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Racial inequities in prenatal care and death of black pregnant women in a municipality in southeastern Brazil

Iniquidades raciais no pré-natal e óbito de gestantes negras em município do sudeste do Brasil

Inequidades raciales en la atención prenatal y mortalidad de mujeres gestantes negras en un municipio del sureste de Brasil

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Abstract:
Objective: to analyze prenatal care visits and types of delivery among black pregnant women compared to other racial groups, as well as the maternal mortality profile according to age, marital status, educational level, and race/color. **Methods:** a retrospective documentary study with a quantitative approach was conducted using data obtained from the Informatics Department of the Unified Health System, covering the period from 2011 to 2021. The findings were analyzed using descriptive statistics, with estimates of absolute and relative frequencies. **Results:** a higher proportion of care with seven or more visits was observed among pregnant women of white and Asian race/color. The frequency of zero to three visits was higher among indigenous and black women. Cesarean section was more prevalent in all groups, particularly among Asian and white women, while vaginal delivery was more prevalent among black and indigenous women. Most maternal deaths occurred among pregnant women aged between 20 and 29 years, with 8 to 11 years of education, who were single and black. **Conclusion:** racial inequities in health were identified, highlighting the need for the effective implementation of the National Policy for Comprehensive Health of the Black Population to combat racism and promote health equity.
Keywords: Women's Health; Prenatal care; Racial groups; Racism.

Resumo:
Objetivo: analisar as consultas de pré-natal e tipos de parto de gestantes negras na comparação com os demais grupos raciais, bem como o perfil de óbito materno conforme idade, estado civil, escolaridade e raça/cor. **Método**: estudo documental retrospectivo com abordagem quantitativa, cujos dados foram coletados através do Departamento de Informática do Sistema Único de Saúde, considerando o período de 2011 a 2021. Os achados foram analisados por meio de estatística descritiva, com estimativas de frequências absolutas e relativas. **Resultados**: houve maior proporção de assistência com sete ou mais consultas entre gestantes de raça/cor branca e amarela. Já a frequência de zero ou a três consultas foi maior entre indígenas e negras. Em todos os grupos a cesariana foi mais presente, sendo mais frequente entre gestantes de raça/cor amarela e branca, enquanto o parto vaginal foi mais presente entre negras e indígenas. A maioria dos óbitos maternos ocorreu em gestantes com idade entre 20 e 29 anos, 8 a 11 anos de estudo, solteiras e negras. **Conclusão**: verificado iniquidades raciais em saúde, que sugerem a necessidade da efetivação da Política Nacional de Saúde Integral da População Negra para combate ao racismo e promoção de equidade em saúde.
Palavras-chave: Saúde da mulher; Cuidado pré-natal; Grupos raciais; Racismo.

Resumen:
Objetivo: analizar las consultas de atención prenatal y los tipos de parto de gestantes negras en comparación con los demás grupos raciales, así determinar como el perfil de la mortalidad materna según edad, estado civil, escolaridad y raza/color. Método: estudio documental retrospectivo con enfoque cuantitativo, cuyos datos fueron recolectados a través del Departamento de Informática del Sistema Único de Salud, considerando el período de 2011 a 2021. Los hallazgos fueron analizados mediante estadística descriptiva, con estimaciones de frecuencias absolutas y relativas. Resultados: hubo una mayor proporción de asistencia con siete o más consultas entre gestantes de raza/color blanca y amarilla. La frecuencia de cero a tres consultas fue mayor entre indígenas y negras. En todos los grupos, la cesárea fue más frecuente, especialmente entre gestantes de raza/color amarilla y blanca, mientras que el parto vaginal fue más frecuente entre negras e indígenas. La mayoría de las muertes maternas ocurrió en gestantes de 20 a 29 años, con 8 a 11 años de estudio, solteras y negras. Conclusión: se verificaron inequidades raciales en salud, lo que sugiere la necesidad de la efectiva implementación de la Política Nacional de Salud Integral de la Población Negra para combatir el racismo y promover la equidad en salud.
Palabras clave: Salud de la mujer; Atención prenatal; Grupos raciales; Racismo.

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INTRODUCTION

The race/color variable, whose completion in health information system forms became mandatory in Brazil through Ordinance No. 344/2017, is recognized as a strategic component for identifying unequal experiences related to birth and life in Brazil, which have repercussions on health and in several indicators, such as life expectancy at birth and mortality. Despite the issue of underreporting, these data demonstrate a more unfavorable reality for black and mixed race people[1,2-4].

