



Maternal Health of Women and Girls of African Descent in the Americas

Analysis
July 2023



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Key Messages

Findings:

One:

Afrodescendent women and girls in the Americas are disadvantaged before, during and after pregnancy.

Two:

Afrodescendent maternal deaths in particular are **alarmingly high** in both absolute terms and when compared to those of non-Afrodescendent and non-Indigenous women in the region.

Three:

Structural racism^a and sexism are evident in maternal health disparities that exist **across income levels and** national and regional **borders.**

Causes:

One:

There is a **dearth of quality health data disaggregated by race and gender** collected and analysed. As a result, any poor maternal and sexual and reproductive health outcomes for women and girls of African descent **remain invisible** in many countries of the Americas.

Two:

National and local **policies, plans and programmes overlook** the particular **health-related vulnerabilities faced by people of African descent.**

Three:

The intersection of **structural racism and sexism** in health service delivery and medical education **hampers access to and provision of** quality comprehensive **maternal and sexual and reproductive health care** for women and girls of African descent in the Americas.

Recommendation:

Overall:

National governments, international organizations and health care providers in the region **can meet** the maternal and sexual and reproductive health needs of Afrodescendent women and girls by addressing the **root causes of structural racism, sexism and discrimination.**

Introduction

Leave no one behind is the central, transformative promise of the 2030 Agenda for Sustainable Development and its Sustainable Development Goals. It represents the unequivocal commitment of all United Nations Member States to eradicate poverty in all its forms, end discrimination and exclusion, and reduce the inequalities and vulnerabilities that leave people behind. Despite this commitment, discrimination, racism, sexism and intolerance continue to exist in all societies. They manifest in disparities across health and development outcomes. In the case of maternal health in the Americas, the situation has worsened since 2016. In Latin America and the Caribbean, the maternal mortality ratio (MMR)^b increased by 15 per cent between 2016 and 2020; in North America, the MMR increased by 17 per cent in the same period. The determining factors identified for this rise include increasing inequalities and social exclusion. Afrodescendent women and girls have been particularly hard hit.

This analysis aims to bring visibility to the disparities in maternal health outcomes faced by Afrodescendent women and girls. As we approach the end of the International Decade for People of African Descent (2015–2024), there is an urgency to act to address the adverse maternal health outcomes for Afrodescendent women and girls.

Afrodescendants in the Americas

In 2015, there were approximately 209 million Afrodescendants in the Americas,^{20, 67} meaning that about one in four Latin Americans and Caribbeans and one in seven Americans and Canadians identified as Afrodescendant or Black. The term Afrodescendant refers to the "descendants of the African victims of the Trans-Atlantic and Mediterranean Sea slave trade. The group includes those of the Sub-Saharan slave trade", as defined by the United Nations Working Group on People of African Descent. In this analysis, we use the term Afrodescendant to refer to Black and mixed race (Black and another race) populations identified as being of African descent. The term Afrodescendent is used as the adjectival form of Afrodescendant.

Objective

Legacies of European colonialism and the Transatlantic slave trade, including institutionalized racialized hierarchies, combined with beliefs about and practices based on the perceived inferiority of women creates a double bind for women and girls of African descent. This document analyses available national health data to explore whether and how the intersection of racism and sexism (gendered racism) impacts maternal and sexual and reproductive health and rights (SRHR) access and outcomes for Afrodescendent women and girls in the Americas.

Summary

This analysis reports on maternal and SRHR for Afrodescendent women and girls in nine countries^c in the Americas region across five indicators^d. The indicators include maternal mortality and several other measures of maternal and SRHR for which negative outcomes can include maternal death.

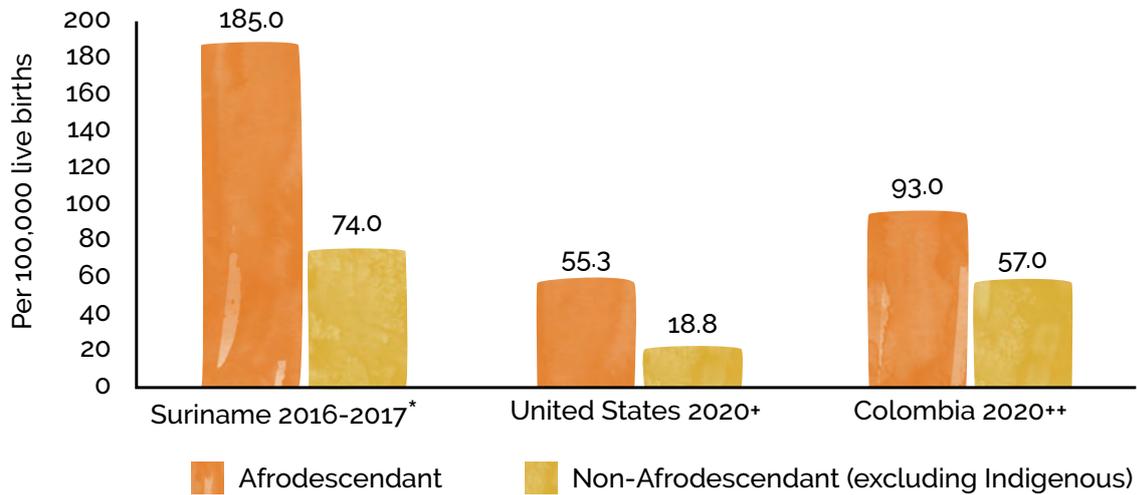
We compare maternal and SRHR outcomes for Afrodescendent women and girls to those of non-Afrodescendent women and girls, excluding Indigenous women and girls.

We find that women and girls of African descent experience deep disparities in maternal and SRHR outcomes in almost all of the countries studied^e. The available data suggest that, for Afrodescendent women and girls, systemic racism and gender discrimination are foundational organizing principles on which structural barriers to achieving the highest attainable standard of maternal and SRHR are constructed.

