



# Barriers in Accessing Care for Consequence of Unsafe Abortion by Black Women: Evidence of Institutional Racism in Brazil

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## Abstract

Women face difficulties in accessing post-abortion care, as hierarchical care operates under discrimination mechanisms that condemn women in abortion. In addition, it is the Black and Brown women who are more subject to unsafe abortions and need hospitalization to complete the termination of pregnancy or treat associated complications. This study aimed at identifying factors associated with the institutional barriers in access to health services for women who underwent abortion by race/color. The survey encompassed 2640 users admitted to public hospitals in Salvador, Recife, and São Luís. Differences among covariables according to race/color (Black, Brown, and White women) were analyzed and tested for statistical significance using Pearson's  $\chi^2$  test. The regression analysis initially included variables that may express the technical criteria of priority in care (time of pregnancy when abortion occurred and conditions of arrival), then the sociodemographic characteristics, and, lastly, the type of abortion declared. Black women faced more institutional difficulties (27.7% vs 19.5% in White women and 18.7% in Brown women), such as waiting to be attended and getting a bed. The association between being Black women and institutional barriers remained, even after adjustments in the regression model. Institutional racism limits access to health services and timely care for Black women, acting as a performative mechanism, legitimizing and generating exclusionary behaviors. The results demonstrate that the intersection between racial discrimination and abortion stigma redouble institutional barriers that are denominated intersectional discrimination.

**Keywords** Racism · Health inequalities · Health care · Abortion · Reproductive health

## Introduction

In several parts of the world, women face difficulties in having access to safe abortion and post-abortion care, even in

countries where the practice is legal [1, 2]. In Brazil, abortion is allowed only when the pregnancy results from rape or for a life-threatening pregnancy and, more recently, in cases of fetal anencephaly. In order to accomplish this, women have resorted to the self-administration of misoprostol, and then they seek hospitalization in order to complete uterine emptying [3, 4]. Timely attention to these cases is known to be crucial [5] in order to avoid complications of a procedure that when performed safely offers minimal health risks [6]. In healthcare services, it is necessary to prioritize the most severe cases, longer pregnancies and especially those that demonstrate signs and symptoms compatible with potentially life-threatening conditions and near miss [7].

However, in the hierarchy of priorities for care, in addition to technical criteria, discrimination mechanisms operate, although not always explicit [8], based on the social characteristics of those who declared to have had or supposedly caused an abortion [9]. This is reflected not only in interpersonal relationships [8] but also in the organization of care, from the almost exclusive use of curettage and the performance of

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these procedures at the end of shifts to bureaucratic hospital discharge, with revision appointments, and no information for infection prevention and post-abortion contraception [10, 11].

Access to health services includes entry into the service with the continuity of treatment and subsequent care. The process of the utilization of health services is the result of the behavior and the characteristics of people seeking care in interaction with the professionals who guide them within the health system, which largely defines the type and intensity of care resources utilized in order to solve the health problems of those who utilize services [12].

In Brazil, even with restricted abortion legalization, the State foresees a humanized care for women in abortion situations, based on the ethical and legal frameworks of sexual and reproductive rights, affirmed in the international and national human rights plans, having as principles guiding equality, freedom, and dignity of the human being, with no discrimination or restrictions on access to healthcare being allowed, as stated in the Technical Standard—Humanized Attention to Abortion [13].

Studies conducted in different hospitals of the public health network find that Brazilian women under abortion conditions suffer discrimination when they arrive at healthcare services. There are recurring attitudes such as delayed care, lack of interest of professionals in listening and guiding them, and explicit verbal violence with condemnatory and prejudiced words and attitudes [14–17]. Despite its illegality in the country, the practice of abortion is a frequent phenomenon among women from different social classes, racial groups, educational levels, and religions, as evinced in two national population surveys [3, 18]. However, there is a higher occurrence among Black women, those with less formal education, and those living in the north, northeast, and midwest—the poorest regions of Brazil [3]. On the other hand, these are the women who most often perform unsafe abortions and need hospitalization to complete the abortion process or treat associated complications [3, 18, 19]. As a result, in Brazil, the risk of maternal death from abortion is almost six times higher among uneducated women compared with that among more educated women, and it is almost three times higher among Black women when compared with White women [20].

In order to highlight the impact of social inequalities and racism, the research carried out in different regions of Brazil finds that Black women are almost always at a disadvantage when compared with White women, with regard to access and use of health services, even among groups belonging to similar social strata [21–25]. The authors also emphasize how these barriers to access health services reiterated situations of discrimination and social exclusion for Black women. Those, compared with White women, had less access to education, had lower social and economic status, and lived in worse living and housing conditions, and, with regard to reproductive health, had less access to contraceptive methods and were more likely to get pregnant, even if they did not want to.

However, little is known about Black women regarding abortion and the barriers faced when utilizing healthcare services in Brazil. This study aimed at filling this gap, through an investigation of the access conditions to hospitalization by women in abortion circumstances, with an emphasis on the institutional barriers faced by women, applying a racial perspective and seeking to interpret the identified differences under the light of scientific literature on institutional racism. Such racism is understood as the set of practices that result in unequal access to wealth, services, and opportunities due to racial background, underlying the norms that guide the actions of institutions, even if it is not explicitly legalized [26–28]. Institutional racism affects individual behaviors and interpersonal relationships and may contribute to negative outcomes to sexual and reproductive health [29].

