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Interrupted Lives: Racism and Maternal Mortality Among Black Women in Brazil

Camila Aparecida Siqueira Souza[1], Jackson Santos dos Reis[2], Mariana Medeiros Mota Tessarolo[2] Luiz Carlos Ferreira[3], Andrea Pereira Diniz Soares[4], José Paulo da Silva Ferreira[5], Ewerton Naves Dias[6]

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Revisão de Literatura

ABSTRACT

Introduction: Maternal mortality in Brazil remains high and reflects health inequities, with a greater risk of death among Black women, associated with mechanisms of structural, institutional, and interpersonal racism that affect access, quality of care, and health surveillance. **Objective:** To analyze how racism is related to maternal mortality among Black women in Brazil through a literature review. **Method:** An integrative review was conducted using searches in the Virtual Health Library (VHL) and Google Scholar, applying DeCS descriptors and inclusion/exclusion criteria, followed by standardized data extraction, critical appraisal, and thematic synthesis of eligible studies. **Results:** Thirteen studies (2006-2025) were included. The evidence converged into four themes: (1) Structural, institutional, and interpersonal racism as determinants of the risk of maternal death, including the invisibility of the race/color variable and biases in clinical practice; (2) Quality of care and obstetric violence during prenatal care, childbirth, and the postpartum period, with communication failures, reduced autonomy, and unequal pain management; (3) Access and care barriers within the Health Care Network, including delays, care-seeking peregrination, and discontinuity of care; (4) Surveillance and public policies, highlighting the importance of qualified recordkeeping, timely investigation of deaths, and equity targets to drive change. **Conclusion:** Racism is related to maternal mortality among Black women by producing and sustaining barriers to access, worsening the quality of care, and contributing to monitoring failures, thereby increasing the occurrence of preventable outcomes. To address this problem, the literature indicates consistent and measurable actions: improving and using the race/color variable, reducing delays in care through care pathways and target response times, strengthening respectful care practices (including communication, consent, and adequate pain management), and consolidating surveillance with accountability and explicit equity goals.

Keywords: Obstetric violence. Maternal mortality. Racism. Black population.

Vidas interrompidas: racismo e mortalidade materna de mulheres negras no Brasil

RESUMO

Introdução: A mortalidade materna no Brasil permanece elevada e expressa iniquidades em saúde, com maior risco de óbito entre mulheres negras, associado a mecanismos de racismo estrutural, institucional e interpessoal que atravessam o acesso, a qualidade do cuidado e a vigilância em saúde. **Objetivo:** Analisar como o racismo se relaciona à mortalidade materna de mulheres negras no Brasil, por meio de uma revisão de literatura. **Método:** Revisão integrativa com buscas na Biblioteca Virtual em Saúde (BVS) e no Google Acadêmico, utilizando descritores DeCS e critérios de inclusão/exclusão, seguida de extração padronizada, avaliação crítica e síntese temática dos estudos elegíveis. **Resultados:** Foram incluídos 13 estudos (2006-2025). As evidências convergiram em quatro temáticas: (1) Racismo estrutural, institucional e interpessoal como determinante do risco de morte materna, inclusive pela invisibilização do quesito raça/cor e por vieses na prática clínica; (2) Qualidade do cuidado e violência obstétrica no pré-natal, parto e puerpério, com falhas de comunicação, menor protagonismo e manejo desigual da dor; (3) Acesso e barreiras assistenciais na Rede de Atenção à Saúde, com atrasos, peregrinação e descontinuidade do cuidado; (4) Vigilância e políticas públicas, destacando a importância do registro qualificado, investigação oportuna de óbitos e metas de equidade para induzir mudanças. **Conclusão:** O racismo se relaciona à mortalidade materna de mulheres negras ao produzir e sustentar barreiras de acesso, piora da qualidade do cuidado e falhas de monitoramento, aumentando a ocorrência de desfechos evitáveis. Para enfrentar o problema, a literatura indica ações consistentes e mensuráveis: qualificar e utilizar o quesito raça/cor, reduzir atrasos assistenciais com fluxos e tempos-alvo, fortalecer práticas de cuidado respeitoso (com comunicação, consentimento e manejo adequado da dor) e consolidar vigilância com responsabilização e metas explícitas de equidade.

