Listening to stories to build continuous education strategies in mother and child health

Escutando histórias para construir estratégias de educação permanente em saúde materno-infantil em Alagoas

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Abstract

Maternal and child health constitutes a subsector of public management that is responsible for social and human development indicators such as fertility rates, infant mortality, and maternal mortality. In this article, we discuss the first results of a qualitative research conducted with healthcare providers from the Brazilian Unified Health System (SUS), in primary and tertiary care in the state of Alagoas. We invited these subjects to contribute in identifying challenges and potentialities that mark their professional daily lives to build continuous health education strategies, bridging the gap between scientific dissemination and the exercise of an interprofessional and humanized practice in maternal and child health. We reflect here on two worrying aspects that emerged in the stories: permanent education focused on continuous education and the challenges in facing day to day racism. Data analyses are guided to construct an experimental strategy that contributes to developing successful practices in the care of those who experience the pregnancy-puerperal cycle in our territory.

Keywords: Maternal and Child Health; Permanent Education; Alagoas; Racism; Obstetric Racism.

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Resumo

A saúde materno-infantil configura um subsetor da gestão pública que é responsável por indicadores de desenvolvimento social e humano, tais como as taxas de fecundidade, de mortalidade infantil e de mortalidade materna. Neste artigo, dialogamos sobre informações oriundas do primeiro desfecho de uma pesquisa qualitativa com trabalhadoras de saúde que atuam no Sistema Único de Saúde (SUS), nos cenários da atenção primária e terciária no estado de Alagoas. Convidamos essas sujeitas para estarem como parceiras na identificação de desafios e potencialidades que marcam seus cotidianos profissionais a fim de construirmos estratégias de educação permanente em saúde que possibilitem a aproximação entre a divulgação científica e o exercício de uma prática interprofissional e humanizada em saúde materno-infantil. Refletimos aqui sobre dois aspectos que nos inquietaram nas histórias que escutamos: a educação permanente focada na educação continuada e os desafios frente a práticas de racismo cotidiano. Essas primeiras análises nos guiaram a refletir os resultados da pesquisa, fazendo-nos imaginar a construção de uma estratégia experimental que contribua com o desenvolvimento de práticas exitosas no cuidado em saúde de pessoas que vivenciam o ciclo gravídico-puerperal no nosso território.

Palavras-chave: Saúde Materno-Infantil; Educação Permanente em Saúde; Alagoas; Racismo; Racismo Obstétrico.

Seja forte como meu Gonguê
Essa luta é de viver
Os tambores irão nos defender
Nessa guerra, flores irão nascer[1]

"Maternal and child health"[2] is a subsector of public management responsible for social and human development indicators such as fertility and infant and maternal mortality rates. The term also designates research areas in the life, human, and social sciences, with many updates in recent decades. Despite its importance for the lives of women[3] and other people with uteruses, this scientific production is relatively restricted to the academic sphere and does little to contribute scientific evidence for the training and performance of health workers. Evidence-based practice stands out when we look at government programs aimed at family planning, prenatal care, humanized childbirth, and the health of the mother/baby binomial after birth.

In this article, we present a reflection on this issue based on an investigation involving health workers in the state of Alagoas[4]. This information comes from the first outcome of a qualitative approach, organized based on an invitation to these subjects to act as partners in identifying challenges and strategies for Continuous Education in Health (CEH) in primary and hospital care settings. We discuss alternatives for expanding access to scientific research results and discussion forums in light of the precarious conditions of universalizing the service in our territory.

1 Excerpt from the song "Meu Maracatu é Arma" by singer and composer Fernanda Guimarães from Alagoas.

2 The quotation marks here express some controversies surrounding using the term maternal and child health in public policies, a debate fostered by gender and sexuality studies and feminist and women's movements over time. On the one hand, we highlight the centralization of the pregnancy-puerperal cycle with a focus on the mother, which removes the woman's protagonism and autonomy as a subject—and of other bodies that experience the cycle—from the scene, reducing her to a body that gestates. The focus here seems to be on the care of the fetus and the child, even when the monitoring is done via interventions on the woman's body. On the other hand, they call on us to offer comprehensive health care to women and other people who experience the cycle, which considers needs other than reproductive health. To demand that health care promotes and guarantees the protagonism of the "subject-woman-citizen of health [...] who has rights over her body, over herself" (Medeiros; Guareschi, 2009, p. 41, free translation).

3 We will prioritize the term women and the feminine gender even though we consider that other bodies with uteruses, in addition to cisgender women, also experience experiences of gestation, birth, puerperium, and abortion, demanding comprehensive and equitable care that recognizes their singularities and needs.

4 Parts of this research project were supported by funding from the Pro-Humanities Call for Proposals from the National Council for Scientific and Technological Development (CNPq), as part of the REMA Network – Maternities destitute, violated and abused: construction of research, support and training networks around the right to maternity (2023-2024) and by the Call for Research Support – Human Sciences; Social and Applied Sciences; Linguistics, Literature, and Arts from the Alagoas Research Foundation – FAPEAL (2022). This research is also part of the project developed by the author Débora Allebrandt, funded by a Research Productivity Grant – PQ from CNPq.

The stories presented are situations experienced by the workers interviewed[5]. First, we highlight the intersection of social pain-markers[6] of gender, race, and class in the situations presented. Second, the interviews raised some reflections on the conditions and limits of care that arise for each of the actors involved in care, such as health workers, public managers, and women of reproductive age. Here, we reflect on two aspects that concerned us in the stories we heard: the CEH focused on continuous education and the challenges in facing racism in the daily life of services.

