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Obstetric Violence within the Brazilian Healthcare System: A Critical Analysis of the Childbirth Narratives of Tupinambá Indigenous Women from the Olivença, Ilhéus Community

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Obstetric Violence within the Brazilian Healthcare System

A Critical Analysis of the Childbirth Narratives of Tupinambá Indigenous Women from the Olivença, Ilhéus Community

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I. Abstract

The objective of this research project is to hear the personal narratives of Tupinambá Indigenous Brazilian women living in the Olivença community in Ilheus, Bahia regarding their experiences giving birth in order to discern the prevalence of various forms of obstetric violence within their experiences. In the context of this study the term "obstetric violence," derived from an extensive literature review, encompasses 1) physical abuse, 2) the unethical imposition of medical interventions, 3) the denial or lack of privacy, 4) undignified care which includes verbal abuse, 5) discrimination, 6) abandonment, neglect or the refusal to grant assistance, 7) detention in services and 8) institutional unpreparedness. After hearing fourteen personal childbirth narratives from Tupinambá women, I analyzed each narrative in order to identify the presence of these forms of obstetric abuse, and subsequently determined which forms are most common among the sample population and how this pattern compares to the national indicators and patterns.

My findings were thus: the most common forms of obstetric violence present in the Tupinambá narratives are institutional unpreparedness with 14 cases, neglect with 10 cases, a medical professional's refusal to grant assistance with 5 cases, unethical medical interventions with 4 cases, and undignified care with 4 cases.

KEYWORDS: obstetric violence, childbirth narrative, Indigenous women, Tupinambá

Resumo

O objetivo deste projeto de pesquisa é ouvir as narrativas pessoais dos Tupinambá mulheres brasileiras indígenas que vivem na comunidade Olivença, em Ilhéus, Bahia sobre suas experiências que dão à luz, a fim de discernir a prevalência de várias formas de violência obstétrica dentro de suas experiências. No contexto deste estudo, o termo "violência obstétrica",

derivado de uma extensa revisão da literatura, significa 1) O abuso físico, 2) a imposição antiético de intervenções médicas, 3) a negação ou a falta de privacidade, 4) cuidados indigna que inclui abuso verbal, 5) a discriminação, 6) abandono, negligência ou recusa de assistência, 7) detenção em serviços e 8) despreparo institucional. Depois de ouvir catorze narrativas parto pessoais de mulheres Tupinambá, eu analisei cada narrativa, a fim de identificar a presença destas formas de abuso obstétrica e, posteriormente determinou quais as formas são mais comuns entre a população de amostra e como este padrão se compara com os indicadores e padrões nacionais .

Meus resultados foram assim: as formas mais comuns de obstétrica violência presente nas narrativas Tupinambá são despreparo institucional com 14 casos, a negligência com 10 casos, a recusa de um profissional médico para conceder uma ajuda com 5 casos, as intervenções médicas antiéticas com 4 casos e cuidados undignified com 4 casos.
PALAVRAS-CHAVE: violência obstétrica, narrativas parto, as mulheres indígenas, Tupinambá

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II. Acknowledgements

This study would have been utterly impossible without numerous people whom I feel so fortunate to know. With the risk of seeming novice, I have also taken this space to express more personal gratitudes, especially to my host family in Olivença, because, as anyone who wishes to replicate this project will quickly learn, the people of this community and their most generous hospitality and openness is the epicenter of this study's fruition and success. This, however, does not begin to do them their proper justice, but their names on this paper are just as important, if not more so, than mine.

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To my new sisters, Luisa and Laura. Thank you for becoming my impromptu and invaluable research assistants by helping me record interviews and clarify potentially confusing interview questions during interviews. And an obvious thank you for the many soccer games, fun and loud trips to the river, the constant laughter, the sing-a-longs, your patient guidance, and, most of all, for the opportunity to finally know what a wonderful thing it is to have sisters.

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I of course cannot forget my youngest siblings, Albert, Laila and Elaine. Thank you my darlings for being my *constant* playmates, dedicated caretakers and precocious teachers. I enjoyed every minute with you and I know you are all incredibly brilliant and will do so many wonderful things in the future. I will think of and love you no matter where I am in the world. Many hugs and kisses, your sister Cassandra.

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A very special thank you to my host mother, Luciana Beatriz, a woman who is the absolute epitome of strength, compassion, knowledge and beauty. Without you as well this study would never have been possible. You were invaluable in so many ways. Thank you for helping to identify informants, offer advice that led to clearer interview questions and a better cultural understanding on my part, as well as arrange and accompany me to interviews making both me and the women being interviewed feel safe and comfortable with your calming and knowledgable presence. More importantly, thank you for welcoming me into your home, sharing your stories and wisdom with me in our nightly conversations, teaching me different crafts that I will be sure to pass along to others as per your instructions, and caring for me as if I was your own daughter. You too came into my life like an angel, minha mãe. Thank you and I will think of you always.

And finally, thank you so very much to the entire Olivença Tupinambá community for welcoming me so warmly as not only a guest but as a friend and member of your community. I will think of home whenever I think of you. Yours truly, Cassamba

III. Dedication

My only regret is that this study does not even begin to illustrate the undeniable strength, kindness, and beauty of all the women I became so blessed to know in this community. Thus, it seems only right that this be a tribute, however small in scale, to them. Thank you for allowing me to know you and your stories.

As always, this too is for my own mother - the source of my strength and every opportunity I've had in the world. I know that you, like so many women everywhere, suffered while bringing your children into the world and I hope that even small bits of work like this will help to someday change this sad fact. And I know that I don't say it nearly enough, but thanks Mom. Thank you for everything.

IV. List of figures, tables and abbreviations

Graphs:

Abbreviations:

Cesarean Section = C-Section

Unified Healthcare System of Brazil = SUS

National Health Foundation = FUNASA

Special Secretariat on Indigenous Health = SESAI

Ministry of Health = MS

V. Introduction

Understanding Obstetric Violence

DEFINING OBSTETRIC VIOLENCE

Obstetric violence is a form of medical abuse that is recognized by researchers, scholars and activists on an international level. The term "obstetric violence" itself, in the context of this study, can most simply be understood as "the various forms of violence during institutional care to women during pregnancy, childbirth, postpartum and abortion" (Diniz et al, 2015:378-9). The focus, however, of this study is on institutional abuses that occur during childbirth. The following is a list of the major forms of obstetric violence, the corresponding human right(s) the abuse offends, and specific examples of such abuses on which the critical analysis of this study is based. The first seven forms come specifically from Diniz et al (Diniz et al, 2015:379) and the eighth form comes from Gonçalves da Silva et al (Gonçalves da Silva et al, 2014:725):

1) Physical Abuse

- Human right: right to be free from harm and abuse
- Example: physical restraint in painful positions; unnecessary medical interventions such as repetitive vaginal exams, episiotomies, and cesarean sections performed without clinical justification and/or "teaching" purposes for the doctor

2) A medical professional's imposition of interventions without the patient's informed consent, or based on false or distorted information

- Human right: right to information, to informed consent and refusal; right to have choices and preferences respected, including the choice of companionship during hospital stay
- Example: a medical professional performing medical interventions without receiving the verbal or written consent of the patient

3) Non-confidential care, the denial or lack of privacy

- Human right: right to confidentiality and privacy
- Example: collective maternity wards, sometimes even without curtains to give privacy

4) Undignified care, including verbal abuse

- Human right: right to dignity and respect

- Example: disrespectful communication with women, underestimating and mocking her pain, demoralizing their calls for help; humiliation of sexual nature, such as “when you did you liked it, so do not cry now”

5) Discrimination from medical professionals based on specific attributes of the patient

- Human right: equality, freedom from discrimination, equitable care
- Example: differential treatment based on attributes deemed positive or negative such as race, socio-economic status, age, and marital status

6) Abandonment, neglect or refusal to grant assistance

- Human right: right to health care in a timely manner and to the highest attainable standard of health
- Example: abandonment, neglect or refusal to attend to women with needed medical attention with significant risks to their physical safety

7) Detention in services

- Human right: right to liberty and autonomy
- Example: a women being arrested due to a medical professional's suspicion she had an abortion

8) Institutional unpreparedness

- Human right: right to healthcare to the highest attainable standard of health
- Example: physical structure - lack of room and beds in the maternity ward and minimum if any comfort for the accommodation of the patient's companion

RECOGNITION AND VISIBILITY

During the second half of the 21st century, activists and lobbyists finally succeeded in problematizing this issue with some degree of formal recognition when obstetric violence "was recently recognized as a public health issue by the World Health Organization" (Diniz et al, 2015:377). The fact that formal recognition, which has not yet yielded concrete and widespread awareness of the issue, arrived so late is precisely part of the problem: the issue of obstetric violence within childbirth care and the larger healthcare models that encompass them is not

placed in the critical limelight, thus effectively disappearing the problem altogether and allowing systemic violence to continue unchecked. On this point exactly, Diniz et al make the point that obstetric violence, "although considered a 'recent' or a 'new' research theme, reports of women subjected to abusive treatment during institutionalized childbirth appear in different historical moments" (Diniz et al, 2015:377).