Palavras-chave: Violência obstétrica. Mortalidade materna. Racismo. População negra.

Autores

1. *Acadêmica de enfermagem na Universidade de Guarulhos, São Paulo, Brasil.*
2. *Mestres em Psicogerontologia pela Faculdade Educatie, São Paulo, Brasil.*
3. *Mestre em Unidade de Terapia Intensiva pelo Instituto Brasileiro de Terapia Intensiva, São Paulo, Brasil.*
4. *Mestre em Enfermagem pela Universidade de Guarulhos, São Paulo, Brasil*
5. *Dourorando em Enfermagem pela Universidade de Guarulhos, São Paulo, Brasil.*
6. *PhD em Pscologia pela Universidade de Porto, Portugal.*

Autor correspondente*: Ewerton Naves- email: ewertonnaves@gmail.com*

1 INTRODUCTION

Maternal mortality remains one of the principal indicators of health inequity in Brazil. According to the World Health Organization (WHO), maternal death is defined as the death of a woman during pregnancy or within 42 days of the termination of pregnancy, irrespective of its duration or location, provided that it results from direct or indirect obstetric causes, excluding accidental or incidental causes (Silva; Paula, 2021).

Despite the efforts undertaken since the 1990s to reduce these deaths, including policies such as the National Pact for the Reduction of Maternal and Neonatal Mortality and the gradual improvement of the obstetric care network, Brazil continues to report rates above the targets established in international forums. This scenario indicates the persistence of structural problems and barriers within the health system that hinder the reduction of maternal deaths (Brasil, 2007).

However, an aggregated interpretation of these indicators conceals profound racial disparities. Women who self-identify as Black or Brown consistently experience significantly higher maternal mortality rates than White women across all regions of the country (Ramires, 2021). Estimates suggest that Black pregnant women are approximately five times more likely to die from causes related to pregnancy, childbirth, or the postpartum period (Teixeira et al., 2012). These findings are reinforced by analyses demonstrating, among other inequities, reduced access to qualified information during prenatal care, delayed referral to specialized services, and limitations in the adequate management of obstetric complications (Oliveira; Kubiak, 2019).

The literature further shows that the universal and equitable access to health services guaranteed by the Brazilian Constitution does not necessarily translate into equity in health outcomes. Black and Brown populations occupy distinct socioeconomic and geographic positions that directly affect their morbidity and mortality profiles (Cordeiro, 2006). These differences are deeply shaped by a colonial history marked by slavery, which forged social, political, and economic structures capable of perpetuating racial discrimination, a phenomenon encompassed by the concept of structural racism (Santos, 2024).

In Brazil, racism operates through three interrelated dimensions. Structural racism refers to the set of institutions, values, and practices that, once naturalized, reproduce racial hierarchies and regulate opportunities for life and well-being (Almeida, 2019; Gonzalez, 2020). Institutional racism is expressed through the policies and routines of services, determining who has access, under what conditions, and with which outcomes. Interpersonal racism, in turn, emerges in interactions between individuals and involves discriminatory attitudes that may or may not be explicitly recognized (Krieger et al., 2010). In obstetric care, these dimensions are intertwined, influencing both the organization of the health care network and the lived experience of each woman in her encounters with health professionals.

Obstetric violence, classified by the WHO as a public health issue, functions as one of the primary mechanisms through which racism affects the reproductive health of Black women. It encompasses actions or omissions during prenatal care, childbirth, and the

postpartum period that cause unnecessary pain, harm, or suffering, and that occur without informed consent or in violation of the woman's autonomy (Ramires, 2021). Episodes of negligence, humiliation, clinically unwarranted interventions, denial of analgesia, or the use of abusive language constitute violations that intensify the risk of severe complications, including death (Paiva et al., 2022).

Over the past decade, qualitative and quantitative studies have portrayed the magnitude of this problem with increasing precision. In 2017, 62.4% of maternal deaths, including late maternal deaths, occurred among Black and Brown women throughout the national territory (Brasil, 2021). These data underscore the importance of understanding how discriminatory practices intersect with other vulnerabilities, such as low educational attainment, food insecurity, exposure to community and domestic violence, precarious labor conditions, and geographic barriers, thereby creating a context of cumulative risk (Saraiva; Campos, 2023).