We use the first person plural to demarcate collective authorship that groups shared ethical-political positions and heterogeneous scientific and affective investments. We are all cisgender women (mothers and non-mothers), White, and researchers experiencing unique moments in our professional trajectories. Our coalition begins with resistance to obstetric violence that permeates our bodies and that mobilizes activism for women's rights in our territory, advancing with engagement in training strategies for good practices of care during the pregnancy-puerperal cycle and the transformations in the lives and subjectivity of mothers. We are inspired by intersectionality, which, as defined by Patricia Hill Collins and Sirma Bilge (2021), operates a synergy between research and critical praxis, postulating the interdependence between scientific knowledge and care for "maternal and child health."

We are Débora Allebrandt, a White, cis/hetero woman, mother of Olívia and baby Íris. Olívia was born in 2019, and despite my many class and racial privileges, the hostile scenario of childbirth care and birth that I encountered at that time made me experience first-hand the lack of care and obstetric violence. Based on this experience, I combined my research interests focused on reproductive governance with a feminist dialogue on gender technologies that mobilize and undermine sexual and reproductive rights. Telma Low Silva Junqueira, feminist, bisexual, from Recife/Northeastern Brazil, a professor, and a pet parent, who chose not to gestate or become mother. I dedicate myself to research that considers training and praxis in health in the context of the SUS supported by feminist gender studies, especially Black feminism. Nádia Meinerz, a White cisgender woman, I do not define myself based on sexuality, and I am a feminist anthropologist. I also became a mother of two children born in the hostile environment described by Débora, more specifically in the private healthcare network in Alagoas. Working as a doula is one of the paths I take to reconnect with the experience of childbirth (offering information, welcoming, and supporting other women) and to respond to gender violence. Vivyan Amorim, a White, cis, bisexual woman from Alagoas, and a bachelor in Social Sciences. I have been interested in studying/researching feminist studies of gender, human rights, health, and people with disabilities at the intersection of race and class.

The signature of the text does not exhaust the responsibility for producing the data presented. We highlight the contribution of a broader group of professors, undergraduate and graduate students, and health workers who acted as volunteer researchers[7]. The mobilization for participation in the research took place in the second half of 2021

5 So far, we have conducted 34 interviews discussing the following thematic axes: reproductive decisions, prenatal monitoring, childbirth care, postpartum care, breastfeeding, and care for babies up to 2 years of age.

6 We use the term pain-markers instead of markers to emphasize that issues of gender, color, race, ethnicity, class, disability, sexuality, territory, and generation, among others, in a society structured by racism, capitalism, cis-heteropatriarchy, ageism, and adult-centrism, ableism, mark with pain the bodies, subjectivity, and lives of subjects considered subordinate, marginalized, and dissident. In the health field, it is common to use "social determinants of health and/or social determination of health," which may or may not be synonyms depending on the theoretical conception used. There is criticism about how the World Health Organization (WHO), in 2010, used the term social determinants of health, which is very much linked to the idea of inequality. According to Carolina Borghi, Rosely Oliveira, and Gil Sevalho (2018, p. 886), this conception "[...] does not consider the historicity and, consequently, the processual nature in which social issues are situated; and by fragmenting contexts into factors, it imposes a linear ordering on the determinants."

7 The following people contributed to the research: professors Andrea Marques Fregadolli and Maria de Lourdes Fonseca Vieira and students Bruna Campelo, Izabella Carvalho, and Pedro Santos Matheus Soares from the School of Medicine at UFAL; the students Pietra Gonzalez, Geane Lima, Maria Beatriz Alencar, Maria Daniella Souza, Marielle Teixeira, Gabriela Borguetti, and Kemilly Jacinto from the Psychology course at UFAL; the students Yrla Silva and Giovanna Corrêa from the Social Sciences course and volunteer researchers Bárbara Oliveira; Débora Brandão, Rayane Oliveira, Melissa Moura Saraiva, Yara Lima da Costa, Thaísa Ferreira Cerqueira, Thaysa

via the social networks of the researchers (including the volunteers) and also through the managers of the State Health Department of Alagoas (who work in the Rede Cegonha and the Teaching-Service Integration)[8]. Despite this institutional support, we emphasize that the research was not conducted directly in the services or during the participants' working hours. It was mainly conducted via digital platforms while the workers were at home.

Conducting the research directly in the service would require centralized authorization from the State Health Secretary, transferred from this hierarchical relationship to the heads of the services. We sought to move away from this authority, initiating a relationship of sharing with the workers who were interested in reporting their experiences and engaging in CEH activities. This engagement resulted in many interviews being conducted at night after an entire workday, balancing work shifts and family responsibilities. Although these are factors that made the implementation difficult, we take as emblematic the commitment of these workers to the topic of our investigation and potentially the improvement of the training scenario for professionals working in maternal and child health in Alagoas, in addition to pointing to an issue that has long been denounced by studies and feminist and women's movements: the overload of female work with paid and unpaid activities, the latter being very focused on taking care of the home and family, resulting in double and triple work shifts.

Anna Bárbara Araújo (2019), in her analysis of care as work, counters one of the theses of difference feminism (Carol Gilligan, 1982), according to which women have a particular and privileged perspective focused on relationships and concern for others, easily recognized as the ability to care. This argument makes us normalize the triple shifts as a positive moral attribute in personal relationships and broader institutional political dynamics. The author directs her criticism at the notion of "need" as a guide for public policies, explaining that the history of material deprivation causes many care workers to face this reality with resignation, having no parameter of comparison for the construction of population-equitable policies[9].