OBSTETRIC VIOLENCE IN BRAZIL

In Brazil particularly, obstetric violence is devastatingly common. An article entitled "Abuse and Disrespect in Childbirth Care as a Public Health Issue in Brazil" written by researchers Cecilia McCallum, PhD and Ana Paula dos Reis, MSc, documenting obstetric violence in Brazil published in the *Journal of Human Growth and Development* states that the staggering rate of reported violence occurs in 25 percent of women, and this statistic is again confirmed by Brazilian journalist Carolina Pompeo in her article entitled "Uma em cada quatro mulheres sofre violência obstétrica no Brasil" which simply means "One in every four women suffers obstetric violence in Brazil" (Pompeo, 2014). Although the recorded rate is so high, in the case of Brazil proving the prevalence of obstetric violence in childbirth care within both the public and private healthcare systems is distressingly complex because, according to lawyer Sabrina Ferraz, "it is more difficult to understand obstetric violence" (Pompeo, 2014) as a tangible form of violence, and it often goes unrecognized and unreported. Yet there is still a large amount of women that continue to report mistreatment by health professionals during childbirth which is exemplified in the "Violence: A Glimpse of the City" study conducted in São Paulo that "clearly states with many narratives, the childbirth institutions [were characterized by] an experience of violence, and often providers had aggressive and intimidating postures, humiliated patients and did not respect their pain" (Diniz et al, 2015: 378).

INDIGENOUS WOMEN, HEALTHCARE AND OBSTETRIC VIOLENCE

Within Latin America, Brazil has one of the smallest indigenous populations by percentage, "since indigenous people make up only 0.4 percent (896,917 individuals) of the total population according to the latest national demographic census" (Coimbra et al, 2013:2). However this relatively small population is characterized by a vast ethnic and linguistic diversity and it is estimated that there are "as many as 300 indigenous ethnic groups, speakers of over 200 distinct languages, . . . constituting one of the national indigenous populations with the greatest ethnic diversity in the world" (Coimbra et al, 2013:2).

There is, however, virtually no data on the rates of obstetric violence within Indigenous communities in Brazil, but one study investigating the correlation between race and maternal mortality in the state of Mato Grasso hints at the presence of obstetric violence when it found that Indigenous women are 5.71 times more likely to die in childbirth than white women and that "Indigneous women died more of 'complications during labor' with [a rate of] 27.2%" (Texeira et al, 2012:27). Identifying and understanding the health indicators of Indigenous peoples in Brazil is especially difficult because "indigenous peoples in Brazil have not been adequately addressed by the major national health surveys" (Coimbra et al, 2013:3). In fact, the first national survey addressing the health and nutrition of Indigenous peoples, specifically women and children, was not executed until 2008-2009. This systemic lack of information focusing on Indigenous Brazilians is arguably due to the fact, as pointed out by analysts Coimbra et al, that "comparative analyses indicate that indigenous peoples are among the most politically and socioeconomically marginalized segments of society" (Coimbra et al, 2013:2).

Marginalization is again the running theme when speaking of the position Indigenous peoples occupy within SUS, the Unified Health System of Brazil. "Historically, health services

for indigenous peoples in Brazil existed separate to the mainstream health system [and] this disconnection reflected the ‘special status’ of indigenous Brazilians, who until the 1988 Constitution, were formally designated as wards of the state" (Shankland, Athias, 2007:79). In 1990, after the 1988 Constitution "declared health a universal right of citizenship and replaced the old public health system" (Coelho, Shankland, 2011:50), SUS was created. As "wards of the state," Indigenous peoples fell under the jurisdiction of the federal government, specifically the Ministry of Health, for healthcare services and this later created ideological and systemic problems because "there was the dilemma of how to address specific ethnic groups’ problems without jeopardizing the system’s principle of providing the same care to all and not targeting one population group over another for specific services or special attention" (Coelho, Shankland, 2011:51). Eventually it was decided that healthcare services for Indigenous peoples would be addressed separately from the main system, and subsequently the system was fragmented and the Indigenous Health Subsystem was created in 1999 as a separate entity that was governed by the federal government.

The subsystem contains 34 Special Indigenous Health Districts (DSEI) that were physically planned according to territories inhabited by Indigenous peoples, allowing districts to ignore the district and municipal boundaries, and a total of 717 health posts (Garnelo, 2012:26,29). Initially, the subsystem was managed by the National Health Foundation (FUNASA) but was later power was transferred in 2010 to the Special Secretariat on Indigenous Health (SESAI), a branch of the Ministry of Health (MS), after charges of internal corruption and a breakdown of trust among district and Indigenous leaders. The subsystem functioned in the following manner under FUNASA: DSEIs organize basic services and health posts that were generally partnered with NGOs provide primary care, and health authorities organize patient

referrals to SUS-affiliated public hospitals (Coelho, Shankland, 2011:51). Under the SESAI the subsystem more or less follows the same procedure, but power was shifted to "ensur[e] service quality while promoting greater management autonomy at the district level" (Coelho, Shankland, 2011:52). For the sake of this study it is important to clarify that Indigenous women, including the participants of this study, give birth at SUS-affiliated hospitals.

Currently, discourse on the newly restructured subsystem is dominated by critique and reports of negligence. For instance, a report documenting institutional violence based on figures from one 2011 that was commissioned by the Catholic Indigenous Missionary Council "describes 53 cases of negligence in healthcare in 16 states, which affected 53,000 people" (Glock, 2013). Again noting their almost institutional anonymity as mentioned by other analysts, Ida Pietrcovsky, an adviser to United Nations Children's Fund (UNICEF), says there is a serious "lack of systemic information on the health of indigenous peoples" (Glock, 2013).

Social Relevance

The extremely high rate of obstetric violence in Brazil, 25 percent or 1 in 4 women, speaks for itself in terms of proving the social relevancy of a study that focuses on this form of institutional mistreatment. As fore mentioned, a plethora of researchers and scholars who hail from a diverse set of backgrounds and specialities of study have published articles and studies that document the high magnitude of obstetric violence as well as theorizing its probable systemic causes and the specific demographics of its victims. However, a consistent and problematic gap in this collection of research is the inclusion of Indigenous women. Within all of my research using various forms of literary sources such as books, articles, editorials, studies, and surveys there is virtually no mention of the rate of obstetric violence within Indigenous communities. This study is an attempt to begin filling this gap in the relevant research.

Personal Relevance

Speaking from my own positionality as a woman, I find childbirth and motherhood to be a rather curious phenomenon in the context of social and cultural norms because motherhood is so intimately connected to many notions of femininity, yet the pregnancy and childbirth process itself is often a great physical and psychological hardship due to systemic violence and inequalities that are largely ignored, especially within the healthcare model of Brazil. Before beginning any research and formalizing project objectives, the phenomenon of obstetric violence was at the forefront of my mind as a potential topic of research due to the fact that my own mother suffered various forms of mistreatment when giving birth in the United States while serving in the Army, a place infamously sexist when dishing out opportunities and systemically prejudiced in treatment at the time and arguably today as well. This theme of a form of violence that targets a woman when she is embedded in a societal structure that both permits and propagates differential gendered treatment has gnawed at me, and every other feminist I am sure, and I was thus curious as to whether or not this specific kind of unjust treatment during childbirth was not only present throughout the world such as in Brazil but burrowed deeply enough to be systemic in nature and practice.

Aims of this Study

The first aim of this study is to familiarize the reader with the concept and nature of obstetric violence as a public health issue that is recognized by scholars and researchers on an international scale, while more specifically illuminating its disturbingly high prevalence within the Brazilian healthcare system, SUS, and more specifically within the subsystem of Indigenous healthcare. And, although there is literature available from various sources documenting and further investigating various forms of obstetric violence in Brazil, there is virtually no data

whatsoever that focuses on systemic obstetric violence within Indigenous communities. Therefore, it is my hope as a researcher that this collection and analysis of childbirth narratives from Indigenous women from the Olivença Tupinambá community will serve as a spark and cornerstone for further focused research on the possible link.

Furthermore, this study, although small in scale, can potentially offer very tangible examples of the various forms of obstetric violence in Brazil in an area that Diniz et al in their own exhaustive critical analysis of the phenomenon characterize as "still [being] surrounded by imprecisions" (Diniz et al, 2015:377). Just as the antithesis of obstetric violence is the "humanization of labor," a humanization of the study on obstetric violence through personal narratives can re-contextualize the phenomenon as a form of violence that intimately affects the lives of real women, particularly Indigenous women who, to the extent of my research, have been routinely excluded from these studies, while at the same time further problematizing the issue in an effort to garner widespread attention and subsequent action.

