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Racial discrimination and health: health professionals' actions in providing care women in the induced abortion process

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Abstract *This paper aims to evaluate the racial inequalities in the care provided by health professionals concerning induced abortion. This systematic review study used the Preferred Reporting Items for Systematic Reviews and Meta-Analyzes (PRISMA) model, based on the following bases: Brazilian Virtual Health Library (BVS), Scientific Electronic Library Online (SciELO), National Library of Medicine, and National Institutes of Health (PubMed), Science Direct, Capes periodicals portal, with the descriptors: "racism OR social discrimination AND abortion, induced AND health personnel OR comprehensive health care OR delivery of health care OR human rights", selected via the DeCS and Medical Subject Heading (MeSH). Eighteen papers published between 2005 and 2020 in national and international literature were analyzed following the inclusion and exclusion criteria. Most studies found a significant relationship between racial discrimination and institutional violence, including access and quality of care for patients undergoing an induced abortion. Racial discrimination is a significant risk factor for adverse care outcomes.*

Key words *Abortion, Health professional, Racial discrimination, Emergency medical services, Human Rights*

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Introduction

Racism is a neglected but relevant cause of health disparities in multiethnic societies[1]. Different types of racism and other expressions of discrimination must be recognized, critically analyzed, and actively reversed. We empirically distinguish and recognize human rights omissions and violations and then analyze the sources of racism in close relation to an intersectional view of forms of discrimination based on gender, class, and ethnicity[2]. Most societies are racist, and this phenomenon is linked to racism and vulnerability, resulting in health inequalities. Nowadays, racism is identified as a relevant health concern but neglected and often ignored[3-6].

Human rights are not data, but a construct, a human elaboration in constant construction and reconstruction[7]. As Piovesan[8] points out: "As a moral claim, human rights are born when they should and can be born". Considering the temporal perspective of these rights, it appears that the meaning of human rights signifies a multiplicity of meanings; among which we highlight the contemporary understanding characterized by the universality and indivisibility of these rights[9], based on the Universal Declaration[10], and subsequently confirmed in the Vienna Declaration of Human Rights[11]. Santos[12] adds: "we have the right to be equal when our difference makes us inferior; and we have the right to be different when our equality deprives us of character. Hence the need for equality that recognizes differences and a difference that does not produce, feed, or reproduce inequalities".

Several authors discuss the marginalization and coverage of health services, identifying a significant lack of access to medical coverage[13,14], configuring itself in such a way as institutionalized racism, provided by discriminatory access to facilities, goods, and services[15]. Consequently, institutionalized racism is still evident in societies but mimicked in different social practices[16]. Personally-mediated racism is related to prejudice and discrimination based on race, which may or may not be intentional. However, it manifests itself due to disrespect, mistrust, devaluation, accusation, and dehumanization[17].

Indeed, the human right to health, also known as the right to the highest possible health standard, comprises legally binding international components. One of the most critical components of the right to health is the International Covenant on Economic, Social, and Cultural Rights (ICESCR), especially ICESCR General Comment N° 14[18]. The right to health based on this comment encompasses essential elements assessed by the framework of four crucial indicators: availability, accessibility, acceptability, and quality (Chart 1). Availability refers to the existence and number of health facilities, goods, and services. Accessibility focuses on physical and economic access to health facilities' goods and services. Furthermore, accessibility has four dimensions: non-discrimination, physical, economic, and access to information. Acceptability is related to the sensitivity of health facilities, goods, and services to medical culture and ethics. Concerning quality health facilities, goods and services must be scientifically and medically adequate and of satisfactory quality[19].

Previous research in first world multiethnic countries such as the U.S.[20], United Kingdom[21], Australia[22], and New Zealand[23], and multiethnic developing countries such as Brazil[24], Mexico[25] and comparatively Brazil, Mexico, Colombia, and Peru[26], have emphasized racism as the cause of persistent health disparities. For example, a US-based survey of health disparities by race provided evidence of significant inequalities between the African American population and the country's white population. In the U.S., African Americans have higher mortality rates than their white counterparts for most leading causes of death[27]. However, health disparities are not biologically or culturally determined; they are explained by a complex structure of social, economic, and political factors[28]. Therefore, racism-related health disparities are a crucial argument for the relevance of social determinants of health[29,30]. Regarding human rights, non-racism and other discrimination are positions worth considering[31]; notably, accessibility to health facilities, goods, and services without discrimination is essential[32].