We recommend increased and better quality data disaggregation and analysis by race and gender; the full adoption of equity- and people-centred primary health care-focused health policies, plans and programmes in partnership with civil society and Black women community leaders, including midwives, and traditional healers across the Americas; an intersectional approach to maternal health that addresses racism and sexism, including their intersection with other factors such as disability, location and socioeconomic status; eliminating racist assumptions in medical education curricula; and increasing the presence of medical personnel of African descent to address structural racism and discrimination in maternal and SRHR care for Afrodescendent women and girls.

Pregnancy-related Deaths

Figure 1: Maternal mortality ratio among women aged 15–49 years, by race/ethnicity



*Statistically significant at the 5% level
 +In the United States, the sample consists of girls and women aged 15-44
 **Preliminary data

Source: For Suriname (Verschueren et. al, 2020), United States (National Vital Statistics System, 2020), Colombia (DANE, 2021)

Figure 1 reports pregnancy-related deaths for women and girls in three of the countries (Suriname, United States and Colombia), as these (with Brazil) are the only countries in the study that publish race-disaggregated data on the MMR. The MMR for Afrodescendant women and girls far outstrips that of non-Afrodescendant women and girls in all three countries, particularly in the United States, where the MMR for Afrodescendant women and girls is nearly three times higher than that of non-Afrodescendant women and girls. In Suriname and Colombia, the MMR for Afrodescendant women and girls is 2.5 times higher and 1.6 times higher than that of non-Afrodescendant women and girls, respectively. All differences between Afrodescendant and non-Afrodescendant women and girls are statistically significant.

The literature on pregnancy-related deaths demonstrates that across the Americas, cardiovascular conditions (eclampsia, pre-eclampsia and cardiomyopathy) are the leading preventable causes of maternal death for women and girls, but that women and girls of African descent experience these outcomes at rates of up to five times those of white women and girls. Explanations based on social determinants fail to account for these differences because they persist despite socioeconomic status and education. For example, in the United States, the pregnancy-related mortality rate for Afrodescendant women who completed college education or higher is 5.2 times higher than that for white women with the same educational attainment.

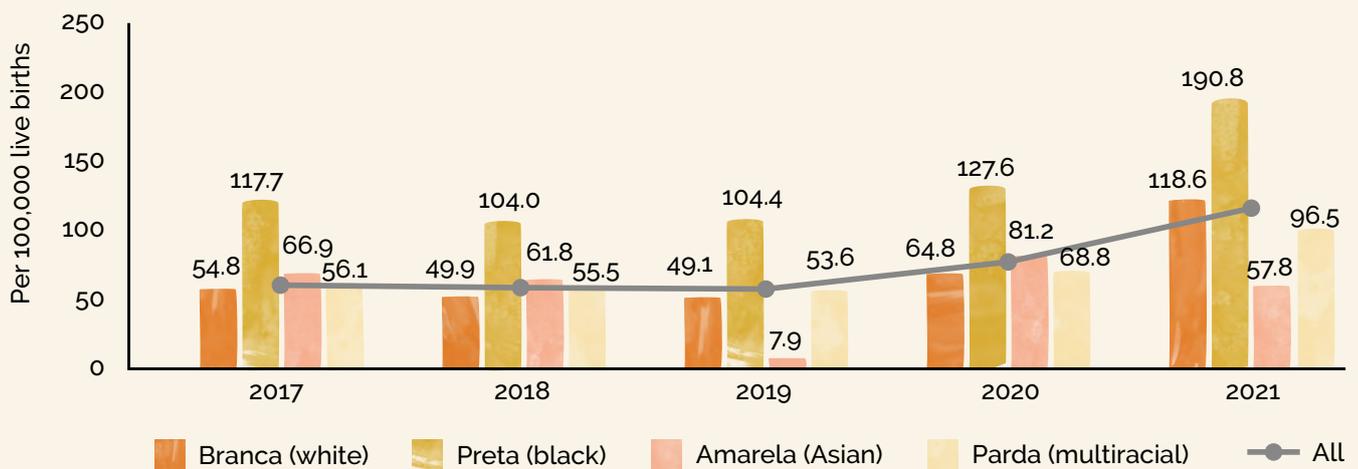


Maternal deaths in the United States: **Non-Hispanic African American women and girls are three times more likely to die** while pregnant or within 42 days of giving birth than non-Hispanic white women in the United States.²⁰ Maternal **deaths persist regardless of income and education levels**, with maternal deaths among African American college graduates still 1.6 times higher than among white women with less than a high school diploma.⁵⁴

Studies also highlight that racism and discrimination by medical providers increase the likelihood that women and girls of African descent will experience mistreatment in maternity care. Obstetric mistreatment^f has been found to increase MMR and create barriers to health care usage for both Afrodescendent and Indigenous women and girls. In one United States study, white women reported almost 15 percentage points lower experience of mistreatment than all other women.

At the same time, it must also be noted that in absolute terms, Afrodescendent women and girls in the United States fare better than non-Afrodescendent women and girls in Colombia and Suriname. The absolute differences among these three countries reveal possible significant regional inequities in the allocation and availability of maternal and SRHR services, including access to safe abortion.