Definition of Terms

- Childbirth: the act or process of giving birth to children
- Obstetric: of, relating to, or associated with childbirth or obstetrics
- Obstetrics: medical - a branch of medicine that deals with the birth of children and with the care of women before, during, and after they give birth to children
- Cesarean section: a surgical operation for giving birth in which a cut is made in the mother's body so that the baby can be removed through the opening; medical - surgical incision of the walls of the abdomen and uterus for delivery of offspring
- Episiotomy: surgical incision of the perineum to enlarge the vaginal opening for obstetrical purposes during the birth process
- Perineum: an area of tissue that marks externally the approximate boundary of the outlet of the pelvis and gives passage to the urinogenital ducts and rectum; also, the area between the anus and the posterior part of the external genitalia

- Lithotomy position: birthing position in which the mother lies on her back with her legs in stirrups
- Supine position: birthing position in which the mother lies face-up on her back
- Fundal pressure: pressure placed on the pregnant woman's abdomen to speed labor process
- Prenatal: medical - relating to pregnant women and their unborn babies
- SUS: Unified Health System of Brazil (Portuguese acronym)
- Narrative: a story that is told or written
- Ethnography: the study and systematic recording of human cultures; also, a descriptive work produced from such research

VI. Methodology

Location

This study was conducted in Terra Indígena Tupinambá de Olivença, the Tupinambá Indigenous community located in Olivença, Ilhéus, Bahia, Brazil. According to Prêmio Culturas Indígenas, Edição Xicão Xukuru, a textbook that is an informative compilation of Indigenous peoples and cultures of Brazil that was published by the Brazilian federal Ministry of Culture, this community has approximately 628 inhabitants and is located 14 kilometers from the central city of Ilhéus in a region of land that is not officially demarcated as Indigenous land (Prêmio Culturas Indígenas, 2008: 91). More specifically within the entire Olivença Tupinambá community, the fieldwork was conducted in the communities of Tukum (the community in which I lived for the duration of research process) and Serra Negra, the neighboring community of Tukum. This particular Indigenous community was chosen as the site of this study after I visited Tukum during an SIT program activity and also due to the personal and professional connection the Academic Director Gabriela Venutra has with the Program Advisor Nádia

Batista, a resident and leader of the Tukum community, making arrangements for my study in this location logistically possible.

Sample Population

The sample population of this study is Tupinambá Indigenous women living in the Olivença Tukum and Serra Negra communities. The only requirement of the participants is that they be mothers, so there is a diverse range of ages and the number of children among the women interviewed. The decision not to place more specific demographic limitations on the sample population is partly due logistically to the relatively small size of the female Tupinambá general population, and my desire as a researcher to have a more diverse range of narratives.

Sampling Techniques

All of the interview participants were identified by the Project Advisor Nádia Batista, with the help of Luciana Beatriz, my host mother in Tukum, and they also arranged the actual interview times and locations. Due to the fact both Ms. Batista and Beatriz live in the Olivença community, they had an intimate knowledge of women who both qualified as informants and who would be willing to participate, thus the requirement process was rather informal in that informants were sometimes asked in passing or just before the interview due to these personal relationships, but the sampling technique is most akin to the "snowball" technique. This particular sampling technique built upon pre-existing personal connections and trust was best suited for this study due to the potentially sensitive nature of the interview topic.

Data Collection and Analysis

The primary data for this project was collected through 14 semi-structured ethnographic interviews. Thirteen of these interview were with Tupinambá women who have children regarding their childbirth experiences, and the fourteenth interview was with the community

midwife of Serra Negra regarding her perception of the challenges Tupinambá women face when giving birth. Semi-structured interviewing was the only data collection technique used because, although a survey of the same interview questions in which the informants write their responses could have been theoretically possible, the participants had varying levels of education and literacy, thus relying on written-based form of data collection was not logistically possible. The interviews were then critically analyzed, based on the definitions and examples of obstetric violence found in the literature review, to determine the prevalence of various forms of obstetric violence in the childbirth experiences of the participating Tupinambá women. Based on the consensus reached in the literature review, the defining characteristics / forms of obstetric violence on which the study's data analysis is based includes:1) physical abuse 2) a medical professional's imposition of interventions without the patient's informed consent 3) the denial or lack of privacy 4) undignified care, which includes verbal abuse 5) discrimination from medical professionals based on specific attributes of the patient 6) abandonment, neglect or refusal to grant assistance 7) detention in services 8) institutional unpreparedness.

Interviews

*As part of the precautions I took to preserve the ethical integrity of this study and ensure the comfort of those participating, I promised all of the informants that I would never use their name anywhere in my study and its publication. The following is a list of interview dates, times, and locations respectively:

Interview # 1: 28 April 2016, 3:00 pm, house of Informant #2, Tukum

Interview # 2: 28 April 2016, 3:15 pm, house of Informant #2, Tukum

Interview # 3: 28 April 2016, 3:35 pm, house of Informant #2, Tukum

Interview # 4: 29 April 2016, 3:15 pm, house of Informant #2, Tukum

Interview # 5: 29 April 2016, 3:30 pm, house of Informant #2, Tukum

Interview # 6: 7 May 2016, 4:45 pm, house of Informant #6, Tukum

Interview # 7: 7 May 2016, 6:15 pm, my room in host mother's house, Tukum

Interview # 8: 8 May 2016, 8:51 am, Serra Negra Indigenous School

Interview # 9: 8 May 2016, 9:00 am, Serra Negra Indigenous School

Interview # 10: 8 May 2016, 9:06 am, Serra Negra Indigenous School

Interview # 11: 8 May 2016, 9:12 am, Serra Negra Indigenous School

Interview # 12: 8 May 2016, 9:16 am, Serra Negra Indigenous School

Interview # 13: 8 May 2016, 9: 40 am, Serra Negra Indigenous School

Interview # 14: 8 May 2016, 9:50 am, Serra Negra Indigenous School

* #14 was the Serra Negra community midwife interview

Ethical Considerations and Fieldwork Ethics

To mitigate some of the interviewee's anxiety about sharing personal health and experiential information and to ensure their emotional and psychological comfort, I always remained on the side of caution when attempting to gather information. Before beginning every interview, I assured the informant that I would never use their name in my research, both in my field notes and final monograph and presentation. In addition, I promised all of the informants that I would never take photos of them for the purpose of this study. Some informants allowed me to record their interview and others did not, and their decision was of course respected.

Furthermore, the structure of my interview questions were first a series of general informational questions such as "how many children do you have?", "where did you give birth?" and "did you attend your prenatal exams?". The questions that focused more on the childbirth narrative were designed to be open-ended and without leading and personal questions so to ensure that the informants can construct their answers as a personal narrative with the freedom to add and omit anything they want in the process. If I had clarification questions or, as was

sometimes the case, the informant did not know how to begin answering the "can you describe your experience giving birth?" question because they found it to be too broad, I would then ask follow-up questions such as "did the doctor say anything to you?" and "what was the structure of the maternity ward in the hospital?" To learn more specific details and prompt more free-association speech from the informant.

All of the informants were also told before the interview that they were in no way required to answer all of the questions if they did not feel comfortable, and if during the interview I suspected that they were too timid or uncomfortable to continue I would discretely end the interview early. I found that this structure very effectively lent itself to ensuring the comfort of the informants while also allowing me to gather information because those that were timid only answered the more general questions and did not provide a great deal of elaboration on more personal aspects of their experience, and other informants that were more comfortable sharing with me were able to speak freely and then I asked a few follow-up questions for clarification.

Another ethical concern I had about undertaking this research project is that as a foreign, particularly American, university student researcher, the participants might assume that I have more authority and power than I do, especially within the medical field, after I presented myself as a student of public health in Brazil. For more than just the sake of research ethics, I wanted to present and position myself as the equal of the informants to make them feel more comfortable. I did this primarily by allowing Project Advisor Nádia Batista and my host mother, who accompanied me to all but two interviews, to first introduce me to the informants and explain the general objectives of the research project and then before the interview began I would introduce myself and the project again, ensure their anonymity, and ask for consent again. I also attempted

to always physically position myself on equal ground with the participants by sitting next to them, although this was not always possible as I was sometimes given the only available chair because of my status as a guest.

Conflict of Interest: The author claims no conflict of interest.