Given the need to systematize the knowledge accumulated in recent years, this proposal aims to assess racial discrimination in the care of women with abortions by health professionals.

Methods

This systematic review is based on the recommendations of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)[33]. An electronic search for papers was performed in the Virtual Health Library (BVS) databases (BDENF - Enfermagem, BINACIS, IBECS, LILACS, MEDLINE), Scientific Electronic Library Online (SciELO), National Library

Chart 1. Structure referring to the International Covenant on Economic, Social and Cultural Rights (ICESCR).

Data	Definition
Availability	Must have a sufficient amount of functioning public health facilities, goods and services, and programs
Accessibility	Health facilities, goods, and services must be accessible (i.e., physical, financial, and information access) to everyone within the State's jurisdiction, without discrimination
Acceptability	The social and cultural distance between health systems and their users determines acceptability. All healthcare facilities, goods, and services must respect medical ethics and be culturally appropriate and sensitive to gender and age. They must also be designed to confidentially respect and improve the health status of the individuals involved
Quality	Health facilities, goods, and services must be scientifically and medically approved and of satisfactory quality

Source: ICESCR[18].

of Medicine, and National Institutes of Health (PUBMED), Science Direct, CAPES Journal Portal (JSTOR Archival Journals, OneFile (GALE), Science Citation Index Expanded (Web of Science), Scopus (Elsevier), Social Sciences Citation Index (Web of Science), Sociological Abstracts (ProQuest), Taylor & Francis (online - Journals), with descriptors "*racism OR social discrimination AND abortion, induced AND health personnel OR comprehensive health care OR delivery of health care OR human rights*", chosen following search in Health Science Descriptors (DeCS) and Medical Subject Heading (MeSH).

Studies published regardless of the year of publication, in English, Spanish and Portuguese, and evaluating racial discrimination in the care provided by health professionals in situations of induced abortion were included. Literature review papers, articles in the form of theses, dissertations, monographs, editorials, case reports, and those that did not meet 80% of the items required by the methodological quality assessment scales used in this study were excluded. The following data were extracted from each included study: authors, year of publication and study, study design, location, studied population, evaluated outcome, methodological limitations, and main results.

The quality of observational studies was assessed using the Strengthening the reporting of observational studies in epidemiology (STROBE) scale[34], which proposes a list of 22 items that must be present in the body of the papers to be considered of quality. Paper quality categories were established in its version translated and validated in Brazil in 2008[35] and works meeting 80% or more of the items on the list are considered "A" category[34,35]. The Standards for Reporting Qualitative Research (SRQR)[36] was used to assess qualitative studies. Studies with quantitative-qualitative methodology were analyzed by both quality instruments. Studies that achieved a score equal to or greater than 80% on at least one of the two scales were included in this paper. Two independent reviewers assessed the thematic eligibility of the papers, and the methodological assessment was conducted by only one of the reviewers.

Results

We identified 3,826 papers and excluded 1,135 works because they were duplicated in the databases. After analyzing the titles and abstracts, we excluded 2,477 papers as they did not meet the research eligibility criteria. The remaining 214 works were read and analyzed in full, and 182 were excluded as they did not meet the inclusion criteria. The remaining 32 papers were analyzed by the STROBE and SRQR scales, and 14 papers were excluded as they did not achieve the minimum score of 80% of the items, leaving a final sample of 18 works. Figure 1 shows the paper selection process.

Chart 2 presents the general characteristics of the selected studies with the distribution of the works by year of publication, the geographic region where they were carried out, the methodological path, sample, and objective. About 78% of papers were published as of 2011.

The survey of papers without time restriction provided the observation of the trend of the historical series. The first paper found is from 2005, then others are from 2007, 2008, and 2009. The theme reappears only in 2011, with publications in all subsequent years up to 2020.

