

Depressive disorder among postpartum women: an analysis according to self-reported race/color

Transtorno depressivo em mulheres no período pós-parto: análise segundo a raça/cor autorreferida

Trastorno depresivo en mujeres en el período posparto: análisis según raza/color autodeclarado

Rosa Vanessa Alves Lima¹  <https://orcid.org/0000-0002-0841-8124>

Luciana Camargo de Oliveira Melo¹  <https://orcid.org/0000-0002-1904-3137>

Nayara Gonçalves Barbosa¹  <https://orcid.org/0000-0003-3646-4133>

Ana Paula Rodrigues Arciprete¹  <https://orcid.org/0000-0002-0353-4820>

Juliana Cristina dos Santos Monteiro¹  <https://orcid.org/0000-0001-6470-673X>

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Corresponding author

Ana Paula Rodrigues Arciprete
E-mail: anapra@usp.br

Associate Editor (Peer review process):

Thiago da Silva Domingos
(<https://orcid.org/0000-0002-1421-7468>)
Escola Paulista de Enfermagem, Universidade Federal de São Paulo, São Paulo, SP, Brasil

Abstract

Objective: To identify the race/color self-reported by women 60 days postpartum; to identify the prevalence of signs of depressive disorder among these women and to verify the association between signs of depressive disorder and the self-reported race/color.

Methods: Cross-sectional study carried out in a noncapital city in the state of São Paulo. An instrument with sociodemographic data and the Edinburgh Postnatal Depression Scale were used for data collection. Data was analyzed using the Statistical Package for Social Sciences, SPSS, version 17.0.

Results: A total of 186 women participated in this study, 60.8% reported being brown, 24.2% had signs of depressive disorder and, among these, 81.7% were black. Signs of depressive disorder were associated with the variables: number of children ($p=0.006$), planned pregnancy ($p=0.04$) and type of delivery ($p<0.001$).

Conclusion: The results of this study contribute to greater visibility of the issue of women's mental health, specifically of black women, because even though no significant association was identified among those who showed signs of depressive disorder, most were black.

Resumo

Objetivo: Identificar a raça/cor autorreferida por mulheres com 60 dias de pós-parto; identificar a prevalência do indicativo de transtorno depressivo nessas mulheres e verificar a associação entre o indicativo de transtorno depressivo e o quesito raça/cor autorreferida.

Métodos: Estudo transversal desenvolvido em um município do interior paulista. Foram utilizados, para a coleta de dados, um instrumento com dados sociodemográficos e a Escala de Depressão Pós-Natal de Edimburgo. Os dados foram analisados utilizando-se o *Statistical Package for Social Sciences*, SPSS, versão 17.0.

Resultados: Participaram deste estudo 186 mulheres, 60,8% referiram ser da cor parda, 24,2% apresentaram indicativo de transtorno depressivo e, entre estas, 81,7% eram da raça negra. O indicativo de transtorno depressivo associou-se às variáveis: número de filhos ($p=0,006$), gestação planejada ($p=0,04$) e tipo de parto ($p<0,001$).

Conclusão: Os resultados deste estudo contribuem para maior visibilidade da temática da saúde mental das mulheres, especificamente das mulheres negras, pois, mesmo que não tenha sido identificada associação significativa dentre aquelas que apresentaram indicativo de transtorno depressivo, a maioria era da raça negra.

Resumen

Objetivo: Identificar la raza/color autodeclarado por mujeres con 60 días de posparto, identificar la prevalencia de indicios de trastorno depresivo en esas mujeres y verificar la relación entre los indicios de trastorno depresivo y el ítem raza/color autodeclarado.

¹Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo, Ribeirão Preto, SP, Brasil.

Conflicts of interest: none to declare.

Métodos: Estudio transversal realizado en un municipio del interior paulista. Para la recopilación de datos, se utilizó un instrumento con datos sociodemográficos y la Escala de Depresión Posnatal de Edimburgo. Para analizar los datos se utilizó el *Statistical Package for Social Sciences*, SPSS, versión 17.0.