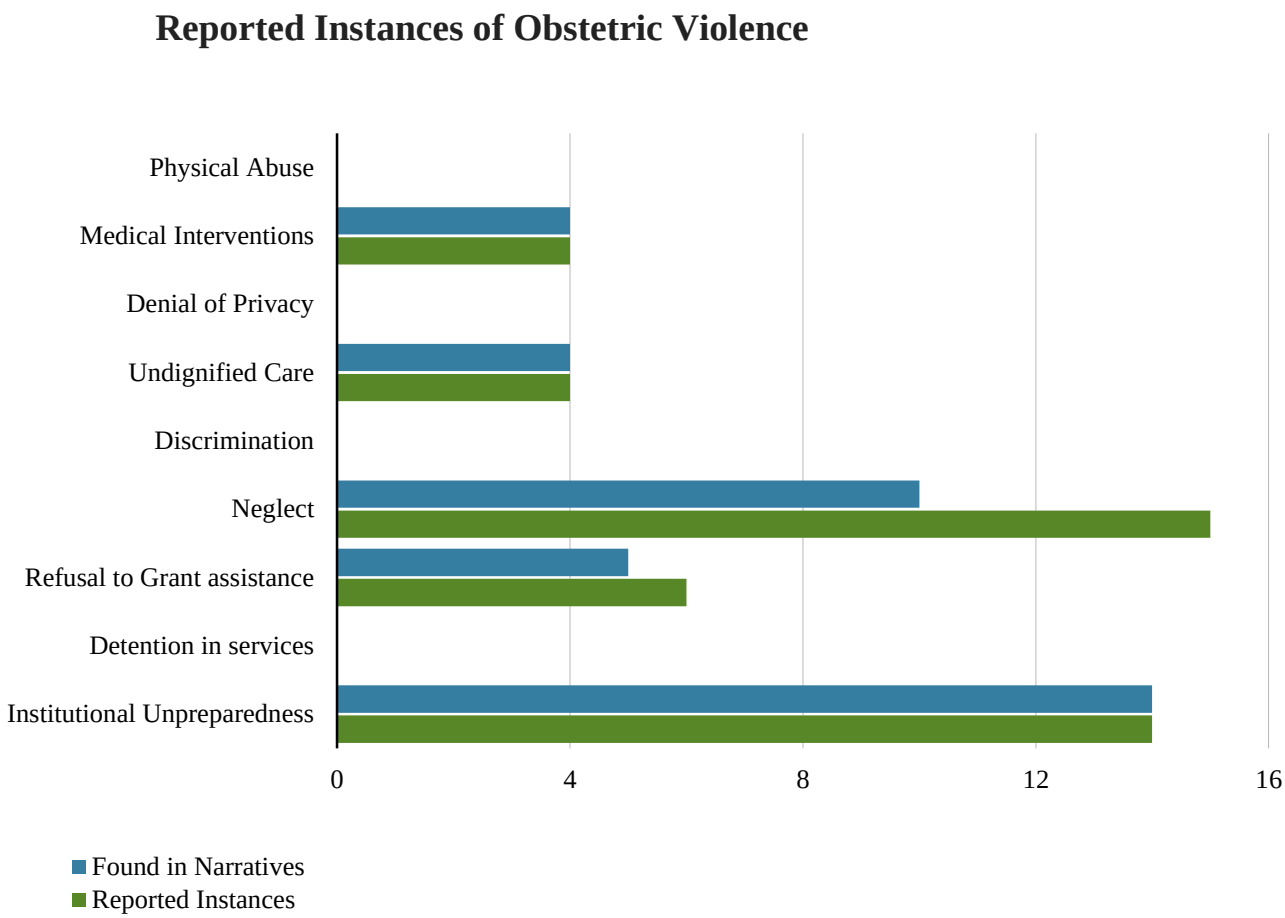
Limitations and Delimitations

This project was completed in approximately four weeks and due to time constraints, the interviews needed to be conducted as soon as possible. The problem with this scheduling is that, although I was living in the same community as the interview participants, I did not have the opportunity to establish a personal connection with all of them before beginning the interview process. Although I feel that the interviews went smoothly and garnered answers and most importantly did not make the informants feel uncomfortable from what I could tell, in an ideal world I would have had more time to establish personal relationships before beginning interviews. A more logistical limitation I encountered during the process of this project was extremely limited internet access due to the remoteness of the location. However, I was able to travel to the city center of Ilhéus to use an internet cafe on two occasions which allowed me to do some more literary research. Unfortunately, I still experienced technical difficulties which prevented me from utilizing the help of a professional to transcribe interviews.

VII. Results

With the absence of her characteristic smile and usual cheerful disposition, Informant 7 somberly told the story of her mother's experience giving birth to her. Days after her due date, the mother of Informant 7 went to the hospital and told the doctor she had not yet gone into labor and that she was in great pain. The doctor sent her home and did nothing. This quickly became a habitual pattern as she was continually sent home multiple times after persistently traveling to the hospital, which is very old, lacking resources and located relatively far from Tukum. After she was finally admitted into the hospital and hours passed as she struggled tremendously to give birth, the doctor finally performed a C-section. The procedure itself was also deeply "traumatic" (Informant 7, Personal Communication, 7 May 2016) in the words of Informant 7, because the doctor cut open her mother's entire abdomen, from the length between her pelvis and just before her rib cage, instead of doing the normal small incision just above the pelvis. It was not until after the birth that the severity of her complications were revealed when the doctor saw that the bedsheets had been completely soaked through with puss spilling out of her body, indicating a massive internal infection. The doctor's only response and explanation for this was a terse, "Oh, I knew this would happen." After a pause, Informant 7 categorized this entire experience as a quintessential example of "negligence" and as being simply "very cruel" (Informant 7, Personal Communication, 7 May 2016).

This is one of the most severe cases of obstetric violence reported by the women interviewed in this study, but the results clearly indicate that this particular narrative is in no way a statistic anomaly in terms of its indications of systemic abuse during the childbirth experiences of Tupinambá women. All fourteen narratives have instances of at least one form of obstetric violence. The following graph demonstrates the most common forms that emerged in the narratives which are institutional unpreparedness, neglect, refusal to grant assistance, medical interventions, and undignified care. Each of these specific forms of abuse will then be discussed in greater detail in relation to the results derived from the narratives.



INSTITUTIONAL UNPREPAREDNESS

Of the fourteen childbirth narratives generated from the ethnographic interviews, all of them indicated various instances of institutional unpreparedness. All the women reported that in the hospital in which they gave birth there was no more than five beds available in the maternity ward, and even as few as two or three beds as reported by Informants 11 and 12 respectively. According to the informants, there is also only one bathroom available to them in the hospital but Informant 3, who has given birth five times in a hospital, stated that there are times when there is absolutely no bathroom available for their use. Another reoccurring pattern that emerged within the narratives is the general lack of resources and supplies in the hospitals, and Informant 1 only ever saw one doctor working in the obstetric ward the day she gave birth.

NEGLECT

Within ten of the fourteen narratives there was evidence of women experiencing some form of neglect from the attending medical staff in hospitals. There was five cases of very long wait times in the hospital, three cases of women being turned away from the hospital by the medical staff, one case that specified receiving very little attention from the doctor, six cases of the doctor never speaking to the women, and one complaint specifically of the doctor not explaining the childbirth process to the woman when giving birth to her first child.

REFUSAL TO GRANT ASSISTANCE

Like the majority of participants, Informant 6 is a small, very thin woman with tiny hips even after giving birth to four children. When I arrived at her house to conduct the interview, she was breastfeeding her youngest daughter who is about a year old. The baby, I immediately noticed, seems healthy but is very large in comparison to the other infants I had seen throughout the community. She told me of her experience giving birth to this baby which she describes as being very "complicated" and "painful" (Informant 6, Personal Communication, 7 May 2016). During labor she was in constant pain and struggled greatly, but the doctor did nothing to intervene. When her daughter was finally born she then began to bleed heavily while experiencing continuous pain and she was unable to walk. The doctor eventually performed a procedure to stop the bleeding.

Some of the most severe and traumatic forms of obstetric violence as experienced by the participants was the medical staff's refusal to grant them assistance through medicine or medical intervention. Within the study sample there were three experiences of "forced birth," meaning the women were forced to give birth naturally despite experiencing complications and massive

amounts of difficulty and pain as in the case of Informant 6, as well as two cases in which the women were never given any kind of medication for their pain throughout the entire process.

MEDICAL INTERVENTIONS

Only three of the narratives had instances of medical interventions, but in all of the experiences the surrounding circumstances are indicators of maltreatment. For instance, Informant 13 had a C-section but does not know the doctor's reasoning for performing the procedure which is evidence of a medical professional performing a procedure without first receiving fully informed consent from their patient. Informant 7 has two experiences of problematic medical intervention. During labor with her first child, she was given medication to speed up the labor process which caused a great deal of pain. After experiencing much pain and difficulty during her second labor process, the doctor decided to perform a C-section which she described as very "traumatic" (Informant 7, Personal Communication, 7 May 2016) because three doctors were operating on her at the same time while the dividing screen used during surgery was placed all the way up to her neck, preventing her from seeing and understanding the process. The mother of Informant 7 only had a C-section after first experiencing neglect and the denial of assistance when she was continuously sent away from the hospital.