In the analysis of care provided by health professionals, the perception of subjects about in-

duced abortion and women as potential mothers are added to the meanings attributed to the maternity hospital to negatively influence the quality of care, leading to the objectification of women undergoing abortion[45]. In general, when asked about the possible reasons that lead women to become pregnant and abort, without distinction of occupational category, the set of professionals describe the users who induced abortion, including one or more of the following characteristics: black, poor financial conditions, less educated, marital bond instability, partner abandonment, lack of family support, and irresponsible and unbridled sexuality[38,39,44,47,48,51,52].

In some cases, a difference was observed in professionals by type of abortion, induced or not; that is, for those women who suffered a miscarriage, an image of fragility and recognition of their suffering is created, but they classify those who induced it as aggressive, aloof, relieved and indifferent. The latter are disqualified[24,29] and are assigned a state of psychic abnormality when performing an abortion.

The results show that health institutions and professionals in these hospitals include institutional violence in their practices[38,40,41,43,49,53], especially with dehumanizing care practices[51,52] and symbolic violence[52]. Furthermore, the non-prioritization of care for women with abortions is evident in the scarce attention given to these users and the existence of racial discrimination. The articles identify the poor conditions of the health units, the deficient service infrastructure, with overcrowding in maternity wards[44,47,51-54].

The analysis of obstetric services identified two areas in which the literature associates the presence and reproduction of institutional violence: on the one hand, the concepts and values of the caregivers themselves regarding abortion[43,53] and the care provided in maternity wards[49,51] and,

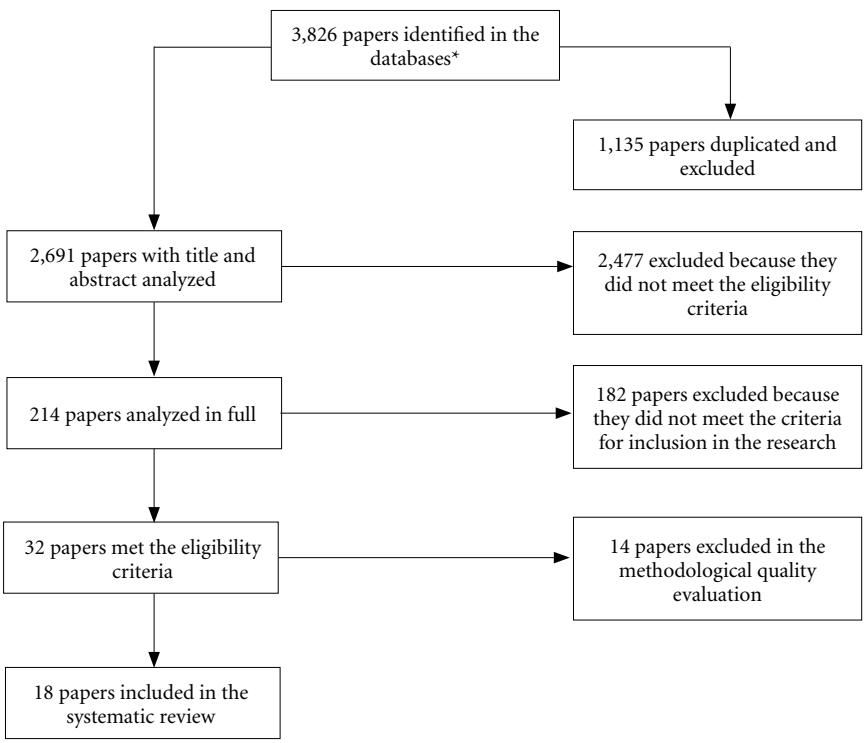

Figure 1. Flowchart of paper selection for systematic review, 2020.

*Databases searched: Virtual Health Library (BVS) (BDENF - Enfermagem, BINACIS, IBECS, LILACS, MEDLINE), Scientific Electronic Library Online (SciELO), National Library of Medicine and National Institutes of Health (PUBMED), Science Direct, Capes Journals Portal (JSTOR Archival Journals, OneFile (GALE), Science Citation Index Expanded (Web of Science), Scopus (Elsevier), Social Sciences Citation Index (Web of Science), Sociological Abstracts (ProQuest), Taylor & Francis Online - Journals).

Source: Elaborated by the authors.