Resultados: Participaron en el estudio 186 mujeres, el 60,8 % declararon ser de color pardo, el 24,2 % presentó indicios de trastorno depresivo y, entre ellas, el 81,7 % era de raza negra. Los indicios de trastorno depresivo se relacionaron a las variables: número de hijos ($p=0,006$), embarazo planeado ($p=0,04$) y tipo de parto ($p< 0,001$).

Conclusión: Los resultados de este estudio contribuyen para una mayor visibilidad del tema de salud mental de las mujeres, específicamente de mujeres negras, ya que, aunque no se haya identificado una relación significativa entre las que presentaron indicios de trastorno depresivo, la mayoría era de raza negra.

Introduction

The postpartum period is characterized by the return of the maternal organism to pre-pregnancy conditions, when biological, as well as psychological and emotional, changes occur.⁽¹⁾ These changes increase the risk of complications that, unless identified and treated, can lead to maternal mortality and morbidity from preventable causes.⁽²⁾

Specifically, regarding psychological and emotional changes, the different situations experienced by women after childbirth, such as adaptation to the maternal role when they are primiparous, concern and responsibility for the child, sleep deprivation and social isolation, increase the risks of illness due to mental disorders.⁽¹⁾ Among these, depressive disorder or postpartum depression (PPD) stands out, which is characterized as any depressive episode after childbirth, usually starting between two weeks and three months postpartum, in which women may experience a depressed mood, loss of interest in daily activities, changes in appetite, changes in sleep patterns, excessive tiredness, feelings of guilt, difficulty concentrating and even suicidal ideation.⁽²⁾

Postpartum depression affects approximately 10-15% of women worldwide,⁽³⁾ however, a higher prevalence is observed in developing countries, ranging from 19-25%⁽⁴⁾. In Brazil, the prevalence of PPD varies from 10.8 to 42.8%.⁽⁵⁾ The risk factors identified were: family or personal history of depression, little social and financial support, difficulties in marital relationships, low self-esteem, obstetric complications, conflicting relationship with the mother and unwanted pregnancy.⁽²⁾

In the United Kingdom, an estimated cost of € 8.1 billion is annually earmarked for the treatment of cases of perinatal depression, anxiety and maternal psychosis.⁽⁶⁾ However, in developing coun-

tries, due to the chronic scarcity and limitation of financial and human resources, PPD is usually underdiagnosed and undertreated, possibly due to the targeting and priority of public policies to prevent maternal mortality related to obstetric complications,⁽⁴⁾ in addition to the double burden of communicable and non-communicable diseases, which result in neglect of mental health.⁽⁷⁾

In addition to these factors, ethnic-racial and gender differences are currently being considered in the context of health and specifically in mental health, as they can increase mental disorders and interfere with the right to mental health of individuals. This leads to a reflection on institutional racism, which occurs when an organization that should provide appropriate and professional service to anyone starts to distinguish these people by their color, culture or ethnic origin.⁽⁸⁾ Often this distinction does not occur explicitly, causing greater discomfort, because those who are affected do not find access to adequate resources to identify and take a stand against such an act.⁽⁹⁾

According to the Ministry of Health, institutional racism is frequently observed in health services, which can affect the black population in the form of early deaths, high maternal and infant mortality rates, higher incidence and prevalence of chronic and infectious diseases and also in the high rates of urban violence, when compared to the white population.⁽⁸⁾ Based on these concepts, the relationship between racial characteristics and the increased prevalence of mental disorders can be explained due to exposure to stress generated by unfavorable socioeconomic positions and mainly by experiences of racial discrimination.⁽¹⁰⁾

In terms of gender issues, the scientific literature shows that women, in general, have a worse health condition when compared to men, and a higher

prevalence of chronic diseases and mental disorders,⁽¹¹⁾ despite having a lower mortality rate.⁽¹²⁾ This is mainly due to factors related to social structure and psychosocial determinants that contribute to the pattern of illness in women, while behavioral determinants (such as health risk) contribute more to the disease pattern in men.⁽¹¹⁾

In this sense, the intersectional analysis of several variables can contribute to a better understanding of health aspects. The proposal of intersecting variables makes it possible to understand how each aspect of the life of the individual, when jointly analyzed, can provide different social experiences.⁽¹³⁾ Thus, intersectional analysis consists of the interaction between the social structures, related to the identity markers of each individual.⁽¹³⁾ For example, black women who experience sexism and racism on a daily basis, cannot fully exercise their right to mental health because they are in an unfavorable situation.⁽¹⁴⁾