UNDIGNIFIED CARE

Four of the narratives revealed the presence of undignified care from the members of the hospital medical staffs, which was characterized by verbal abuse and the perceived demeanor of treatment of the doctors and nurses towards their patients. In the two reported examples of verbal abuse, one woman was told not to cry at all and the mother of Informant 7 was told by her doctor "Oh, I knew this would happen" when referring to the massive degree of complications and pain she experienced due to an internal infection that was ignored by the doctor when she was

repeatedly sent away from the hospital. Regarding the demeanor and treatment of the medical staff, Informant 7 reported that the attending nurse was very forceful and rude to her during her first childbirth experience and Informant 2, who gave birth to all four of her children at a hospital, stated that the "doctors are very arrogant" (Informant 2, Personal Communication, 28 April 2016).

VIII. Discussion

Contextualizing the Results

In Brazil "it is clear that the dominant childbirth care model is a medicalized one" (Carr, Riesco, 2007:406), illuminated by the fact that 97% of all childbirths occurred in hospitals in 2003. Within this commonly noted theme of medicalized childbirth, one of the most surprising and noted characteristics about childbirth trends in Brazil is the extremely high rate of cesarean sections performed. For doctors, the underlying mentality about childbirth that influences decisions to perform procedures is that ". . . it takes long, and the idea is we have to make it fast. It's impolite for doctors to leave cases for the doctors on the next shift. There's a sense that you need to either accelerate it or do a C-section" (Khazan, 2014). Researchers Carr and Riesco theorize that this trend lies also within the socio-cultural conscious of the country asserting that "the culturally determined preferences refer to beliefs that surgery is a status symbol, something available to the privileged classes and the modern way to give birth" (Carr, Riesco, 2007:407). However, they also argue that "these cultural beliefs more accurately represent the physicians'

cultural beliefs or preferences" (Carr, Riesco, 2007:407) which suggests that the power behind the decisions and desires for medical procedures is still stems from medical professionals.

The increase in medicalization is also understood by many researchers as being linked to economic and sociocultural trends that dictate the correlation between a woman's likelihood to receive a cesarean section and a higher salary and level of education, use of private care, and living in a more developed geographical area. As further collaborated in a study entitled *Obstetric interventions during labor and childbirth in Brazilian low-risk women*, "Caesarean section rates were lower in women using the public health system, nonwhites, women with a low level of education" (Leal et al, S1) and those with the highest likelihood are middle-class and wealthy, white women with the means to pay for private insurance and give birth in a private hospital. This trend corresponds directly with the results regarding medical interventions in this study. Of the thirty-eight childbirth experiences of the fourteen Tupinambá women interviewed, there are only three cases of a doctor performing a C-section, one for unknown reasons and the other two due to the informant's difficulty to give birth naturally. As the statistics suggest, the explanation for this pattern could be due to the fact that the informants are all Indigenous women from a low socio-economic background who used the public health system.

However, deviating from the focus on cesarean sections, Eugene Declerq, noting the large increase in rates of medical procedures performed in Brazil, states that a "culture of medical intervention in birth is hardly limited to cesareans and Leal et al. find exceptionally high rates of intervention in vaginal birth, most notably a 56% episiotomy rate (as opposed to 17% in vaginal births in the U.S.); use of the lithotomy position in 92% of births (69% in vaginal births in U.S.); and 37% of mothers experiencing fundal pressure (25% in U.S.)" (Declerq, 2014:S23). These rates of medical interventions raise a red flag for many analysts, such as Estela M. L.

Aquino, who notes that in Brazil "the model rests on the idea that women are to remain passive, immobile during childbirth, while they undergo interventions by unknown health personnel to shorten the time to birth [and] unnecessary and harmful procedures are used to the maximum, as dictated by the reigning mercantile logic and medical (mis-) training" (Aquino, 2014:S2).

The results of this study reveal, however, that the dominant trend in regards to medical intervention within the experiences of the sample population is characterized by neglect and a refusal to grant assistance rather than a surplus of medical procedures. For instance, there is only one reported case, from Informant 7, of a doctor administering drugs to speed the labor process and apart from the two cases of a C-section, from Informant 7 and 13, all of the women reported that they had a natural birth without procedures. Likewise, there were three cases of forced birth, two women were never given any medication for their pain during difficult births, and the mother of Informant 7 had an internal infection that went untreated despite numerous visits to the hospital and complaints of severe pain. Within the conversation of obstetric violence in Brazil which is dominated by high rates of medical interventions, the results of this study are significant because they suggest that, for Indigenous women in particular, the national trends do not match their experiences, and thus require further investigation that demands a greater degree of specificity and scope.

OBSTETRIC VIOLENCE AS GENDER VIOLENCE

It is noteworthy that all of the fourteen narratives had evidence of some form of obstetric violence. This level of perfect consistency of abuse towards the women interviewed is a clear indication that obstetric violence as an international phenomenon functions as one of the many Hydra heads of sexism, in that, as Israeli feminist researcher Sara Cohen Shabot asserts, "it is a

clearly gendered phenomenon; women are its main victims and it has its origins primarily in how women (and their (dis)abilities) are perceived and perceive themselves in Western patriarchal societies" and is thus a feminist issue (Shabot, 2015:3). This medium of sexism is especially at play in Brazil where "many physicians' attitudes toward childbirth weave together Brazil's macho culture with the traditional sexual mores" (Khazan, 2014).

The patriarchal foundational influences of the subconscious and conscious attitudes of the educational culture of Brazilian physicians in turn constructed and valorized certain norms and practices that directly result in the systemic dehumanization of women during their childbirth experiences. This is most easily illuminated by the reflective statement on the issue made by Simone Diniz, an associate professor in the department of maternal and child health at the University of São Paulo, who said that "there's the idea that the experience of childbirth should be humiliating" (Khazan, 2014) for women. A complete disregard for the rights and dignity of women giving birth such as this is arguably the root cause of the undignified care many of the informants experienced. For instance, Informant 2 stated that the "doctors are very arrogant," Informant 3 complained of receiving little attention from her attending physician during a complicated birth, Informant 3 was simply told not to cry, and the nurse attending Informant 7 during her first birth experience was very "rude" and "forceful." From this, it is not unreasonable to assume that the behavior and practices of the attending medical personal that are characterized by negligence experienced by the informants also stem from the trend of medical professionals treating laboring women without dignity. Commenting on this theme, Mariana Bahia, a woman who became an activist against obstetric violence in Recife after her doctor gruffly accused her of having an abortion after actually having a miscarriage, laments that "there is no horizontality between patients and doctors. Doctors are always above us" (Khazan, 2014).

Just as medical professionals are steeped in educational cultural norms that are rooted in sexist patriarchy and an unusually high degree of medicalization, the general population, including women who have experienced obstetric violence, also internalizes various aspects of these values and begins to perceive them as normal and commonplace. On this phenomenon of societal normative conditioning as related to perceptions of obstetric violence, Allison Wolf theorizes that:

"this is because the system works via practices that are deemed normal and natural—they are not violence, they are just the way things are. Similarly, women who experience metaphysical violence in childbirth may not perceive the damage done and may even support medicalized childbirth. This is not due to any deficiency or problem with the woman but rather results from the success that medicalized childbirth has had in establishing itself as the normal way of giving birth... part of metaphysical violence in medicalized childbirth is the obfuscation of the problem—it works, in part, precisely by being able to function undetected under the guise of normal practice" (Shabot, 2015:6).

The reasoning for this, as Wolf asserts, is that a defining element of obstetric violence is the so-called "metaphysical violence" (Shabot, 2015:5) fore mentioned in which the woman, in the midst of a high degree of medicalization during childbirth, essentially loses her sense of individuality during her own labor process and experiences the process not as herself, but rather as a disembodied and fragmented piece of herself that has lost autonomy and agency. Based on this philosophical interpretation, I argue that most of the informants, with the exception of Informants 2, 3, 4, and 7, experienced some degree of this "metaphysical violence" (Shabot, 2015:5) because they did not register their experiences as forms of abuse or maltreatment out of the ordinary but continuously shrugged and described their experience, including the lack of hospital beds and the fact that the doctors never spoke to them, as being very "normal."

OBSTETRIC VIOLENCE AND REPRODUCTIVE JUSTICE IN LATIN AMERICA

In March of 2007, Venezuela became the first country to legally recognize the term obstetric violence and the common presence of obstetric violence within its institutions with the passing of the *Organic Law on the Right of Women to a Life Free of Violence.* Within the law, obstetric violence is defined as

'...the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women' (Pérez D'Gregorio, 2010:1).

