REVIEW

The role of Primary Health Care in the access to legal abortion: international experiences

Melanie Noël Maia [1]
https://orcid.org/0000-0002-5350-0549

Liana Wernersbach Pinto [2]
https://orcid.org/0000-0003-1928-9265

[1] Faculdade de Medicina. Universidade Federal do Rio de Janeiro. Av. Carlos Chagas Filho, 373. Bloco K, 2º andar, Sala 49. Cidade Universitária - Ilha do Fundão. Rio de Janeiro, RJ, Brazil. CEP: 21.044-020. E-mail: melnoelmaia@medicina.ufrj.br
[2] Departamento de Estudos sobre Violência e Saúde Jorge Careli. Fundação Oswaldo Cruz (CLAVES/FIOCRUZ). Rio de Janeiro, RJ, Brazil.

Abstract

Objectives: to analyze the clinical guidelines of countries that offer abortion in Primary Health Care (PHC), aiming to understand how the service delivery and the performance of PHC professionals occurs in different scenarios, to reflect on the viability of this offer in Brazil.

Methods: narrative review carried out from the Global Abortion Policies Database platform, which gathers comprehensive information on abortion laws, regulations and clinical guidelines. Clinical guidelines from countries where abortion is performed at the first level of care were selected, in English, Spanish and Portuguese.

Results: 26 countries were identified and 13 were included in the study. In general, abortion is performed in PHC in the first trimester, using medication or aspiration techniques, by different professional categories depending on the location, without the need for prior ultrasound.

Conclusions: the study of international experiences shows that it is possible to provide abortion in PHC services using the existing workforce and structure, in accordance with the recommendations of the World Health Organization to facilitate access to the procedure. In Brazil, despite the problems related to access to legal abortion, its performance remains restricted to hospitals. It is expected to contribute to the reformulation of regulations regarding abortion in the country.

Key words *Induced abortion, Legal abortion, Health services accessibility, Primary health care, delivery of health care, Practice guideline*

http://dx.doi.org/10.1590/1806-9304202400000286-en

Introduction

In 2022, the World Health Organization (WHO) updated its clinical guidelines concerning abortion care, and highlighted the quality of care as a structural aspect for its recommendations. Accessibility is recognized as one of the main components of quality, and presupposes that healthcare could be obtained timely, at a viable cost, in a geographically accessible location, where resources and techniques that are necessary for their execution are available. Accessibility is understood as aspects of the structure of a given healthcare service or system that are mandatory to achieve healthcare itself, whilst access is the way that people experience these characteristics.[2]

Although it is a simple procedure, with low potential of complications, considered an essential service for reproductive health, several barriers can be observed in the access to abortion across the world, including situations in which it is provided for by law. Some examples are the absence of precise information on availability of abortion, biased counseling, imposition of mandatory waiting periods for the confirmation of a decision of women, the requisition of third party authorization, unavailability of essential medications and restrictions related to facilities and health professionals that may provide the abortion.[1]

Since 2003, when the first edition of the technic document entitled "Safe abortion: technical & policy guidance for health systems"[3] was published, the WHO indicates the offer of abortion in Primary Healthcare (PHC) services as an important mechanism of facilitation of access to the procedure, highlighting that developing these services and qualifying their professionals are some of the most relevant investments that can be made. In the 2022 guidelines, the provision of abortions in PHC is still mentioned as a necessary, safe and effective strategy to promote equitable access. Both medication abortion and vacuum aspiration, considered methods of choice for the execution of the procedure in pregnancies of up to 14 weeks, can be performed with safety in this level of attention.[1]

Brazil's Law is, worldwide, one of the most restrictive in relation to abortion, the latter being allowed only in pregnancies that occurred after a rape, when the pregnant women is at risk of life or in cases of anencephaly.[4,5] Even in this cases, the offer of the procedure in the Unified Health System (SUS – Portuguese acronym) is limited and distributed unequally in the national territory, being present in less than 4% of municipalities and concentrated on those more populous and with a higher human development index. Only 26.7% of female population of childbearing age in the country reside in municipalities that offer legal abortion, and those women present a rate of execution of the procedure almost five times higher than those of women residing in municipalities without the offer of the procedure.[6,7]

The regulation of reference services for interruption of pregnancy cases provided by law can be understood as one of the reasons for the inequality of access observed, since it preconizes that its organization is restricted to hospitals, maternities and other urgency and emergency services with uninterrupted operation, 24 hours a day and seven days per week, among other requisites.[8] In case of being adopted in Brazil, the WHO abortion care guidelines in PHC services, considering the current capacity implemented, legal abortion could be offered in at least 67% of Brazilian municipalities, were 94.3% of women of childbearing age resides.