This criticism is essential for this endeavor, as our invitation to practice CEH seeks to distance itself from a politically opportune use of subjects' agency in situations of social disadvantage in the health field. The normalization of the exploitation of working women from the middle and lower classes (especially Black women) causes managers, users, and workers to demand other types of rewards in their exchanges with them as if moral value made up for the material devaluation of work in health.

The maternal and child health scenario in Alagoas

We are in Alagoas, one of the nine states that make up the northeast of Brazil and the 19th most populous in the country (1.54%), formed by 102 municipalities, with an overall average of 100 women for 99.1 men and a predominantly Black population (69.91%), being the sixth state with the largest *quilombola* population and the 16th with the largest Indigenous population. Alagoas has just over three million inhabitants, with a third of this population living in the capital and two-thirds declaring themselves Brown/Mixed-race or Black. In 2021, it ranked 18th in the number of enrollments in elementary school and 19th in high school. It had a per capita income of R$ 1,110.00, the 25th worst in the country and the 26th in the Human Development Index (HDI) of 0.684 (IBGE, 2022).

Guedes, Lousanny Caires Rocha, José Carlos S. Freitas, Izabella Regina Almeida Santos Carvalho, Ana Cecilia Silvestre Silva, and Jacymara Teixeira da Silva Pinheiro.

8 We produced an animation presenting the research and informative posters about the different types of participation (institution and responsible team, voluntary nature, anonymity of participants, state coverage, online meeting, etc.) included in the Informed Consent Form (ICF).

9 We also highlight the work of Helena Hirata (2016), who addresses the dimension of gender and sexuality in care work and how this relationship is present from the subjectivity of caregivers and those receiving care in a comparative study of gerontology between Brazil, France, and Japan. For Hirata (2014), who dialogues with French feminism, care work should be examined based on notions of consubstantiality and intersectionality between gender, class, and race. The results of her comparative research show that what unites care workers in the three countries is social vulnerability and the precariousness of the work itinerary.

The state is divided into ten health regions, and our research is intended to include the participation of workers from all regions. However, most of the 34 protagonists work and/or live in the first health region—formed by Maceió (state capital) and 11 other municipalities in the metropolitan region—and in the 7th, which includes Arapiraca (2nd most extensive municipality in Alagoas) and 16 other neighboring municipalities[10].

Of the 34 people interviewed, 31 are women and 3 are men. They come from a wide range of areas of training and activity, with particular representation for nursing, with 15 interviewees. Regarding self-definition of race/color, 13 declared themselves as White, six as Black, six as Brown, and one as Yellow. Below, we present two graphs that express this characterization.

Regarding maternal and child health, a local study developed by Elena Duarte et al. (2020, p. 500, free translation) highlights that "in the period of 1996 to 2016, 586 maternal deaths were registered in Alagoas, resulting in a mortality rate of 47.63 deaths for every 100 thousand LB [live births]." This data highlights that Black and Brown women were the ones who died the most, those who had no level of education, and widows. The capital, Maceió, accounted for 142 registered deaths (Duarte et al., 2020).

Other information that allows us to contextualize the geopolitics of the place we are talking about refers to the centralization of the equipment that makes up the Rede Cegonha in the state capital. According to the 2020-2023 State Health Plan, there is "[...] insufficient supply of high-risk prenatal care, neonatal ICU [intensive care unit] beds, high-risk obstetric services" (SESAU, 2020, p. 169, free translation), so many women are left without assistance and, depending on the situation, need to travel to Maceió to be cared for, being far from their families and their territories, without a support network.

The obstetric observatory, specifically the Maternal Health Surveillance Panel, presents data from a historical series from 2012 to 2022. Information from Alagoas regarding childbirth care in 2022 indicates that 55.8% of births were by cesarean section, a rate much higher than the target recommended by the Sustainable Development Goals (SDGs) of 15% and the one adjusted for Brazil of 25%.

Compared with national data, Alagoas had more cesarean sections than the Brazilian average in 2022, corresponding to 54.5%. Regarding maternal mortality and morbidity, in 2022 alone, there were 30 maternal deaths, with a Maternal Mortality Ratio (MMR) per 100,000 live births of 65.6, which is more than double of the SDGs target of 30 deaths per 100,000 live births. When evaluating deaths due to direct obstetric causes, resulting from complications during the pregnancy-puerperal cycle and which also point to the quality of care received, we found that 73.3% of deaths in Alagoas were due to direct obstetric causes, when the national average was 67.5%[11].

These data, as presented, allow us to understand who are the women who are dying in our country due to negligence and violation of the right to health during the pregnancy-puerperal cycle. Just like the dialogues built with the health workers, based on their stories, they asked whether the issues of color/race and ethnicity were identified, problematized, and considered by them in their practice. We will return to this topic later.

The very configuration of the protagonists' profiles points to the relevance of gender and color/race; making these issues visible in our know-how, especially in the context of health, is something that feminist and Black movements have been demanding for a long time. In addition to contributing to the visualization of who are the main people who work and/or directly use the SUS—the vast majority of whom are women and Black—it also allows for a complex and situated analysis of the epidemiological data and health-disease situations of the population.