In other words, social, economic, and cultural factors interact in ways that intensify preexisting inequalities. Many Black women, especially those living in peripheral urban areas, face inadequate sanitation, irregular public transportation, and limited access to specialized services. These conditions hinder the continuity and timeliness of prenatal care. In addition, circumstances such as double work shifts, environmental racism, and mistreatment within health services may discourage women from seeking care. Consequently, the risk of undiagnosed hypertension, untreated hemorrhage, and poorly managed infections increases substantially (Silva; Paula, 2021; Santos, 2024).

Even so, it is important to acknowledge that institutional advances have been made in addressing these inequalities, although they remain insufficient. The National Policy for the Comprehensive Health of the Black Population (PNSIPN), established in 2009, aims to promote health, prevent conditions associated with racial discrimination, and reduce inequalities in health care indicators (Brasil, 2010b). Nevertheless, because this policy has been implemented unevenly and with limited monitoring and evaluation structures, its effectiveness remains constrained. As a result, shortcomings persist in professional training, infrastructure improvement, and accountability for discriminatory practices.

This context is compounded by challenges inherent to the underfunding of the Unified Health System (SUS), the turnover of health care teams, and the absence of specific protocols incorporating an ethnic-racial perspective across all stages of the obstetric care pathway. Even when childbirth humanization policies and measures aimed at improving perinatal care are implemented, the inclusion of race/color indicators does not always translate into concrete actions to reduce adverse events in maternity services (Ramires, 2021).

In light of this context, understanding the association between racism and maternal mortality requires an approach that goes beyond statistical data alone and addresses the historical, structural, and symbolic dimensions of the phenomenon. A literature review that integrates epidemiological evidence, qualitative analyses of care experiences, and reflections on public policies is therefore essential to clarify causal pathways, identify critical points, and support the development of equity-oriented

interventions.

Accordingly, this literature review aims to critically analyze the scientific production on the impact of racism, in its structural, institutional, and interpersonal dimensions, on patterns of maternal mortality among Black women in Brazil, in order to support strategies that promote the right to life and to dignified care for all pregnant women.

2 METHODOLOGY

This study was conducted in accordance with the principles of the integrative literature review, a methodological approach recognized for its ability to incorporate, simultaneously, both experimental and non-experimental investigations, thereby providing a comprehensive understanding of the phenomenon under analysis. By integrating theoretical frameworks and empirical evidence, the integrative review enables not only the conceptual delimitation of the topic, but also the critical appraisal of explanatory models, the assessment of the consistency of the available evidence, and the identification of methodological gaps capable of informing future research agendas. In this sense, it produces an analytical framework that consistently reveals the multiple dimensions involved in complex health issues. In the present review, the process was organized into six sequential and interrelated stages, as described below (Souza; Carvalho, 2010).

The problem identification stage constituted the starting point of the investigation. In light of the alarming indicators showing a higher risk of death among Black pregnant women, the following guiding question was formulated: What evidence does the scientific literature provide regarding the ways in which racism is associated with maternal mortality among Black women? This question reflects a gap that remains insufficiently explored in Brazilian academic production and lies at the center of contemporary debates on health equity and reproductive justice in Brazil.

In the subsequent stage, corresponding to the literature search, a retrieval strategy was established based on two widely accessible electronic sources: the Virtual Health Library and Google Scholar. Prior to the search process, inclusion criteria were defined as national articles, field studies, and investigations centered on maternal mortality among Black women in relation to racism. Exclusion criteria comprised other study designs, the absence of a racial perspective, or a focus on morbidity without the outcome of death. The descriptors “Maternal Mortality,” “Racism,” and “Black Population” were used, selected from the controlled vocabulary of the Health Sciences Descriptors (DeCS), and combined using Boolean operators in order to maximize the sensitivity and specificity of the search results.

Following completion of the search stage, data collection was performed through the standardized extraction of information from the eligible studies. This procedure included essential bibliographic data, methodological design, study population, maternal mortality indicators, the manner in which racism was measured, the main findings, and the limitations reported by the authors, thus ensuring consistency and

uniformity in data extraction.