The Brazilian black population, which relies more heavily on the public health system, faces reduced access to services and high maternal and infant mortality. In this context, racism is presented as the primary social determinant of health[5].

A nationwide study on the influence of race/color on pregnancy and childbirth identified an association between pregnant black women and not only fewer prenatal visits, but also reduced access to examinations and guidance, a weaker connection to the maternity ward where they gave birth, longer travel distances, greater violation of the right to a companion, and a higher frequency of complaints of mistreatment and dissatisfaction[6].

In the Western region of the state of Santa Catarina, a three times higher association with elective cesarean sections was observed among White pregnant women. Paradoxically, despite greater exposure to cesarean sections and the documented risks to the lives of the mother-baby dyad, this population presents lower maternal mortality rate in Brazil when compared to black and mixed race women, who accounted for 66% of total deaths in 2019[5,7-8].

In Brazil, the maternal mortality ratio was estimated at 58 deaths per 100,000 live births for the year 2019, a figure that remains far from the target of 30 deaths per 100,000 set by the Brazilian government[8].

With a greater impact on developing countries, maternal death can be considered a tragedy foretold, as 92% of these cases are preventable, representing one of the most serious violations of women's human rights[9].

The strong association of black women with lower levels of education and income, as well as poorer living and health conditions, shows the need to incorporate race into discussions on inequalities, poverty, and lack of opportunities. The intersectionality between gender, class, race, and overlapping forms of oppressions generates specific vulnerabilities for these women, which the principle of universality of the Unified Health System (*Sistema Único de Saúde* - SUS) has not been able to fully address[10,11].

The National Policy for Comprehensive Health of the Black Population (*Política Nacional de Saúde Integral da População Negra* - PNSIPN), established in 2009 after a prolonged struggle

by the Black Movement, represents formal recognition of racism as a cause for inequalities and harm among the black population in health, as well as the need to promote equity[12].

Thus, studies on the association of skin color with increased vulnerability in health remain scarce. Social factors such as age, race, marital status, education, and socioeconomic status reveal the existence of more vulnerable groups exposed to complications[13,14].

In this context, analyses of consultations, childbirth, and death profiles from a racial perspective can contribute to identifying local needs and advocating for policies that favor improvements in health care. Therefore, this study aims to analyze prenatal consultations and types of childbirth for black pregnant women in comparison with other racial groups, as well as to determine the maternal death profile according to age, marital status, education, and race/color.

METHODS

This is a retrospective documentary study with a quantitative approach, using secondary data collected from the Department of Informatics of the Unified Health System (*Departamento de Informática do Sistema Único de Saúde* - DATASUS). The study included residents of the municipality of Uberlândia, in the state of Minas Gerais (MG), from 2011 to 2021, considering the sociodemographic variables (age, marital status, educational level, and race/color), and healthcare variables (type of delivery and number of prenatal visits according to maternal race/color). Results are presented as absolute and relative frequencies.

The data were extracted from DATASUS, with information on prenatal visits and types of delivery from the Information System on Live Births (*Sistema de Informações sobre Nascidos Vivos* - SINASC), and deaths from the Mortality Information System (*Sistema de Informações sobre Mortalidade* - SIM).

The results were organized in tables created using Microsoft Word® version 2013, and analyzed using descriptive statistics, with estimates of absolute and relative frequencies.

The race/color criterion was based on the classification of the Brazilian Institute of Geography and Statistics (*Instituto Brasileiro de Geografia e Estatística* - IBGE), which defines the Brazilian population as white, black, mixed race (*pardo*), Asian (yellow), or indigenous, and considers black to be the sum of black and mixed individuals[15].

As the study relied on publicly and freely available DATASUS data, an online program of the Ministry of Health (MH), no approval by a Research Ethics Committee with Human Beings was required.

RESULTS

A total of 101,386 documents collected between 2011 and 2021 were analyzed. Pregnant women of white (90.81%) and Asian (88.12%) race/color had a higher frequency of seven or more consultations compared to those of black (84.22%) and indigenous (82.93%) race/color. The proportion of pregnant women not assisted or who attended only up to three consultations was higher for indigenous (4.88%) and black (3.42%) women, compared to Asian (2.61%) and white (1.80%) women.

Cesarean section was more frequent among Asian (81.00%) and white (80.97%) women than among indigenous (68.29%) and black (67.20%) women, while vaginal delivery had higher prevalence among black women (32.78%), followed by indigenous (31.71%), white (19.02%) and Asian women (19.00%).