The absence of access to legal abortion, besides constituting a violation of human rights, may generate severe consequences that are potentially fatal, such as the use of unreliable methods for interrupting a pregnancy. Observing the potential of radical change in the Brazilian panorama concerning accessibility to abortion care, this article aims to analyze clinical guidelines of countries that offer this procedure in the first level of care, in attempt of understanding the organization of services and acting of PHC professional in different scenarios, so that the discussion on the availability of this service in Brazil can be expanded.

Methods

Narrative review of clinical guidelines of countries that offer abortion care in PHC services, which started with the platform Global Abortion Policies Database (GADP),[9] launched in 2017 by WHO and collaborators. GADP is a database of free access that gathers detailed information on laws, regulations and clinical protocols related to abortion in WHO and United Nations (UN) country members. All information present in this database were extracted of source-documents that can be accessed from the platform.[9]

The database possesses functionalities that allow filtrating countries according to some characteristics. For the identification of countries that offer abortion care in PHC services, we used a specific filter for this information ("*Clinical and service-delivery aspects of abortion care - Where can abortion services be provided* - Primary health-care centers"). The clinical guidelines of abortion care (and specific regulations about abortion, when essential information were missing on the guidelines) in the identified countries were accessed, from the platform, with further search for updated versions in the governmental official websites. Those available in Spanish, Portuguese or English were included in the present study. The identification and selection of countries were performed in April 2023.

The analysis of clinical guidelines of countries included in the study, carried out from April to June 2023, aimed to extract data that allow comprehending the functioning of abortion in PHC services, as well as the general characterization of the regulation of access to abortion in those countries. Some of the WHO current recommendations,, directly or indirectly related to the access to the procedure, were used as lens analysis. The document "Abortion care guideline",[1] published by WHO in 2022, presents a group of recommendations, based on scientific evidence that attempted to induce qualified care to abortion situations in different scenarios. The recommendations, are clustered in four domains, namely: laws and policies, provision of services, clinical management and self-management.

With regard to laws, we investigated the situations in which abortion is allowed by law, the limits of gestational age for its execution, the existence of a mandatory waiting period between the request and execution of the procedure, and the mandatory authorization of guardians for minors. In relation to provision of services, we observed the procedures offered in the first level of care (medical and/or surgical abortion), the professionals qualified for its execution and the limit of gestational age that allows the abortion to be done at PHC. With regard to clinical practices, we verified the availability of medicines considered essential, the obligation of ultrasound exam before the procedure and the possibility of self-management at home.[1]

Data collected were compared to Brazilian regulations[4,5,8,10] whenever possible. Considering the strict usage of documents of public access, this study was not submitted to the appraisal of research ethics committees.

Results

Of the 193 countries recognized by UN, 26 offers abortion in PHC services, whilst 11 professedly do not offer this procedure in the first level of care; for 156 countries, there is no specific information available.[9] Of the 26 countries that perform abortions in PHC services, 13 have clinical guidelines in Portuguese, English or Spanish, being included in this study. Figure 1 demonstrates the process of selection of guidelines, and Figure 2 shows the countries that offer abortion in PHC.

The documents included in this review are mostly clinical guidelines published by government departments, which aim to orientate the performance of health professionals in the provision of legal abortion.[11-23] For Mozambique and Colombia, it was necessary to add laws that modified the situations in which abortion is allowed after the date of publication of guidelines;[24,25] for Spain, due to the inexistence of a national guideline, we used the organic law of sexual and reproductive health and voluntary interruption of pregnancy,[26] the decree of guarantee of quality of assistance of voluntary interruption of pregnancy[27] (both with national broadness), and the clinical protocol of one of the autonomous communities of the country[22] (Canary Islands, since it is the only available in GAPD platform in Spanish).

The results are disposed into three topics: Characterization of laws and policies related to abortion in countries that offer its execution in PHC services; Aspects related to the provision of abortion care services in countries that offer its execution in PHC; and Aspects related to clinical management and self-management of abortion in countries that offer its execution in PHC.

