



OBJN
Online Brazilian Journal of Nursing

ENGLISH

Fluminense Federal University

AURORA DE AFONSO COSTA
NURSING SCHOOL



Original Articles

Higher risks for black women in Paraná-Brazil

Alaerte Leandro Martins¹

¹Paraná State Maternal Mortality

ABSTRACT

The knowledge about the Maternal Mortality Ratio is essential to the planning and management of health actions at any level. This indicator can be obtained through the analysis of death certificates and, if possible, through the investigation of the main cause of death of every woman within fertility age. Our findings allow us to conclude that, among the maternal deaths identified by race in Paraná, 17.9% occurred among black women, who corresponded to 21.8% of the total of women in the state in 1991. Among all black women, although only 2.2% were *pretas*, they represented 8.2% of all maternal deaths, which means that a *preta* has a 7 times higher risk of dying because of maternal causes than other women. Asian women presented better socio-economic and demographic conditions than white women and *pretas* (the latter with the worst indicators); however, the risk of death of both – Asians and *pretas* – was very high, suggesting that there might be a relation among race, disease, living conditions and maternal mortality. Therefore, a more profound study of the matter is necessary

Descriptors: maternal health services, blacks, public health

INTRODUCTION

In general, the absence of a woman and a mother at home causes the disruption of the family, sometimes even the disruption of a population, as stated by the World Health Organization (1993):

“A mother’s death directly affects a large number of family and community members who depend on her. Maternal deaths, when high in numbers, can cause serious consequences for the communities, the nations and the population.”

The knowledge about the Maternal Mortality Ratio is essential to the planning and management of health actions at any level. This indicator can be obtained through the analysis of death certificates and, if possible, through the investigation of the main cause of death of every woman within fertility age. The results gathered by the study of this ratio are wide in range and offer specific data on prenatal, delivery and postnatal services, without putting aside important issues such as unwanted pregnancy, abortion and many others.

DEVELOPMENT

MMR: an indicator of unequal development

In its scope, the Maternal Mortality Ratio (MMR) reflects the quality of services rendered to the reproductive needs of citizens. Indirectly, it also reflects the mindset of governmental authorities, especially in regard to women’s health care. The differences in indexes between developed and developing countries are proof of this.

In the United States of America, the 1980

figures showed the death of 9 women per 100,000 live births; in that same year, in Brazil, the official maternal mortality ratio was of 70 deaths per 100,000 live births (Ana Cristina Tanaka and collaborators, “*Situação de Saúde Materna e Perinatal no Estado de São Paulo*”, 1989). According to the Pan-American Health Organization (PAHO), in that same year Paraguay had 365 deaths per 100,000 live births; Chile, 73; and Argentina, 70.

According to Ana Cristina Tanaka (“*Maternidade: Dilema entre nascimento e morte*”, 1995), this is equivalent to saying that:

“(…) many times, the social status of the individual itself can influence the severity of the disease; that is, depending on the patient’s social class, the pathology can cause a greater/lesser damage to his/her health.”

Women from ethnic minorities are subject to higher risks

Social class and social status – race/ethnicity: an interrelation of difficult approach. This is a concern of Atrash and collaborators (“*Maternal Mortality in Developed Countries: Not just a concern of the past*”, 1995), when they state that:

“(…) the fact of being a member of an ethnic minority in itself does not explain the reason for such a disparity; however, it is important to have this information when we adopt a preventive conduct (…).”

For Berg et al (“*Pregnancy: Related Mortality in the United States, 1987-1990*”, 1996):

“(…) despite the decrease in the mater-

nal mortality ratio in the last 50 years, the relation between the death rate of black and white women is still high if we remember that, in 1940, the ratio was of 2.4 deaths per 100,000 l.b. (live births) and, in 1990, was of 4.1 per 100,000 l.b. Such disparity is due to health conditions before pregnancy, pregnancy associated with morbidity, access and use of health services, and its satisfaction, content and quality (...) efforts to reduce the maternal mortality ratio should include black women as a risk group.”

This is the challenge, since also in Brazil black women die more frequently, either due to their life and health conditions or to the inequalities in the health care assistance.

In the United States, the CDC (Centers for Disease Control and Prevention, “Differences in Maternal Mortality among Black and White Women – United States, 1990”, 1995) showed that the ratio of maternal mortality was two to four times higher for black women, and it attributed the higher rate to the great number of unhealthy pregnancies, to the difficulty of access and use of health services, and finally to the quality of services rendered.

Maternal mortality data broken down by race are rare in Brazil. Studies of the Paraná State Maternal Mortality Committee (1997) showed that in the period from 1994 to 1996:

“(…) among the deaths for which data about race were obtained, 78.3% were white women, followed by the black race (pretas and pardas) with 20.8% (67 deaths), while 0.9% were of Asian race.”