## Materials and Methods

This cross-sectional study is part of the GravSus-NE research, a multicenter investigation conducted in three capitals of northeastern Brazil: Salvador, Recife, and São Luís. A census was conducted at 19 public hospitals in the aforementioned three cities, between August 31 and December 30, 2010, reaching 2804 women aged 18 years old and over living in these municipalities, who had been hospitalized in aborting circumstances or abortion resulting to complications, regardless of the severity of the clinical signs and the type of abortion declared (spontaneous or induced). Abortion cases protected by law (i.e. rape or for a life-threatening pregnancy and, more recently, in cases of fetal anencephaly) [3] were considered ineligible; ectopic pregnancy and hydatidiform mole; and abortion resulting from other abnormal products of conception, whose clinical and legal justifications legitimize uterine emptying under safe conditions.

Methodological details have been published [11, 30]. In summary, the data were produced through face-to-face interviews with the application of a structured questionnaire and the data extraction from the medical records to classify the conditions that women arrived at the hospital. Interviews were conducted in the mornings and afternoons 7 days a week, including holidays, after the women were discharged. There were 5.8% losses and 2.7% refusals. The field team consisted of higher-level health professionals protected by professional secrecy, with experience in hospital work and medical records management.

Race/color information was collected through the question “Which of the following would you choose to identify your skin color or race?” The alternative answers were White, Black, Asian, Brown, and Indigenous considering the official racial classification of the Brazilian Institute of Geography and Statistics [31]. For the present analysis, women who declared themselves Black, Brown, and White were considered. Indigenous and Asian origins were excluded due to their small number (5.3% of the total) and in light of important distinctions

that would make it difficult to aggregate them in any other group.

Information on institutional barriers to accessing abortion care was obtained from two questions with multiple and stimulated responses: “Did you have any difficulties to be admitted to this hospital?”: “Waited too long to be attended,” “waited for a place/bed,” “parturients were seen first”; and “other difficulties (there was no ultrasound equipment/lack of professionals/specialized doctors)” and “had no difficulty.” For the analysis, the construct was dichotomized in “yes,” when there was at least one positive response to the alternatives of institutional barriers and “no” if the interviewee answered that “there were no barriers.”

Two groups of covariables were defined: (a) sociodemographic: age group (18 to 24 years, 25 to 29 years, 30 years and more), level of education (basic, high school, graduate), religion (yes, no), stable partnership (yes, no), and children (yes, no) and (b) type of declared abortion (spontaneous, induced), gestational age when abortion occurred (until 12 weeks, 13 weeks and more), place of origin before arrival at the hospital (home; another unit, with referral form; another unit, without referral form; transferred from another hospital; not specified), reason for choosing the hospital (close to home/work; recommended by physician/friend; would be well cared for/would not have to wait a lot; was aware that it cared for abortion cases; others), transport used to get to the hospital (private, taxi, bus/public transportation, another transport, on foot, ambulance), and conditions of arrival at the hospital (good, regular, serious, and very serious).

The conditions of arrival at the hospital were classified as “good,” “regular,” “severe,” and “very severe.” These classifications were constructed based on information extracted from medical records and on criteria previously defined in a Consensus Conference [32] by specialists and researchers who investigate the topic of abortion and/or have experience with intensive care. In our study, the classification of these arrived conditions was performed by two independent health professionals with training in obstetrics (doctor or nurse). In case of a disagreement between the two professionals, a third, with the same training, would be contact. Also, we take into account the following: (a) the level of consciousness; (b) signs of impaired clinical conditions, severe obstetric morbidity, and near miss; (c) the presence of infection, considering the definitions of the Society of Critical Care Medicine and American College of Chest Physicians [33]; and (d) the intensity of blood loss, according to the definitions of the American College of Surgeons (Trauma Committee)—Advanced Trauma Life Support® (ATLS®) [34].

Initially, a descriptive analysis was performed and stratified by race/color according to the selected characteristics, with the differences between proportions being tested for statistical significance using the Pearson  $\chi^2$  test at a level of 5% ( $p$  value  $\leq 0.05$ ).

To assess the potential confounders, the association between “race/color” and “institutional barriers to access to hospitalization” was tested, adjusted by covariates selected in the literature; those that could lead to implicit mechanisms of discrimination—age group (18 to 24 years/25 and more), level of education (basic/high school/graduate), stable partnership (yes/no), children (yes/no), and type of abortion declared (spontaneous / induced)—and those that reflected the technical criteria for prioritization (gestational age when abortion occurred and conditions of hospital arrival) ([Supplementary material](#)).

Regression analysis was performed to estimate the prevalence ratio (PR). We use logistic models and confidence intervals (CI), with delta and bootstrap methods.

The following categories were considered as references: “race/White” and “without barriers.” The covariates selected for entry into the model were those informed by the scientific literature on the subject and those with a level of statistical significance of  $\leq 0.05$ . The variables were entered into the block model progressively (forward), and those whose association was not statistically significant ( $p$  value  $> 0.05$ ) were removed. Initially, those that can express the technical criteria of priority in care (gestational age when abortion occurred, conditions of hospital arrival) were included; later, the sociodemographic characteristics (age, education, stable partnership, and children) that may give rise to implicit mechanisms of discrimination and, lastly, the type of abortion declared were included. Data processing and descriptive analysis was performed using STATA software version 13.0 for Windows, and regression models was performed using the PrLogistic package, R software, version 4.0.2 for Windows.

The project was approved by the Ethics Committees of the three universities and by CONEP (CEPISC UFBA 006/09, CEP CCSUFPE 061/09, CEP HUUFMA 002065/2009-30). The study ensured the voluntary participation of the women interviewed, exempting them from the signing of the Informed Consent Form (ICF), which was read and signed exclusively by the interviewer. The choice of the Oral Consent Form aimed at increasing the trust and protection of the interviewees, who could not be formally linked to an illegal and clandestine practice in the country. The interviews were conducted after hospital discharge, while the women were waiting for the administrative procedures to leave the hospital. All participants were given the right not to answer any questions, and the anonymity and confidentiality of their replies were safeguarded.