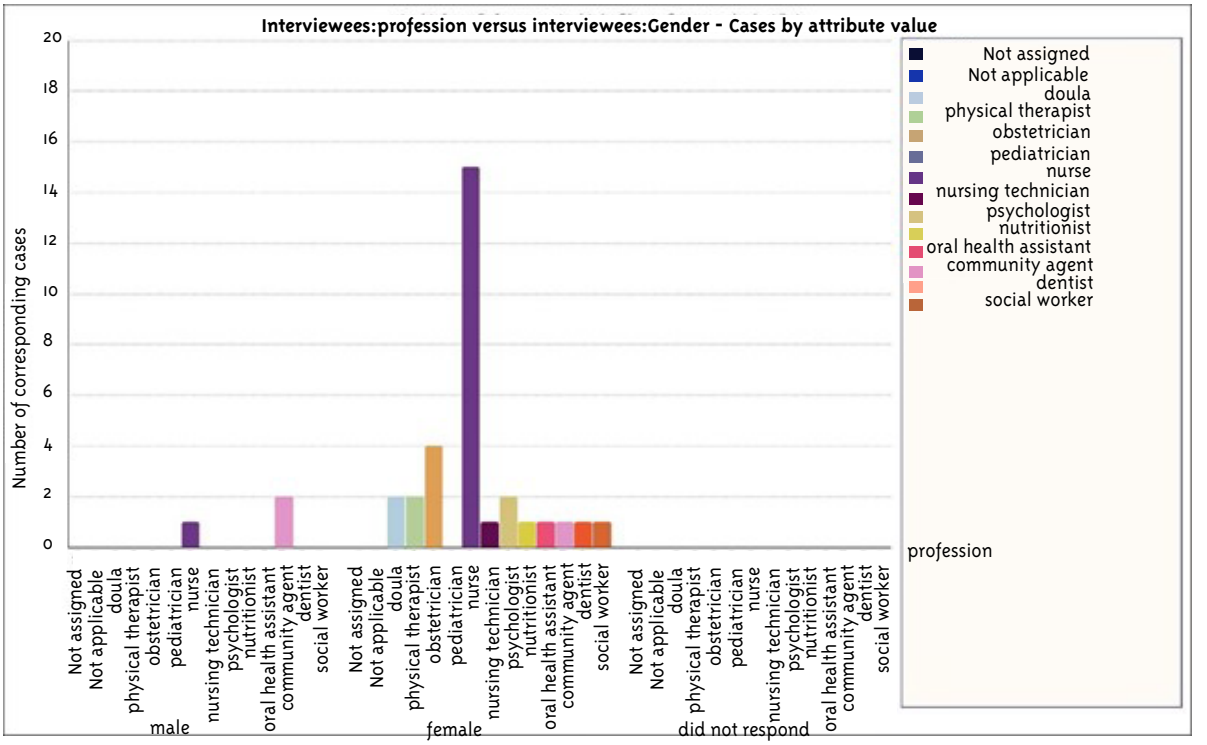
It is from this perspective that Black feminism considers intersectionality a theoretical, methodological, and political tool in the various areas of knowledge as a way of identifying and confronting inequalities and oppressions that mark the experiences, especially of Black, Indigenous, disabled, trans, transvestite people, etc. that seem to "escape" the idea of a universal Western

10 Available at https://egestorab.saude.gov.br/paginas/acessoPublico/relatorios/relHistoricoCoberturaAB.xhtml
11 Source: https://observatorioobstetricobr.org/paineis/

subject–White, cis, hetero, Christian. According to Kimberlé Crenshaw (2002, p. 177, free translation)

> Intersectionality [...] specifically addresses the way in which racism, patriarchy, class oppression, and other discriminatory systems create basic inequalities that structure the relative positions of women, races, ethnicities, classes, and others. Furthermore, [...] it addresses how specific actions and policies generate oppressions that flow along such axes, constituting dynamic or active aspects of disempowerment.