Based on the above, the present study aims to deepen the theme of postpartum depression, so that ethnic-racial differences that can lead to exclusion and inequalities in the health system are considered. The study is justified because the use of race/color as a category of analysis can generate important information that will contribute to the qualification of health services, since research gathering ethnic-racial data allows the elaboration, implementation and evaluation of public policies that promote racial equality.⁽¹⁵⁾

Thus, this study aims to identify the race/color self-reported by women 60 days postpartum; to identify the prevalence of signs of depressive disorder among these women and to verify the association between signs of depressive disorder and their self-reported race/color.

Methods

This is a cross-sectional study,⁽¹⁶⁾ developed in a large noncapital city in the state of São Paulo.

The reference population of the study consisted of women 60 days postpartum who accompanied their children for routine childcare consultations at

a Basic Health Unit, selected for the study because it had the highest number of live births through the Unified Health System (SUS) in the city in 2018. Sample size was calculated with information from the 2018 Annual Report of the unit and previous research involving mental health (signs of depressive disorder).⁽¹⁷⁾ The women were selected to participate in the study by simple random sampling. Based on the sample calculation performed, considering a sampling error of 5%, a confidence level of 95% and a predicted loss of 10%, a minimum sample of 150 women was calculated, which was reached in 186 participants. These women were selected following the inclusion criteria: being over 18 years old, having children born at full-term gestational age. The exclusion criteria were women with children with pathologies that required special care and monitoring that was not routine, and women with hearing, visual or cognitive impairment.

Thus, those who met the established inclusion and exclusion criteria were invited to participate in the study. On this occasion, the research was presented and clarifications on data collection were carried out, considering the moment before or after the consultation of the child's 2nd month of life as ideal for approaching these women.

For data collection, two instruments were used. The first instrument was built and elaborated by the researchers, based on national and international scientific literature and on previous research carried out by them. It included identification data and sociodemographic and obstetric characteristics of the women participating in the study, also containing information on self-reported race/color according to the Brazilian classification system. This classification system is used by the Brazilian Institute of Geography and Statistics (IBGE) and employs five categories of race/color: white, black, brown, yellow and indigenous, and the Brazilian black population is constituted from the aggregation of subjects who self-declared black and brown.⁽¹⁸⁾

The second instrument was the Edinburgh Postnatal Depression Scale (EPDS): an instrument in the public domain and already validated in Brazil, easy to use and interpret, which can be applied by health professionals or self-administered.⁽¹⁹⁾ In the

present study, the scale was self-administered, without the interference of the researchers. It consists of a 10-item scale that analyzes the presence and intensity of depressive symptoms in the last seven days. The sum of the points for each question makes a minimum score of zero and a maximum of 30. A cutoff point greater than or equal to 13 points has a high predictive value indicative of depressive disorder.⁽²⁰⁾

When the participating woman presented any signs of depressive disorder, this fact was duly communicated to the nurse and/or physician of the health unit, according to the agreement signed before the beginning of the research with the unit manager, as part of the study protocol. This agreement was made so that these women were monitored according to the institution's evaluation (treatment by the unit's psychologist, referral to the specific service of the municipal health network, or even immediate assistance by a professional from the unit).

Before data collection, a pilot study was carried out, with the purpose of operationalizing the work, and the data collected in the pilot study was not excluded, as there was no change that compromised the validation of the collected data.

Data was stored in an electronic spreadsheet structured in Microsoft Excel, by double typing, and analyzed using the statistical program Statistical Package for Social Sciences, SPSS, version 17.0. The characterization of the participants was based on descriptive statistics, with the presentation of absolute and relative frequencies and, for the quantitative variables, the means and medians, standard deviations, minimum and maximum were calculated, indicating the variability of the data. Fisher's Exact Test was used for the analysis of association between the variables of interest. For all analyses, a significance level of 5% was considered.