Subsequently, the selected studies underwent critical appraisal. Each article was examined with regard to its methodological robustness, relevance to the research question, and internal coherence among objectives, methods, and results. Based on this assessment, the studies composing the final corpus were confirmed, as well as the recurring themes that would support the synthesis.

During the data analysis and synthesis stage, the extracted information was organized into comparative matrices. This procedure made it possible to identify convergences and divergences, highlight recurrent findings, and condense the available knowledge into broad thematic categories, while maintaining fidelity to the original data.

Finally, in the stage of data presentation and interpretation, an integrated narrative of the findings was developed. The final synthesis, constructed in light of the study objective, describes the current state of knowledge, highlights the remaining gaps, and proposes practical implications for care delivery, health management, and future research.

3 RESULTS AND DISCUSSION

The final sample consisted of 13 studies included after the application of the eligibility criteria. The main characteristics of these publications, including authorship, year, setting/context, study design, population, principal findings, and contributions, are presented below in Table 1, in order to allow comparative visualization and a broader understanding of the body of evidence analyzed.

Table 1. Characterization of the studies included in the integrative review on racism, obstetric violence, and maternal mortality among Black women in Brazil.

No.	Authors	Article title	Journal	Year
1	Miranda VTS et al.	Obstetric violence, racism, and their consequences in the lives of Black women	*Research, Society and Development*	2025
2	Cohn A; Trindade L	The applicability of equity in the Brazilian Unified Health System (SUS) in maternal deaths among Black women	*UNISANTA Law & Social Science*	2024
3	Aires DS et al.	Bodies and the boundaries of the skin (maternal mortality and race)	*Caderno Eletrônico de Ciências Sociais*	2024
4	Saraiva VCS; Campos DS	The cheapest meat on the market is Black meat: notes on racism and obstetric violence	*Ciência & Saúde Coletiva*	2023
5	Ferreira VO et al.	Institutional racism and comprehensiveness of care in pregnancy and childbirth	*Saberes Plurais: Educ. Saúde*	2022
6	Coelho FF et al.	Preventable maternal death: contributing factors and the race/color perspective	*Revista da Escola de Enfermagem da USP*	2022
7	Ramires AC et al.	Practices of racism in obstetric care: a phenomenological case study	*Saúde Coletiva*	2021

No.	Authors	Article title	Journal	Year
8	Silva BMC; Paula SHB	Maternal mortality among Black women in a municipality of the São Paulo Metropolitan Region	*Sexualidade, Gênero e Saúde Sexual e Reprodutiva*	2021
9	Assis GM et al.	Racial inequalities and maternal mortality: access and color	*Revista Brasileira de Saúde Materno Infantil*	2018
10	Kalckmann S et al.	Childbirth care for Black women in a hospital in Maranhão	*Saúde e Sociedade*	2016
11	Domingues RMSM et al.	Evaluation of childbirth care and racial inequity in Brazil	*Cadernos de Saúde Pública*	2013
12	Trevisan JA et al.	Socioeconomic and clinical profile of Black women prone to maternal death	*Revista Eletrônica Gestão & Saúde*	2013
13	Martins AL	Maternal mortality among Black women: analysis of committee reports	*Cadernos de Saúde Pública*	2006

Source: The authors.

After the analysis and synthesis of the included studies, four central themes were identified to organize the evidence found: (1) structural, institutional, and interpersonal racism as a determinant of the risk of maternal death; (2) quality of care and obstetric violence throughout prenatal care, childbirth, and the postpartum period; (3) access and the main barriers to care within the Health Care Network; and (4) surveillance and public policies, with emphasis on the production and use of information, accountability, and the promotion of equity. Each of these themes is presented and discussed in detail below.

