. Padilla, B. Saúde dos imigrantes: Multidimensionalidade, desigualdades e acessibilidade em Portugal. *Rev. Interdisc. Mobi. Humana* **2013**, *21*, 49–68. [CrossRef]
44. Padilla, B. Health and Migration: Participative methodologies as tools to promote citizenship. *Interface* **2017**, *21*, 273–284. [CrossRef]
45. Padilla, B.; Gomes, M.S. Empoderamento, Interseccionalidade e Ciberativismo: Uma Análise do "Manifesto Contra o Preconceito às Mulheres Brasileiras em Portugal". *Rev. TOMO* **2016**, *28*, 170–201. [CrossRef]
46. Tonhati, T.; Araújo, A. Mulheres, "um corpo no mundo": Migração feminina no Brasil. *Refúgio Migrações Cid.* **2023**, *18*, 15–30.
47. Brasil. Ministério das Relações Exteriores. Available online: https://www.gov.br/mre/pt-br/assuntos/portal-consular/BrasileirosnoExterior.pdf (accessed on 2 July 2024).
48. Relatório de Migrações e Asilo. Agência para a Integração, Migração e Asilo. Available online: https://aima.gov.pt/media/pages/documents/92dd0f02ea-1726562672/rma-2023.pdf (accessed on 1 October 2024).
49. European Union. *Plano de Ação para a Integração e a Inclusão 2021–2027*; Publicações da União Europeia: Luxembourg, 2024; Available online: https://ec.europa.eu/info/sites/default/files/action_plan_on_integration_and_inclusion_2021-2027.pdf (accessed on 15 June 2024).
50. Migration Integration Policy Index (MIPEX). Available online: https://www.mipex.eu/ (accessed on 22 July 2024).
51. Oliveira, C.R. *Indicadores de Integração de Imigrantes: Relatório Estatístico Anual 2023*; Observatório das Migrações: Lisboa, Portugal, 2023.
52. Almeida, G.R.; Dos Santos, A.G.R.; Gomes, L.F.L.; Silva, L.C.; De Oliveira, M.A.S. Violência Obstétrica e a Autonomia da Mulher Durante o Período Gravídico e Puerperal. *Rev. Multidisc. Saúde* **2023**, *4*, 88–95. [CrossRef]
53. Eslier, M.; Azria, E.; Chatzistergiou, K.; Stewart, Z.; Dechartres, A.; Deneux-Tharaux, C. Association between migration and severe maternal outcomes in high-income countries: Systematic review and meta-analysis. *PLoS Med.* **2023**, *20*, e1004257. [CrossRef]
54. Topa, J.; Neves, S.; Nogueira, C. Vivências de mulheres brasileiras nos serviços de saúde materna. *Rev. Núcl. Estud. Pesqui. Sobre Gênero Direito* **2016**, *5*, 25–51. [CrossRef]
55. Topa, J. Cuidados de Saúde Materno-Infantis a Imigrantes na Região do Grande Porto: Percursos, Discursos e Práticas. Ph.D. Thesis, Universidade do Minho, Minho, Portugal, 2013. Available online: https://repositorium.sdum.uminho.pt/bitstream/1822/26676/1/Joana%20Bessa%20Topa.pdf (accessed on 29 June 2024).
56. Estatística da Saúde 2022. Available online: https://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_publicacoes&PUBLICACOESpub_boui=660522170&PUBLICACOESmodo=2 (accessed on 15 June 2024).
57. European Commission, Directorate-General for Justice and Consumers; Rozée, V.; Schantz, C.; van der Waal, R.; van der Pijl, M.; Holubová, B.; Villarmea, S.; Alcaide, A.R. *Case Studies on Obstetric Violence: Experience, Analysis, and Responses*; Publications Office of the European Union: Luxembourg, 2024.
58. Conceição, H.N.; Gonçalves, C.F.G.; Mascarenhas, M.D.M.; Rodrigues, M.T.P.; Madeiro, A.P. Desrespeito e abuso durante o parto e depressão pós-parto: Uma revisão de escopo. *Cad. Saúde Pública* **2023**, *39*, 1–13. [CrossRef]
59. Diniz, S.; Salgado, H.O.; Andrezzo, H.F.A.; Carvalho, P.G.C.; Carvalho, P.C.A.; Aguiar, C.A.; Niy, D.Y. Abuse and disrespect in childbirth care as a public health issue in Brazil: Origins, definitions, impacts on maternal health, and proposals for its prevention. *J. Hum. Growth Dev.* **2015**, *25*, 377–384. [CrossRef]
60. Barroso, A.M. *Sexualidade num Portugal Multicultural—Estudo Transcultural Entre Portugueses e Imigrantes*; Universidade Lusófona de Humanidades e Tecnologias: Lisbon, Portugal, 2018.
61. Yin, R.K. *Case Study Research and Applications: Design and Methods*, 6th ed.; Sage: Thousand Oaks, CA, USA, 2018.
62. Santos, V.; Moura, M.; Pinto, J.P.; Almeida, V.; Maio, J. Socio-demographic features of puerperas and pregnancy follow-up: What has changed in 17 years? *Acta Med. Port.* **2011**, *24*, 877–884. [CrossRef]
63. Direção-Geral de Saúde. *Relatório de Análise dos Registos das Interrupções da Gravidez*; Direção-Geral de Saúde: Lisbon, Portugal, 2022; Available online: https://www.spdc.pt/images/Relatorio_de_IG_2022_2.pdf (accessed on 2 October 2024).
64. Braun, V.; Clarke, V. Using thematic analysis in psychology. *Qual. Res. Psychol.* **2006**, *3*, 77–101. [CrossRef]
65. Torlig, E.G.d.S.; Resende, P.C., Jr.; Fujihara, R.K.; Montezano, L.; Demo, G. Proposta de Validação para Instrumentos de Pesquisa Qualitativa (Vali-Quali). *Adm. Ensino Pesqui.* **2022**, *23*, 5–31. [CrossRef]
66. Braun, V.; Clarke, V. *Successful Qualitative Research: A Practical Guide for Beginners*; Sage: Newcastle upon Tyne, UK, 2013.

67. Braun, V.; Clarke, V. One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qual. Res. Psychol.* **2020**, *18*, 328–352. [CrossRef]
68. Diário da República: Lei n.º 14/85, de 6 de Julho. Available online: https://diariodarepublica.pt/dr/detalhe/lei/14-182871 (accessed on 2 June 2024).

Disclaimer/Publisher's Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.