Maternal mortality was higher among young women (53.12%), those with low levels of education (65.62%), single women (43.75%), and black women (56.25%).

The absolute and relative frequencies of prenatal consultations and type of delivery by race/color for the period from 2011 to 2021 are in Tables 1 and 2; the sociodemographic data regarding maternal deaths are in Table 3.

The analysis of information from SINASC/DATASUS regarding the number of prenatal consultations performed in Uberlândia, from 2011 to 2021, according to maternal race/color, revealed some similarities and also inequalities in prenatal care.

While more than 80% of pregnant women in all groups were assisted with seven or more consultations, white women had the highest coverage (90.81%), followed by Asian (88.12%), black (84.22%), and indigenous women (82.93%).

Fewer prenatal visits (no care or up to three consultations were more common among indigenous (4.88%) and black (3.42%) women, followed by Asian women (2.61%), and then white women (1.80%). In 341 records, the race/color information was ignored.

Cesarean section was more frequent among Asian (81.00%) and white (80.97%) women than among indigenous (68.29%) and black (67.20%) women, while the reverse sequence was observed for vaginal deliveries, with a higher prevalence in black women (32.78%), followed by indigenous (31.71%), white (19.02%) and Asian (19.00%) women.

Table 1. Prenatal consultations according to maternal race/color. Uberlândia/MG, Brazil, 2011 to 2021*.

Consultations by race/color	White N (%)	Black or Mixed N (%)	Asian N (%)	Indigenous N (%)	Unknown N (%)
None	166 (0.35)	318 (0.60)	4 (0.95)	1 (2.44)	2 (0.59)
1 to 3	695 (1.45)	1485 (2.82)	7 (1.66)	1 (2.44)	6 (1.76)
4 to 6	3516 (7.34)	6.464 (12.27)	38 (9.03)	5 (12.19)	22 (6.45)
More than 7	43482(90.81)	44386 (84.22)	371 (88.12)	34 (82.93)	308 (90.32)
Unknown	23 (0.05)	48 (0.09)	1 (0.24)	- (-)	3 (0.88)
Total	**47,882 (100)**	**52,701 (100)**	**421 (100)**	**41 (100)**	**341 (100)**

Source: DATASUS, SINASC - Information System on Live Births, 2023* The data for the year 2021 were preliminary from DATASUS.

Table 2. Type of delivery according to maternal race/color. Uberlândia/MG, Brazil, 2011 to 2021*.

Delivery by Race/Color	White N (%)	Black or Mixed N (%)	Asian N (%)	Indigenous N (%)	Unknown N (%)
Vaginal	9109 (19.02)	17278 (32,78)	80 (19.0)	13 (31.71)	55 (16.13)
Ceasarian	38770 (80.97)	35413 (67.20)	341 (81.0)	28 (68.29)	286 (83.87)
Unknown	3 (0.01)	10 (0.02)	0 (0.0)	0 (0.0)	0 (0.0)
Total	**47882 (100.00)**	**52701(100.00)**	**421(100.00)**	**41 (100.00)**	**341 (100.00)**

Source: DATASUS, SINASC - Information System on Live Births, 2023 * The data for the year 2021 were preliminary from DATASUS.

Regarding maternal death, analysis of SIM/DATASUS data identified 32 cases, with absolute and percentage results presented according to age, education, marital status and race/color (Table 3). The highest occurrence of maternal death was observed among young women, with low education, single and black. Among the notified maternal death cases, 16 (50.00%) women were aged between 20 and 29 years; 12 (37.50%) were aged between 30 and 39 years; 03 (9.38%) were aged 40 years or older and 1 (3.12%) was aged between 15 and 19 years.

Regarding education, it was observed that the majority of deaths, 20 cases, occurred in women who had between 8 and 11 years of education, corresponding to 62.50% of the total. Furthermore, 5 (15.63%) had 12 or more years of education and 1 (3.12%) had less than 8 years of education. This variable showed a higher proportion of missing information, with 6 cases (18.75%) lacking data on education (Table 3).

Concerning marital status, 14 deaths (43.75%) were reported among single women, followed by 12 (37.50%) among married women. The categories "widow," "legally separated," and "other" each accounted for 1 (3.12%) death, while marital status information was missing in 3 cases (9.38%). Regarding race/color, it was observed that 14 deaths (43.75%) occurred among white women, 10 (31.25%) among black women, and 8 (25.00%) among mixed race women, totaling 18 (56.25%) cases in the black population. No deaths of any other race/color besides white, black, and mixed race were identified, nor were any cases identified with race/color information unknown or missing (Table 3).