- **Structural, Institutional, and Interpersonal Racism as a Determinant of Maternal Mortality**

Excess maternal mortality among Black women in Brazil is neither a statistical anomaly nor an inevitable side effect of poverty. Rather, it reflects a historically produced social arrangement that distributes risks and protections unequally, in which race/color structures opportunities for education, employment, housing, and mobility across territories, thereby shaping, from an early stage, the possibility of reaching health services, remaining in care, and making informed decisions about one's own body. From this perspective, pregnancy and childbirth do not begin at the maternity hospital door, but much earlier, in neighborhoods with fewer public resources, irregular transportation, and greater exposure to urban violence, all of which translate into everyday barriers to prenatal care and to the timely use of the health care network. By identifying this pattern as structural racism, the literature moves away from moralizing explanations that blame women for "poor adherence" and instead places the focus on social determinants and on the duty of the health system to design responses proportional to risk (Saraiva; Campos, 2023).

When this broader background reaches institutions, it appears in the form of institutional racism: rules, routines, and prioritization criteria that seem neutral but produce different outcomes according to race/color. Examples include the irregular completion of race/color fields in medical records, the absence of equity indicators in clinical protocols, mortality committees that fail to analyze data by race/color, and

referral pathways that do not take into account the peripheral location of many pregnant women. The effect is twofold: inequality is reproduced in practice and, because it is not measured, remains invisible to management, which continues to evaluate performance without recognizing for whom the system fails the most. By advocating for complete records, routine analysis, and public reporting by race/color, the literature argues that information is both a clinical and a political tool, as it guides priorities, directs resources, and allows accountability focused on processes rather than individual blame (Cohn, 2024).

In the clinical encounter, the interpersonal dimension completes the cycle by transforming stereotypes into care decisions. The belief that "Black women tolerate more pain" still influences the assessment and management of symptoms, resulting in delayed provision of analgesia, less credibility given to warning signs, and less attentive communication during critical decision-making moments. These attitudes are not isolated deviations, but rather mechanisms of a culture that normalizes suffering and weakens consent, especially during labor, when power asymmetries are intensified and response time is critical. Recognizing and addressing implicit biases through practical training, supportive supervision, and case review is not an "identity-based agenda," but a requirement for patient safety and quality of care (Ramires et al., 2021).

The articulation among structural, institutional, and interpersonal layers helps explain why universal interventions, although necessary, have limited impact if they remain "blind" to race/color. Humanization guidelines and expanded access policies tend to benefit those who are already in a better position within the system, unless they include explicit goals to reduce disparities, deadlines for clinical responses, and regulatory mechanisms that protect higher-risk territories. The studies show that delays in the recognition and treatment of hypertensive disorders and hemorrhages, combined with the need to seek care from multiple services and the underreporting of critical information, create a harmful cycle that could be interrupted through simple protocols and active management, provided that they are guided by disaggregated data (Miranda et al., 2025).

In this sense, the proposed response operates simultaneously on three fronts. At the structural level, social policies that improve income, sanitation, and mobility reduce obstetric risk even before the first prenatal examination; this is an intersectoral agenda that must be aligned with health surveillance and access regulation. At the institutional level, the literature calls for complete use of race/color data, clinical audits with a racial perspective, management contracts with equity goals, and simple public dashboards showing indicator trends. At the interpersonal level, clinical practices based on qualified listening, direct language, informed consent, the presence of a companion, and adequate pain management protect rights and save lives, even in resource-limited settings (Cohn, 2024; Saraiva; Campos, 2023; Ramires et al., 2021).

Finally, treating racism as a determinant does not mean reducing complex problems to a single factor, but rather recognizing that race/color structures the distribution of risks and opportunities and should therefore guide intervention priorities. Establishing maximum times for assessment and treatment in time-dependent conditions, ensuring

medical transport for high-risk pregnancies, monitoring care-seeking peregrination, and guaranteeing analgesia when indicated are already known measures that become more effective when accompanied by race/color analysis and regular feedback to health teams. Under such an arrangement, the system ceases merely to "put out fires" and begins to anticipate problems, thereby responding to the study objective by proposing concrete ways to reduce preventable deaths among Black women (Miranda et al., 2025).

- **Quality of Care and Obstetric Violence Throughout Prenatal Care, Childbirth, and the Postpartum Period**

Quality of care must be understood as a continuum that begins with reproductive planning, extends through prenatal care, and culminates in childbirth and the postpartum period. At each stage, seemingly small decisions accumulate effects, and the evidence shows that Black women more frequently experience informational gaps, delayed clinical responses, and reduced protagonism within the care setting.