The study was authorized by the Health Department of the city studied and approved by the Research Ethics Committee linked to the National Research Ethics Committee (CONEP) of the National Health Council with protocol CAAE: no. 9 2340718.0.0000.5393, on July 3, 2019.

Results

A total of 186 women participated in this study, with a mean age of 26.26 years (standard deviation of 6.25), with a minimum age of 18 and a maximum age of 47. Table 1 shows the distribution of participants according to sociodemographic characteristics. For the income variable, among the participants, only 157 chose to answer this question. It was identified that the majority reported being brown (60.8%), which makes up the black race. Table 2 presents the distribution of women according to obstetric characteristics. It is observed that the highest percentage of women had only one pregnancy (35.5%), one delivery (41.4%), no mis-

Table 1. Distribution of women participating in the study by self-reported race/color, education, religion, occupation, marital status, assistance with baby care and family income in reais.

| | n(%) |
|---|------------------------|
| Self-reported race/color n=186 | |
| White | 43(23.1) |
| Black | 25(13.4) |
| Yellow | 4(2.2) |
| Brown | 113(60.8) |
| Indigenous | 1(0.5) |
| Education (n=186) | |
| Illiterate | 1(0.5) |
| Incomplete elementary school | 30(16.1) |
| Complete elementary school | 17(9.1) |
| Incomplete high school | 45(24.2) |
| Complete high school | 80(43.0) |
| Incomplete undergraduate degree | 6(3.2) |
| Complete undergraduate degree | 5(2.7) |
| Postgraduate degree | 2(1.1) |
| Religion (n=186) | |
| Has a religion | 142(76.3) |
| Believes in God, but has no religion | 27(14.5) |
| Has no religion | 17(9.1) |
| Occupation (n=186) | |
| Paid work at home | 13(7.0) |
| Paid work outside the home | 92(49.5) |
| No paid work | 81(43.5) |
| Marital status (n=186) | |
| Does not have a partner | 22(11.8) |
| Has a partner | 164(88.2) |
| Assistance with newborn care (n=186) | |
| Yes | 132(70.9) |
| No | 54(29.1) |
| Family income (n= 157) | |
| | Amount in BRL |
| Mean | 2,303.45 (SD=1,529.13) |
| Median | 2,000.00 |
| Minimum | 300.00 |
| Maximum | 15,000.00 |

* SD= Standard deviation

Table 2. Distribution of women participating in the study according to number of pregnancies, number of deliveries, number of miscarriages, number of live children, current pregnancy planning and type of delivery

| Variables | n(%) |
|-------------------------|-----------|
| Number of pregnancies | |
| One | 66(35.5) |
| Two | 59(31.7) |
| Three or more | 61(32.8) |
| Number of deliveries | |
| One | 77(41.4) |
| Two | 55(29.6) |
| Three or more | 54(29.0) |
| Number of miscarriages | |
| None | 153(82.3) |
| One | 25(13.4) |
| Two | 7(3.8) |
| Three or more | 1(0.5) |
| Number of live children | |
| One | 78(41.9) |
| Two | 57(30.6) |
| Three or more | 51(27.4) |
| Pregnancy planning | |
| Yes | 90(48.4) |
| No | 96(51.6) |
| Type of delivery | |
| Normal | 117(62.9) |
| C-section | 69(37.1) |

carriage (82.3%), one live child (41.9%) and had not planned the current pregnancy (51.6%). Most women had a normal delivery (62.9%).

As for the prevalence of depressive disorder among the participants, it was found that 45 of them (24.2%) had signs of depressive disorder. The association between signs of depressive disorder and their sociodemographic and obstetric characteristics, including the race/color self-reported by women is shown in table 3.