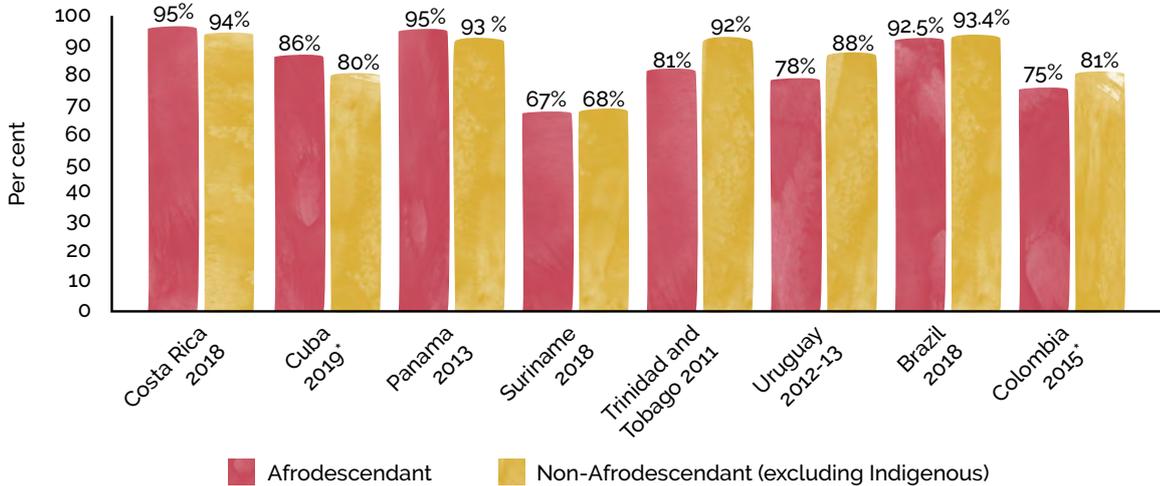
Figure 2: Maternal mortality ratio disaggregated by race/ethnicity in Brazil (2017-2021)^g



Source: the data for births was taken from Departamento de Análise Epidemiológica e Vigilância de Doenças Não Transmissíveis, Secretaria de Vigilância em Saúde (2022a) and the data for maternal deaths from Departamento de Análise Epidemiológica e Vigilância de Doenças Não Transmissíveis, Secretaria de Vigilância em Saúde (2022b).

Antenatal Care

Figure 3: Percentage of women aged 15–49 years attending four or more antenatal care visits, by race/ethnicity^h



*Statistically significant at the 5% level
 Note: The United States was not included because data was not comparable. The United States reports an adequacy of prenatal care index

Source: Costa Rica (MICS, 2019), Cuba (MICS, 2019), Panama (MICS, 2013), Suriname (MICS, 2018), Trinidad and Tobago (MICS, 2011), Uruguay (MICS, 2013), Brazil (PNS, 2018), Colombia (DHS, 2015)

Antenatal care (ANC) visits support the early detection of pregnancy-related complications that can impact maternal mortality and morbidity. The visits also permit health providers to administer additional support for individuals at high risk for birth complications. The World Health Organization (WHO) recommends a minimum of eight routine ANC visits, but few countries in the Americas report women having more than four visits.

In Brazil, Colombia, Trinidad and Tobago and Uruguay, Afrodescendant women and girls report lower likelihoods

of attending at least four ANC visits. While numerical differences are observed, only the results for Colombia are statistically significant.

Afrodescendant women and girls often face structural barriers related to geographic location; access to transportation; access to medical insurance; and a dearth of culturally appropriate and acceptable health services. Disproportionate experiences of physical and/or sexual intimate partner violence can also reduce the likelihood of receiving sufficient ANC.

“ You notice that when a lighter-skinned person enters the room, the health professionals take more time with them. But when a Black person enters, they [look to] leave quickly. When inside, the health professionals don’t fully examine the [Black] person [the way they did the lighter-skinned person], you understand? That is why there’s this difference. ”

–Black woman (preta), Brazil¹⁶.

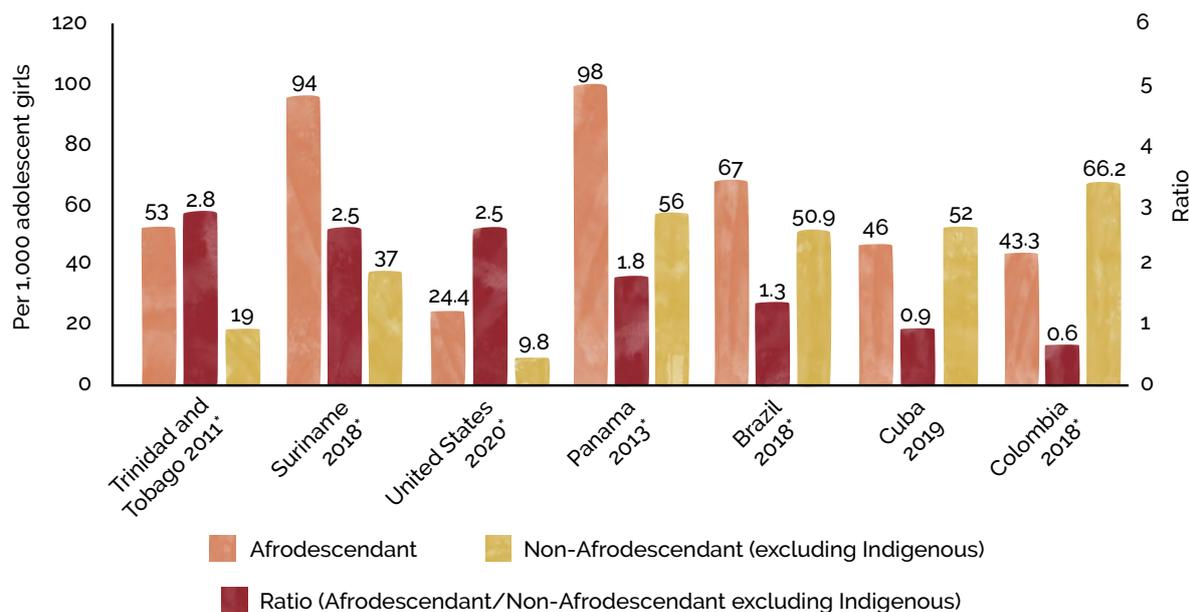
Afrodescendent women and girls in Costa Rica, Cuba, Panama and Suriname are slightly more likely than non-Afrodescendent women and girls to attend four ANC visits or more. In Cuba, the positive differences between Afrodescendent women and non-Afrodescendent women and girls are statistically significant. These split results may reflect some regional differences. For example, in several Central American countries, including Panama, women of African descent have the highest attendance rate at university-level institutions, despite concurrent high unemployment and overrepresentation among manual labourers. Education is one of the factors linked to high ANC attendance.

