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The cheapest meat on the market is black meat: notes on racism and obstetric violence against Black women

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Abstract *This essay debates health inequalities by analyzing obstetric violence directed at Black women. We assume that institutional racism is an important interpretive key to understanding the dynamics of racial violence. We adopted the descriptive analysis of two stories published on the G1 website as a methodology to highlight the racism faced daily by Black women in health services. We found that racism (re)produces the denial of rights, non-access to health services, production of death, and non-realization of Good Living for Black families, and this is evidenced by producing and reproducing suffering, violence, and racism in its most diverse expressions. In this dynamic, implementing the National Comprehensive Health Policy for the Black population is an important mechanism for confronting racism in health.*

Key words *Health inequalities, Institutional racism, Health of the Black population, Obstetric violence, Black women*

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Where do we start?

Black women's bodies and subjectivities are bodies inscribed in a social structure that conflictedly denies them the right to exist. The lyrics of "*A Carne*", masterfully interpreted by Elza Soares, and composed by Marcelo Yuka, Seu Jorge, and Wilson Capellette, already tell us: "The cheapest meat on the market is Black meat". On November 14, 2002, Alyne da Silva Pimentel Teixeira was in her sixth month of pregnancy and sought care from the public health system in Belford Roxo, in Rio de Janeiro state. Alyne was black, 28, married, and the mother of a five-year-old daughter. With nausea and severe abdominal pain, she sought medical care, was given painkillers, and was discharged to return home.

Not having improved, she returned to the hospital when the death of the fetus was confirmed. After hours of waiting, Alyne underwent surgery to remove her placenta's remnants. Her condition deteriorated, and transfer to a hospital in another city was indicated, but her removal occurred with great delay. In the second hospital, the young woman waited several hours in the corridor due to the lack of beds in the emergency room. She ended up dying on November 16, 2002, due to a digestive hemorrhage caused by the delivery of a dead fetus.

Milene de Oliveira, a young Black woman aged 19, was admitted to a maternity hospital in Rio de Janeiro state on March 5, 2022, with 39 gestational weeks. In an interview with the G1 website, the young woman reported unsuccessfully attempting to push for 13 hours in delivery after being admitted to the medical unit. She was harassed and embarrassed all the time, hearing that it was her fault. The young woman even begged for the cesarean procedure, as she could no longer bear the pain and depleted her strength to expel the baby, but her request was denied. During the procedure, the young woman says she heard statements such as "Push, or else your baby will die" and "I am doing my best down here so your husband will want to have another child with you"[1](p.1) when she received stitches. After birth, her son needed to be revived and was sent to the ICU, where he was intubated and breathing with the help of equipment. However, he did not resist and died later.

When we retrieved reports published on the G1 website about obstetric violence against Black women, without any exclusion criteria regarding when the story was published, we came across these two cases, which, while twenty years apart, blatantly showed the historical persistence of suffering produced by the denial of Black women's mothering experience, the result of racism and existing inequalities in our society. Passos[2] shows us that behind the fatalities naturalized by racism and structural violence, we can affirm "that there is a project that does not authorize Black women to be mothers, although motherhood is compulsorily assigned to females"(p.2). The author argues that not all women can enjoy the myth of maternal love in a racist, patriarchal, sexist, colonialist, and elitist society.

In this sense, this starting point refers to an interweaving exercise whose threads can point out how Alyne's case played a crucial role in advancing the recognition of reproductive rights in Brazil, Latin America, and around the world. Recognizing women's rights to safe motherhood and access to quality, undiscriminating PHC services is vital.

However, entangled institutional racism and obstetric violence balance between past and present. Although separated by chronological time, they are faces of the same whole, in which the "new" expresses the revolution of some past aspects; and the "old" already carried with it the germs of the "new", which facilitated this construction.

Regarding health, 76% of Unified Health System (SUS) clients are Black. They also represent the highest percentage of hospitalizations in the SUS, 81%[3]. In 2008, the percentage of Black SUS clients was 67%[4].

