






ORIGINAL ARTICLE

Quilombola women's experience of prenatal care***HIGHLIGHTS**

1. Do *quilombola* women face barriers to quality prenatal care?
2. How is information provided to *quilombola* women during prenatal care?
3. What is the experience of *quilombola* women during prenatal care like?

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Objective: To describe the experience of quilombola women in prenatal care.

Method: This is a descriptive-exploratory study with a qualitative approach. Twenty-six semi-structured interviews were conducted with quilombola women in three communities within the municipality of Abaetetuba, state of Pará, Brazil, during April 2024. The data was transcribed in full, and content analysis was carried out.

Results: The experience of pregnant women was marked by the lack of information received during prenatal care, with guidance concentrated mainly on lectures and pregnant women's groups. This information is often supplemented informally by the women's support network. **Conclusion:** This paper describes the experience of quilombola women in prenatal care, which reveals significant gaps in information. The work of health education is a priority for change in prenatal care, with the aim of guaranteeing guidance for pregnant women and, in this way, promoting better maternal care.

DESCRIPTORS: Prenatal Care; Maternal and Child Health; Quilombola Communities; Health Vulnerability; Health Services Accessibility.

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INTRODUCTION

Women's health care strategies are one of the priorities in public health discussions in Brazil. Humanized and qualified care in the pregnancy-puerperal period is essential if we are to achieve satisfactory clinical results for maternal and newborn health¹⁻². In this sense, one of the measures recommended by international organizations and associations to ensure health in the mother-child binomial is to guarantee comprehensive care during prenatal care³.

Poor prenatal care is associated with unfavorable perinatal outcomes, such as low birth weight, prematurity, neurological problems, as well as contributing significantly to obstetric complications, hypertensive syndromes, gestational diabetes, and maternal deaths².

Although Brazil has prenatal care coverage of more than 90%, this coverage is not evenly distributed, and major inequalities persist, especially in recent years. There is greater difficulty in access for adolescent women, black women, women with less schooling, women without a partner, or multiparous women, revealing the maintenance of social and racial disparities, especially in rural areas and areas where traditional populations live in the North of the country⁴.

Health care for ethnic-racial groups in vulnerable conditions, such as the quilombola population, highlights the inequities in care due to early illness, progression of illness processes, and high morbidity and mortality rates. Vulnerability in the health-disease process of Brazil's black population is a process resulting from the historical-social context of deprivation of rights⁵⁻⁶.

Populations living in the traditional communities of the Amazon have historically faced neglect by the state in contexts of vulnerability in the field of health, education, and the environment, such as riverine communities, extractivist communities, indigenous peoples, and quilombolas⁷. Comprehensive prenatal care for the *quilombola* population is a priority to overcome obstacles to accessing services and guarantee their rights and the quality of prenatal care⁸⁻⁹.

Quilombola women during pregnancy are vulnerable, which is established in a condition of risk, related to stigmas and social conditions that contribute to making women vulnerable, especially in terms of access to means of communication and the use of favorable health resources¹⁰.

In this context, *quilombola* women share a specific culture and customs, many of them inherited from their African roots, and present a particular reality in their way of life. In this context, health-related issues cannot be analyzed in isolation, but must consider their way of life, the social environment in which they live, their culture, values, and customs. In highlighting these issues, it should be noted that health care for *quilombola* women requires interventions that dialogue with their specific health needs¹¹.

The presence of discriminatory practices in health care results in reduced access and inadequate care, influencing the way black women gestate and are born, live, and die. Socio-racial inequalities in Brazil reveal the influence of socio-economic, political, and cultural determinants and the failure to recognize the exclusionary and vulnerable racial singularity of a large part of the population¹⁰.

The lack of health care for black women underpins the social vulnerability that is reflected in their state of health. These factors are associated with ethnic-racial and gender

discrimination, which place this group at a disadvantage in various situations¹¹. The study's guiding question was: How do *quilombola* women experience prenatal care? In this way, the study aimed to describe the experience of *quilombola* women in prenatal care.

METHOD

This is a descriptive-exploratory study with a qualitative approach, carried out with *quilombola* women in the municipality of Abaetetuba, in the state of Pará, Brazil.

To better outline the production of this manuscript, the criteria for reporting qualitative research from the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist¹¹ were used.

The study took place in three *quilombola* communities located in the municipality of Abaetetuba in the state of Pará: Itacuruçá, Arapapuzinho, and Ipanema during the month of April 2024. This study scenario was chosen because it is home to the largest number of *quilombola* communities in the state, with approximately 14,526, making it the fifth Brazilian municipality with the largest *quilombola* population¹².