Table 3. Maternal deaths according to sociodemographic variables, Uberlândia/MG, Brazil, 2011 to 2021*.

Sociodemographic data		Maternal deaths N (%)
Age (years)	15 to 19	1 (3.12)
	20 to 29	16 (50.00)
	30 to 39	12 (37.50)
	40 or more	3 (9.38)
Educational level (years of education)	< 8	1 (3.12)
	8 to 11	20 (62.50)
	12 or more	5 (15.63)
	Unknown	6 (18.75)
Marital status	Single	14 (43.75)
	Married	12 (37.50)
	Widow	1 (3.12)
	Separated	1 (3.12)
	Other	1 (3.12)
	Unknown	3 (9.38)
Race/Color	White	14 (43.75)
	Black	10 (31.25)
	Mixed	8 (25.00)

Source: DATASUS, SINASC - Information System on Live Births, 2023 * The data for the year 2021 were preliminary from DATASUS.

DISCUSSION

A nationwide investigation into teenage pregnancy linked pregnant adolescents from lower socioeconomic backgrounds and of black ethnicity to less access to recommended pregnancy examinations, receiving less guidance, experience greater difficulty finding a maternity hospital, and faced a higher risk of unfavorable pregnancy and childbirth outcomes. A gradient in proportions was also observed, such that the darker the skin color, the higher the frequency of inadequate schooling for age, the later initiation of prenatal care, and the lower likelihood of completing the recommended number of consultations[16].

The lack of adequate prenatal care has been associated with barriers to access, such as low income and education, distance between residence and health service, transportation costs, and the lack of adequate infrastructure, supplies, equipment, professional qualification and health education that impair the quality of care and contributed to the persistence of high mortality, which has been even more pronounced in Brazil due to the high frequency of cesarean sections[17,18].

In this study, a high incidence of cesarean sections was observed, as well as a greater similarity between pregnant women of Asian and white descent, with the latter having more cesarean sections than the other groups.

A study conducted in the state of Mato Grosso do Sul identified similarities in the vulnerability of indigenous and black women, who presented a risk of death four times greater than that observed among white women[19].

The association of black and mixed race women with lower proportions of cesarean section and higher proportions of vaginal delivery identified in this investigation, has also been reported in studies carried out in the southeastern and southern regions of Brazil[4,7,20-21].

A study of the temporal evolution of cesarean sections in São Gonçalo, a municipality in southeastern Brazil, identified that the increase in this type of delivery did not include pregnant women with low levels of education and of black skin color, suggesting the possibility of non-compliance with established protocols for this type of delivery[20].

The exposure of white pregnant women to cesarean section is three times higher, a frequency that can be explained by the greater purchasing power of this group, increased access to the private healthcare system, an interventionist medical cultural context, the false perception of greater safety than vaginal delivery, the expectation of less pain, and even the attribution of greater symbolic value[7]. Another study conducted in a hospital in a municipality in the state of Maranhão with black women found that vaginal delivery was the exclusive mode of delivery observed among them[13].

The difference may represent an advantage for black pregnant women, since their association with vaginal delivery, despite generating greater exposure to obstetric violence, is related to a higher frequency of full term births (greater than 39 weeks) and less exposure to the harms of prematurity[7].

However, this interpretation requires caution. In poorer municipalities in the Porto Alegre metropolitan region, a higher proportion of black and mixed race women was observed, with more vaginal deliveries than cesarean sections, but a greater association with unfavorable outcome (low birth weight)[21].

This lower exposure to cesarean sections, which initially might suggest care in accordance with the recommendations of the Brazilian Ministry of Health, reveals that black women are being less subjected to interventions within a national obstetric context characterized by interventionism, in which medical approaches are perceived as care. Thus, black and mixed race women, as also demonstrated by the lower use of analgesia and higher rates of post-term births in the group, are in fact receiving less care, which is related to the possible cultural rejection of black Brazilian women and their unfavorable symbolic place in a structure dominated by racism[6,22].

Regarding maternal mortality, in 2019 the Ministry of Health estimated 1655 deaths in nationwide, that is, 58 deaths for every 100,000 live births, a Maternal Mortality Ratio well above the target of 30 established by the Sustainable Development Goals (SDGs) by 2030. These data corroborate the results of this study[8]. In Brazil, there is a higher prevalence of deaths in young women, as approximately 50% of them were under 29 years old, 50% were single, 42% had between 8 and 11 years of education and 66% were of black or mixed race/color[8].