We should also highlight that studies point to great inequality in access to health for Black men and women. Socioeconomic characteristics and ethnicity/skin color have determined different experiences between racial groups. Black men and women are evaluated in less time in appointments with health professionals and have fewer medical appointments and tests[3,5]. Ethnicity/skin color in Brazil has been determinant as to how one is born, lives, falls ill, accesses the health system, and dies[6,7].

In this wake, necropolitics[8] directed at Black bodies is evident and surgically naturalized in the daily life of institutions. It is observed in the high Black men incarceration rates, the institutionalization of children and adolescents in shelters, denial of the right to age with quality life, and the countless violence against Black women. When addressing the situation of Black women, one cannot disregard the historical violence and sexual abuse, work exploitation and denial of the right to life, evidenced in the denied or non-as-

sistance in accessing public services, especially health services, in primary, secondary, or tertiary care.

In light of the mentioned above, there is indeed control over the life or death of Black bodies, just as it is noticeable that sexual and reproductive rights, which include access to medical assistance, treatment, medication, and care during pregnancy, with prenatal and puerperal care service, that is, prevention, promotion, and health care, do not materialize in the same way if we think about the relationship between White versus Black women.

When dealing in her work with the denial of humanity and the Good Living of Black women, bell hooks[9] shows us that the agenda of sexual and reproductive rights, health inequalities, and institutional racism is an urgent one, submerged in a sea of interests and political, economic, and social disputes.

In the simulation of institutional racism and obstetric violence:

To identify the expressions of institutional racism, we used the analyses developed by Eurico[10] to qualify the two interdependent and correlated dimensions of institutional racism: "the political-programmatic and interpersonal relationships"(p.299). Regarding the political-programmatic dimension, the author informs that it comprises actions that prevent formulating, implementing, and evaluating efficient, efficacious, and effective public policies in the face of racism and the visibility of racism in daily practices and administrative routines. In turn, the dimension of interpersonal relationships encompasses the relationships established between managers and workers, between workers, between workers and clients, and vice versa, always based on discriminatory attitudes.

In this setting, studies by Werneck[7] identified the engineering engendered by institutional racism from an ideology in healthcare networks linked to thoughts that naturalize that Black people are more resistant to pain or that they hardly get sick and, therefore, tend to minimize complaints from Black people and reduce the use of medication and anesthesia, especially in women in prenatal and childbirth procedures.

The complex nature of the subject calls us to point out that, for almost a decade, the World Health Organization (WHO) recognized obstetric violence as a public health issue, given the evidence of disrespect and mistreatment of women during delivery. It occurs at one of the moments in women's lives when they are most vulnerable and materializes as negligence, verbal and physical violence, and unnecessary, unwanted, and denied procedures.

Assis[11] affirms that obstetric violence needs to be understood as health professionals' appropriation of women's bodies and reproductive processes. It is expressed by dehumanized relationships, medicalization abuse, and the pathologization of natural processes, limiting women's autonomy and ability to decide. The author is emphatic in explaining that the effects of obstetric violence with a racial bias tend to display more intense contours, as they represent structured violence in the dynamics of Brazilian social upbringing, that is, they express racism, sexism, patriarchy, which means more violence, abandonment, lack of care, and naturalized barbarism within society.

Curi *et al.*[12] argue that a considerable body of research and scientific articles "point to Black women as the ones who suffer the most from obstetric violence"(p.7). In this context, Curi *et al.*, who are self-declared white, ask an important question: "But what do we do with it?". Authors believe it is no longer possible to do nothing. Also, considering the question raised, we added the following questions: Are the health services willing to provide adequate professional service to the subjects per skin color/race/ethnicity, origin, and culture? Do the managers know and incorporate the objectives of the National Comprehensive Health Policy for the Black Population? Has the SUS principle of equity materialized in the daily work of professionals? Is there budgetary investment directed towards healthcare, especially the health of the Black population?