The researchers first contacted community leaders to identify and select the communities and participants. Once the *quilombola* communities had been defined, a survey of registered pregnant women was carried out, which totaled 50 women. Inclusion criteria were applied, namely: being a *quilombola* woman; being over 18 years old; being pregnant between the 2nd and 3rd trimester of pregnancy, or having experienced at least one pregnancy process. The exclusion criteria were: women who were not being monitored by primary health care professionals in the municipality. It should be noted that no participants were excluded from the study.

No initial contact was made with the women prior to data collection. A pilot study was carried out with three pregnant women from another *quilombola* community to adapt the data collection technique, who were not included in the study participants.

A total of 26 *quilombola* pregnant women took part in the study. Data collection took place with the support of river transportation to each participant's home, mediated by contact with the community leader. A semi-structured, face-to-face, individualized interview was carried out, with the participation of the lead researcher and the interviewee, without the presence of third parties, guaranteeing the ethical precepts for data collection. Each interview lasted an average of 45 minutes.

During the interview, the lead researcher mediated the following trigger questions: Tell us about your experience with the prenatal care you are receiving. What are the positive or negative aspects of prenatal care for the *quilombola* population? What obstacles do you face during prenatal care?

During the interviews, the process of theoretical saturation was carried out¹³. In the 23rd interview, a chain was observed in the responses of the pregnant women, with the occurrence of the meaning of the event. So, three more interviews were carried out, bringing the total number of participants in the study to 26, as there were no new additions during the interviews. The interviews were recorded on a digital device and transcribed in full.

Once the interviews had been transcribed, the data treatment process began with Content Analysis¹⁴. Among the stages established in the analytical process are: pre-analysis; exploratory reading of the material to identify the elements that would make up the analysis; formulation of a hypothesis; and identification of relevant documents for analysis¹⁴. Following the exploration of the material, categorization and coding were carried out in the study. In this phase, the researcher separated the research information to manage, code, and interpret it¹⁴. The colorimetry strategy was used to identify the recording units, namely: female family members as mentors; participation in pregnant women's groups; lectures during pregnancy; consultations/guidance with nurses; relationships with health professionals.

The results were processed, inferred, and interpreted, seeking the meanings of the data obtained. This is the moment of intuition, reflective and critical analysis¹⁴. During this stage of analysis, the aim was to capture the content contained in all the material collected through the instruments used, which led to the construction of the thematic unit: Orientations and the consultation with the health professional, which made it possible to define the following thematic category: The experience of *quilombola* women: barriers to effective, quality prenatal care. The data was discussed based on health policies aimed at prenatal care and specialized literature on comprehensive prenatal care.

The study was approved under protocol no. 6.497.731/2023 by the Research Ethics Committee of the Institute of Health Sciences at the Universidade Federal do Pará (REC-ICS/UFGPA), in accordance with Resolution no. 466/2012 of the National Health Council (CNS). To preserve confidentiality, anonymity and reliability, the interviewees were identified by the letter (G) for Gravid (Pregnant), followed by a numerical number corresponding to the sequence in which the interviews were conducted (G1, G2, G3, ..., G26), in addition to the guarantee of voluntary participation, through the participant signing the Free and Informed Consent Term (FICT).

This study is part of the dissertation entitled: Prenatal care for *quilombola* women in the state of Pará: a look at the field of reproductive health from the Postgraduate Program in Nursing at the Federal University of Pará.

RESULTS

The participants' ages ranged from 20 to 35. Regarding occupation, 19 (76%) worked in farming, and concerning marital status, 12 were married (46%). Regarding education, 11 (42%) had incomplete primary education, 21 (80%) reported receiving less than one minimum wage, and 23 (88%) of the participants reported between one and five pregnancies.

After analyzing the data obtained, a Thematic Analysis was constructed to better discuss and outline the study.

The experience of *quilombola* women: barriers to effective, quality prenatal care

It can be seen that *quilombola* pregnant women's reports during prenatal care, specific guidance for the pregnancy cycle is a gap in care, as there is a lack of information from health professionals to women. As a result, this information is transferred to family members, who assume the role of holders of the knowledge passed down through the generations, as can be seen in the following statements:

[...] I didn't have any of this during prenatal care, only at home with the older ones, my mother, mother-in-law, but during the consultations with the professionals [...] I didn't have any of this. (G7)

[...] I never took part in it; they didn't tell me what to do, how to do it. I had guidance at home from my mother or grandmother. (G20)