## Results

Of the 2640 women in the study population, 35.7% were Black; 53.3%, Brown; and 11.0%, White. Just over a third of them were between 18 and 24 years old, with no differences

between racial groups. However, compared with those who declared themselves White, Black women had less education and, in a lower proportion, reached higher level (5.9% vs 16.3%); Black women also reported having fewer children (67.2% vs 65.8%) (Table 1). Brown women were in an intermediate position, although closer to Black women, in terms of lower higher education (7.5%) but were the ones who most reported having children (71.2%). There were no statistically significant differences regarding stable partnership.

Spontaneous abortions were mostly reported by women, but abortion was more commonly reported by Black women (31.1% vs 24.2% among White women and 21.0% among Brown women). It was also among Black women that the termination of pregnancy occurred later, i.e., at 13 weeks and over (21.9% vs 17.9% among Brown women and 14.6% among White women) (Table 1).

A higher rate of Black women reported coming directly from their homes (72.2% vs 65.8% of Brown women and 63.1% of White women) and using public transport (35.5% vs 29.9% and 23.0%, respectively) (Table 2).

The main reason given for choosing the hospital where they were hospitalized was the proximity of home or work, and this was particularly important for Black women (36.0%).

Among the latter as well as among the Brown group, the information that such healthcare facility provided care to abortion cases was cited more than among White women (Table 2).

Upon arrival at the hospital, the absolute majority of respondents were in good condition; however, Black (9.8%) and Brown (9.2%) women featured in rates twice as higher vis-à-vis regular, severe, or very serious conditions compared to White women (4.7%) (Table 2).

The most frequent occurrence among Black women remained when the different types of institutional barriers were analyzed separately (waited too long to be attended, waited for a place/bed, parturients were seen first) (Table 3). Black women reported more often (32.2%) having faced institutional barriers than Brown (22.7%) and White (23.2%) women (Fig. 1).

In the simultaneous analysis by logistic regression (Table 4), the association between facing institutional barriers in hospital access and being Black was maintained, even after the adjustment for all variables selected by statistical and theoretical criteria (time of pregnancy when abortion occurred, conditions of arrival, age, education, stable partnership, children, and type of abortion declared).

**Table 1** Sociodemographic characteristics and context of abortion for women in abortion circumstances according to race/color in Salvador, Recife, and São Luís (2010)

Sociodemographic characteristics	Race/color (%)			<i>p</i> value
	Black ( <i>n</i> = 942)	Brown ( <i>n</i> = 1407)	White ( <i>n</i> = 291)	
Age group (years)				
30 or more	36.6	36.4	33.3	0.843
25 to 29	28.1	28.0	28.2	
18 to 24	35.2	35.6	38.5	
Level of education				
Basic	36.4	33.2	33.6	0.000
High school	57.6	59.2	50.2	
Graduate	5.9	7.5	16.3	
Religion				
No	27.9	22.6	25.8	0.014
Yes	72.1	77.4	74.2	
Stable partnership*				
Yes	92.8	88.3	88.5	0.079
No	7.2	11.7	11.5	
Children				
Yes	65.8	71.2	67.2	0.018
No	34.2	28.8	32.8	
Type of abortion declared				
Spontaneous	68.9	75.8	79.0	0.000
Induced	31.1	24.2	21.0	
Gestational age when abortion occurred				
Until 12 weeks	78.1	82.1	85.4	0.009
13 weeks and more	21.9	17.9	14.6	

\*Includes marriage, union with or without cohabitation, and stable partner without living together

**Table 2** Conditions of access to the hospital by women in abortion circumstances according to race/color in Salvador, Recife, and São Luís (2010)

Variables	Race/color (%)			p value
	Black women (n = 942)	Brown women (n = 1407)	White women (n = 291)	
<b>Place of origin before arrival at hospital</b>				
Home	72.2	65.8	63.1	0.000
Another unit with forwarding attendance form	6.0	12.8	13.5	
Another unit with no attendance forwarding form	13.6	13.0	14.1	
Transferred from another hospital	3.1	3.1	4.5	
Did not specify	5.1	5.4	4.8	
<b>Transportation used to arrive at hospital</b>				
Private	28.5	29.2	35.7	0.000
Taxi	17.0	16.9	18.6	
Bus/public transportation	35.5	29.9	23.0	
Another transport	10.7	15.9	12.4	
On foot	5.1	4.9	5.2	
Ambulance*	3.2	3.2	5.2	
<b>Reason for choosing the hospital</b>				
Close to home/work	36.0	27.9	32.0	0.000
Recommended by physician/friend	26.5	31.8	29.2	
Would be well cared for/would not have to wait a lot	13.0	14.8	16.8	
Was aware that it cared for abortion cases	8.4	8.1	3.4	
Others**	16.2	17.4	18.6	
<b>Conditions of arrival at hospital</b>				
Good	90.2	90.8	95.3	0.029
Regular, serious, and very serious	9.8	9.2	4.7	

\*Transferred from another service or \*\*did not choose/was forwarded/transferred