Among the 45 participants who showed signs of depressive disorder, 81.7% were black, that is, they had black or brown skin color. There was no statistically significant result for the association between these variables, although most women with signs of depressive disorder were black. In addition, Table 3 also shows the association between signs of depressive disorder and other sociodemographic and obstetric variables. Showing signs of depressive disorder showed a statistically significant association with the variables: number of children, planned pregnancy and type of delivery. That is, women with three or more children ($p = 0.006$), who did not plan pregnancy ($p = 0.04$) and who had a C-section ($p < 0.001$)

Table 3. Association between signs of depressive disorder and selected sociodemographic and obstetric variables

| Maternal characteristics | Signs of depressive disorder | | | p-value* |
|-------------------------------------|------------------------------|----------------------|-------------------------|----------|
| | Yes (n = 45) n(%) | No (n = 141) n(%) | Total (n = 186) n(%) | |
| Race/color | | | | 0.18 |
| White | 8(17.8) | 35(25.5) | 43(23.1) | |
| Black/brown | 36(81.7) | 102(72.3) | 138(74.2) | |
| Yellow | 0(0.0) | 4(2.2) | 4(2.2) | |
| Indigenous | 1(0.5) | 0(0.0) | 1(0.5) | |
| Education | | | | 0.55 |
| Elementary school | 24(53.3) | 68(48.2) | 92(49.5) | |
| High school | 17(37.8) | 70(49.6) | 87(46.8) | |
| Undergraduate degree | 4(8.9) | 3(2.1) | 7(3.8) | |
| Religion | | | | 0.88 |
| Has a religion | 34 (75.6) | 108(76.6) | 142(76.3) | |
| Believe in God, but has no religion | 7 (15.6) | 20(14.2) | 27(14.5) | |
| Has no religion | 4 (8.9) | 13(9.2) | 17(9.1) | |
| Occupation | | | | 0.21 |
| Paid work at home | 5(11.1) | 8(5.7) | 13(7.0) | |
| Paid work outside the home | 24(53.3) | 68(48.2) | 92(49.5) | |
| No paid work | 16(35.6) | 65(46.1) | 81(43.5) | |
| Marital status | | | | 0.37 |
| Does not have a partner | 7(15.6) | 15(10.6) | 22(11.8) | |
| Has a partner | 38(84.4) | 126(89.4) | 164(88.2) | |
| Income (minimum wage = BRL 998) | | | | 0.21 |
| Less than one | 5(11.1) | 11(7.8) | 16(8.6) | |
| From one to two | 13(28.9) | 57(40.4) | 70(37.6) | |
| More than two | 21(46.7) | 50(35.5) | 71(38.2) | |
| Number of children | | | | 0.006 |
| One | 11(24.4) | 67(47.5) | 78(41.9) | |
| Two | 16(35.6) | 41(29.1) | 57(30.6) | |
| Three or more | 18(40.0) | 33(23.4) | 51(27.4) | |
| Assistance with newborn care | | | | 0.46 |
| Yes | 30(66.7) | 102(72.3) | 132(71.0) | |
| No | 15(33.3) | 39(27.7) | 54(29.0) | |
| Pregnancy planning | | | | 0.04 |
| Yes | 16(35.6) | 74(52.5) | 90(48.4) | |
| No | 29(64.4) | 67(47.5) | 96(51.6) | |
| Type of delivery | | | | <0.001 |
| Normal | 0(0.0) | 117(83.0) | 117(62.9) | |
| C-section | 45(100.0) | 24(17.0) | 69(37.1) | |

* Fisher's Exact Test

were more likely to have signs of depressive disorder than women with one or two children, who planned the pregnancy and who had a normal delivery. The other sociodemographic and obstetric variables did not present statistically significant results when associated with signs of depressive disorder.

Discussion

A total of 186 women took part in this study, among them 138 belonging to the black race, that

is, with black and brown skin, corroborating national data that shows that the majority of Brazilian women are black (51.8%), as well as the majority of the Brazilian population that corresponds to 54% of black people.^(21,22)

The present study identified that 24.2% of the participants had signs of depressive disorder, most of them being black women. A systematic literature review that included surveys from 40 countries showed that prevalence rates of depression vary significantly throughout the world, ranging from 0% to 60%.⁽²³⁾ It was possible to observe that in countries such as Denmark, Singapore and Malta there is a less significant amount of reports or symptoms of postpartum depression, compared to countries such as Brazil, South Africa, Italy and Chile. This difference is related to the different methodologies of the studies, and the social, cultural and economic characteristics of each region. It should be noted that the studies most cited in the review were carried out in economically developed western countries.⁽²³⁾ Therefore, the development of depressive disorder in the postpartum is related to several environmental, social and emotional factors linked to individuals and their collectivity, which demonstrates the importance of the present study, as it considers the reality of women assisted locally in the studied city.