During prenatal care, irregular scheduling, delayed performance of examinations, and insufficient guidance about warning signs create a favorable environment for complications that could otherwise be prevented or mitigated. When a pregnant woman reaches childbirth without understanding what signs to observe, without a clear point of reference for complications, and without a mobilized support network, the maternity service begins to operate under pressure and with less room for shared decision-making (Domingues et al., 2013).

During labor, pain assessment and management function as a "thermometer" of care quality, because they require technical competence, communication, and respect. Studies report unequal provision of analgesia and lower use of non-pharmacological pain relief methods among Black women in labor, as well as greater exposure to interventions lacking strong clinical indication, such as routine episiotomy, almost always accompanied by brief explanations and little room for informed refusal. The language used by professionals, the companion's access to the care setting, and the clarity with which risks and benefits are communicated shape both consent and the woman's protagonism. Thus, disrespectful practices and imposed decisions, even when well-intentioned, constitute obstetric violence and increase the risk of adverse outcomes (Kalckmann et al., 2016).

It is important to emphasize that obstetric violence is not limited to extreme events; it manifests in the accumulation of small acts of disrespect, silencing, and impediment that signal to the woman in labor that her pain does not matter and that her opinion carries little weight. Treating this issue as a component of quality shifts the discussion from the moral to the technical domain: clinical communication, the presence of a companion, timely analgesia, clear documentation of consent, and judicious indication of interventions are all safety practices and should be monitored as such, through simple indicators and explicit targets (Kalckmann et al., 2016; Domingues et al., 2013).

From an organizational standpoint, overburdened teams and high staff turnover encourage the use of "shortcuts" that eliminate essential steps, such as detailed

explanations, confirmation of understanding, and review of care options. Without continuing education focused on communication, pain management, and implicit biases, and without indicators disaggregated by race/color, management fails to identify for whom and where routines are breaking down, and corrective measures remain dependent on isolated initiatives and on the greater awareness of some professionals (Ferreira; Andrade; Oliveira, 2022).

The proposed improvements do not require major investments: safety checklists with mandatory items such as pain being assessed and managed, the presence of a companion, documented consent, and tested warning criteria; rapid response protocols with target times for hypertensive disorders and hemorrhage; and monthly feedback based on a small number of indicators sensitive to change can already reduce variability and increase predictability in care. When services monitor these items by race/color, they can identify more quickly where Black women's experiences remain worse and may add targeted measures such as listening shifts, staffing adjustments, and reinforcement of pain relief methods (Domingues et al., 2013).

Finally, improving care also requires strengthening the immediate and late postpartum period, a time when many complications emerge. Active follow-up during the first weeks, with clear guidance on warning signs, facilitated access for reassessment, and breastfeeding support, reduces readmissions and completes the safety cycle. In summary, treating quality of care and obstetric violence as two sides of the same coin helps transform humanization guidelines into observable practices, restores women's protagonism, and reduces the space for imposed conduct, with even greater benefits for those who suffer most from inequality (Assis et al., 2018).

- **Access and Barriers to Care Within the Health Care Network**

Universal access, as provided for in the Brazilian Constitution and in SUS legislation, must be examined through the perspective of those who move through the health care network. For many Black women, this journey begins with attempts to schedule appointments at distant facilities, at times incompatible with work responsibilities, and under conditions of intermittent public transportation, followed by travel for examinations that are not always available within their territory and, even when they are, involve queues that push the window of opportunity beyond what is clinically recommended. Each delay increases the likelihood that subtle warning signs, such as blood pressure and glycemic changes, will be missed, even though they require timely adjustments in care and prompt referral to high-risk services (Trevisan et al., 2013).

Barriers are not only logistical; they are also symbolic. Memories of disrespectful care, expectations of discrimination, and unwelcoming technical language reduce spontaneous demand for care and transform absences into labels of "poor adherence." When the network interprets this phenomenon as individual choice, it shifts responsibility away from institutional processes and reproduces inequality. When,

however, it recognizes that bonding and reception are part of access, it reorganizes schedules, expands service hours, creates rapid communication channels, and reconnects pregnant women who have missed stages of care (Trevisan et al., 2013; Assis et al., 2018).