### Discussion

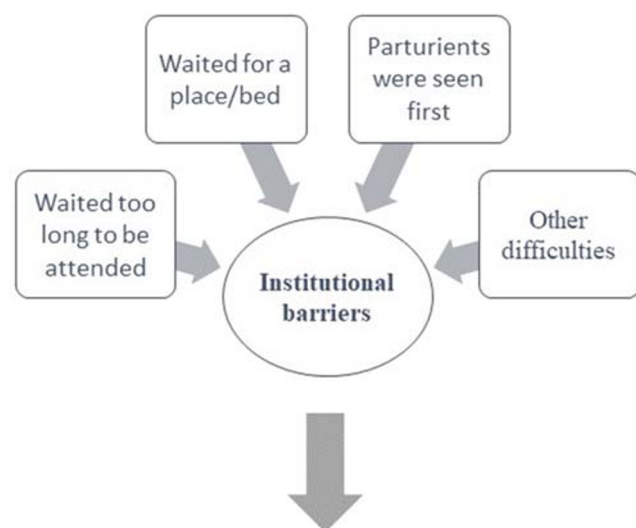
The results of this study demonstrate that in Brazil, as in previous research on prenatal and childbirth care [22, 35], Black

and Brown users are the least educated, and the latter report having more children. However, based on the aforementioned results, Black women are at a greater disadvantage in virtually all indicators examined and are the most affected by barriers to

**Table 3** Description of institutional barriers to access hospitalization according to race/color in Salvador, Recife, and São Luís (2010)

Had some difficulty being admitted to this hospital?	Race/color (%)			p value
	Black women	Brown women	White women	
<b>Waited too long to be attended</b>				
No	82.0	89.6	88.2	0.000
Yes	18.0	10.4	11.8	
<b>Waited for a place/bed</b>				
No	92.3	94.0	97.9	0.002
Yes	7.7	6.0	2.1	
<b>Parturients were seen first</b>				
No	89.3	93.3	92.7	0.002
Yes	10.7	6.7	7.3	
<b>Other difficulties*</b>				
No	95.6	96.7	96.5	0.387
Yes	4.4	3.3	3.5	

\*There was no ultrasound equipment/lack of professionals/specialized doctors



Institutional Barriers	Race/color (%)			P-value
	Black	Brown	White	
No	67.8	77.3	76.8	0.000
Yes	32.2	22.7	23.2	

**Fig. 1** Proportion of institutional barriers according to race/color in Salvador, Recife, and São Luís (2010)

access to hospital admission for abortion completion. These findings are especially relevant because the study population is composed exclusively of users of the Brazilian Unified Healthcare System (SUS) from one of the poorest regions of the country and, therefore, does not include the most privileged sectors of the population, which could expand the effect found.

The research had its strong feature on obtaining its results from a hospital census encompassing all services that provided care to abortion in the three cities investigated, allowing for the identification of the institutional barriers faced by the vast majority of the SUS user population and does not have the financial resources to afford pregnancy termination in private offices and clinics [36]. However, the study only enabled

measuring situations in which barriers did not permanently prevent access to hospitals and continuity of care until hospital discharge [12]. Another limit concern is the impossibility of obtaining the interview of four women hospitalized, with a health condition classified as extremely serious due to induced abortion, resulting, subsequently, in their death. This is a differential selection bias, since they were Black women, who potentially faced barriers in access to timely care as evidenced in previous studies on abortion death [37]. This issue is reinforced by the findings in the previous analyses of GravSus-NE study, where Black women delayed the search for hospital care due to the fear of being mistreated, which leads them to the conditions of greater worsening when they finally arrived to health services [38]. It is permissible to assume that if these cases had been included in the study, the magnitude of the association observed between Black race/color and institutional barriers would be greater.

It should be noted that the data were produced through structured questionnaires, applied by interviewers trained for this purpose, at the time of hospital discharge, when the users were in good condition. However, the losses, although not significant, occurred mainly among more serious cases who entered the obstetric center directly or those who passed away and whose data were retrieved from the medical records, but were not interviewed.

Black women reported more induced abortion and had their pregnancies terminated later, conditions that contribute to their greater vulnerability to complications and the need for hospital care. These findings are consistent with those of Brazilian population studies [3, 4], which have demonstrated that Black and Brown women are the ones who most admit to having performed illegal and unsafe abortions. There is also evidence that these women and those from poorer socioeconomic backgrounds often end up aborting at a higher gestational age, exposing themselves to greater risk of post-abortion complications [16]. In particular, second trimester abortion carries a higher risk of morbidity and mortality, accounting for most serious complications and deaths in the context of unlawful practice, since it is usually performed by

**Table 4** Multiple logistic regression analysis of the relationship between race/color and institutional barriers in hospital access among women in abortion circumstances, according to selected characteristics In Salvador, Recife, and São Luís (2010)

Characteristics	Model 1	Model 2	Model 3	Model 4
Race/color				
Black women	1.4 (1.1–1.7)	1.3 (1.1–1.7)	1.4 (1.1–1.7)	1.4 (1.1–1.7)
Brown women	1.0 (0.8–1.2)	0.9 (0.7–1.2)	1.0 (0.8–1.2)	1.0 (0.8–1.2)
White women	1.0*	1.0*	1.0*	1.0*

\*Reference group for all the race/color categories; 95% CI: 95% confidence interval

Model 1 not adjusted; model 2 adjusted for technical criteria of priority in care (gestational age when abortion occurred, conditions of arrival at hospital); model 3 adjusted for sociodemographic characteristics (age group, level of education, stable partnership, and children); model 4 adjusted for type of abortion declared

people without the necessary skills and/or in unhealthy environments [39].

Several factors may contribute to the later completion of pregnancy termination, from the delay to confirm and publicize it, for fear of social condemnation, to making the decision for abortion and to obtain the necessary resources to perform it. Younger women outside a marital union may have less social support and consequently face more difficulties in achieving each of these steps in the decision-making process [40, 41]. However, in addition to individual barriers, given the decision to abort and the impossibility of having safe conditions to perform it, women still face institutional barriers when they seek healthcare services [14, 15].