In addition, many, primarily rural, Afrodescendent communities in the region traditionally receive care from midwives. Cuba also has a tradition of maternity homes that operate mainly in rural areas. Midwives and maternity homes serve both to maintain community traditions and as an alternative to the mistreatment women and girls of African descent experience in hospitals and clinics. Many, though not all, countries in the region include midwifery care as part of their ANC reporting.

Finally, it should be noted that these data do not reflect the quality of ANC visits. This parallel challenge may have a bearing on why few pregnant women seek the recommended eight visits where available.

Births to Adolescents

Figure 4: Adolescent birth rate (15–19 years), by race/ethnicityⁱ



*Statistically significant at the 5% level

Source: Costa Rica (MICS, 2019), Panama (MICS, 2019), Suriname (MICS, 2018), Trinidad and Tobago (MICS, 2011), Brazil (National Census, 2010), United States (National Vital Statistics System, 2020), Colombia (National Census, 2018).

Pregnancy and childbirth are the main causes of mortality for girls and young women aged 15–19. Childbearing adolescents are also at high risk for birth complications, and their infants have a higher likelihood of low birthweight, preterm birth and other conditions. Adolescents who give birth are also more likely to experience poor physical and mental health outcomes in the future, experience intimate partner violence and be unemployed.

Despite progress made over the last two decades in reducing adolescent pregnancy among girls and young women aged 15–19 in Latin America and the Caribbean, the region still has the second highest adolescent pregnancy rate in the world (60.7 births per 1,000 for girls and young women aged 15–19 between 2015 and 2020). The Americas have also seen the slowest decline in adolescent fertility among world regions. Afrodescendent girls experience the highest

pregnancy rates in the region, alongside adolescent girls with lower educational attainment, those from the lowest wealth quintiles and Indigenous girls. Figure 4 shows that racial/ethnic inequalities are most profound in Panama, Suriname and Trinidad and Tobago, while in Cuba and Colombia, Afrodescendent girls experience less adolescent pregnancy than their peers. The differences reported are significant for all countries save Cuba.

The factors influencing adolescent pregnancy and parenthood include high unemployment and low educational attainment among adolescents across the Americas. Racial

and gender discrimination in employment and geographic isolation make this problem more acute for youth of African descent. Several studies have shown that job training and tangible support for continued schooling have reduced adolescent pregnancy rates in several Latin American countries, particularly for girls and young women who are not yet mothers. Media, such as TV shows that explore the reality of early pregnancy, has also been found to reduce pregnancy among adolescents in the United States across races and ethnicities.



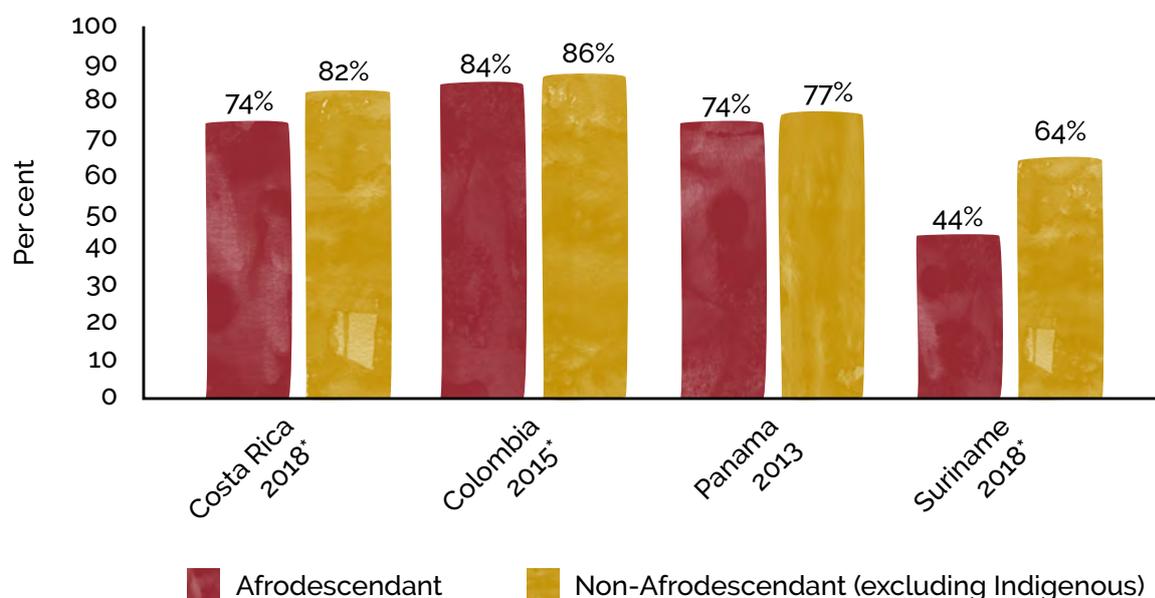
In Panama, the United Nations Working Group of Experts on People of African Descent expressed concern that **many girls dropped out of school as a result of early pregnancy**. This problem affected Indigenous and Afro-Panamanian girls in particular. Although a **legal provision** in Panama **stipulates that girls should remain in education** during and after pregnancy, the Working Group pointed out that there was **no effective mechanism in place to ensure compliance with the Act**.⁶⁵



Source: ©UNFPA/Tuane Fernandes

Family Planning

Figure 5: Contraceptive needs met by modern methods for girls and women aged 15–49 years who are married/in a union, by race/ethnicity



*Statistically significant at the 5% level

Source: Costa Rica (MICS, 2018), Colombia (DHS, 2015), Panama (MICS, 2013), Suriname (MICS, 2018).

Measures of unmet family planning^j needs reflect how and whether health systems are delivering on human rights and supporting the ability of women to realize their preference to delay or limit births. Women who report an unmet need for family planning face the possibility of unwanted or mistimed births that can lead to unsafe abortions that contribute to maternal mortality and morbidity.