Echoing the definition and examples pinpointed by both Diniz et al and Gonçalves da Silva et al, Article 51 of the law lists the following as quintessential examples of obstetric violence:

"(1) Untimely and ineffective attention of obstetric emergencies; (2) Forcing the woman to give birth in a supine position, with legs raised, when the necessary means to perform a vertical delivery are available; (3) Impeding the early attachment of the child with his/her mother without a medical cause thus preventing the early attachment and blocking the possibility of holding, nursing or breast-feeding immediately after birth; (4) Altering the natural process of low-risk delivery by using acceleration techniques, without obtaining voluntary, expressed and informed consent of the woman; (5) Performing delivery via cesarean section, when natural childbirth is possible, without obtaining voluntary, expressed, and informed consent from the woman" (Pérez D'Gregorio, 2010:1).

This form of legal recognition set a precedent in Latin America, and Argentina followed suit in 2009 as well as Mexico in 2014 (Shabot, 2015:7). In the case of Brazil, to date there has been no piece of legislation that specifically acknowledges or addresses the common presence of obstetric violence. However, in response to the high C-section rates, there is a federal program from the Ministry of Health in place in which $4 billion has been invested called "Rede

Cegonha" or the "Stork Network . . . that plans to educate both mothers and doctors about the benefits of giving birth the old-fashioned way" (Khazan, 2014).

This recent government recognition and action is situated within the history of activism and literature surrounding reproductive rights and reproductive justice throughout Latin America. The positioning of reproductive rights as a politicized mode of human rights is of, as Finnish postdoctoral researcher Hanna Laako posits, a "newer generation of rights," and in terms of their practical implementation, "generally statements about reproductive rights are not binding and they are among the most disputed rights at a global level" due to their intimate connection to issues such as abortion, birth control, coerced sterilization, female genital mutilation, access to quality healthcare, and adequate education on STDs (Laako, 2016:4). During the 1990s, reproductive rights were then repositioned more specifically as women's rights and were "especially bound to the campaign on making violence against women visible" (Laako, 2016:4). After the highly active period of activism during the 1990s, however, the momentum "stagnated as a result of stronger political divides related to political and ideological struggles" (Laako, 2016:4) and many of the government sponsored reproductive health policies focused on population control which, in an obvious simplification, "appear[ed] dubious" (Laako, 2016:4), most especially to people of color.

And it is from this that one of the major critiques of the formulation of international reproductive rights emerged. People of color, both in the global South and North, argued that the majority of the focus and results of Western feminist reproductive rights campaign were singularly for the benefit of white, affluent and middle-class women at the expense of women of color because "simultaneously those same rights have been diminished for women of colour and women from developing countries" (Laako, 2016:4). As a means of addressing this duality of

identities and the need for both reproductive and social rights, the philosophy of reproductive justice began to gain momentum and even replace the term reproductive rights in certain circles because "as an intersectional theory, it highlights the lived experience of reproductive oppression in communities of colour and expands the narrower focus on legal access and individual choice to a broader analysis of racial, economic, cultural and structural constraints" (Laako, 2016:4). It is from this theory of intersectional reproductive justice that I will speak of humanized birth and its significance to Indigenous women in Latin America.

HUMANIZED BIRTH AND THE ROLE OF INDIGENOUS MIDWIVES

According to Simone Diniz, in Brazil, the mentality of many physicians is that "childbirth is something that is primitive, ugly, nasty, inconvenient" (Khazan, 2014). Shabot asserts that this seemingly inherent disgust of the female body giving birth is deeply rooted in the psyche of the patriarchal rationality of society and the placement of a woman's body within that society, saying that during childbirth in a medicalized setting

"laboring bodies are violently turned into objects not only because this is comfortable for the medical staff—passive Cartesian corpses being easier to handle than live bodies with desires and particularities—but mainly because they are feminine bodies threatening their own passive femininity: bodies acting from immanence, reaching towards transcendence; living, vigorous, sexual bodies challenging patriarchy" (Shabot, 2015:14).

I feel it is important to note, however, that while, as in the case of Brazil and many other countries around the world, medical professionals emerge from an educational system and culture situated and steeped within a patriarchal society at large that has internalized to some degree the prevailing sexist attitudes and practices, this discussion is meant in no way to simplistically vilify medical professionals in the name of reproductive justice. As previously

expressed, the aim of this study is to make visible the prevalence of systemic obstetric violence within the Brazilian healthcare system as experienced by Indigenous women.

On this note exactly of addressing obstetric violence as a product of systemic norms within the medical educational model, Gonçalves da Silva et al, a team of professional obstetric nurses in São Paulo, in their documentation of witnessed occurrences of obstetric violence from various medical professionals reflect that "the violence practiced by obstetric nurses, whose basis of education should be holistic and humanized, is surprising. It leads to the reflection on how these health professionals are being educated" (Gonçalves da Silva et al, 2014:725). In response to their own investigation into the flawed medical training system in Brazil, Diniz et al recommend various interventions in the medical education curriculum that includes a mandatory course on women's, sexual, and reproductive rights during undergraduate years; more investment in the training of midwives and obstetric nurses whom they call "the experts in psychological childbirth"; and modify the teaching norms in Training Birth Centers so students are not exposed mostly to medical interventions that are not based on scientific evidence of their safety, effectiveness, and necessity (Diniz et al, 2015:381).

The evident flaws in this system of education have sparked a campaign within the reproductive justice philosophy for the "humanization of birth." The educational midwifery association Nueve Lunas in Oaxaca, Mexico defines the humanization of birth as the following:

"A ‘humanised birth’ [parto humanizado, humanised delivery, referring to the birthing woman] refers to a model that takes into account explicitly and directly the opinions, necessities and emotional values of women and their families in the processes of attention during pregnancy, birth and puerperium; having as a fundamental aim that they are living a special moment and pleasurable lived experience in the conditions of human dignity where woman is the subject and protagonist of her own birth, acknowledging the right to freedom of women and couples to take

decisions about where, how and with whom to give birth in the most poignant moments of their life." (Laako, 2016: 8)

The Latin American and Caribbean Network for Humanization of Birth, a multi-national alliance of networks, has spearhead this movement for the systemic humanization of birth as the antithesis to obstetric violence in Latin America. It was formed after the First International Congress on the Humanization of Birth which was held in Brazil in 2000, and interestingly enough, it is Brazil that has been at the forefront of this collective mobilization due "in part because in Brazil the movement also stems from within official agencies like the Ministry of Health" (Laako, 2016:8). However, these government programs have received criticism, and specifically the Stork Network for which Aquino comments that the "introduction of the Rede Cegonha (Stork Network) strategy represents, symbolically and materially, a downgrading of both the feminist agenda and construction of the SUS" (Aquino, 2014:S2).

In Mexico, as well as other countries in Latin America, the reproductive justice movement is centered around the defense of institutional and traditional (at times meaning Indigenous) midwifes as viable and competent providers of obstetric care, which is significant because "it challenges some dominant, core perceptions of reproductive rights in childbirth in development by arguing that the clinical–medical view, which has been focused merely on access to medical services as the main component of ensuring reproductive rights, does not necessarily safeguard the rights of women but, in fact, may jeopardise these rights by exposing women to obstetric violence" (Laako, 2016:2).

Many researchers and medical professional have also firmly recommended that Brazil invest more in the training of midwives as a means of combatting institutional violence (Diniz et al, 2012:99) (Diniz et al, 2015:381). Despite the current discourse surrounding midwifery and the humanization of birth, Brazil still has a serious lack of trained midwives and "as of March 2007,

there were 2227 nurse-midwives registered with the government's national registry of all health establishments" (Carr, Riesco, 2007:409). The larger problem at hand is the fact that medical professionals and resources are highly concentrated in large, wealthier urban areas which creates an obvious disparity in the availability and quality of healthcare throughout the country (Carr, Riesco, 2007:409). Returning to the results of this study, this disparity in resource distribution is significant because it contextualizes the perfect consistency of occurrences of institutional unpreparedness as experienced by the interviewees. From this lack of institutional resources, Carr and Riesco argue that "the glut of physicians, especially in urban areas, has been—and still is—a source of substantial resistance to a more independent non-physician provider for women giving birth" (Carr, Riesco, 2007:409) such as local midwives.