In the present study, part of the interviewees reported waiting for the parturient women to be attended first, which constitutes a discriminatory mechanism for users in aborting circumstances. Apparently, this is redoubled among the Black women who reported more of this form of discrimination, as well as the longest waiting time to be met and to obtain a place in a hospital bed. This could not be explained by the lower severity of their clinical condition, since on the contrary, they were the ones who most often came to the hospital under regular, severe, and very serious conditions and with abortions occurred in later pregnancies. Other forms of social discrimination, such as being young and childless, could equally not explain the observed association as there were no age differences or types of partnership that were statistically significant. However, in adjusting the regression model for these variables, the association between having faced institutional barriers and being Black remained, indicating the likely existence of mechanisms of institutional racism.

Black women have more unfavorable outcomes, expressed in institutional barriers of access to hospital admission for post-abortion care. Racist practices, even if not constituted as explicit norms in health services, are institutionalized in behaviors in terms of organizational care. As the main obstacle for Black women, institutional racism limits care and access to health services, acting as a performative or productive mechanism, legitimizing and generating exclusionary behaviors [26, 27].

In Brazil, studies on access to obstetric care had already demonstrated that Black and Brown women have fewer appointments, fewer ultrasounds, more inadequate prenatal care, and more hypertensive syndromes [22, 23]. As for the international scenario, in countries such as the USA and South Africa, even under legal practice conditions, Black women endure restricted access and are more exposed to unsafe abortion [42, 43].

US publications have emphasized that racial discrimination is a factor that impairs access because racism is an institutionalized system and impacts women's individual behavior, living conditions, and reproductive health [29, 43]. The possibility cannot be ruled out, in so far as groups that suffer from

different forms of social discrimination on a daily basis (especially of class, gender, and race) may be more sensitive to perceived situations of stigma, as discussed in a study about the narratives of Black and Latino women in spontaneous abortion circumstances in healthcare services in the USA [44].

However, such issues assign relevance to studies on discrimination suffered in post-abortion care, so that they do not redouble social vulnerabilities, imply attention delays, and increase maternal morbidity and mortality due to abortion complications. Above all, the need for future research to address the interactions between racial discrimination and the stigma of abortion is clearly evinced in what has been termed intersectional discrimination [42, 45].

Racism and its manifestations undermine the reproductive lives of Black women, and interacting with the stigma of abortion makes it difficult to access healthcare services and the quality of care received. The agenda of demands put forth by the women's movement for reproductive rights must consider the intersectional discrimination that consequently places Black women at a disadvantage in access to comprehensive and universal healthcare.

Finally, it is necessary to review the current legislation on abortion in Brazil, which is ineffective to curb its practice and only reinforces social inequalities. In the same way, changes in the model of abortion care itself in the public health system are imperative, placing maternities, abortion, and parturient women within the same institutional space. In these health facilities, structured for childbirth and birth care, women who have abortions tend to have their demands neglected, including those with spontaneous losses, because they are viewed as suspicious of having induced abortion [10, 11]. In addition to personal abuse, situations of discrimination can contribute to exposing women, particularly Black women, to avoidable health risks.

Ideally, research on abortion should be applied outside the hospital environment, especially due to the possibility of "gratitude bias," which results in a better assessment of individuals about the care provided, after past experiences, in view of the imminent hospital discharge. However, in face of difficulties in locating women to be interviewed at home, their interview in the hospital has become imperative to avoid losses [30, 46]. Despite the 10 years between the end of the GravSus-NE survey and the finalization of this study, 10 years have passed, but the data remain current, as scientific evidence shows that Black women continue to suffer institutional racism from reproductive health services [22, 23, 47], and women in situations of abortion continue experiencing institutional violence [10, 15, 17]; during this period, there were no advances in the reproductive rights agenda in the Brazilian State [48, 49].

In summary, this study has filled an important gap in research on the issue of abortion in Brazil by introducing the analysis of racial inequalities and the role of institutional

racism for women's reproductive health. It is hoped that these results could be a stimulus for future research, deepening the issues addressed here and enriching the debate on health equity in the country and in similar contexts in order to ensure the expansion of Black women human rights.

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**Author Contribution** Goes EF and Aquino EML participated in all stages of the manuscript, including conception, data analysis, interpretation, writing, and review of the final version of the manuscript. Menezes GMS and Almeida MCC participated in the data analysis, interpretation, writing, and final review of the manuscript. Barreto-de-Araújo TV, Alves SV, and Alves MT participated in the study's conception, development, and critical revision of the final version of the manuscript.

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## Compliance with Ethical Standards

**Conflict of Interest** The authors declare that they have no conflict of interest.

**Ethics Approval** The project was approved by the Ethics Committees of the three universities and by CONEP (CEPISC UFBA 006/09, CEP CCSUFPE 061/09, CEP HUUFMA 002065/2009-30). The study ensured the voluntary participation of the women interviewed, exempting them from the signing of the Informed Consent Form (ICF), which was read and signed exclusively by the interviewer.

**Consent to Participate** The choice of the Oral Consent Form aimed at increasing the trust and protection of the interviewees, who could not be formally linked to an illegal and clandestine practice in the country. The interviews were conducted after hospital discharge, while the women were waiting for the administrative procedures to leave the hospital. All participants were given the right not to answer any questions, and the anonymity and confidentiality of their replies were safeguarded.