Figure 5 shows that Afrodescendant women and girls who are married or in a union are less likely to report that their family planning needs have been met. Generally speaking, women with lower incomes and lower levels of formal education lack access to family planning services. Afrodescendant women – who are overrepresented among the poor – appear to conform to this generality, demonstrating lower met needs

in every country studied. Only the results from Panama were not statistically significant. The high cost of health care in the region may also impact access to modern contraception.

Given that marriage rates are generally low in some countries of the Americas and single heads of household are common, reporting only on women who are married or in a union overlooks many women. Where the information is available (for example, Suriname and Trinidad and Tobago), there is a parallel report of high unmet needs among unmarried women.

Skilled Birth Attendance

The vast majority of births in the Americas are attended by skilled health professionals^k, an indicator of the availability of health services for women and a significant achievement for the region. Afrodescendent women and girls do not appear to be uniquely disadvantaged on this indicator. However, further consideration of the quality of care provided by birth attendants should be considered as a factor in maternal and SRHR outcomes for women and girls of African descent, as they are more likely to experience obstetric mistreatment and lack proper postnatal care resources, an occurrence correlated with increased maternal mortality and morbidity.



The degree of **dissatisfaction with the quality of health services in Brazil is 5.3 per cent higher among Afrodescendent women than among white women.**⁴⁷

Systemic Racism and Sexism as Structural Determinants of Maternal Mortality, Maternal Health and Sexual and Reproductive Health

As demonstrated in data from nine countries in the Americas, Afrodescendent women and girls experience worse outcomes than non-Afrodescendent women and girls for three of the five maternal mortality and maternal and SRHR indicators: MMR, adolescent birth rate and family planning. Results for ANC were mixed, with Afrodescendent women and girls experiencing much worse outcomes than non-Afrodescendent women and girls in half of the countries studied and slightly better outcomes than non-Afrodescendent women and girls in the other half. The results for C-sections and skilled birth attendants for all women and girls were similarly above and below WHO standards, respectively.

Why are Afrodescendent Women and Girls Disadvantaged?

The literature on Afrodescendent women's health in the Americas makes numerous references to the social

determinants of health (SDH) model^l as the primary cause of health inequities. However, the SDH model cannot explain most of the maternal mortality and maternal and SRHR inequalities reported in this analysis because they occur across educational attainment, income and geography.

Studies that attribute health inequalities solely to SDH also often leave the response to the question of why Afrodescendent women are, for example, overrepresented among the poor and thus experience worse health up to the untrained reader. Common regressive explanations put forward by both professional and lay readers include a lack of intelligence (as this relates to the ability to engage in health-seeking behaviours or to be medication compliant); flawed cultural practices (for example, the stereotyping of Black or African traditional health practices and cultures as "backwards"); or even biological deficiencies (viewing Black women's bodies as extraordinary, diseased or disruptive). This analysis counters the circulation of uninformed, racist and racialist opinions with the presentation of empirical data on the probable causes of these health inequalities.



Deep linkages exist between the advances in the field of gynaecology and racism, as surgical techniques for performing caesarean sections and repairing obstetric fistula were invented through experimentation on enslaved African women who were thought not to "feel pain in the same way as whites." This racialized science continues in medical education, with medical students and physicians still reporting a belief that "Black people's nerve endings are less sensitive than white people's nerve endings."⁵



Medical education's bias also means that **textbooks only describe childbirth as modelled on** a specific pelvic morphology that is common to **European women** yet highly variable among non-white ethnicities, making other pelvic presentations abnormal or high risk. **As a result**, evidence shows that **self-reported pain among new Afrodescendent mothers is minimized or overlooked** by health practitioners and Afrodescendent women experience higher maternal mortality.^{40, 65}

The tenacity of the disadvantages faced by Afrodescendent women and girls is due in large part to the unique consequences of gendered racist beliefs held by decision makers about women and girls of African descent. These beliefs stigmatize based both on race and gender, linking both to a proscribed set of undesirable characteristics. For example, Afrodescendent women and girls are stereotyped as hypersexual. As a result, Black girls' age and physical and sexual maturity are overestimated (adultification), leading adults to punish them more harshly (school suspension, arrests and incarceration³⁹) and provide them with less empathy, nurturing and protection from sexual victimization than white girls.

Although there is some debate about whether racism, sexism and other exclusionary ideologies are social or structural determinants of health (or both simultaneously), here, gendered racism is considered structural and systemic, underpinning the national policies, institutional practices and beliefs of decision makers that define Afrodescendent women's and girls' well-being. The structural determinants of health inequities (StDH) model^m better explains how gendered racism impacts maternal mortality and maternal and SRHR for Afrodescendent women and girls.

The following recommendations focus particularly on those StDH related to public policies and culture and societal values to explain the inequalities seen across these maternal and SRHR indicators.

Data Collection

Since the 2001 United Nations World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance and the resulting Durban Declaration and Programme of Action, as well as the adoption of the Beijing Declaration and Platform for Action (1995), policies and legislation in several countries of the Americas have included provisions against discrimination and have mandated the inclusion of ethno-racial and gender variables in censuses and national surveys to track inequalities by race. Despite these advances, a persistent gap in the availability and quality of health sector data disaggregated by both race and gender remains a challenge in the region, to the extent that some countries with robust data collection analysis methods do not

report health data by race and gender.

Most countries of the Americas have approved the Pan American Health Organization's (PAHO) Plan of Action for Strengthening Information Systems for Health 2019–2023. The plan aims to support Member States in strengthening health information systems, ensuring they also include health care data on vulnerable populations.

The latter will require an increase in the quantity and quality of disaggregated data available for analysis. A 2022 report on regional progress on the Plan of Action found that 10 countries in the Americas report collecting data disaggregated by age, sex and ethnicity at the national and subnational level and five more countries expect to do so by 2023.

However, even as countries improve their collection of disaggregated data, additional efforts are needed to support countries to regularly and systematically analyse and report administrative data by race/ethnicity. Efforts to improve the quality of subnational and administrative data collection are important because there are systematic errors in racial assignment in mortality data that might underestimate maternal mortality for certain populations, for example. There are indications that in Brazil³⁰ and the United States², coroners often make racial misattribution errors because data often cannot be shared between data platforms (for example, when death certificate information cannot be cross-referenced with a driver's licence where the deceased self-identified her race, the coroner uses their judgment).