Characterization of laws and policies related to abortion in countries that offer its execution in PHC services

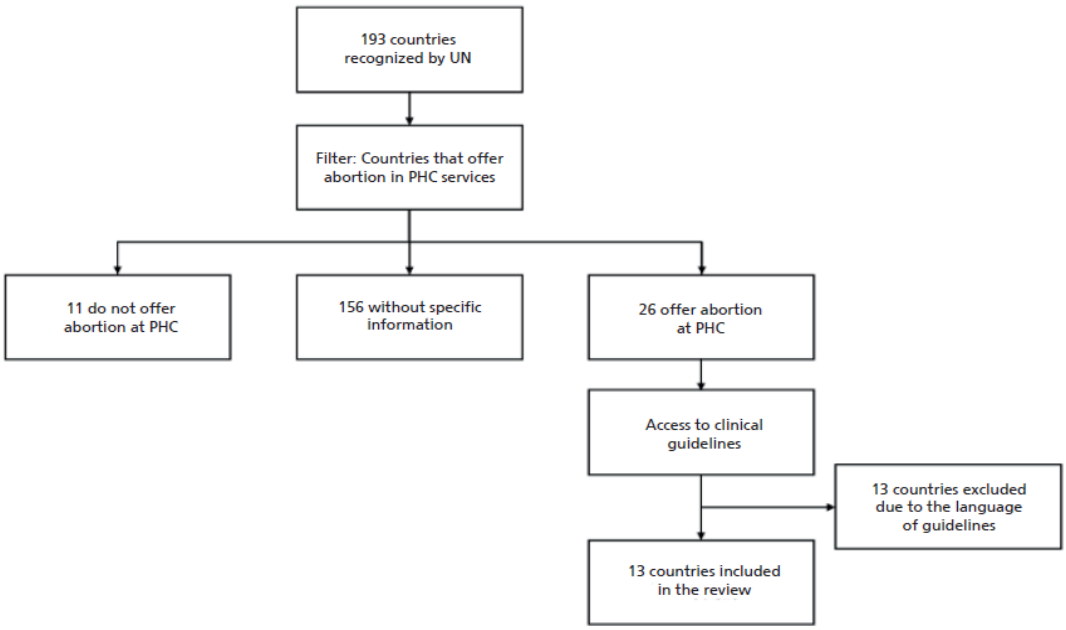
Eight countries allow abortion by women's choice, being the limit of gestational age mostly placed in the transition of the first to the second trimester of pregnancy.[11,15,19,23,24,26] Colombia and Singapore stand out for authorizing abortion by women's choice up to 24 weeks of pregnancy.[21,25] In Mexico, although the regulation of the procedure occurs in sub-national level, the Supreme Court of Justice decriminalized abortion in up to 12 weeks in national level, averting women or professionals to be punished for its execution in the entire country.[17] India, Zambia and Ethiopia allow the execution of abortion in specific situations and the legal permissives of the first two are broader, since they include cases in which pregnancy stand out as damages to mental health.[12,14,20] Bangladesh situation is worth to be presented separately, since abortion is allowed in the country only to save women's life, but menstrual regulation (MR) is comprehended as a strategy of reproductive planning, and not as means of abortion.[18]

Whilst the mandatory waiting period is current in four countries,[13,21,23,26] in Colombia and Argentina a maximum term is legally established, in which the procedure should be performed (respectively, from five to ten days after the first consultation), aiming to protect the requesting person from medical, bureaucratic and legal barriers that may delay the access.[15,16] The Ethiopian guidelines are not clear whether the interval of three days, in which counseling and diagnosis measures occur, is a mandatory waiting period.[12]

Regarding abortion in minors, in three countries the involvement of parents or guardians is not necessary for the authorization of the procedure,[11,12,16] and in four countries this authorization is necessary.[14,18-20] Spain, Ireland, Argentina, Mexico and Mozambique present varied targeting per age group, defining an age from which the consent could be provided independently (12 years in Mexico and 16 in the others).[15,17,23,24,26]

Figure 1

Flowchart of selection of clinical guidelines for the narrative review.



UN= United Nations; PHC= Primary Healthcare.

Figure 2

Countries that offer abortion in Primary Healthcare services.

Table 1 presents the details of laws and policies related to abortion in 13 countries included in the study.

Aspects related to the provision of abortion care services in countries that offer its execution in PHC

The guidelines researched mostly indicate the possibility of execution of medical abortion and vacuum aspiration in PHC,[11-14,16-20,22] with a limit of 12 weeks for the provision of abortion in this level of care.[11-15,17-20] Some countries establish a lower limit of gestational age for medical abortion than vacuum aspiration abortion.[12,19,20] Such limits find justification in previous WHO publications and scientific evidence available in the period of publication of these guidelines, which established safety and effectiveness of medical abortion only up to nine weeks.[1]

With regard to the professionals that can provide abortion in the first trimester, some countries restrict the practice only to physicians,[16,20,21,23,27] whilst others include nurses,[17] obstetricians[11,14] and mid-level practitioners.[11,12,13,18,19] The guidelines of Argentina do not approach this information clearly (using the term "health professionals").[15] Only Spain restricts the practice of abortion of first trimester to physicians specialized in Gynecology and Obstetrics.[27] Table 2 resumes the individualized information of surveyed countries.