## References

- Doran F, Nancarrow S. Barriers and facilitators of access to first-trimester abortion services for women in the developed world: a systematic review. *J Fam Plan Reprod Heal Care* [Internet]. 2015;41(3):170–80 Available from: <http://jfprhc.bmj.com/lookup/doi/10.1136/jfprhc-2013-100862>.
- Ganatra B, Faundes A. Role of birth spacing, family planning services, safe abortion services and post-abortion care in reducing maternal mortality. *Best Pract Res Clin Obstet Gynaecol* [Internet]. 2016;36:145–55 [cited 2018 Jan 4] Available from: <http://www.ncbi.nlm.nih.gov/pubmed/27640082>.
- Diniz D, Medeiros M, Madeiro A. Pesquisa Nacional de Aborto 2016. *Cien Saude Colet* [Internet]. 2017;22(2):653–60 [cited 2017 Oct 28] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S1413-81232017000200653&lng=pt&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232017000200653&lng=pt&tlng=pt).
- BRASIL. 20 anos de pesquisas sobre aborto no Brasil. Brasília: Ministério da Saúde; 2009. 72 p
- Pacagnella RC, Cecatti JG, Parpinelli MA, Sousa MH, Haddad SM, Costa ML, et al. Delays in receiving obstetric care and poor maternal outcomes: Results from a national multicentre cross-sectional study. *BMC Pregnancy Childbirth*. 2014;14(1) [cited 2018 Jan 05] Available from: <https://doi.org/10.1186/1471-2393-14-159>.
- Kapp N, Whyte P, Tang J, Jackson E, Brahmi D. A review of evidence for safe abortion care. *Contraception*. 2013;88(3):350–63.
- Souza JP, Cecatti JG, Haddad SM, Parpinelli MA, Costa ML, Katz L, et al. The WHO maternal near-miss approach and the maternal severity index model (MSI): Tools for assessing the management of severe maternal morbidity. Myer L, editor. *PLoS One* [Internet]. 2012;7(8):e44129 [cited 2017 Dec 26] Available from: <http://dx.plos.org/10.1371/journal.pone.0044129>.
- Blair IV, Steiner JF, Havranek EP. Unconscious (implicit) bias and health disparities: where do we go from here? *Perm J* [Internet]. 2011;15(2):71–8 Available from: <http://www.ncbi.nlm.nih.gov/pubmed/21841929%5Cn>, <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=PMC3140753>.
- Yam EA, Dries-Daffner I, Garcia SG. Abortion opinion research in Latin America and the Caribbean: A review of the literature. *Stud Fam Plann* [Internet]. 2006;37(4):225–40 [cited 2018 Jan 4] Available from: <http://www.ncbi.nlm.nih.gov/pubmed/17209281>.
- McCallum C, Menezes G, dos Reis AP. O dilema de uma prática: Experiências de aborto em uma maternidade pública de Salvador, Bahia. *História, Ciências, Saúde-Manguinhos* [Internet]. 2016;23(1):37–56 [cited 2017 Sep 18] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0104-59702016000100037&lng=pt&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-59702016000100037&lng=pt&tlng=pt).
- Aquino EML, Menezes G, Barreto-de-Araújo TV, Alves MT, Alves SV, da CC de Almeida M, et al. Qualidade da atenção ao aborto no Sistema Único de Saúde do Nordeste brasileiro: o que dizem as mulheres? *Cien Saude Colet* [Internet]. 2012;17(7):1765–76 [cited 2015 Oct 30] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S1413-81232012000700015&lng=en&nrm=iso&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232012000700015&lng=en&nrm=iso&tlng=pt).
- Travassos C, Martins M. Uma revisão sobre os conceitos de acesso e utilização de serviços de saúde. *Cad Saude Publica* [Internet]. 2004;20:S190–S8 [cited 2017 Feb 1] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0102-311X2004000800014&lng=pt&nrm=iso&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2004000800014&lng=pt&nrm=iso&tlng=pt).
- BRASIL. Norma Técnica de Atenção Humanizada ao Abortamento: Norma tecnica. Brasília: Ministério da Saúde (MS); 2005.
- Cameiro MF, Iriart JAB, Menezes GM d S. “Largada sozinha, mas tudo bem”: Paradoxos da experiência de mulheres na hospitalização por abortamento provocado em Salvador, Bahia, Brasil. *Interface—Comun Saúde, Educ* [Internet]. 2013;17(45):405–18 [cited 2015 Oct 30] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S1414-32832013000200013&lng=en&nrm=iso&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-32832013000200013&lng=en&nrm=iso&tlng=pt).
- Faria N. Entre a autonomia e a criminalização: A realidade do aborto no Brasil. In: *Mulheres Brasileiras e Gênero Nos Espaços Público e Privado - Uma Década de Mudanças na Op Pública* [Internet]. São Paulo: Fundação Perseu Abramo; 2013 [cited 2015 Oct 30]. Available from: <http://www.saraiva.com.br/mulheres->