Ninety per cent of health plans prioritize the achievement of health equity, yet **only one third of the 32 health plans** surveyed for a 2019 Pan American Health Organization study **identified Afrodescendants as a population that experiences barriers to health.**⁴⁴

Why do Afrodescendent Women and Girls have Worse Maternal Health Outcomes?

I. Discriminatory attitudes and behaviours among health service providers⁴⁶

Obstetric mistreatment by health providers

⊕ Engage in verbal or physical abuse of pregnant person⁶⁰

↳ Increased maternal injury; Increased birth injuries; Reduced likelihood of seeking post-partum care; Reduced use of all health services, not just gynaecology

⊕ Disregard traditional beliefs⁶⁰

↳ Reduced cultural acceptability of health services; Reduced use of all health services, not just gynaecology

⊕ Turn pregnant Afrodescendent women away from the first hospital they visit²⁰

↳ Increased obstetric complications; Reduced use of all health services, not just gynaecology

⊕ Provide less appropriate and timely prenatal, labour and newborn care to Afrodescendent women and girls²⁰

↳ Increased maternal injury and death; Reduced use of health services; Increased birth complications

⊕ Deny labouring Afrodescendent women anaesthesia due to beliefs about Afrodescendants and their ability to feel pain²⁰

↳ Increased maternal injury; Increased birth injuries; Reduced likelihood of seeking post-partum care; Reduced use of all health services, not just gynaecology; Increased C-section rate

II. Racially Biased Medical Education

Erroneous curricular content

⊕ Inability of Afrodescendants to feel pain⁵⁹ Afrodescendants have thicker skin/less sensitive nerve endings than whites, hence less pain sensation

↳ Increased maternal injury; Increased birth injuries; Reduced likelihood of seeking post-partum care

⊕ Afrodescendants' blood coagulates more quickly than whites'

↳ Increased post-partum haemorrhage (slower intervention to stem haemorrhage); Increased maternal mortality

⊕ Afrodescendants have a higher propensity toward drug addiction than whites

↳ Service denial; No pain treatment

Curricular Omissions

⊕ Normal variations in the shape of the pelvic opening for birth and delivery adaptations⁵

↳ Treatment of Afrodescendent women and girls' bodies as problematic; Increased risk of obstetric intervention during birth; Poor maternal outcomes

III. Health Policy

⊕ Health policies in the region rarely name Afrodescendants among groups that experience barriers to health⁴⁴

↳ Reduced incentive to collect better data on Afrodescendants

⊕ Maternal health policies rarely include indicators of racial difference in outcomes

↳ Absence of interventions for Afrodescendent and Indigenous women and girls; Lack of initiatives to address adolescent pregnancy for Afrodescendent and Indigenous girls



Policy, Plans and Programmes

Health-related policies across the Americas also overlook the importance of race and gender as proxies for vulnerability that can be ameliorated through targeted policies, plans and programmes. Part of the neglect is due to a lack of disaggregated data on which to base policy prescriptions, but there also exists a reluctance to develop plans and programming to address the specific needs of Afrodescendants.

A 2019 PAHO study of national health plans found that 34 per cent of 32 countries had incorporated or referred to executing strategies to address discrimination in the health sector. Several of these countries' health plans also named specific populations that face obstacles to health equity. Only 30 per cent of these 32 countries identified Afrodescendent people among the vulnerable.

Although the health sector is most implicated in improving maternal mortality and maternal and SRHR for women and girls of African descent, health-related sectors, like education and labour, also have incidence, particularly as related to adolescent pregnancy. Currently, there is little data on the extent to which non-health sectors integrate health objectives into their policies. Given the findings of economic studies related to the impact of job skills programmes on reducing poverty and pregnancy in young people aged between 15 and 19 years, efforts should be made to improve communication between and among ministries of education, labour and health to address the maternal and SRHR of Afrodescendent girls and young women.

Universal health coverage and primary health careⁿ models of care have been shown to increase access to health care and improve health outcomes. Countries that begin to implement primary health care-focused reforms in line with the recommendations of the PAHO High-Level Commission: 40 years of Alma-Ata to implement health services that embody these priority characteristics will improve health care quality for all, including women and girls in situations of vulnerability.

Medical Education and Hospital Procedures

Any history of Western medicine would be incomplete without mentioning how girls and women of African descent were used non-consensually as bodies on which to develop and test obstetric interventions.⁵⁸ Many of the ideas about Black/women of African descent espoused in the past continue to be taught in medical education. And these ideas are reinforced through the actions of healthcare providers. Some studies demonstrate that 50–60 per cent of medical providers hold racist beliefs about Black people's biology.²³

Commonly held beliefs and corresponding actions among medical personnel include the belief that Black people are more likely to abuse and become addicted to drugs and have thicker skin (less sensitive nerve endings) than white people, resulting in Black people receiving less pain treatment than white people;²³ the belief that Black people's blood coagulates more quickly than others, delaying interventions for haemorrhage;⁵⁹ and the belief that Black women are excessively promiscuous and fertile,⁶¹ leading to disproportionate non-consensual sterilization of Afrodescendent women.¹

The results of these beliefs are seen even in health treatment and outcomes beyond maternal and SRHR. A study of cardiologists that used scripted video vignettes to control for patients' medical histories and personalities found that "the race and sex of the patient affected the physicians' decisions about whether to refer patients with chest pain for cardiac catheterization... [the negative] findings are most striking for Black women."⁶¹

Many studies have shown that race and gender concordance between patients and doctors can have a profound impact on improving patient satisfaction and health outcomes. In the United States, Afrodescendants represent 13.6 per cent of the population. In 2021, they made up 11.5 per cent of registered nurses and 11 per cent of first-year medical students (a jump of 21 per cent over 2019). Data on the race of health professionals in the rest of the Americas region is not as readily available, but there is some indication that in Brazil, for example, less than 20 per cent of physicians are Afrodescendants, despite them making up 56 per cent of the population.