Aspects related to clinical management and self-management of abortion in countries that offer its execution in PHC

Both mifepristone and misoprostol are registered in all countries included in the study. With regard to the execution of ultrasound exam, only Spanish regulations determine this exam as a mandatory prerequisite for the execution of abortion.[27] Most researched guidelines contemplate the possibility of self-management of abortion at home, with variations in the maximum gestational age allowed (between seven and 12 weeks).[11,13-15,17-20,22,23] The information related to this topic are consolidated in Table 3.

Discussion

When documents are used as data source, it is important to comprehend them as means of communication, and not only as an information repository; thus, aspects as authorship and context in which they were produced should be valued.[28] Of the 13 countries included in the study, four are classified by UN as having very high human development index (HDI) (in descending order of HDI: Ireland, Singapore, Spain and Argentina), three present high HDI (Mexico, Colombia and South Africa), other four present medium HDI (Bangladesh, India, Cambodia and Zambia) and two present low HDI (Ethiopia and Mozambique).[29] By means of comparison, Brazil is classified as a country with high HDI, scoring the 87º position in the 2021/2022 report, between Mexico (86º) and Colombia (88º).[29]

The clinical guidelines of several countries were published in partnership with or counted on the support of organizations that act in the defense of reproductive rights, such as the United Nations Population Fund (UNFPA) and Ipas (an international, non-governmental organization that seeks to increase access to safe abortions and contraception), or WHO itself. This support is mentioned in all documents, except for Ireland, Spain and Singapore.[11-20]Notably, these three countries are the only that present very low maternal mortality ratio (MMR).[30] All others present low or moderate MMR,[30] and describe in their guidelines a still unfavorable scenario for maternal mortality, with deaths by abortion standing among the main causes. To this extent, they explicitly signalize the need for ensuring the access to safe abortions whenever provided for by law, as a manner of averting maternal deaths.[11-20]

With regard to laws and policies, the WHO recommends abortion to be excluded from penal codes, since the criminalization does not decrease its occurrence, but increase health risks associated with clandestine and unsafe procedures, affecting women of higher vulnerability situation in a disproportionate manner.[1] In the same way, the organization has recommendations that are opposite to laws and regulation that restrict abortions to determinate situations or establish gestational age limits, as well as practices that impair the access to the procedure, such as mandatory waiting periods and the need for third party authorization.[1]

When analyzing the characterization of laws and policies related to abortion in countries included in the study, it is possible to identify some guidelines with a discourse more focused on the defense of reproductive autonomy, such as in the publications of Argentina, Colombia and Mexico – which are the most recent due to legal changes that occurred in the last four years.[15,17,25] These countries exemplify the movement of change that has been observed in Latin America, previously characterized by very restrictive laws and highly patriarchal societies.[31] Bangladesh and India are in a distinct situation: relaxation of laws observed in the access to abortion seem to be primordially directed for the prevention of maternal deaths, not prevailing in the guidelines a valorization of reproductive autonomy.[18,20] At the same time, the Human Development Report 2021/2022 evidences that these two countries are classified as having a diminished equality between men and women, in relation to HDI results.[29]

When comparing the Brazilian regulation with the countries included in this study, we observe a

Table 1

Characterization of laws and policies related to abortion in countries that offer its execution in Primary Healthcare services (PHC).