- brasileiras-e-genero-nos-espacos-publico-e-privado-uma-decada-de-mudancas-na-op-publica-5657301.html
16. Kalkmann S, Pinto EA. Aborto: Livre escolha? BIS Bol do Inst Saúde [Internet]. 2010;12(2):185–91 [cited 2016 Aug 16] Available from: [http://periodicos.ses.sp.bvs.br/scielo.php?script=sci\\_arttext&pid=S1518-18122010000200014&lng=pt&nrm=iso&tlng=pt](http://periodicos.ses.sp.bvs.br/scielo.php?script=sci_arttext&pid=S1518-18122010000200014&lng=pt&nrm=iso&tlng=pt).
  17. Madeiro AP, Rufino AC. Maus-tratos e discriminação na assistência ao aborto provocado: A percepção das mulheres em Teresina, Piauí, Brasil. *Cien Saude Colet* [Internet]. 2017;22(8):2771–80 [cited 2018 Jan 4] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S1413-81232017002802771&lng=pt&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232017002802771&lng=pt&tlng=pt).
  18. Diniz D, Medeiros M. Aborto no Brasil: Uma pesquisa domiciliar com técnica de uma. *Cien Saude Colet* [Internet]. 2010;15(suppl 1):959–66 Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S1413-81232010000700002&lng=pt&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232010000700002&lng=pt&tlng=pt).
  19. Menezes G, Aquino EML. Pesquisa sobre o aborto no Brasil: Avanços e desafios para o campo da saúde coletiva. *Cad Saude Publica* [Internet]. 2009;25(suppl 2):s193–204.
  20. Adesse L, Levin J, Monteiro MFG. As mulheres pretas, as analfabetas e as residentes na Região Norte têm um risco maior de morrer por complicações de gravidez que termina em aborto. Trabalho apresentado no XVI Encontro Nacional de Estudos Populacionais [Internet]. 2008;1–10. Available from: [http://www.abep.nepo.unicamp.br/encontro2008/docsPDF/ABEP2008\\_1038.pdf](http://www.abep.nepo.unicamp.br/encontro2008/docsPDF/ABEP2008_1038.pdf)
  21. Batista LE, Escuder MML. Medindo desigualdade na saúde. *Bol Epidemiológico Paul* [Internet]. 2005;15–6 [cited 2016 Aug 16] Available from: [bepa-agencia@saude.sp.gov.br](mailto:bepa-agencia@saude.sp.gov.br).
  22. Diniz CSG, Batista LE, Kalkmann S, Schlitz AOC, Queiroz MR, Carvalho PC d A. Desigualdades sociodemográficas e na assistência à maternidade entre puérperas no Sudeste do Brasil segundo cor da pele: Dados do inquérito nacional Nascer no Brasil (2011–2012). *Saúde e Soc* [Internet]. 2016;25(3):561–72 [cited 2017 Feb 1] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0104-12902016000300561&lng=pt&nrm=iso&tlng=en](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-12902016000300561&lng=pt&nrm=iso&tlng=en).
  23. Leal M d C, Gama SGN d, Pereira APE, Pacheco VE, Carmo CN d, Santos RV, et al. A cor da dor: Iniquidades raciais na atenção pré-natal e ao parto no Brasil. *Cad Saude Publica* [Internet]. 2017;33(suppl 1):e00078816 [cited 2017 Sep 18] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0102-311X2017001305004&lng=pt&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2017001305004&lng=pt&tlng=pt).
  24. Martins AL. Mortalidade materna de mulheres negras no Brasil. *Cad Saude Publica* [Internet]. 2006;22(11):2473–9 [cited 2016 Jul 26] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0102-311X2006001100022&lng=en&nrm=iso&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2006001100022&lng=en&nrm=iso&tlng=pt).
  25. Lopes F, Buchalla CM, Ayres JR de CM. Mulheres negras e não-negras e vulnerabilidade ao HIV/Aids no estado de São Paulo, Brasil. *Rev Saude Publica* [Internet]. 2007;41:39–46 [cited 2016 Aug 17] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0034-89102007000900008&lng=en&nrm=iso&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102007000900008&lng=en&nrm=iso&tlng=pt).
  26. Werneck J. Racismo institucional e saúde da população negra. *Saúde e Soc* [Internet]. 2016;25(3):535–49 [cited 2017 Feb 1] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0104-12902016000300535&lng=pt&nrm=iso&tlng=en](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-12902016000300535&lng=pt&nrm=iso&tlng=en).
  27. Goes EF, Nascimento ER d. Mulheres negras e brancas e os níveis de acesso aos serviços preventivos de saúde: Uma análise sobre as desigualdades. *Saúde em. Debate* [Internet]. 2013;37(99):571–9 [cited 2017 Jan 31] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0103-11042013000400004&lng=pt&nrm=iso&tlng=en](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-11042013000400004&lng=pt&nrm=iso&tlng=en).
  28. Jones CP. Levels of racism: A theoretic framework and a gardener's tale. *Am J Public Health* [Internet]. 2000;90(8):1212–5 [cited 2016 Aug 17] Available from: <http://www.ncbi.nlm.nih.gov/pubmed/10936998>.
  29. Prather C, Fuller TR, Marshall KJ, Jeffries WL. The impact of racism on the sexual and reproductive health of African American Women. *J Women's Heal* [Internet]. 2016;25(7):664–71 [cited 2017 Feb 1] Available from: <http://www.ncbi.nlm.nih.gov/pubmed/27227533>.
  30. Aquino EML, Reichenheim M, Menezes GMS, de Araújo TVB, Alves MTSSBE, Alves SV, et al. Avaliação da qualidade da atenção ao aborto na perspectiva das usuárias: Estrutura dimensional do instrumento QualiAborto-Pt. *Cad Saude Publica*. 2020;36(Suppl 1):e00197718.
  31. IBGE. Pesquisa Nacional por Amostra de Domicílios: Síntese de indicadores 2015 [Internet]. Rio de Janeiro: IBGE; 2016. [cited 2017 Nov 15]. Available from: <https://loja.ibge.gov.br/pnad-2015-sintese-de-indicadores.html>
  32. Eugênio L, Fernandes De Souza P, Vieira LM, Zulmira S, De M, Hartz A. Conferência de consenso sobre a imagem-objetivo da descentralização da atenção à saúde no Brasil. In: Zulmira Maria de Araújo Hartz; Lígia Maria Vieira da Silva. (Org.). Avaliação em saúde: dos modelos teóricos à prática na avaliação de programas e sistemas de saúde. Salvador-Rio de Janeiro: Edufba-Fiocruz, 2005, v., p. 65–102.
  33. American College of Chest Physicians/Society of Critical Care Medicine Consensus Conference: Definitions for sepsis and organ failure and guidelines for the use of innovative therapies in sepsis. *Crit Care Med*. 1992;20(6):864–74 [cited 2020 Set 14] Available from: <https://pubmed.ncbi.nlm.nih.gov/1597042/>.
  34. American College of Surgeons. Advanced Trauma Life Support (ATLS) Student/Faculty Manual Combo Package [Internet]: American College of Surgeons; 2004. [cited 2020 Set 14] Available from: <https://books.google.com.br/books?id=EuwyQwAACAAJ>
  35. Leal M d C, Gama SGN d, Cunha CB d. Desigualdades raciais, sociodemográficas e na assistência ao pré-natal e ao parto, 1999–2001. *Rev Saude Publica* [Internet]. 2005;39(1):100–7 [cited 2016 Aug 16] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0034-89102005000100013&lng=en&nrm=iso&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102005000100013&lng=en&nrm=iso&tlng=pt).
  36. Silveira P, McCallum C, Menezes G. Experiências de abortos provocados em clínicas privadas no Nordeste brasileiro. *Cad Saude Publica* [Internet]. 2016;32(2):e00004815 [cited 2018 Jan 4] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0102-311X2016000200705&lng=pt&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2016000200705&lng=pt&tlng=pt).
  37. Santana DS, Cecatti JG, Parpinelli MA, Haddad SM, Costa ML, Sousa MH, et al. Severe maternal morbidity due to abortion prospectively identified in a surveillance network in Brazil. *Int J Gynecol Obstet* [Internet]. 2012;119(1):44–8 Available from: <http://www.sciencedirect.com/science/article/pii/S0020729212003359>.
  38. Goes EF, Menezes GMS, Almeida M-CC, Araújo TVB, Alves SV, Alves MTSSBE, et al. Racial vulnerability and individual barriers for Brazilian women seeking first care following abortion | Vulnerabilidade racial e Barreiras individuais de mulheres em busca do primeiro atendimento pós-aborto. *Cadernos de Saúde Pública* [Internet]. 2020;36(Suppl 1):e00189618 [cited 2020 Set 14] Available from: <https://doi.org/10.1590/0102-311x00189618>.
  39. Harris LH, Grossman D. Confronting the challenge of unsafe second-trimester abortion. *Int J Gynecol Obstet*. 2011;115(1):77–9.
  40. Diniz D, Medeiros M. Itinerários e métodos do aborto ilegal em cinco capitais brasileiras. *Cien Saude Colet* [Internet]. 2012;17(7):1671–81 [cited 2016 Jun 7] Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S1413-81232012000700002&lng=en&nrm=iso&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232012000700002&lng=en&nrm=iso&tlng=pt).