Graph 1 – Information about the interviewees



Source: prepared by the authors

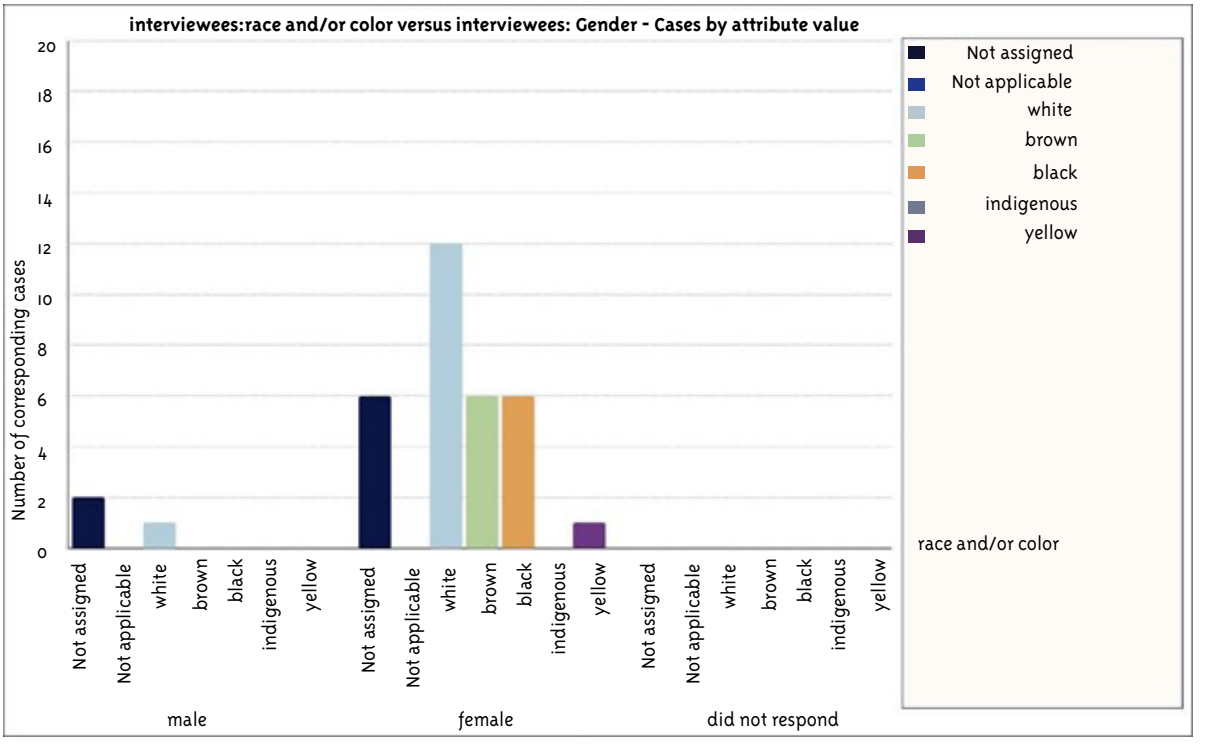
Our research discussed the maternal and child health debate from the theoretical-methodological tripod of intersectionality, CEH, and interprofessionality. This approach occurred precisely because we consider that the SUS has become a place of oppression and disempowerment for many women who are pregnant, give birth, postpartum, and have abortions, especially Black women, Indigenous women, women with disabilities, poor women, *quilombolas*, etc. An intersectional analysis of the country's health situation allows us to identify and denounce obstetric racism and obstetric violence as expressions of these structures and axes of domination that Crenshaw (2002) invites us to assess.

The obstetric observatory draws attention to the fact that

> In Brazil, maternal mortality is twice as high among Black and Indigenous women as among White women. Women with less education and at the extremes of age groups also have higher maternal mortality. [...] Worldwide, between 2015-2019, around 48% of all pregnancies were unplanned. In Brazil, in 2011/2012, this figure was 54%, which indicates difficulties in accessing reproductive planning services.[12] (free translation)

12 Available at https://observatorioobstetricobr.org/a-historia-de-aparecida/

Graph 2 – Information about the interviewees



Source: prepared by the authors

This scenario invites us to think about how racism in Brazil affects the health care process during the pregnancy-puerperal cycle and how this vulnerability is intensified among Black and Indigenous women with low education, who have little or no access to health education and reproductive planning. The concept of vulnerability is guided here by the ideas of Ilana G. Ambrogi, Luciana Brito, and Débora Diniz (2020) and relates to context and relationships. The authors consider gender, economic, and social inequalities as mitigating factors in the layers of vulnerability, especially in contexts historically marked by patriarchal, oppressive, underdeveloped, and, we would add, racist, ableist, and cis-heteronormative colonialism. Their study conducted with 54 women who were mothers of children affected by the Zika virus in Alagoas from December 2016 to March 2017 found that the vast majority were Afro-descendants (80%) and adolescents (only 3 were over 20 years old) and did not receive satisfactory health care.

According to DATASUS, the most recent data on reproductive health inequity show that, in 2022 alone, 1,370 maternal deaths were reported in Brazil, 430 of which were in the northeast and, more specifically, 30 deaths in Alagoas. When analyzing these rates based on color/race, we identified that: I) 397 of the maternal deaths were of White women, 77 in the northeast and 2 in Alagoas; II) 926 were Black women (188 Black and 738 Brown), 341 in the northeast and Alagoas, 26 of the 30 women were Black (3 Black and 23 Brown); III) 20 Indigenous women, 3 in the northeast, including 1 in Alagoas; IV) 4 Yellow, 1 in the northeast, precisely in Alagoas; and V) 23 of the deaths had their color/race ignored, 8 in the northeast–the highest number among all regions of the country–and none in Alagoas[13].

This panorama highlights the countless rights violations that plague the lives of women of reproductive age in our country, especially Black, Indigenous, and poor women. Therefore, we

13 Available at http://tabnet.datasus.gov.br/cgi/deftohtm.exe?sim/cnv/mat10al.def

ask ourselves: What have we done to ensure that obstetric racism, which seems to characterize health care in Brazil, is discussed, denounced, and combated in health education and practice? Furthermore, how does obstetric racism relate to obstetric violence in the daily life of the SUS?

A survey conducted in Pernambuco with self-identified Black women and users of the SUS in 2017 debates the issue of health inequities among the Black population, listing some of the many situations of oppression that marked their healthcare processes. Kelly Lima, Camila Pimentel, and Tereza Lyra (2021, p. 4914, free translation) highlight, based on intersectional analysis, different expressions of obstetric violence to which Black women were subjected, highlighting that:

> Uncertainties about the place of birth and the pilgrimage fall particularly heavily on Black women, creating conditions of vulnerability. Studies show that Black women, when compared with White women, receive less guidance and are less connected to the reference maternity hospital, generating a greater risk of pilgrimage at the time of birth. Because they are less connected to the maternity hospital and receive less information during prenatal care, obstetric risks are greater for Black women.

Talita Rodrigues (2023) launched an intersectional analysis of maternal mortality data by race/color in Pernambuco between 2016 and 2021, indicating that 79.5% of maternal deaths were among Black women and 20.5% were among White women.