[...] I didn't have any guidance; everything I learned was either at home or on my own, day-to-day with my children. The professionals weren't very involved; they didn't ask how the emotional aspect was going, nor did they give much guidance. So, these are marks that remain, which I've come to terms with over time, but I didn't have that support. I had to keep it to myself. (G19)

[...] I didn't get much advice; my sisters, mother, and grandmother were the ones who told me things, and the advice I got was given more at home than at the clinic. When I went for a consultation, the doctor would only ask if I was feeling anything, if I was in pain, he would look at my tests, and if there were any changes, he would give me medication. But he didn't give me any further explanations, and I didn't feel comfortable asking either. (G26)

When asked about receiving guidance or taking part in a group for pregnant women, the majority of women reported not knowing about the groups in the places where they had prenatal care during their prenatal experience. These groups are essential for guiding women, as they have the power to provide information. However, few women attended lectures and did not receive collective guidance on topics inherent to pregnancy and childbirth, according to the following statements:

[...] what I was told the most was to watch my diet, that's all. But every time I went, I never saw or took part in any lectures on pregnancy, caring for the baby after it was born, or childbirth. These things don't exist around here. (MQ9). No groups or lectures, but once in a while, they would talk to me about how to look after the child, not to make an effort. (G11)

[...] I didn't take part in any pregnancy groups, nor did I have much guidance. When I had a consultation, the doctor just asked if I was okay, told me how the baby was, listened to the heartbeat, looked at the tests, and that was it. If he had to give me any medication, he'd give it to me, and then I'd tell him if it worked, that was it. (G18)

[...] I never took part in any lectures, and I was never asked to take part in groups for pregnant women, none of this more specific guidance stuff. Most of the time, I didn't stay long in the nurse's or doctor's room; they just did the screening by checking my blood pressure, listened to the baby, said I was fine and told me not to eat fried food, that's all, and gave me the medicines or tests I needed to do. (G24)

The woman's experience throughout the pregnancy process and her reception are fundamental in prenatal care, so that she can understand the moment of transition she is going through. However, the analysis of these women's statements suggests that communication is still based on the curative model, with the medicalization of health problems and little emphasis on their integral health during pregnancy.

[...] it was good, he didn't ask that many questions, he just asked about my exams and if I needed anything, then he would give me medicine, tell me how to take it, and that was it. Consultations used to be very quick. (G1)

[...] it took a long time for my appointment, and that was really bad. Because we'd leave home early, sometimes without eating anything, and we'd spend hours waiting to be seen. Then, when the appointment came, it was very quick. I'd see how the baby was, look at my tests, if there was anything wrong, I'd be given medicine and told to do other tests, and that was it, that was basically it [...] (G5)

[...] the appointment took longer during the screening with the nurse, who listened to my heart, asked me how I was, then wrote everything down and took it to the doctor when it was time for me to be seen. There in the doctor's office, he'd look at my test, see if everything was OK, if it wasn't, he'd give me some prescription medicine, and that was basically it; it wasn't something that took long, what really took long was waiting for him to arrive. (G13)

[...] well, I think it was good. I think that they did what had to be done, which was to give the exams, medicines, listen to the heart, and that was basically it, so I think it was good. (G23)

[...] when I went for a consultation, the doctor would only ask if I was feeling anything, if I was in pain, he would look at my tests, and if there were any changes, he would give me the medication. But they didn't give me any further explanations, and I didn't feel comfortable asking either. (G26)

Thus, *quilombola* pregnant women face several challenges, including a lack of guidance, which results in a lack of knowledge about health issues during pregnancy, childbirth, and the puerperium. Pregnancy is a period filled with insecurity, in which access to qualified information should be a priority for these women.

DISCUSSION

Health vulnerability is a concept that encompasses social and economic inequalities that impact access to quality healthcare. In a context where millions of people still face significant obstacles to accessing essential services, it becomes crucial to analyze how factors such as race, social class, and geographical location influence the health of some populations¹⁵⁻¹⁶, especially *quilombola* populations.

Vulnerability is a condition of people or groups who are at risk of suffering damage to their health due to social, economic, and environmental factors. It is characterized as a social construct, involving aspects such as inequality, exclusion, and access to goods and services. It also proposes the discussion that health should be understood integrally, considering the interactions between biological, social, and cultural dimensions. This perspective seeks to identify and address the barriers that prevent equitable access to health, promoting a more integrated and sensitive approach to the needs of vulnerable populations¹⁷.

Within this approach, vulnerability is influenced by a series of issues, such as unemployment, low income, precarious working conditions, social isolation, violence, lack of support networks, limited access to education and information, living in areas of high vulnerability, age, gender, ethnicity, among others¹⁸⁻²⁰.