Let us remember that this process includes the lack of investment facing public health, especially after Constitutional Amendment 95/2016, which aimed to freeze investments in health for 20 years. We should understand that Black women experience different types of racial and gender discrimination, which compromise their inclusion in society as a subject of rights when they intersect, especially regarding health, where inequalities imposed by racism and sexism differentiate women in accessing health services and the delivery scene[13]. However, realizing these aspects requires deep analysis to interconnect several societal determinations. To this end, we rely on Collins and Bilge[14] (p.15-16) analyses to demarcate that intersectionality investigates how power relationships influence social relationships in a society marked by diversity and individual

daily experiences. As an analytical tool, intersectionality considers that "the categories of race, class, gender, sexual orientation, nationality, ability, ethnicity, and age group are interrelated and shape each other".

Thus, a critical reading of the social reality and its historical, economic, political, and intersectional dimensions will enable a more qualified intervention from a theoretical, technical, operational, ethical, and political viewpoint, especially regarding the barriers faced by the population to access to health, particularly those interposed by structural racism.

Black women, rights, and Good Living!

Davis[15], in her classic work *Women, Race and Class*, and Collins[16], discuss the importance of the social place held by Black women, who, even after having formally broken with the ties caused by racism, manage to fight for rights to preserve their lives and that of their descendants. Black women are head of families, part of single-parent families, who collectively care for children, older adults, and their partners, most of whom are incarcerated. Black women hold a significant place from an economic viewpoint, as they perform several work activities to ensure the support of the family and provide the means for social reproduction through domestic work and care for children and older adults. Malcolm X's statement, "There is no capitalism without racism", is blunt and explanatory of the racialized processes that unfold in capitalism[15].

Moura[17] addresses the relationship between racism and capitalism and shows that economic domination also reveals its racial domination face, since poverty is an important demarcator allocating the Black population, especially women, to a place of social immobility and economic dependence. In this sense, it is not hard to understand how abuse and exploitation of these women's work persist. In capitalist reality, they are not seen as subjects or as women: they are disposable bodies. Thus, they are susceptible to violence and denial of rights. What they verbalize, their needs are perceived as problems, statements that only attract "problems":

Nobody ever helps me into carriages, or over mud-puddles, or gives me any best place! And ain't I a woman? Look at me! Look at my arm! I have ploughed and planted, and gathered into barns, and no man could head me! And ain't I a woman?[18].

This speech was delivered as an intervention at the Women's Rights Convention in Akron, Ohio, United States, in 1851. At a clergy meeting where women's rights were being discussed, Sojourner rose to speak after hearing from ministers that women should not have the same rights as men because they would be fragile, intellectually weak because Jesus was a man and not a woman, and because, finally, the first woman was a sinner.

Reflecting on her work *Ain't I a Woman?*, hooks[9] warns us of violence-based life conditions structured in diasporic societies as naturalized dynamics. However, violence, also expressed in the denial of the right to life, harms Black women more, keeping them without access to rights such as education, food, housing, and especially health.

Silva[19] reinforces this perspective, based on the debate on femicide, perceived by the author as the apex of gender violence. However, the author believes that femicide is mediated by numerous types of violence, which include a lack of healthcare. Simultaneously, the policy of naturalized death and the lack of access to services express necropolitics and violence (re)produced in capitalism, which are exponent when we articulate the themes of racism, sexism, and patriarchy. The critical analysis of these hierarchies is only perceptible from intersectional perspectives, as suggested by Crenshaw in the 1980s in the emblematic "Document for the meeting of experts in aspects of racial discrimination related to gender".

It is no coincidence that the cruelty pedagogy category, which we call racist, stands as an important heuristic key to reflecting on the countless types of violence in health directed at Black women. Segato[20] says that "the cruelty pedagogy is all the acts and practices that teach, accustom, and program subjects to transmute living and its vitality into things"(p.13). However, we should underscore that while female bodies are generally perceived as objects, Black female bodies are objectified, animalized, manipulated, and dominated by the interests of others from a very early age. They are Black women not perceived as children, and hooks[9] stressed that Black women were not even seen as women working in the fields as men.