In Alagoas, we take the research in which Duarte et al. (2020) analyzed data produced between 1996 and 2016, pointing to the relevance of color/race as an essential factor in identifying and overcoming health inequities. The study concludes, "The profile observed in Alagoas is in line with the literature, characterized by the predominance of the age group 20-29 years old (in numbers and percentages), of Black and mixed race/skin color, and low schooling." (Duarte et al, 2020, p. 596)

The "*Nascer no Brasil*" (2014; 2023) research is a great reference for racial inequities in prenatal care, labor, and childbirth. In the article "*A cor da dor: iniquidades raciais na atenção pré-natal e ao parto no Brasil*," [The color of pain: racial iniquities in prenatal care and childbirth in Brazil] Maria do Carmo Leal et al. (2017) highlight how Black and Brown women will have their pregnancy-puerperal cycle marked by lack of assistance. At first glance, the lower exposure of Black and Brown women to the use of interventions such as oxytocin, episiotomy, and cesarean section could mean care that is more in line with the scientific evidence recommended by the Ministry of Health. However, "[...] in clinical practice, the obstetric assistance model adopted in Brazil favors intervention and healthcare professionals largely perceive these practices not only as adequate, but as indicative of "good care" (Leal et al., 2017, p. 10, free translation).

These studies support the importance of intersectional analysis for the various fields of knowledge, especially for health, which still seems so far removed from this debate in the context of training, care, and management. One of the authors of this article conducted research in a maternity ward of a teaching hospital together with other researchers. It was clear how the white walls, the images of White women and babies on banners, and in the registry books of the nursing stations did not seem to correspond to the profiles of women and babies who used them. Telma Low, Ana Clara Oliveira, Lanna Silva, Lívia da Silva, and Roberta Crispim (2020), when thinking about these images in dialogue with the proposal of ambiance as one of the guidelines of the National Humanization Policy (Brasil, 2004), realized that the banners seemed focused on

> [...] a notion of health based on the logic of whiteness as a universal and dominant standard, so distant from the daily lives of many women who use the SUS, although so predominant in institutionalized spaces of knowledge-power, such as hospitals. (Low et al, 2020, p. 73, free translation)

Considering and asking questions about these issues, often seen as "unimportant," is a way of denouncing the false racial democracy still present in care practices and health policies in Brazil. It is also a call to position ourselves, in a technical, ethical, and political way, as responsible for

constructing forms of health care that genuinely meet the principles of equity, integrality, and universality of the SUS.

Shared stories[14]

In the data analysis process, we reflected on how we usually work academically with oral narratives and the challenges of translating orality into written language. We emphasize that in the first-person narratives of our interlocutors, there is a choice of which stories to tell and how to tell them. In addition to highlighting this protagonism, we emphasize that these experiences marked their praxis and reverberated in recurring situations—practical examples of positive changes in care and situations that cannot be normalized.

It is important to emphasize that they are the result of the recognition by the workers mentioned of the importance of permanent education strategies—including ongoing training initiatives[15]—for improving care, especially the effectiveness of the actions of the Rede Cegonha.

> *Then, things started to arrive, and the change in behavior gradually began. Until I went to Sofia [Feldman] to improve the Rede Cegonha. And I spent 15 days there, and that was really a turning point for me, so there were some things that I was still resistant to, right?* [...] *After I went to Sofia, I completely freed myself. So, when I returned from Sofia, episio(tomies) went to zero. So, since 2014, I haven't performed any episio. Even when I'm with a student, when there's a birth, even when I'm on some sporadic shifts that I do at the university hospital, I haven't performed an episio since 2014.* [...] *I respect women's autonomy, women's desire to lie down, women's desire to stand, women's right to eat, not eat, yeah... all of these things. So, it was a turning point, and all of this was reflected in my residency as a preceptor, right? So I have residents who have seen me perform an episio. I have residents who have rarely seen me perform an episio, and I have residents who have never seen me perform them because it varied depending on the time of my development process, let's say... in obstetrics. So today, I discuss scientific evidence a lot with the residents. I discuss obstetric violence a lot, and I discuss women's autonomy a lot, right? I discuss these things a lot because now everything is really based on evidence, right? So, unnecessary interventions, things that have no basis, that's... I've completely freed myself now.* (Jane, obstetric nurse, Black)

In our interviews, we asked about professional development, training activities, and alternative ways the workers found to continue their training. This interviewee's account expresses the decisive way in which continuing education changed her practices. For Jane, this experience at the maternity hospital, Sofia Feldman, located in Belo Horizonte, a reference for humanization and good practices in Brazil, was a turning point. She acknowledges her resistance, before this training, to "abandoning" practices that have no scientific basis, such as episiotomy. We emphasize that she admits to knowing that episiotomy was inadvisable, to say the least. So, it is not about "access" to information but about a change that allows the professional to transform this information into practice. After this experience, she no longer performed episiotomies.

We can imagine that working for two weeks in a hospital like Sofia is indeed a transformative experience. Unfortunately, most training/qualification and professional development

14 The shared stories will be used to create podcast episodes that, as inputs for ongoing education actions, form a strategy for bringing together concrete situations (identified by workers as challenging for maternal and child health care), scientific research results, and reflection on good practices.