Increasing the number of Afrodescendent medical school and allied health sciences graduates will undoubtedly support improvements in the well-being of Afrodescendants in the region.³⁵

A Call to Action

Health authorities should see maternal mortality among Afrodescendent women and girls in the Americas as a crisis in need of an immediate solution. We make the following recommendations to reduce maternal mortality and ensure the highest attainable standard of maternal health for girls and women of African descent in the Americas in the short and medium terms. Equity is at the heart of each of these recommendations, and, as such, they address some of the structural causes of the maternal and SRHR outcomes presented in this analysis.

Governments and International Organizations



1. Increase the availability and quality of disaggregated official statistical data on MSRH.

Any policy, plan or programme to improve the maternal mortality and maternal and SRHR outcomes for Afrodescendent women and girls must be based on the analysis of robust data disaggregated by race and gender. While important steps have been taken in the region to include ethnicity, race and skin colour as variables in household surveys and census data and to improve the quality of health information systems, there are still many countries lagging behind that either have yet to collect disaggregated health data or that collect the data but do not analyse the results by race and gender, particularly in the area of health.

In fact, of the 15 countries considered for this analysis, Canada, the Dominican Republic and Venezuela were rejected due to a lack of data disaggregated by race. Similarly, Jamaica was rejected because the ethnicity/race variable was collected but could not be found in the raw data. And Ecuador and Peru were eliminated from the analysis because the formulation of their maternal and SRHR indicators was incompatible (not comparable) with that of the majority of countries in the study.

Race and gender data disaggregation is also important to targeting policies in health-adjacent sectors like education and labour.



2. Employ a life-cycle approach to data collection, policymaking and programming.

When designing maternal and SRHR policies and programmes, age is an important variable for understanding risk and defining interventions. Adolescents are an important

public for which specific policy around job training and initiatives to reduce dropout and improve maternal mortality and maternal and SRHR outcomes is key. Policies meant to address maternal and SRHR should take into account the specific needs of adolescent girls and boys. Additionally, although maternal and SRHR for adolescents is a priority, inequalities in maternal mortality increase exponentially with age, particularly for women of African descent. Policies, plans and programmes seeking to improve maternal outcomes should also collect data and provide interventions for women of advanced maternal age.



3. Instigate the participation of Afrodescendent women and girls in maternal health policy design and accountability provisions.

Participation is a central tenet of health equity and the right to health. Any health policy aimed at improving maternal outcomes for Afrodescendent women and girls should emphasize their inclusion in its design, in decision-making processes and in holding the government accountable for results.



4. Strengthen the health system in the Americas as a whole by adopting a primary health care-focused universal health coverage model of care.

Good rights-based service delivery should be comprehensive, accessible, acceptable, efficient and person-centred while providing adequate coverage, continuity of care and quality care, encouraging coordination and having accountability mechanisms in place. Although many countries in Latin America and the Caribbean are progressing towards primary health care and universal health coverage, the United States still has to prioritize universal coverage.

In addition, supporting culturally appropriate maternal health care is important. According to the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, acceptable health requires an urgent focus on ensuring an end to the demonization and belittling of Indigenous and traditional health. Instead, it should promote an inclusive approach that is respectful and seeks to understand and support integration into primary health care, as well as recognition of their importance.⁶⁸



5. Ensure health and health-related policies, plans and programming address the StDH and not just the SDH.

Countries have an obligation to work with health institutions to define standards of care and medical education that support Sustainable Development Goal 3, ensuring healthy lives and promoting well-being for all at all ages. Policies that lump Afrodescendants and Indigenous peoples with other marginalized groups may fail to address the particular barriers faced by women of colour, many of which are perpetrated by the medical establishment itself and through racially biased medical education.⁴³

Health and health-related policies that directly benefit Afrodescendent women and girls should address the structural roots of inequities. A policy focus on the SDH might expand the reach of health education or authorize cash transfers to populations living in poverty while a policy focused on the StDH would be anti-racist in character. For example, an StDH-focused health plan might assign funds to “health-care institutions, physician practices and academic medical centres to recognize, address and mitigate the effects of racism on patients, providers, international medical graduates and populations.”⁸⁴ Both types of policies and plans

(SDH and StDH) are important to address poor maternal and SRHR outcomes for Afrodescendent women and girls.

To accomplish this, countries will have to improve communication among ministries of health, education and labour (to start) and facilitate the creation of co-financing mechanisms to support programming to study, reduce and eventually eliminate the negative impacts of gendered racism.



6. Invest in increasing the representation of Afrodescendants in the health workforce and Afrodescendent women among physicians.

Governments and the health sector should create educational pathways for people of African descent to receive higher education training in health research and health care through the provision of targeted scholarships, fellowships and low-interest loans. Health facilities can also open specific residency opportunities for medical school graduates from underrepresented groups. Past successes in training medical professionals under programmes supported by PAHO/WHO should be replicated with an eye towards racial and gender equity.



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Health Systems and Medical Education



7. Improve the collection of race/ethnicity and gender disaggregated data at the administrative level to complement official statistics.

Local administrative databases should, to the extent possible, be compatible with national data collection tools and be uniform in quality across health centres. Where administrative data include disaggregation by race/ethnicity and gender, they support the collection of more accurate data on health inequalities nationally. Preliminary studies of health equity in subnational policies suggest that local governments may be better than national at developing policies and plans and implementing programmes that collect and are designed as a result of analysis of disaggregated health data.⁴⁴ This is an area for future research attention.



8. Invest in interventions and establish policies to stem obstetric mistreatment, disrespect and abuse.

According to WHO, “disrespectful and abusive treatment during childbirth in facilities have included outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications and detention of women and their newborns in facilities

after childbirth due to an inability to pay.”⁸⁴ Interventions to address mistreatment must both define the behaviours and attitudes to be eliminated and establish institutional policies accompanied by enforceable sanctions.