The transition between points of care is a decisive test: referrals are often delayed, medical transportation is not always available at the required time, and the reference maternity hospital may be located in another municipality, thereby creating an administrative barrier on top of the geographic barrier. The practical consequence is peregrination among services until care is finally obtained, a situation associated with worse outcomes and greater stress for the woman and her family. The alternative lies in active regulation with preferential pathways for high-risk pregnancies, intermunicipal agreements, monitoring of door-to-conduct time, and the definition of escalation routes when the local network becomes saturated (Martins, 2006; Trevisan et al., 2013).

In primary care, longitudinality and coordination of care are essential to anticipating problems. Teams that monitor warning signs, follow pending examinations, and maintain active contact are able to reduce acute events and organize arrival at the appropriate maternity service at the right time. Such coordination requires timely information and a design that respects people's actual territories rather than merely administrative boundaries; for this reason, system integration and reduced duplication of records help make access more than a formal principle (Assis et al., 2018).

When access is measured through simple indicators such as time to the first appointment, time to key examinations, peregrination, and door-to-conduct time, and these data are analyzed by race/color, management can identify bottlenecks that would otherwise remain invisible in general reports. Monthly feedback with feasible targets, concrete support, such as reinforcing transportation at critical hours, and fine-tuning of schedules transforms data into action and directly responds to the study objective of proposing feasible pathways to reduce inequalities in access (Assis et al., 2018).

- **Surveillance and Public Policies: Information, Accountability, and Equity**

Health surveillance is not merely an archive of numbers; it is a transformative practice that begins with qualified data collection, continues with critical analysis, and culminates in changes to both clinical and managerial routines. Within this cycle, the race/color variable cannot be treated as a decorative item: its completeness and routine use are conditions for making inequality visible, defining priorities, and establishing accountability among teams and managers. When recordkeeping fails, visibility is lost regarding for whom the network works and for whom it fails, and the public response tends to remain universalist, yet insufficient to reduce persistent disparities. By contrast, when data are reliable and returned in a simple form through a small number of indicators sensitive to change, teams begin to understand where to concentrate efforts and how to assess whether an intervention has made a difference (Cohn, 2024; Assis et al., 2018).

The investigation of deaths and near-miss events must move beyond the model of long, delayed reports that never return to practice. What changes routines are concise documents produced close to the time of the event, with objective recommendations, clear deadlines, and defined responsibilities, accompanied by brief feedback meetings at the unit level. This logic shifts the focus from who committed the error to what failed in the process, thereby creating safety for reporting failures and producing institutional learning, rather than reinforcing a punitive culture that pushes problems underground (Martins, 2006; Assis et al., 2018).

Effective public policy combines transparency, targets, and support for health teams. Quarterly dashboards with historical series by race/color, completeness of records, door-to-conduct times for hypertension and hemorrhage, the presence of a companion, peregrination, and active postpartum follow-up provide a useful picture for decision-making. Based on this picture, management contracts and regional agreements may link part of financing to equity outcomes, while preserving local autonomy and inducing priority for those who need it most, without turning the indicator into an end in itself (Assis et al., 2018).

The educational component closes the cycle: short, recurrent training sessions based on real cases audited locally, including simulations of communication, use of pain scales, and management of referrals, are more effective than long and sporadic courses. By explicitly addressing implicit bias and language, training ceases to be generic and begins to correct precisely where data indicate higher risk, thereby bringing surveillance, management, and clinical care together into the same agenda of continuous improvement (Ferreira; Andrade; Oliveira, 2022; Ramires et al., 2021).

The intersectoral dimension is also relevant: regulated medical transport, intermunicipal agreements for high-risk pregnancies, simplification of forms, and minimal integration among systems, even through standardized spreadsheets, are contextual conditions that allow information to be translated into actual resource allocation and timely clinical response. Without these mechanisms, surveillance may identify the problem, but services remain unable to act with the speed required by time-dependent events (Trevisan et al., 2013; Martins, 2006).