This study adopts the concept of vulnerability to assess health guidance practices in the gestational process of *quilombola* women. The lack of information about pregnant women is a major factor in the poor prenatal care provided to *quilombola* women.

Lack of information on the part of pregnant women is a critical factor affecting the quality of prenatal care. People with less information face difficulties in interpreting information materials and medical prescriptions, which can result in obstacles to ensuring their health and, consequently, in inappropriate health-related decisions. This reality not only undermines the effectiveness of guidance on their health, but also perpetuates social inequalities, leading to worse health outcomes among vulnerable groups²¹.

In women's health, regarding obstetric and neonatal care, health services must be characterized by quality and humanization, with a commitment to welcoming women and newborns with dignity, recognizing them as subjects of rights. Despite the progress made in maternal and child health since the implementation of the Program for the Humanization of Childbirth and Birth (PHPN), the National Policy for Comprehensive Women's Health Care and, more recently, the Alyne Network, the quality of prenatal care continues to be questioned when it is related to the issue of race/color²²⁻²⁴.

Women's experience of prenatal care is still mostly based on the curative model. Women often don't take part in lectures or groups for pregnant women, and the advice they receive is based on medicalizing their needs, disregarding a holistic and comprehensive view of pregnancy.

The Alyne Network highlights the importance of guidance during prenatal care as an essential part of comprehensive health care for pregnant women and their newborns. This program emphasizes the need to provide clear, evidence-based information on care during pregnancy, including warning signs, types of delivery, and preparations for birth, as well as ensuring the woman's active participation in decisions about her health, guaranteeing an environment of dialogue and listening between health professionals and pregnant women²³.

This humanized approach not only contributes to women's autonomy but also aims to address emotional and psychological aspects, recognizing the importance of psychological support during pregnancy²². Although the importance of these recommendations is recognized, care is still poor, both in terms of the procedures recommended and the way they are carried out by health professionals^{1-3,7,22}.

One study showed that educational level and health information are determinants of women's full awareness of prenatal health issues²⁵. Another study²⁶ states that women with lower educational and socioeconomic conditions are less likely to receive the most appropriate prenatal care.

Many health professionals still focus only on the pathophysiological needs of pregnant women, neglecting the importance of educational processes as fundamental tools for promoting the well-being of pregnant women and their companions. This limited approach can result in a prenatal experience that does not consider the emotional, cultural, and social dimensions. Concerning information, black and brown women receive less information about normal childbirth and the place of delivery, and are more likely not to receive adequate guidance during prenatal care²⁷⁻²⁸.

These observations lead us to reflect on the need to raise awareness of interethnic differences. It is important to create spaces that support dialogue about the particular health demands of quilombola women. These strategies are fundamental for the development of public policies that take into account the cultural, social, economic, and ancestral particularities of this group, thus promoting more inclusive and effective care. The creation of these spaces can strengthen the formation of support networks, ensuring that the voices of black women are heard and their needs met in a comprehensive manner²⁹.

Often, the lack of training of health professionals in welcoming and caring for *quilombola* women, deficits in the organization of health services, and geographical barriers are conditions that accentuate health inequalities. The challenges of implementing comprehensive health care in the Amazon region have become a topical and political field of action. The expansion of Family Health Strategy (FHS) teams, mobile health units, and river units is a suggestion for practical solutions to reduce health inequities³⁰.

Thus, the articulation of the support network for pregnant women, the provision of information for women in the pregnancy-puerperal cycle, focusing on the integrality of their health (biopsychosocial), the training of health professionals, as well as the organization of the health system, with mobile and river units, are current strategies to guarantee higher quality gestational care and thus reduce vulnerability in terms of access to information and health services for the *quilombola* population.

A limitation of the study was the lack of resources to use other data collection techniques that could support the data, such as observation during prenatal consultations at the health unit.

FINAL CONSIDERATIONS

The study described the experiences of Amazonian *quilombola* women in prenatal care. The results showed the need for public policies in the field of reproductive health in *quilombola* communities and the reorganization of the maternal health care network, with the provision of services within their communities, favoring women's health during prenatal care.

The results presented revealed the limitations of access to health services by *quilombola* women in prenatal care, especially in terms of information, which women do not have access to due to the need for strategies to be employed in prenatal care.

Territorial, financial, and educational limitations are factors that make it impossible to provide quality care during pregnancy, as recommended by the Ministry of Health's (MH) maternal and child health programs and policies.

Given this, it is essential to give visibility to the demands that emerge from the experiences of *quilombola* women during prenatal care. It is necessary to show that structural/location weaknesses and rights violations are part of the daily lives of black women in *quilombola* communities.

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