An analysis of data on this type of death in municipalities in Mato Grosso do Sul also found that 50% of deaths occurred in women aged between 20 and 29 years, with similar percentages when comparing cases between single and married women, with 30.8% and 23.1% respectively[23].

The results show an association between incomplete information on marital status and especially education, with proportions of missing records of 35.1% and 54.0%, respectively, making a more complete analysis of the problem difficult.

It is known that exploring variables related to maternal death is of fundamental importance due to its potential to broaden the understanding of the issue, reveal possible inequities in the territory, and contribute to the proposal of interventions aimed at reducing the preventable death of these women[24].

Regarding variables related to maternal death, it has been shown that extremes of age are associated with an increased risk of death[14]. This risk is also increased in the absence of a social support network for the pregnant woman. Thus, with regard to marital status, it is observed that the conditions “single”, “widowed” and “legally separated” place the pregnant woman in a vulnerable position and more prone to neglecting care during the pregnancy[25].

Low education increases the risk of maternal death by limiting the understanding of information, impaired self-perception of risk and, consequently, access to services[26]. Among women with darker skin, vulnerability to death is increased, due to genetic predisposition to diseases (especially hypertensive syndromes of pregnancy) and the association of this group with unfavorable social contexts[26]. The participation of these comorbidities in the causality of maternal death and vulnerabilities related to racial aspects has been recorded and is not completely elucidated[27].

The association between racial variable and death has been documented. As recently as 1999, in São Paulo, a maternal mortality rate in black women was 6.4 times higher than that among white women[28].

According to research that identified a 2.3 times higher risk of death for black women in the municipality of Rio de Janeiro between 2010 and 2019, this perverse inequality can be explained by the persistence of racism. However, it is argued that securing this position depends on more frequent and in-depth debate, with the use of specific methodologies as occurs in the United States and which are not yet validated in the country[29].

According to the 2022 Demographic Census, the black population represents 50.76% of the total in the municipality of Uberlândia, with 39.79% being mixed race and 10.97% black[30]. In the present investigation, it was observed that 56.25% of maternal deaths occurred in this

population. Among the white population, however, an inverse relationship was found, since, although whites constitute 48.85% of the local population, the proportion of maternal deaths was 43.75%.

The data highlight the vulnerability of the black population, which has encountered not only difficulties in accessing services, but has also received poorer quality care[28].

In a recent analysis prepared by the United Nations Population Fund, it was possible to observe statistically significant differences, with a higher maternal mortality rate for those with African descent compared to non-African descent in countries such as Colombia, Suriname and especially the United States. In the latter, it was found that inequality persisted regardless of socioeconomic and income level, since a mortality rate of those with African descent with higher education or above was observed to be 5.2 times higher than that found in white women with the same educational level[31].

Regarding such differences in health treatment, one study associated black women with difficulties in access and poor quality of care. This situation can be explained by what has been termed a "structural custom" in the unconscious reproduction of discrimination by health professionals, which ends up influencing not only individual feelings, thoughts and behaviors, but also institutional processes and policies[12,32].

In this context, the defense of the PNSIPN as a tool for transforming reality becomes even more important[5], since the PNSIPN recognizes the existence of racism and advocates for the articulation between spheres of power, intersectorality, participatory management, and the relevance of diverse social actors within the municipality in the process of identifying the needs of the local black population, thus combating racism, discrimination, and ethnic-racial inequalities in health[5].

CONCLUSION

The results show hat black pregnant women have greater difficulty accessing health services and care, which may be contributing to higher mortality in this group. The production of these unfavorable findings after the creation of the PNSIPN suggests its non-implementation at the municipal level, highlighting its urgency and importance in recognizing racism as a social determinant of health.

The research presents limitations inherent to the nature of secondary data. The possibility of underreporting, errors in filling out or typing the information, which is updated periodically, should be considered, which may lead to changes in the search results, depending on the access dates.

On the other hand, it is essential to conduct studies to understand the institutional points related to the reproduction of racism and the production of health inequities, with the aim of developing future interventions. It is also important to qualify the attention and favor comparison with other racial groups in the evaluation of aspects such as pilgrimage, waiting time, access to exams and guidance, presence of a companion, use of anesthetics, gestational age, birth weight, APGAR score, and others. Thus, the use of other methodologies that increase the reliability of the results is recommended, including statistical association tests.

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