Another national study conducted in 1997 in the states of Rio Grande do Norte, Mato Grosso

and Pará, by researchers Ana Cristina d’Andretta Tanaka and Lia Mitsui (“*Estudo da Magnitude da Mortalidade Materna em 15 Cidades Brasileiras*”, 1999), states that:

“(…) the white skin colour prevailed in 28.5% of the deaths. However, if we consider the pardas of different skin tones as only one colour, they would total 51.5% of the deaths. There was no death in which the deceased was considered as being preta.”

White women are the majority, but black women’s risks are higher.

In our research conducted in the state of Paraná during the years of 1993 to 1998, we found 956 female deaths due to maternal causes, with an annual average of 160 deaths. The majority of deaths occurred among white women (53.4%); black women amounted to 17.9% of the deaths, including here *pardas* and *pretas*; and Asian women represented 1.4%.

Women of unknown race counted for 27.4% of the cases. In order to analyse this information, we should first realize that home visits are essential to collect this information and, as we know, maternal death frequently leads to a major family disruption. As a consequence, the family is frequently not found. Secondly, this information depends on the understanding and importance the interviewer or health professional gives to the issue.

As we compare the distribution of the female population and the number of maternal deaths per race, in 1993, we observe that these women’s relative risk of death caused by pregnancy, delivery and puerperium was 7.4 times higher among *pretas* than among white women, and five times higher among Asians in

comparison to white women.

We observed the percentile distribution of women according to their race is different among those living and deceased. It would be expected that the distribution were similar. This difference may have occurred because of the high percentage of cases unknown or because death risks are differentiated per race.

Pretas and Asian women had higher mortality rates. This is even more evident when we observe the ratio of female mortality due to maternal causes for women ranging from 10 to 49 years of age and according to race, in which *pretas* had a ratio of 21.7; Asians, of 14.6; and whites, of 2.9 per 100,000 women.

With regard to the Maternal Mortality Ratio per race, it stood at 385.4 per 100,000 live births among Asian women, 342.3 among *pretas*, and 51.6 among white women. This shows us that maternal death was 7.5 times higher among Asian women and 6.6 times higher among *pretas* when compared to white women.

These ratios, specially among *pretas* and Asian women, are extremely high if compared to those of other developing countries, such as Kenya, Namibia or even Paraguay and Peru, among others (WHO/Unicef, 1996).

Causes of maternal death

Several studies on maternal mortality – such as that of Siqueira and collaborators (“*Mortalidade Materna no Brasil*”, 1984), and of Ruy Laurenti (“*Os Muitos Brasís: Saúde e população na década de 80*”, 1995), among others – show that the four main causes of maternal death in Brazil are: hypertensive syndrome, haemorrhagic syndrome, puerperium infections, and abortion. According to Ana Cristina Tanaka and collaborators (1989), of all maternal deaths in the state of São Paulo, between 1980 and 1984, 33.8% were caused by hypertension, 16.6% by haemorrhage, and 13.4% by abortion. Other causes, such as problems during labour

and puerperium infections, among others, did not reach the percentage of 10% each.

In the study conducted in Paraná, the main cause of maternal death was hypertension, which caused 33.6% of deaths, mainly affecting Asian women (77.8%), followed by black women (36%). Among the latter the percentage of *pretas* was as high as 46.9%.

The hypertensive syndrome was 2.5 higher among Asian women than among white women and 1.5 higher among *pretas* in comparison to white women, in spite of the fact that these women’s characteristics were very different. While Asian women tended to be older, married and with a higher family income, with more years of schooling, less children and a higher percentage of first-time pregnancies, most *pretas* were younger, single, earned less income and had fewer years of schooling, a higher number of children and a lower percentage of first-time pregnancies. These differences allowed the researchers to hypothesize that racial issues probably have a relation with the disease that caused death, but it is also associated to socio-economic factors.

According to A. A. Lopes (“*Hipertensão Arterial em Negros*”, 1999), the retardation in the intrauterine development (at least in the United States), the occurrence of low weight in newborn babies, type II diabetes and fatal nephritic diseases are higher in the black population than in the white population. Thus, they have concluded that all these factors lead black people to have a higher frequency and more severe cases of hypertension.

The occurrence of diseases among black women and their impact on their reproductive health and maternal mortality is probably due to: firstly, a genetically-determined tangle that leads to pregnancy-induced hypertension, which is the main cause of deaths in the country, but that also contributes significantly to the other causes

of maternal death, whether directly (infection, abortion and others) or indirectly (vascular cerebral accident, cardiopathies, diabetes, nephritic diseases and others). Secondly, one must take into account black women's living conditions and access to health care.

CONCLUSIONS

Ethnic/racial and socio-economic factors

Our findings allow us to conclude that, among the maternal deaths identified by race in Paraná, 17.9% occurred among black women, who corresponded to 21.8% of the total of women in the state in 1991. Among all black women, although only 2.2% were *pretas*, they represented 8.2% of all maternal deaths, which means that a *preta* has a 7 times higher risk of dying because of maternal causes than other women.