Chart 2. Descriptive characteristics of studies on racial inequalities and abortion care provided by health professionals, 2020.

Author (year)	Journal	Study location	Methodological Approach	Sample	Objective
Motta[37] (2005)	Rev. Bras. Saude Mater. Infant.	Rio Grande do Norte (RN), Brazil	Qualitative exploratory-descriptive research. Semi-structured interviews and data from medical records	17 women aged 15 to 30 years	Evaluate the qualitative characteristics of the interpersonal relationship between health professionals and women with incomplete abortion.
Bispo and Souza[38] (2007)	Rev. Baiana de Enferm.	Feira de Santana (BA), Brazil	Qualitative research. Semi-structured interview	9 women (brown and black) aged 19 to 39 years	To analyze the respondent's perception of institutional violence.
Gesteira et al.[39] (2008)	Acta Paul. Enferm.	Salvador (BA), Brazil	Qualitative research, detailed case study, content analysis, focus group	05 nurses and 04 nursing assistants	To observe the health problem that involves women in the process of induced abortion. The discourse of nursing staff professionals regarding the care provided to women was analyzed to change care for these women towards humanization.
Harries et al.[40] (2009)	BMC Public Health	Western Cape (South Africa)	Qualitative research. Focus group	Thirty-four health professionals involved in a range of aspects of providing abortion services.	Despite changes in abortion legislation in South Africa in 1996, barriers to women's access to health services still exist, including opposition by professionals, compounded by the lack of trained and willing abortion professionals.
Aguiar and d'Oliveira[41] (2011)	Interface (Botucatu)	São Paulo (SP), Brazil	Qualitative research. Semi-structured interview	21 women above 18 years	To present and discuss data from a survey on institutional violence in public maternity hospitals for women with an induced abortion situation.
Benute et al.[42] (2012)	Rev. Bras. Ginecologia e Obstetrícia	São Paulo (SP), Brazil	Quantitative research, cross-sectional study. Self-applicable questionnaire	Professionals (n=119) working in the Department of Obstetrics, University Hospital, and the public hospital in the outskirts of São Paulo.	To verify the knowledge about Brazilian legislation and the perception of professionals working in obstetrics related to induced abortion.
Aguiar et al.[43] (2013)	Cad. Saúde Pública	São Paulo (SP), Brazil	Qualitative research. Semi-structured interview	Eighteen health professionals working in public and private networks, including obstetricians, nurses, and nursing technicians.	To analyze institutional violence, medical authority, and power in maternity hospitals from the perspective of health professionals in caring for women undergoing an induced abortion.
Carneiro et al.[44] (2013)	Interface (Botucatu)	Salvador (BA), Brazil	Qualitative research. Semi-structured interview. Content analysis	Nineteen women aged over 18 years about the experience at different stages of hospitalization and evaluating the care received.	To understand the experience of women hospitalized for an abortion caused in three public hospitals in Salvador, Bahia, from the path and interactions they establish with professionals and other users.

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Chart 2. Descriptive characteristics of studies on racial inequalities and abortion care provided by health professionals, 2020.