In this sense, the Good Living agenda, therefore, becomes urgent, as it reveals that the right to quality health, education, work, family, and community life are among the greatest needs of women, as this means access to life.

Addressing needs leads us to highlight the violent reality of these women. It is not by chance that Werneck[7] already showed us in her reflections that the Black population, especially Black

women, suffered from the impacts of what were called, at the time, health inequalities. Non-access to health services, the high maternal and child mortality rates, negligence and mistreatment during appointments, when they occur, and more recently, cases of medical errors, as the press shows us, are not unrelated to this social reality forged in racism, sexism, and patriarchal rationale.

The key to understanding these complex processes permeated by physical and psychological violence lies in unveiling racism, sexism, and patriarchy. These hierarchical systems are structured within the production and reproduction of social relationships in Brazil and other countries that experienced the dynamics of colonization and slavery. They help us to understand why Black bodies are considered disposable, subject to manipulation, experiments, and fierce violence. The situation is worse in the case of Black women since sexism scales up this violence and naturalizes body control, affecting sexual and reproductive rights. It is not by chance that Lélia Gonzalez[21] signals that the Black population holds a "nonplace" in the social structure, adversely equated and stereotyped, hence the sentence "trash will speak out, and nicely so"(p.69) shows that Black women are not heard, assisted, perceived as subjects, nor can they have access to healthcare.

From this perspective, the State has a fundamental and functional role in this Black people dehumanization logic since it integrates the racial and gender hierarchization structure. The State triggers institutional and organizational functions, and it is within the functioning of these institutions that subjects socialized in this racist and sexist dynamic reproduce actions and statements and offer services based on this logic that denies rights and life. When we analyze the cases of police invasion in the Rio favelas, which are allegedly justified to preserve order and secure public safety, we infer that there is a massive production of death and denial of rights since they are Black subjects, favela residents without access to life, schooling, and health. The racist and sexist State[22] has the power to control Black bodies and the lives of Black women and their children. Thus, living or dying is not an option but an imposition.

In this sense, there is no way to naturalize cases of limb mutilation, episiotomy without prior notice, failure to perform surgical deliveries in case of need, failure to administer anesthesia, and obstetric violence, based on the assumption of an extremely racist and sexist logic, which disseminates falsely the idea that "Black women are strong; Black women are babybearers!"[21](p.92).

Philosopher Mbembe's reflections on necropower and the impacts on the lives of individuals under the influence of racial markers show us that the State is an important part of the gears of racist sociability. It also shows us that, besides power over life or death, the racist system can mutilate these Black bodies, cause intense suffering, and preserve the pillars of this domination over the dynamics of denial of this reality[21].

It is the racial democratic myth that occurred, especially in Brazil, imposed by whiteness and its narcissistic pacts[23]. It naturalizes barbarism and violence and is not perceived by those who suffer it. There is no identification with the guidelines that address Blackness, the suffering, especially of dark Black people, and no aggregation for collective struggles. Paraphrasing Munanga[24], racism was successful in Brazil!

Final considerations

The present essay aimed to portray from two reports and statistical data how racism and sexism weave a network of complexities whose very conflicting dynamics build on the denial of motherhood to Black women. The intersectional analysis reveals the historical (in)visibility regarding the racial diversity of SUS clients, disregarding equity in the services, hindering the discussion on comprehensive and integrated care in the delivery scene, and preventing the reduction of racism impact on the mothering experience. Simultaneously, this reflection aligns with the debate that involves interweaving the categories of being a Black woman, equity in the SUS, racism, and health service actions.

In this sense, it is essential to put on the agenda a critical analysis of the principle of equity of the SUS, which aims to guide health actions toward social justice, in order to bring this debate to light, considering diversity and the needs of different social groups, treating them unequally according to the care required in order to face health inequalities.

Collaborations

The authors worked on the design and final drafting of the manuscript.

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