Speaking specifically about the Tupinambá community, this does not seem like a realistic alternative because there is currently only one woman who works as a midwife in the entire community, specifically in Serra Negra who is not available to the entire community due to distance and lack of transportation. For instance, Informants 4 and 7, who live in Tukum and do not have regular access to the midwife, stated that they went to the hospital to give birth because this was the only option. Although all of the women interviewed gave birth at least once in a public hospital, it is worth mention that three of the women, who live in Serra Negra, said they preferred to give birth at home with the midwife, with their reasoning being greater comfort and a faster process. Likewise, the midwife herself acknowledged the presence of obstetric violence in the public hospitals lamenting that "the women arrive in pain and are then ignored" (Informant 14, Personal Communication, 8 May 2016) and then are told not to cry out in pain. She also noted that "the women are timid and the doctors don't know they are suffering" (Informant 14, Personal Communication, 8 May 2016) which gives credence to the statement that there is a lack

of horizontality among doctors and their patients (Khazan, 2014). However, the midwife says that ultimately the women in this community prefer to give birth at the hospital due to their fear of pain and possible complications, which matches the statements of eight of the interviewees.

This demonstrates the reliance Tupinambá women have on SUS when the time comes for them to give birth, and thus there is a clear need for reform with the healthcare system to properly address the needs of these women so to provide them with the quality and dignity they deserve as a fundamental human right as guaranteed to them in the Brazilian Constitution.

VIIII. Conclusions

Results and their Significance

The results of this study indicate a pattern that Tupinambá women routinely experience some form of obstetric violence in SUS public hospitals. Within all fourteen childbirth narratives collected, there was evidence of at least one form obstetric violence with the most common being institutional unpreparedness, neglect, refusal to grant assistance, unethical treatment during medical interventions, and undignified care. While these results fit into the international discourse surrounding obstetric violence and reproductive justice, they are significant because they indicate that the experiences of abuse during obstetric are deviate from the dominant trend in regards to extremely high rates of medical intervention because the experiences of the sample population are characterized by neglect and a refusal to grant assistance rather than a surplus of medical procedures. It is also noteworthy that all of the interviewees gave birth at least once in a SUS-affiliated public hospital and the majority stated that they prefer this due to their belief that the presence of a trained medical staff will ensure more safety and less suffering. Due to the reliance Tupinambá women have on SUS when the time comes for them to give birth, it is necessary that there be a demand for reform within the SUS healthcare system to ensure that

Indigenous women are treated ethically and with dignity, as it is their Constitutional and human right.

Management Recommendations and Recommendations for Further Study

For those wishing to replicate this study, I recommend the following. If possible, allot enough time in the beginning stages of the research process to establish at least some degree of a personal connection with the entire community, specifically with the sample population so to build trust and allow them to know you on a personal level as well. I believe this will aid the interview process in that the interviewees will perhaps be more comfortable speaking about their experiences. It might also be helpful to organize one of the interview sessions as a group discussion among the interviewees, with the possibility that this might help ease their anxiety and timidness. Possible avenues of future studies both within this community and topic of obstetric violence are the perception medical professionals who serve the Tupinambá community have towards the women when they give birth, and an analysis of the availability and quality of healthcare resources such as health posts and maternity wards for Tupinambá women during pregnancy and childbirth.

X. References

Aquino, E. M. (2014). Reinventing delivery and childbirth in Brazil: Back to the future. Perspectivas, S1-S3. Retrieved March, 2016.

Carr, M., & Riesco, M. (2007). Rekindling of Nurse-Midwifery in Brazil: Public Policy and Childbirth Trends. Journal of Midwifery & Women's Health, 52(4), 406-411. doi: 10.1016/j.jmwh.2007.02.015

Coelho, V., PhD, & Shankland, A., D. (2011). Making the Right to Health a Reality for Brazil's Indigenous Peoples: Innovation, Decentralization and Equity. MEDICC Review, 13(03).

Coimbra, C. E., Santos, R. V., Welch, J. R., Cardoso, A. M., Souza, M. C., Garnelo, L., . . . Horta, B. L. (2013). The First National Survey of Indigenous People's Health and Nutrition in Brazil: Rationale, methodology, and overview of results. BMC Public Health, 13(1), 52. doi:10.1186/1471-2458-13-52

Declercq, E. (2015). Childbirth in Brazil: Challenging an Interventionist Paradigm. Birth, 42(1), 1-4. doi:10.1111/birt.12156

Declerq, E. (2014). Is medical intervention in childbirth inevitable in Brazil? Cad. Saude Publica. doi:10.1590/0102-311XCO055S114

Diniz, S. G., D'Oliveira, A. F., & Lansky, S. (2012). Equity and women's health services for contraception, abortion and childbirth in Brazil. Reproductive Health Matters, 20(40), 94-101. doi:10.1016/s0968-8080(12)40657-7

Diniz, S. G., Salgado, H. D., Andrezzo, H. F., Carvalho, P. G., Carvalho, P. C., Aguiar, C. A., & Niy, D. Y. (2015). 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. Journal of Human Growth and Development, 25(3), 377. doi:10.7322/jhgd.106080

Do Carmo Leal, M., Esteves Pereira, A., Soares Madeira Domingues, R., Theme Filha, M., Bastos Dias, M., Nakamura-Pereira, M., . . . Granado Nogueira da Gama, S. (2014). Obstetric interventions during labor and childbirth in Brazilian low-risk women. Cad. Saúde Pública, S1-S16. doi:10.1590/0102-311X00151513

Garnelo, L. (2012). Política de Saúde Indígena no Brasil: Notas sobre as tendências atuais do processo de implantação do subsistema de atenção à saúde. In Saúde indígena: Uma introdução ao tema (pp. 18-59). Brasília.

Glock, C. (2013, June 01). Healthcare for Native People in Brazil is Ailing. Inter Press Service.

Gonçalves da Silva, M., Carreira Marcelino, M., Pinheiro Rodrigues, L., & Carcman Toro, R. (2014). Obstetric violence according to obstetric nurses. Revista Rene, 720-728. doi: 10.15253/2175-6783.2014000400020

Hanna Laako (2016): Understanding contested women's rights in development: the Latin American campaign for the humanisation of birth and the challenge of midwifery in Mexico, Third World Quarterly, DOI: 10.1080/01436597.2016.1145046

Khazan, O. (2014, April 14). Why most Brazilian women get C-sections. The Atlantic.

McCallum, C., & Reis, A. P. (2005). Childbirth as ritual in Brazil: Young mothers' experiences. Ethnos, 70(3), 335-360. doi:10.1080/00141840500294417

McCallum, C., & Reis, A. P. (2008). Users' and providers' perspectives on technological procedures for 'normal' childbirth in a public maternity hospital in Salvador, Brazil. Salud

Pérez D'Gregorio, D. (2010). Obstetric violence: A new legal term introduced in Venezuela. International Journal of Gynecology and Obstetrics, 1-2. doi:10.1016

Pompeo, C. (2014, September 26). Uma em cada quatro mulheres sofre violência obstétrica no Brasil. Gazeta Do Povo. Retrieved March, 2016.

Pública Méx Salud Pública De México, 50(1), 40-48. doi:10.1590/s0036-36342008000100010

Vogt, S. E., Silveira da Silva, K., & Bastos Dias, M. A. (n.d.). Comparison of Childbirth Care Models in Public Hospitals, Brazil. Rev Saude Publica. doi:10.1590/ S0034-8910.2014048004633

Shabot, S. C. (2015). Making Loud Bodies “Feminine”: A Feminist-Phenomenological Analysis of Obstetric Violence. Hum Stud Human Studies, 39(2), 231-247. doi:10.1007/s10746-015-9369-x

Shankland, A., & Athias, R. (2007). Decentralisation and Difference: Indigenous Peoples and Health System Reform in the Brazilian Amazon. IDS Bulletin, 38(1), 77-88. doi:10.1111/j.1759-5436.2007.tb00339.x

Xukuru, X. (2008). Tupinambá. In Prêmio Culturas Indigenas (pp. 91-92). São Paulo: SECS SP.

Zamariano Fanaia Teixeira, N., Rocha Pereira, W., Aparecida Barbosa, D., & Amaral Carneiro Vianna, L. (2012). Maternal mortality and race in the Brazilian State of Mato Grosso. Revista Saúde Maternidade, 27-35.

Informant 1, 28 April 2016 [Personal Communication]

Informant 2, 28 April 2016 [Personal Communication]

Informant 3, 28 April 2016 [Personal Communication]

Informant 4, 29 April 2016 [Personal Communication]

Informant 5, 29 April 2016 [Personal Communication]

Informant 6, 7 May 2016 [Personal Communication]

Informant 7, 7 May 2016 [Personal Communication]

Informant 8, 8 May 2016 [Personal Communication]

Informant 9, 8 May 2016 [Personal Communication]

Informant 10, 8 May 2016 [Personal Communication]

Informant 11, 8 May 2016 [Personal Communication]

Informant 12, 8 May 2016 [Personal Communication]

Informant 13, 8 May 2016 [Personal Communication]

Informant 14, 8 May 2016 [Personal Communication]

XI. Appendices

CSP Monograph Appendix Questions

This study was designed specifically in the context of the Brazilian healthcare system due to its high rates of obstetric violence, but this form of abuse is international in scale and exists to some degree I am sure in the United States as well. Although there are many Native American communities, the Tupinambá community is very unique in and of itself and played a major role in shaping the design and results of this study. There is potential to replicate this study within a Native American community in the United States, but I imagine the results would vary and differ do the differences between the countries' healthcare systems.