41. Heilborn ML, Cabral C d S, Brandão ER, Faro L, Cordeiro F, Azize RL. Itinerários abortivos em contextos de clandestinidade na cidade do Rio de Janeiro - Brasil. *Cien Saude Colet* [Internet]. 2012;17(7):1699–708 [cited 2017 Feb 1] Available from: [http://www.scielo.org/scielo.php?script=sci\\_arttext&pid=S1413-81232012000700008&lng=pt&nrm=iso&tlng=pt](http://www.scielo.org/scielo.php?script=sci_arttext&pid=S1413-81232012000700008&lng=pt&nrm=iso&tlng=pt).
42. Mosley EA, King EJ, Schulz AJ, Harris LH, De Wet N, Anderson BA. Abortion attitudes among South Africans: findings from the 2013 social attitudes survey. *Cult Health Sex* [Internet]. 2017:1–16 [cited 2017 Feb 15] Available from: <https://www.tandfonline.com/doi/full/10.1080/13691058.2016.1272715>.
43. Dehlendorf C, Harris LH, Weitz TA. Disparities in abortion rates: a public health approach. *Am J Public Health*. 2013;103(10):1772–9.
44. Bommaraju A, Kavanaugh ML, Hou MY, Bessett D. Situating stigma in stratified reproduction: abortion stigma and miscarriage stigma as barriers to reproductive healthcare. *Sex Reprod Healthc*. 2016;10:62–9.
45. Earnshaw VA, Kalichman SC. Stigma experienced by people living with HIV/AIDS. In: *Stigma, Discrimination and Living with HIV/AIDS* [Internet]. Dordrecht: Springer Netherlands; 2013. p. 23–38. [cited 2017 Nov 18] Available from: [http://link.springer.com/10.1007/978-94-007-6324-1\\_2](http://link.springer.com/10.1007/978-94-007-6324-1_2).
46. Aquino EML, Menezes GMS, Barreto-de-Araújo TV, Alves MT, Almeida M d CC, Alves SV, et al. Avaliação da qualidade da atenção ao aborto: protótipo de questionário para usuárias de serviços de saúde. *Cad Saude Publica* [Internet]. 2014;30(9):2005–16 Available from: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0102-311X2014000902005&lng=pt&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2014000902005&lng=pt&tlng=pt).
47. Batista LE, Rattner D, Kalckmann S, De Oliveira MCG. Humanização na atenção à saúde e as desigualdades raciais: Uma proposta de intervenção. *Saude e Soc*. 2016;25(3):689–702.
48. Fonseca SC, Domingues RMSM, Leal M d C, Aquino EML, Menezes GMS. Aborto legal no Brasil: revisão sistemática da produção científica, 2008-2018. *Cad Saude Publica*. 2020;36(Suppl 1):e00189718.
49. Domingues RMSM, Fonseca SC, Leal M d C, Aquino EML, Menezes GMS. Aborto inseguro no Brasil: revisão sistemática da produção científica, 2008-2018. *Cad Saude Publica*. 2020;36(Suppl 1):e00190418.

This study presents data from the Gravsus survey, and the researchers, leaders of the study, are co-authors of this study.

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