15 Continuing education/training is one of the expressions of EPS, according to Ordinance MS/GM No. 1,996 of August 20, 2007. It refers to the training process, usually disciplinary, that the workers themselves undertake to update themselves on a certain topic, which does not necessarily correspond to the knowledge necessary to perform the functions they perform in the service. EPS, on the other hand, aims to improve the work process within the services, being considered education for work, through work, and at work, constructed collectively with/among teams, which move to identify the challenges they encounter in their daily work and, by reflecting and discussing them collectively, seek strategies for overcoming them collaboratively. (Brasil, 2009)

activities will not be carried out in immersive practices in a new context but in the professionals' place of work, with all its limitations and vices. In other words, most professionals need to learn or almost be convinced that episiotomy is unnecessary and potentially harmful in a context where it is still practiced and not performing it can be seen as unfavorable.

Furthermore, an immersion practice takes the professional directly into the practical context. Although the services are practical, many training activities are lectures and courses that offer information that the professionals already have. We believe that offering training today informing that there is no evidence of the effectiveness of episiotomy will not be new to professionals who work in maternity wards. However, why is it so difficult to convert this information into practice?

The flow of scientific evidence and good practices in health services involves the creation of guidelines, booklets, and protocols. Often, workers receive this information through lectures, events, and reading materials. We also need to consider the large circulation of professionals in these services. The challenge is that without engagement in active changes, or if there is "resistance," as Jane reflects, no quality information will be transformed into practice in the services.

The interlocutors showed great interest in improving their training and performance. Furthermore, it is worth remembering that these interlocutors spontaneously wanted to participate in the research. They listed individual initiatives such as online and in-person courses, reading scientific articles, and participating in institutionally promoted activities. At the same time, if they decide to pursue a postgraduate degree, they do not receive support from management, either in terms of financial support, when applicable, or permission to attend classes during working hours.

Most of the interviewees mentioned the existence of a calendar of training activities, periodic meetings, and training. Although some of the institutional actions were aimed at all professionals involved in care and these trainings involved topics related to care in critical situations—Cardiopulmonary Resuscitation (CPR) in newborns, hemorrhage control, etc.—many trainings were aimed mainly at single-professional teams. Training that values the humanization of care and addresses, for example, how to manage grief among postpartum women, offered to hospital doulas but open to other interested professionals, was not a mandatory part of the institutional training. These initiatives seem to go against the principle of interprofessionality, which is one of the foundations of equity in care in the SUS, according to Márcia Ogata et al. (2021, p. 6)

> The IPE [Interprofessional Education] movement also expresses a commitment to transforming health practices in the context of the SUS when it emphasizes the explicit purpose of promoting interprofessional collaboration and learning for effective teamwork. This emphasis can be seen as an essential distinction between CEH [Continuing Education in Health] and IPE. Historically, the idea of bringing together students or professionals from different areas in the same space was already considered interprofessional, as if insertion in the dynamics of health work - considering its eminently collective nature - was enough to stimulate interprofessional collaboration.

If the maxim of interprofessionality is to do things together, separate training does not seem to meet the need for professional updating. Furthermore, there seems to be a thematic division: topics focused on humanization are part of the training of specific areas, while training focused on acquiring techniques is offered to all. This strategy seems to reduce CEH to continuing education, as well as being a way to avoid the resistance of many professionals to discuss topics such as obstetric violence and racism, which is the focus of the next situation.

Challenges facing racism in the daily routine of services

According to data from the *Nascer no Brasil 1* survey, which investigated in depth various contexts of labor and birth, Black postpartum women had a higher risk of having inadequate prenatal care, receiving less guidance on the beginning of labor and possible complications, lack of connection to

the maternity hospital, absence of a companion, and pilgrimages to the birth. Furthermore, they are less likely to have a cesarean section and episiotomy but receive less local anesthesia when an episiotomy is performed (Carmem Leal et al., 2017). This is a striking example of what has been defined as "obstetric racism" by Daná-Ain Davis.

> [...] the intersection of obstetric violence and medical racism. Obstetric violence is a form of gender-based violence experienced by people giving birth who are subjected to acts of violence that result in their being subordinated because they are obstetric patients. The term suggests that institutional violence and violence against women coalesces during pregnancy, childbirth, and postpartum (Women's Global Network for Reproductive Rights 2017). Obstetric violence includes dehumanizing treatment and medical abuse such as birth rape, or violations experienced during childbearing. [...] The term obstetric racism is an extension of racial stratification and is registered both from the historically constituted stigmatization of Black women and from their recollections of interactions with physicians, nurses, and other medical professionals during and after pregnancy. Obstetric racism is a threat to maternal life and neonatal outcomes. It includes, but is not limited to, critical lapses in diagnosis; being neglectful, dismissive, or disrespectful; causing pain; and engaging in medical abuse through coercion to perform procedures or performing procedures without consent. Informing women's interpretations of those encounters is a fluency of historically constituted racism, segregation, and policing. Obstetric racism emerges specifically in reproductive care and places Black women and their infants at risk. (Davis, 2020, p. 753-755, free translation)

In our interviews, most professionals reported not seeing situations of obstetric violence and racism in their practice and service, although they recognized that these practices exist.