9. Address racism and racist ideologies in health science training curricula, not only in the context of cultural competency coursework.

The curricular reform of medical education should address not only the erroneous beliefs and biases about marginalized groups that future health professionals bring to their training but also research and eliminate those biases created and reinforced by the training itself. Information on any differences in outcomes or incidence of disease by race must be tempered by explanations of the non-biological nature of race and the role of racism as a predictor of poor health outcomes. These additions will contribute to reducing the propensity towards naturalization and acceptance of race-based health inequalities in access and outcomes.



Endnotes

- a. Structural racism describes how our systems are structured to produce racial inequalities between white people and racial and ethnic minorities, leading to racial health disparities.
- b. The maternal mortality ratio is the number of maternal deaths per 100,000 live births.
- c. The countries are Brazil, Colombia, Costa Rica, Cuba, Panama, Suriname, Trinidad and Tobago, the United States and Uruguay. Countries were selected based on the proportion of Afrodescendent women in their population, the availability of relatively recent national survey data (2010 and forward), the availability of data disaggregated by ethnicity, race or skin colour and the comparability of indicators. Two sample t-tests were conducted to compare the outcomes between Afrodescendent and non-Afrodescendent women and girls for each indicator.
- d. Maternal mortality ratio; antenatal care coverage (percentage) at least four visits; adolescent birth rate (15–19 years), contraceptive needs met (15–49 years); births delivered by caesarean section (percentage); and births attended by skilled birth attendance (percentage).
- e. The findings reported here support the conclusions of several recently published reports on Afrodescendent health by PAHO, the Economic Commission for Latin America and the Caribbean and the Lancet Regional Health journal.
- f. Obstetric mistreatment is a pattern of behaviours displayed by medical staff towards pregnant and birthing mothers across seven dimensions: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and poor conditions and constraints presented by the health system.
- g. The Brazilian Institute of Geography and Statistics (IBGE) collects data on the colour or race of the Brazilian population based on self-identification from the following variables: white (branco), Black (preta), multiracial (pardo), Asian (amarelo), and Indigenous (indígena). The category negra (African descendant) in Brazil refers to the sum of the people who self-identify as *preta* or *parda*.
- h. Antenatal care visits: The percentage of women aged 15–49 years with a live birth in a given period that received antenatal care four or more times.
- i. The adolescent birth rate is defined as the number of births to women aged 15–19 years during the three years preceding the survey divided by girls and young women aged 15–19 years during the same period, expressed per 1,000 girls and young women.
- j. Family planning refers to the percentage of women who are married or in a union and aged 15–49 years with met needs of family planning.
- k. Skilled birth attendants include physicians, nursing staff and midwifery personnel.
- l. The SDH are defined as the conditions in which people are born, grow, live, work and age. Examples include income and social protection, education and unemployment and job insecurity.
- m. The StDH include the social and political structures and policies in a country.
- n. Primary health care orients its structures and functions towards the values of equity and social solidarity and the right of every human being to enjoy the highest attainable standard of health without distinction of race, religion, political belief or economic or social condition.
- o. This analysis has four limitations:
 - i. The analysis includes data from only nine of the 35 countries of the Americas. These nine represent the countries that had available race/ethnic and gender disaggregated data available for maternal and SRHR indicators. The small sampling of countries highlights the need for more publicly available disaggregated data across the region to improve the accuracy of conclusions about the health of populations in situations of vulnerability.
 - ii. Most of the data reported here were taken from multiple indicator cluster surveys and recent demographic health surveys, but we also included data from several other national surveys. The juxtaposition of data from multiple sources may complicate comparability across countries.
 - iii. Self-reported race or ethnicity and self-reported skin colour were used to categorize the Afrodescendent population. In countries where the surveys only included the ethnicity of the head of household, the same category was assigned to all the women and children in the household. This proxy may not be an accurate measure of the target population. Similarly, we found some differences in outcomes between Afrodescendent groups (for example, between *preta* and *parda* populations in Brazil) that we have not included here. The analysis of these differences might provide crucial information on which populations are at the highest risk for poor maternal outcomes.
 - iv. While in some of the surveys used for this analysis, the Afrodescendent sample surpasses a million observations (Brazil, Colombia and the United States), in countries like Cuba and Uruguay, the samples consist of fewer than 100 people (see Table 1). Variations in sample sizes can impact the results of key indicators and can under- or overestimate the situation of Afrodescendent women and girls.^v

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Table 1: Percentage and sample size of Afrodescendent and non-Afrodescendent girls and women aged 15–49 years old that have given birth in the last two years (ANC)

Country	Year	Source ^b	Information on ethnicity	Afrodescendent women and girls		Non-Afrodescendent women and girls (excluding Indigenous)	
				Categories	N	Categories	N
Brazil	2019	PNS	Woman (skin colour)	Preta; Parda	1,365,691	Branca	754,281
Colombia	2015	DHS	Woman	Afrocolombiano; Raizal from Archipelago; Palenquero from San Basilio	615	None of the above	5,055
Costa Rica	2018	MICS	Head of household	Negro/ Afrodescendent; Mulato(a)	1,402	Mestizo(a); blanco(a)	5,158
Cuba	2019	MICS	Head of household (skin colour)	Negro	77	Blanco; Mulato, mestizo, Otro	832
Panama	2013	MICS	Head of household	Negro/ Afrodescendiente	1,504	Otro grupo	4,986
Suriname	2018	MICS	Head of household	Maroon; Creole	553	Hindustani; Javanese; Mixed ethnicity	396
Trinidad and Tobago	2011	MICS	Head of household	African	170	Indian; Mixed	229
United States ^a	2020	Census	Woman	Black	8,949,510	White, Asian, Native Pacific	52,830,930
Uruguay	2012	MICS	Head of household	Afro o negra	24	Blanca; Otro	236

(a) Sample population covers women aged 15–44 years

(b) DHS: Demographic and Health Survey; MICS: Multiple Indicator Cluster Survey; PNS: Pesquisa Nacional de Saúde (National Health Survey); United States Census

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