Prior to conducting this project, I had very little opportunity, if any at all, in my academic career to find and utilize primary data as a learning tool and a source of credible knowledge for which I could claim some degree of ownership. In this study, although it relies on secondary literary sources to provide background knowledge and points of analysis for the discussion of the results, the results themselves, derived from all the ethnographic interviews, are the focus of this study and the cornerstone of my personal learning.

This project would have been radically different if not for the program field activity that took place in the Tupinambá community because it was after this activity that I decided I wanted to shift the focus of my research on obstetric violence in Salvador to the more specific location of the Tupinambá community and investigate the prevalence of abuse within the healthcare subsystem for indigenous health.

The biggest concern I had about undertaking this project was remaining ethical throughout and not exploiting the women who agreed to be interviewed. The FME class was most helpful in helping me to construct interview questions that did not inadvertently lead answers or offend the interviewees.

A more logistical limitation I encountered during the process of this project was very limited internet access due to the remoteness of the location. However, I was able to travel to the city center of Ilhéus to use an internet cafe on two occasions which allowed me to do some more literary research. Unfortunately, I still experienced technical difficulties which prevented me from utilizing the help of a professional to transcribe interviews. There were no real time constraints in the sense that I was not able to complete certain tasks or needed to sacrifice quality, but I feel this project, in an ideal world, would have benefitted from more time because the interviews were potentially sensitive and if I had more time to get to know the informants on a more personal level beforehand they might have felt more comfortable sharing their narratives with me.

For the initial literary research process I utilized my home university's library to find relevant publications for background information and points of analysis for the primary data. The primary data for this project was collected through 14 ethnographic interviews that generated 15 childbirth narratives. This was the only data collection technique used because, although a survey of the same interview questions in which the informants write their responses could have been theoretically possible, the participants had varying levels of education and literacy, thus relying on written-based form of data collection was not logistically possible. The interviews were then critically analyzed, based on the definitions and examples of obstetric violence found

in the literature review, to determine the prevalence of various forms of obstetric violence in the childbirth experiences of the participating Tupinambá women.

Nádia Batista, my Project Advisor, was indispensable to me during the research process because she identified informants, arranged interviews, approved my interview questions, and gave me books and other literature regarding the Indigenous healthcare subsystem, the Indigenous peoples and cultures of Brazil, human rights, and violence against women. The style in which Nádia advised me was very helpful because she made resources available to me with and without my asking and then allowed me to conduct interviews and write the monograph as I saw fit without being overbearing. Luckily, and I believe this is a tribute to Nádia, I did not reach any dead ends either with interviews or resources during the research process.

This research project gave me the opportunity to live in the Olivença Tupinambá community and learn more about the Tupinambá people and culture historically and contemporarily. Most of the actual process of being integrated into the community and culture was through my host family, but obviously it was through the interview process that I was able to meet many of the women in the community and understand enter their childbirth experiences. While I knew Indigenous peoples, and most especially Indigenous women, in Brazil are systematically and culturally marginalized, it was not until hearing these narratives that I understood how common place institutional abuse during childbirth is in the lives of Tupinambá women.

I found that the CSP process allowed me to independently solidify the lessons learned in the FME course and realize that the research process, while planned and prepared for, tends to take a course of its own. The most important lesson learned however is the importance and necessity of a local advisor and all of the other people close to you that contribute enormously to

the success of the project. Given what I now know, to those who wish to replicate this project I would suggest that they do their best to become a member of the community and form personal relationships both for the benefit of the interview process and their personal experience. Also, from this experience, I realized that this research process was invaluable to me in so many ways and I hope to have the opportunity to continue this line of research in the future.

Termo de Consentimento Livre e Esclarecido

Prezado(a) Senhor(a)

Gostaríamos de convidá-lo(a) a participar de nosso estudo: **Parto: As narrativas de mulheres no contexto da violência obstétrica dentro do sistema de saúde brasileiro**, que tem como objetivo: **Ouvir as narrativas pessoais de mulheres brasileiras que deram à luz recentemente sobre suas experiências de parto a fim de discernir a prevalência da violência obstétrica**.

O estudo, consistirá na realização de entrevistas, observações e/ou participações junto aos participantes do estudo e posteriormente haverá a análise do conteúdo destas entrevistas e/ou observações. Será conduzida dessa forma, pois pretendemos trabalhar com a experiência de vida dos(as) participantes do estudo.

Trata-se de um estudo, desenvolvido por **Cassandra Ashley Fareira** orientada pela **sra. Nadia Batista**.

Garantimos que, a qualquer momento da realização desse estudo, qualquer participante e/ou estabelecimento envolvido, poderá receber esclarecimentos adicionais que julgar necessários. Qualquer participante selecionado(a) tem o direito de recusar-se a participar ou retirar-se do estudo em qualquer fase do mesmo, sem nenhum tipo de penalidade, constrangimento ou prejuízo. O sigilo das informações pessoais dos participantes será preservado, especificamente, quanto ao nome, à identificação de pessoas ou de locais. Todos os registros efetuados no decorrer desta investigação científica serão usados para fins acadêmicos e serão inutilizados após a fase de análise dos dados e de apresentação dos resultados finais na forma de monografia ou artigo científico.

Em caso de concordância com as considerações expostas, solicitamos que assine este "Termo de Consentimento Livre e Esclarecido" no local indicado abaixo. Desde já agradecemos sua colaboração e fica aqui o compromisso de notificação do andamento e envio dos resultados deste estudo.

Qualquer dúvida ou maiores esclarecimentos, entrar em contato com a responsável pelo estudo:
e-mail: gabriela.ventura@sit.edu **Telefone:** (71) 99719.6010 (do SIT Study Abroad: Brasil-Saúde Pública, Raça e Direitos Humanos).

Aluno:	Orientador(a) : Gabriela Ventura
Estudante no Programa do SIT Study Abroad: Brasil-Saúde Pública, Raça e Direitos Humanos	
_____ , _____ de _____ de 2016. (cidade)	_____ Orientador(a): Nadia Batista

Eu, _____, assino o termo de consentimento, após o esclarecimento e da concordância com os objetivos e condições da realização do estudo "**Parto: As narrativas de mulheres no contexto da violência obstétrica dentro do sistema de saúde brasileiro**", permitindo, também, que os resultados gerais deste estudo sejam divulgados sem a menção dos nomes dos pesquisados.

_____ , _____ de _____ de 2016.	_____
(cidade)	Assinatura do Pesquisado(a)

Interview Questions

Questions for women speaking about their childbirth experiences:

1. Can I record this interview?
2. How many children do you have? What are their ages?
3. How old were you when you had your first child?
4. Where did you give birth to your children? (Hospital? Health post? At home?)
5. Do you prefer / think it is better to give birth in a hospital? Why?
6. Did you go to all of your prenatal appointments?
7. During your pregnancy, did you experience any problems or complications? What did the nurse and doctor say / do?
8. Did you see a midwife from this community as well?
9. Can you describe your experience giving birth?

*This is framed as a very open question to allow the informants to speak freely and feel more comfortable regarding the personal information they share, but if they did not know what to say because, as was often the case, they did not know how to begin I would then ask some or all of the following guiding questions to help them begin telling their story and later to clarify details:

a. Did you like the nurses and doctor?

b. What was the structure of the hospital like?

c. What was the structure of the maternity ward like? (How many beds, bathrooms, etc.?)

d. Did you have to wait a long time after arriving at the hospital?

e. Was a family member with you at the hospital?

f. Did the doctor give you medicine?

g. Did the doctor perform any procedures?

h. Were there any problems during your delivery?

i. Did the nurses and doctor speak to you?

j. Were you allowed to walk around in the maternity ward during labor?

*This question was interpreted by the informants to mean "were you physically able to walk" as in terms of the intensity of pain

k. Were you given food during and after labor?

l. Did you have a normal birth or a cesarean section?

Questions for the community midwife:

1. Can I record this interview?
2. For how many years have you worked as a midwife?
3. What types of services do you provide for pregnant women?
4. What do you think are the biggest challenges here for pregnant women?
5. Do you think the women here prefer to see you or go to the hospital to give birth? Why?
6. How do you think the nurses and doctors treat the women in the hospital?
7. Do you think there are more challenges for Indigenous women when they give birth than other women in Brazil? Why?
8. Do you know of any forms of problems or abuse Indigenous women suffer when they give birth here?