Author (year)	Journal	Study location	Methodological Approach	Sample	Objective
Lemos and Russo[45] (2014)	Interface (Botucatu)	Rio de Janeiro (RJ), Brazil	Qualitative and ethnographic approach, using participatory observation	11 health professionals	To analyze the view of health professionals about induced abortion and its relationship with professional practice.
Nieminen et al.[46] (2015)	BMC Medical Ethics	Kuopio University Hospital (Finland)	Quantitative research. Cross-sectional study. Self-applicable questionnaire	548 medical and nursing students and professionals	To study how Finnish medical and nursing students and professionals assess conscientious objection both per se (whether it should be allowed or not) and as a complex process, as are the professionals and instances for which conscientious objection can be allowed.
Aniteye et al.[47] (2016)	BMC Health Services Research	Accra (Ghana)	Qualitative research. Semi-structured interview	Three hospitals and five health centers. Participants (n=36) consisted of an obstetrician/ gynecologist, obstetric nurses, and pharmacists.	To explore the challenges in providing obstetric care to induced abortion patients, avoiding racism and institutional violence by health professionals.
Mccallum et al.[48] (2016)	Hist. Ciên. Saúde-Manguinhos	Salvador (BA), Brazil	Qualitative research. Participatory observation	One hundred thirteen professionals, including doctors, nursing assistants and technicians, psychologists, social workers, and nutritionists.	To analyze the hospital experience of women in the face of voluntary interruption and the viewpoint of health professionals, evaluating how the institution structures abortion care and the symbolization processes imbricated to it that can profoundly affect women's experiences.
Chavkin et al.[49] (2017)	Health and Human Rights	England, Italy, Norway, Portugal	Qualitative research. Comparative multiple case study that triangulates multiple data sources, including interviews with key stakeholders from all sides of the debate.	Fifty-four hospital managers from countries involved in research on care for women in abortion situations.	To investigate the effectiveness and acceptability of laws and policies that allow conscientious objection (abuse of professional power) and guarantee access for women in abortion situations.
Madeiro and Rufino[50] (2017)	Ciência & Saúde Coletiva	Teresina (PI), Brazil	Qualitative research. Semi-structured interview	Seventy-eight women admitted to a public hospital of reference in Teresina due to induced abortion complications.	To identify the magnitude and impact of institutional violence on care for induced abortion complications.
Ishoso et al.[51] (2018)	PLoS ONE	Kinshasa (Democratic Republic of Congo)	Quantitative research. Descriptive cross-sectional study	843 obstetric and gynecological patients admitted as emergency cases	To analyze the extent and characteristics of induced abortion-related complications, including length of hospital stay, the mortality rate from induced abortion complications and its characteristics, and deaths occurring after two hospitalization days.

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Chart 2. Descriptive characteristics of studies on racial inequalities and abortion care provided by health professionals, 2020.

Author (year)	Journal	Study location	Methodological Approach	Sample	Objective
Orpin et al.[52] (2019)	Benue (Nigeria)	Qualitative research. Semi-structured interview	16 health professionals	To examine how health professionals perceive the disrespect and abuse to women undergoing an abortion, emphasizing induced abortion during care in Benue state, Nigeria.	Examinar como os profissionais de saúde percebem o desrespeito e abuso às mulheres em situação de aborto, com destaque ao aborto provocado, durante o atendimento no estado de Benue, Nigéria.
Dorr and Dietz[53](2020)	PLoS ONE	Veracruz (Mexico)	Qualitative research. Participatory observation	60 health professionals	To analyze the care of patients undergoing abortion care concerning the cultural, individual, and institutional racism.
Goes et al.[54] (2020)	Research performed in Salvador (Bahia), Recife (Pernambuco) and São Luís (Maranhão), Brazil	Quantitative research. Analytical cross-sectional study	2.640 users admitted to public hospitals.	To analyze the factors related to individual barriers in searching for the first post-abortion care by ethnicity/skin color.	Analisar os fatores relacionados às barreiras individuais na busca do primeiro atendimento pós-aborto segundo raça/cor.

Source: Elaborated by the authors.

on the other hand, institutional norms and the work process[37,39,42]. These factors combined show attitudes and practices that refer to institutional violence. Studies have pointed to physical violence in most cases of induced abortion by not offering medication, whether analgesics or anesthetics, to relieve pain[52,53]. Concerning verbal violence, questioning women's morality emerges, which is also verbally stigmatized[46,47], with depersonalization and embarrassment[41].

In Brazil, Gesteira et al.[39] point out the influence of the context of the illegality of abortion and society's moral values on professionals' perceptions about the poor quality of care. However, in this study, the discussion of its results quickly addresses the broader social context elements without an in-depth analysis of institutional violence.

Some studies discuss the sociocultural conditioning that influences professionals and their care practices[51-53]. The authors note pre-judgment attitudes of professionals and their difficulties in letting go of their convictions in caring for women. However, attitudes and ethical conflicts are analyzed, disregarding the immediate institutional context of motherhood and the historically constituted political processes that define the possible actions of institutions and individuals working in them.

Harries et al.[40] recognize the context involving institutional practices, with low investment in workers' qualification and fragmented and verticalized work process, with implications for the relationship between workers themselves and between them and users. Thus, the insufficient training of professionals and managers to address social and subjective issues that interfere in health care practices is also admitted.