Ultimately, the proposal is both simple and demanding: measure well, provide rapid feedback, establish clear targets, support those responsible for implementation, and sustain the cycle. Under such an arrangement, policy ceases to be a mere list of intentions and becomes a set of observable routines, monitored by race/color and corrected iteratively until the difference in risk between groups decreases consistently, thereby responding to the study objective and lending concrete support to the constitutional promise of equity in obstetric care (Assis et al., 2018; Cohn, 2024).

4 FINAL CONSIDERATIONS

This study aimed to understand how racism, in its structural, institutional, and interpersonal dimensions, shapes the risk of maternal death among Black women in

Brazil. The integrated reading of the results and discussion showed that these inequalities are not residual. They are produced in everyday life, in under-resourced territories, in the way the health care network is organized, and, ultimately, in the interactions between health professionals and service users. When unfavorable income, housing, transportation, and educational conditions are combined with services that neither record race/color nor analyze their own data through this lens, care becomes more delayed, more fragile, and less respectful precisely for those who are most in need of protection.

Across the continuum from prenatal care to the postpartum period, a coherent pattern was identified: Black women face greater obstacles in reaching and remaining in care, receive less useful information for decision-making, and encounter greater resistance in the recognition and management of pain. Added to this are delays in the identification and treatment of time-dependent complications, peregrination among services until adequate care is obtained, and greater exposure to interventions without robust indication. These findings help explain the persistence of preventable outcomes and indicate that improving communication, analgesia, informed consent, and response times is just as strategic as expanding the supply of services and available appointments. In other words, equity is not achieved simply by increasing the number of services, but by ensuring that services function differently in order to correct inequalities that already exist at the point of entry.

Access, understood as a trajectory rather than an isolated act, proved to be decisive. Where active regulation, timely medical transport, and coordination among primary care, maternity services, and diagnostic support are lacking, delays multiply, increasing clinical risk and placing pressure on both professionals and families. Symbolic barriers also play an important role: previous experiences of disrespect and fear of discrimination discourage service users from seeking care and later reappear in medical records as “poor adherence.” Recognizing bonding and welcoming practices as components of access makes it possible to reorganize schedules, create preferential pathways for high-risk pregnancies, and reconnect pregnant women who have missed stages of care, thereby reducing loss to follow-up and the late use of emergency services.

Surveillance and public policy emerge as the link that transforms information into decisions. Without reliable recording of the race/color variable and without routine analysis using this lens, management remains blind to those who are most adversely affected. Investigations of deaths and near-miss events need to be rapid, useful, and returned to teams with objective recommendations, clear deadlines, and defined responsibilities. Simple dashboards, regularly publicized, favor social accountability and help maintain focus on the points that truly change outcomes, such as door-to-conduct times for hypertension and hemorrhage, the presence of a companion, and documented pain assessment. When equity targets are incorporated into management contracts and followed through with technical support and continuing education based on real cases, services learn and adjust routines more quickly and with less individual blame.

As a practical implication, the findings indicate that reducing maternal mortality among

Black women does not depend on novel solutions, but rather on consistently applying what is already known to work. The central triad is clear: measure well, provide rapid feedback, and agree on concrete changes that protect rights and ensure timely clinical response. This includes completing and using the race/color variable, organizing preferential pathways and transportation for high-risk pregnancies, adopting protocols with target times for time-dependent complications, strengthening communication and consent through clear language, ensuring analgesia when indicated, and sustaining short feedback cycles based on a small number of indicators sensitive to change. When this arrangement becomes routine, the difference in risk according to race/color is reduced, and the principle of equity ceases to be merely a normative statement and begins to materialize in everyday care.

Some limitations should be acknowledged. Part of the Brazilian scientific literature is concentrated in specific contexts and may not capture all regional variations across the country. In addition, underreporting of the race/color variable may reduce the accuracy of some indicators. Even so, the convergence of findings across different methods and sources lends robustness to the conclusions. In summary, treating racism as a determinant and organizing responses proportional to this risk is both a technical and an ethical requirement. By combining qualified surveillance, management guided by equity targets, and clinical practices grounded in respect, communication, and timely response, the Unified Health System (SUS) moves closer to its constitutional commitment to protect the lives of all women, with explicit priority given to those who have historically borne the greatest burden of maternal mortality in Brazil.

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