The association between the self-reported race/color and signs of depressive disorder did not show a statistically significant result, although it is evident that most women who present these signs belong to the black population. Unlike the present study, previous work showed that there is a strong statistical association between signs of depressive disorder and race/color in Brazil, indicating that 28.4% of brown women are at a significant risk of developing depressive disorder in the postpartum period.⁽²²⁾ In addition to the previous study, research carried out in Salvador, state of Bahia, points to the association of signs of depressive disorder in black postpartum women in the state, where 19.8% were identified with signs of depressive disorder, and among of these, the majority (90%) were black and brown; however, the significant relationship was found only among those women who were black (46.7%).⁽²⁴⁾

It is considered that countries with greater inequality in the distribution of wealth have greater PPD rates, since per capita income is inversely associated with PPD prevalence; also, young women's work load of more than 40 hours per week represents a predictor of PPD.⁽⁵⁾ Additionally, countries with high maternal and child mortality rates and higher fertility rates have higher PPD rates.⁽⁵⁾

In developing countries, PPD results from the interaction between low socioeconomic conditions, interpersonal problems and adverse life events.⁽⁷⁾ In addition, there is a higher prevalence of the disease in women than in men, 5.5% and 3.2%, respectively. This fact is related in the literature with the changes that occur in the physiological issues of women during and after menarche, since the prevalence of the disease before this period is similar to that of men; in addition, gender inequities existing in societies also influence women's mental health.⁽²⁵⁾ Among the risk factors for PPD, the following stand out: abuse during childhood, domestic violence, low maternal educational level, low socioeconomic conditions during pregnancy, lack of social support, history of mental disorders,⁽⁴⁾ unemployment, low female empowerment, marital instability and low partner support, divorce, unplanned pregnancy, history of fetal loss and grief.⁽⁷⁾ Other factors that stand out include anxiety and high levels of perceived stress during pregnancy, young age, tobacco use, obstetric complications, low birth weight, newborns with disease symptoms within 4-6 weeks postpartum and use of artificial formulas.⁽²⁶⁾

Added to these factors are race issues, since, as mentioned earlier, the social content of this concept is considered here, referring to structural racism.⁽⁸⁾ Thus, regarding the mental health of black people, racism is largely responsible for the high prevalence of common mental disorders in black people, as it is a known impact factor for mental illness.⁽²⁶⁾ A systematic review on mental disorders and race/color showed that depression symptoms affected more black women (52.8%) than white women (42.3%).⁽²⁷⁾ For this reason, it is important to emphasize the need to add ethnic-racial and gender dimensions to scientific research on mental health, since the literature has shown this

relationship, but the ethnic-racial dimension has been little considered in specific groups, such as postpartum women.⁽²⁸⁾ In this sense, intersectional analysis should be valued, since gender analysis cannot be considered separately, without encompassing race, class, sexuality, nationality and other identity markers, as these relationships and entanglements need to be acknowledged and established for understanding the complexity of people and their living conditions,^(29,30) which points to the need to deepen the theme of the present study.

Still in this logic, a statistically significant association is highlighted in this study between signs of depressive disorder and obstetric variables of number of children, pregnancy planning, and type of delivery.

Among study participants, those who had three or more children were more likely to present signs of positive depressive disorder than women with one or two children. These findings are different from a study carried out in Kenya, which points out that there is a higher prevalence of signs of depressive disorder in women who have two children compared to those with three or more children.⁽³¹⁾ In Brazil, a study identified an increased risk for depressive disorder among postpartum women who had more children when compared to primiparous women, in which postpartum women with up to two children were 1.58 times more likely to develop the disorder, and postpartum women with three or more children had these odds increased to 1.95.⁽²²⁾ Multiparous women may be more concerned in terms of the impact of pregnancy on the family structure, regarding the relationship with the partner, with older children and financial issues.⁽³²⁾ However, it is important to highlight that the different contexts of postpartum women, whether multiparous or primiparous, make them need to reorganize their lives when they have children, so that this transition to maternity is healthy.⁽³³⁾ Thus, it is relevant to understand the experience of being a mother, as maternity can be loaded with insecurity, conflicts and inexperience, especially regarding baby care,⁽³²⁾ which can generate emotional conflicts.