Asian women presented better socio-economic and demographic conditions than white women and *pretas* (the latter with the worst indicators); however, the risk of death of both – Asians and *pretas* – was very high, suggesting that there might be a relation among race, disease, living conditions and maternal mortality. Therefore, a more profound study of the matter is necessary.

Thus, it is indispensable that, in the strategies used to reduce the maternal mortality in Brazil, we observe the specificities of each race, especially those of Asians and *pretas*, considering race and the socio-economic status as risk factors.

Note 1: This article was based on the Master's thesis presented to the Postgraduate Program of the School of

Public Health at the State University of Ponta Grossa, Paraná, under the orientation of Professor Dr. Ana Cristina d'Andretta Tanaka, of the Maternal-Infantile Department of the School of Public Health at the University of São Paulo.

Note 2: In Brazil, the racial classification in the Census is done through self-declared skin colour, and most researches and surveys follow this practice. There are five options to be chosen from: branco (white), preto (black), pardo (racially mixed), amarelo (yellow, for Asian-descendants), and indígena (Indigenous – although it is not a skin colour, it is the option for Brazilian Indigenous persons).

In the articles presented herein most researchers count black (*preta*) and racially-mixed (*parda*) populations together, by calling it the black (*negra*) race or the black (*negra*) population.

Since in the English language skin colours are not usually used to designate racial groups, in this publication we have decided – in order to be more comprehensible and to avoid misunderstandings – to use the Portuguese words *pretos/pretas* and *pardos/pardas* when dealing with disaggregated data on the black population, and Asian instead of yellow (*amarelos/amarelas*).

REFERENCES

1. Atrash HK, Alexander S, Berg CJ. Maternal mortality in developed countries: Not just a concern of the past. *Obstet. Gynecol.* 1995 out;86(4).
2. Atrash HK, Koonin LM. et al. Maternal mortality in the United States, 1979-1986. *Obstet. Gynecol.* 1990;dec. 76(6): 1055-60.
3. Berg CJ, Atrash HK et al. Pregnancy – Related mortality in the United States, 1987-1990. *Obstetrics Gynecology*, 1996 aug; 88(2):161-167.
4. Center for Disease Control and Prevention- CDC. Differences in maternal mortality among black and white women – United States: *MMWR* 1995 jan 13, 44(1):6-7/13-14..
5. Comitê Estadual de Morte Materna no Paraná(Brasil). Relatórios dos Comitês de Morte Materna do Paraná – 1992 .
6. Comitê Estadual de Morte Materna no Paraná(Brasil). Situação da mortalidade materna no Paraná – 1993. Curitiba; 1995 .
7. Comitê Estadual de Morte Materna no Paraná(Brasil). Relatório trienal 1994-96. Mortalidade materna no Paraná, do anonimato ... à ação. Curitiba; 1997.
8. Comitê Estadual de Morte Materna no Paraná(Brasil). Situação da mortalidade materna no Paraná – 1989-96. Curitiba ;1997.
9. Comitê Estadual de Morte Materna no Paraná(Brasil)Os riscos da mortalidade materna no Paraná – 1989-1998. Seminário dos dez anos dos comitês de mortalidade materna no Paraná – 1999 ago 12-14.
10. Laurenti R. Perfil da mortalidade materna. In: Minayo, MCS (org), *Os muitos brasis:saúde e população na década de 80.* São Paulo, Hucitec/ Abrasco. 1995: 304-319.
11. Lopes AA, Port FK. The low birth weight hypothesis as a plausible explanation for the black/white differences in hypertension, non-insulin dependent diabetes, and end- stage renal disease. In: *American Journal of kidney Diseases.* 1995 feb;25(2):.350-356.
12. Lopes AA. Raça e hipertensão arterial. *HiperAtivo.*1996 jul/set;3(3):153-72.
13. Lopes AA Hipertensão arterial em negros. *Kardia: o desafio em cardiologia.* São Paulo: Lemos.1999 jan/abr;2(1):16-23.
14. Organização Mundial de Saúde. *La salud materna: um perene desafio.* Washington: DC. 1993.
15. Tanaka ACA. Situação de saúde materna e perinatal no Estado de São Paulo, Brasil. *Rev Saúde Pública,* São Paulo. 1989;23:67-75.
16. Tanaka ACA. Maternidade dilema entre nascimento e morte. São Paulo – Rio de Janeiro: Hucitec/Abrasco. 1995.
17. Tanaka ACA, Mitsui L. Estudo da magnitude da mortalidade materna em 15 cidades brasileiras. São Paulo: UNICEF; 1999 p.114. Available from: www.saude.gov.br/programas/mulher/document.htm

Recebido: 07/03/2003

Aprovado: 31/03/2003