In general, the perceptions of health professionals regarding women in situations of induced abortion were marked by negative values, which influenced the senses and meanings attributed to this practice and, consequently, about the women attended, making them responsible for the pregnancy and its interruption, with naturalized discriminatory attitudes[39].

Discussion

From the exposure of the main findings, we consider that the study met the proposed objectives, bringing significant results and discoveries about racial inequalities by analyzing care for abortion induced by health professionals. Studies have

reported verbal and physical abuse in patients, care dehumanization, lack of privacy and confidentiality, ill-treatment, and negative and hostile attitudes of the staff as a barrier to the use of qualified services[39,47,51,52]. Similar to the findings of this review, factors such as inadequate staff, infrastructure, equipment and supplies, and lack of supervision by health professionals were also described as important factors that contribute to disrespect and racism[37,38,47,53]. Disrespect and racism were essentially defined as a hostile, inadequate, or negative attitude of the team[48,53].

Racism occurs at multiple levels, including institutional, interpersonal, and internalized. Institutionalized racism results in differentiated access to society's resources, services, and opportunities by ethnicity. Concerning resources, institutionalized racism includes disparities in access and quality of education, safe housing, employment, health resources, and environmental conditions. These, combined with the lack of opportunities to influence policies, limit the power of racial and ethnic minorities enforcing decisions. Interpersonal racism refers to prejudice and discrimination resulting in different assumptions about the abilities and reasons of others according to their race. Discrimination includes treating other people differently based on their race and is more commonly considered racism[15,16]. Finally, internalized racism results in accepting negative attributes, competencies, and values by members of marginalized groups. Internalized racism limits someone's ability to reach their maximum potential[55].

Only three studies with a quantitative approach were identified, which has an impact since there is no comprehensive information on the opinions, attitudes, and knowledge of health professionals regarding abortion, mainly induced abortion, which was the focus of the search. Perhaps this is due to a possible lack of support for conducting more comprehensive surveys with these professionals, since quantitative surveys, generally applied to quite numerous samples, require standardized, validated, and reliable questionnaires that can be used for this purpose, besides significant amounts of financial resources and institutional support. Another result that drew attention was the lack of data on mental health professionals.

Our review results highlighted a research where racial and ethnic minority women experience greater lifetime exposure to chronic stressors, which may increase their risk of poor pregnancy outcomes[56]. The accumulation of stress throughout a woman's life, known as allostatic load, is associated with worse health outcomes[57]. Racial discrimination is one chronic stressor that can be a risk factor for adverse birth outcomes. The definitions of racism vary, but they all include the concept of unequal treatment due to skin color or other individual traits[55].

Finally, another fact that perhaps must be researched in greater depth and, if possible, in greater breadth, is the perception of racist attitudes in clinical care in abortion situations. The literature points to research suggesting a broad acceptance of abortion cases allowed by law[58-61], and situations of severe fetal malformation also have the approval of most health professionals[62].

Conclusion

Despite its limitations, this review has some critical implications for a field of research that has received little attention. Forced abortions are common, and women who have them suffer various types and degrees of stigma. Racism and other related ideologies such as sexism and classism are relevant health concerns, although application in practice seems insufficient based on the evidence of disrespect and abuse. Our data show how institutionalized racism manifests itself in the lack of qualified human resources, insufficient quantity and quality of functional health products, and income-related discrimination within medical facilities. We also highlight examples of internalization by victims of racism and reproduction of discrimination by health professionals.

Strengthening the health system's capacity by employing an adequate number of health professionals, especially in areas with unmet needs, along with improving infrastructure facilities, will also reduce disrespect and abuse practices allegedly caused by problems such as overcrowding in facilities and lack of health professionals.

Underlying social perceptions point to the need for awareness campaigns and educational interventions at broader socio-political and community levels, including educating women and men about the rights to respectful care. Finally, racism violates the right to health in all dimensions.

Collaborations

AP Ferreira worked on the design, research, methodology, and final writing. MR Godinho and CST Nichele worked on the research, methodology, and final writing. VR Girianelli worked on the methodology and final writing. AB Silva and GCP Cardoso worked on the conception and final writing.

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