In the present study, women who did not plan pregnancy (64.4%) showed signs of depressive

disorder. Not planning a pregnancy can lead to poor acceptance of the pregnancy, an increase in maternal and child morbidity and mortality rates, besides representing an increased risk for mental disorders.⁽³⁴⁾ In Rio Grande do Sul, a study showed that pregnancy planning can reduce the risk of developing depressive disorder during postpartum by 30%, with gestational planning being a protective factor against this disorder.⁽³⁵⁾ A national survey identified that 80% (n=151) of the women who showed signs of postpartum depressive disorder had not planned their pregnancy,⁽²³⁾ corroborating the results of the present study.

Considering the type of delivery, our results revealed that 100% of women who had signs of depressive disorder underwent C-section. A meta-analysis developed with 28 studies from different parts of the world confirmed that there is a relationship between the cesarean procedure and depressive disorder in postpartum women, even considering the different designs and the different adjustments of studies related to complications during pregnancy.⁽³⁶⁾ A study carried out in Botucatu, state of São Paulo, also showed a relationship between women who underwent C-section and signs of depressive disorder in postpartum, and that these women have twice as many chances of developing this disorder.⁽³⁷⁾ In addition, post-surgical risks such as infection, postpartum hemorrhage, ureter and bladder injury, uterine rupture, chronic pelvic pain and gastrointestinal dysfunction can increase women's postpartum stress, causing psychological damage and, thus, increasing the risk for depressive disorder.⁽³⁷⁾ This evidence is consistent with the results of the present study, and calls attention to the need for these women who had C-sections to receive adequate care to go through the postpartum period, minimizing the risks for depressive disorder.

Extending the theme of this study to society implies acknowledging the intersections of identity markers, how they intersect, connect and overlap, which is a learning and requires constant deconstruction and construction of our values and how we understand society.⁽²⁹⁾ Thus, reflecting on the physical and mental health of women who go through the postpartum period, we highlight the

importance of this population's access to the health system, since difficulties in accessing preventive services, in particular, negatively impact people's quality of life. Considering the specificities of the black population, and especially of black women, who suffer from numerous situations of inequity in health and in other sectors, evidence indicates that the strengths and weaknesses in access to health signal the relevance of the education of professionals who will serve this population and the strengthening of public policies aimed at positive discrimination, in order to favor dignified care for this population.⁽³⁸⁾ From this perspective, it is important to emphasize that the strengthening of strategies such as the National Policy for the Comprehensive Health of the Black Population and other policies for promoting racial equality are essential to guarantee the promotion of comprehensive health to the black population and reduce ethnic-racial inequalities and racism in SUS institutions and services.

A limitation of the present study involves the impossibility of monitoring the health outcomes and referrals of the participants who were identified with signs of depressive disorder. In addition, data collection was carried out in a single health unit, which despite being justified by the greater number of live births in the municipality, makes it impossible to generalize the data and can be considered a limitation as well.

Conclusion

The study showed that most participants were black, 24.2% of all women had signs of depressive disorder, and among these, most were black (black or brown skin). Despite this finding, signs of depressive disorder did not present a statistically significant association with the race/color variable. These signs were associated with the variables: number of children, pregnancy planning and type of delivery. The results of this study contribute to a greater visibility of women's mental health issue, in general, and specifically of black women, allowing reflection and discussion on the greater presence of black women as users of services at the SUS and

on the higher percentage of black women who have signs of depressive disorder in the postpartum period. Furthermore, the results have important implications for women's mental health practice, as they provide support for greater attention to those with a greater number of children, without pregnancy planning and who had a C-section, pointing to the need to create programmatic actions specific and focused on the mental health of women with these conditions, so that they experience motherhood in a healthier way, minimizing possible risks of mental disorder.

Contributions

Lima RVA, Melo LCO, Barbosa NG, Arciprete APR, Monteiro JCS contributed to the study conception, data analysis and interpretation, article writing, relevant critical review of the intellectual content and approval of the final version to be published.

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