> [...] *In all this time on duty, I never noticed any change in the attitude toward women regarding color, rights, race, and color. I never noticed. I know that statistics show that Black women die more. They receive fewer non-pharmacological methods for pain relief; they end up suffering more obstetric violence. Furthermore, I know the evidence shows this, but I have not noticed this in the service. Also, because as a Black woman, I have treated everyone the same way, so like that. I have not noticed any different or inappropriate behavior from my colleagues due to race and color. But I know that, statistically, this has been happening, right?* (Jane, obstetric nurse, Black)

In Jane's practice, in addition to not recognizing racism in everyday life, she reveals that she does not usually include race in epidemiological data. Thus, this erasure of color/race makes it impossible to identify and confront racism in practice. It is worth noting here that healthcare professionals are facing forms of racism and discrimination. According to Ana Cláudia Rodrigues da Silva:

> Health care is subject to racial scrutiny, and the higher the hierarchy in these professions, the more this care is questioned, and the less valued the occupation, the more this care/servitude becomes normalized. For example, Black physicians and nurses are questioned about their competence to be in the position of caring for patients. In contrast, nursing assistants and technicians and those who make up the so-called general service and do the "unwanted, dirty work" are not questioned about the place they occupy because, in the structure of the c*asa-grande*, they are where they should be, in the kitchen. (Silva, 2022, p. 9)

Another interlocutor demonstrates how she tries to eliminate racial inequalities in her practice:

> [...] *So I've never seen it, but I know about this data, and I'm sure it happens! Absolutely sure. Not so much there because it's like this: even though the hospital has its problems, it tends to be more humanized* [...] *as are usually the obstetric nurses who accompany these women, and the majority are women* [...] *I feel that there is this welcome. I'm not going to lie to you: if there are two women in*

labor, one of them is White and the other is Black, I'm going to choose the Black woman. Sorry, guys... Nevertheless, I choose these factors and others, right? We know these people have historically [been discriminated against]*, right? There is nothing like that anymore, in terms of affection and information. I'm not generalizing, of course, right? Nevertheless, I prefer to be with them and, I don't know, give my best and do the best job possible, you know?* [...]. *Judge me all you want. [laughs]* [...] *Nevertheless, I know this data, it's real data,* [...] *it's unfortunate, right, and depressing to think that a woman will receive less support, that these professionals will be more violent, right? They won't take care of her simply because she's Black.* (Comigo-ninguém-pode, doula, White)

Jane and Comigo-ninguém-pode claim to know that there are differences reported in the literature despite not having witnessed them in practice. Conversely, Liana brings another perspective:

[...] *In the maternity ward, most of the women we see declare themselves to be Brown or Black, with incomplete elementary school education, often illiterate; we rarely see women who have completed high school, and high education is scarce. What we notice, at least as doulas in the SUS, is that there really is obstetric racism. I say this without data or statistics, but with my 3 years of experience in the SUS and the births I have attended, we notice that White women are more welcomed and respected regarding their care. Not that they don't experience violence; they do, too. Nevertheless, with Black women, we often notice a "need" for episiotomies, which we have come to realize were always offered to Black women. Today, several obstetrician-gynecologists are defending its non-use and non-necessity in the female body, even denouncing it as genital mutilation. So, regarding this issue of race and education, we notice that since they have little education, it makes them place themselves in a more subservient position, of not understanding the process that is happening of often suffering violence. We talk to them, explaining that they can go to the ombudsperson, but without fully understanding the situation.* (Liana, doula, White)

Liana's speech demonstrates the apparent subtlety of how behaviors differ according to the race/color of the parturients and gives us clues to understand how these everyday microaggressions are not perceived as forms of obstetric racism by their colleagues. Therefore, we need to ask ourselves what tools are necessary for epidemiological data to become part of the professionals' perspective on their daily work and how we can foster racial literacy through ongoing and interprofessional education. Research has pointed out what scholars on racism in Brazil denounce: the challenge of identifying and naming racism and of people perceiving themselves as racist (Almeida, 2019; Gonzalez, 2020; Bento, 2022). The narratives we present invite us to consider that Black workers, and not just White workers, may not identify racism in their daily lives, especially in obstetrics, so we ask ourselves how this and other debates have been inserted not only in services but also in health training.

Final considerations

American sociologist Ruha Benjamin discusses how pregnancy and gestation expose Black women. In contextualizing the epidemiological data in this article, we noted that of the 30 maternal deaths in 2022 in Alagoas, 26 were Black women. This indicator demonstrates how many more Black women died in this state where most health professionals did not recognize obstetric racism practices. For Benjamin (2022), the Black population is exposed to social judgments, cruel treatment, and indifference, and it is this exposure that produces maternal mortality and obstetric racism. The author also reminds us that, especially in the context of childbirth and birth, vulnerability is a condition of human life. That said, she asks: What do we need to create a world where we can be vulnerable but not exposed? We also wonder whether the podcasts we are producing could act as a CEH strategy capable of encouraging the fight against racism and obstetric violence in our state. What other tools can raise awareness/train/convene students, professors, workers, and managers to transform their praxis effectively?

In the following stages of the project, we will seek to assess how and if podcasts impact professionals

in their practices. Throughout the project, we have learned much about how CEH challenges us as researchers and professors. It is not just about creating and formatting new guidelines following the latest scientific evidence in the field or disseminating it. The professionals we interviewed know the data and are aware of the existence of harmful behaviors such as obstetric violence and obstetric racism. Change in maternal and child health depends on a transformation in the way we understand and act toward women because each of them matters and needs to be treated with respect and dignity based on the best scientific evidence of care available.

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Author contribution

Nádia Meinerz proposed and conceived the article. Vivyan Amorim systematized the interviews using the Nvivo software. All authors analyzed the interviews. Débora Allebrandt, Telma Low Silva Junqueira, and Nádia Meinerz wrote and revised the text.

Received: 05/15/2024
Resubmitted: 05/15/2024
Approved: 05/28/2024