Country	Situations in which abortion is permitted (gestational age limit)	Mandatory waiting period	Specificities for minors
South Africa[11]	By women's choice (up to 12 weeks and six days) Risk of damage to women's physical or mental health; substantial risk of fetus physical or mental anomalies; pregnancy resulting from rape or incest; risk of social or economic damages to women (up to 20 weeks and 6 days) If the continuity of pregnancy is a risk for women's life; severe fetal malformation or risk of lesion for the fetus (after 20 weeks and six days)	No	No consent besides that of the pregnant woman is necessary, regardless of the age. Minors may benefit in consulting an adult (parents, guardians or other adult relative or friend) before interruption of pregnancy. However, consulting an adult is not mandatory and the service cannot be refused if the minor opt not to do it.
Ethiopia[12]	If the pregnancy is resulting from rape or incest; if the continuity of pregnancy puts the life of mother or child at risk or the mother's health; if the fetus has severe and incurable anomalies; if the pregnant women, due to physical or mental impairment or being minor, is physically or mentally unable to raise the children (up to 28 weeks) In case of severe and imminent risk that may be avoided by immediate intervention (without gestational age limit explicitly defined)	Women eligible for pregnancy interruption should obtain the service within three labor days. This period is used for counseling and diagnosis measures that are necessary for the procedure	The sign of consent term for the realization of procedure should not be demanded for minors (<18 years), and consent from parents or guardians is not necessary
Mozambique[13,24]	By women's choice (in the first 12 weeks) If the pregnancy is resulting from rape or incest (in the first 16 weeks) If there is secure motivation to predict that the newborn will suffer a severe and incurable disease or congenital malformation(In the first 24 weeks) If the fetus is not viable; if the interruption avoid risk of death or severe and enduring lesion for the body of physical health of the pregnant women, or recommendable in case of chronic-degenerative diseases (without limit of gestational age explicitly defined)	Pregnant women's consent should be obtained with minimum antecedence of three days in relation to the date of intervention. If it is not possible to perform and the execution of abortion is urgent, the physician will decide each situation, relying on the opinion of other physicians when possible	When the pregnant woman has less than 16 years, the consent of a legal ascendant representative should be obtained, or, in the absence, of collateral relatives. If it is not possible and the abortion is urgent, the physician will decide each situation, relying on the opinion of other physicians when possible
Zambia[14]	When the pregnancy is resulting from rape or incest; when there is substantial risk of the fetus suffering from severe physical or mental anomaly; when the continuity of pregnancy represents a risk for the physical or mental well-being of women, or will significantly affect the economic or social situation of women (up to 12 weeks) When the continuity of pregnancy represents risk for women's life; when the continuity of pregnancy represents risk of damage to the fetus or severe fetal malformation (after 12 weeks)	No	If the patient's age is under the age of legal consent for medical or surgical procedures (under 18 years), the approval of parents or guardians to interrupt pregnancy should be scheduled. The best interest of the minor will prevail over that of parents or guardians

Argentina[15]	By the choice of the girl, adolescent, woman or person with other gender identity able to be pregnant (up to 14 weeks) When the pregnancy is resulting from rape or there is any risk for the life or health of the pregnant person (without explicitly defined gestational age limit)	No	Girls under 13 years: May provide consent with the assistance of parents or any person who formally or informally provides care, who should also sign the informed consent Adolescents 13-16 years: may provide the consent independently, except for situations in which a technique that may severelyendanger the health or life is necessary. In this cases, the assistance of parents or any person who formally or informally provides care. After 16 years: all people, with or without malformation, may provide their consent independently
Colombia[16,25]	By women's choice (up to 24 weeks) When the continuity of pregnancy represents risk for the life or health of women; in case of severe malformation of the fetus that makes its life unfeasible; when the pregnancy is resulting from a conduct, properly reported, which constitutes sexual intercourse without consent, abusive or artificial insemination or non-consented transfer of in vitro fertilization embryo, or from incest (without gestational age limit)	No	Minor women, like every women, in the exercise of their essential rights of free development of personality, autonomy and dignity, is authorized to access health services and request the procedure of voluntary pregnancy interruption
Mexico[17]	Legal abortion is regulated at state level, not at national level. The interruption of pregnancy resulting from rape is allowed in all states, and there is federal regulation for this situation, which should be followed in the entire country. Other situations in which it is permitted, limits of gestational age vary from state to state.	Varies according to each state	In case of sexual violence, girls and adolescents older than 12 years can request independently the voluntary interruption of pregnancy. In case of girls under 12 years, it can be requested by parents or guardians; in the absence of these, the competent authority should be informed, and have the obligation to preserve the protection and best interest of children.
Bangladesh[18]	Penal code permits abortion only with the purpose of saving women's life. In spite of the restrictive nature of the law, the services of "menstrual regulation" (MR) were included in the family planning program of the government. MR is "a provisory method for establishing non-pregnancy for a woman at risk of pregnancy, regardless if she is pregnant or not". The MR services have no conflicts with the current abortion laws, since they are provided as a substitutive of family planning methods of the government, and not as means of abortion.	No	A guardian's consent is necessary for youngsters under 18 years
Cambodia[19]	By women's choice (up to 12 weeks) When there is a presumable cause for the fetus not to be normally developed or that may cause risks for mother's life; when the baby to be born may have a severe and incurable disease; when the pregnancy is resulting from rape (without explicitly defined gestational age limit).	No	For minors, one of the parents or guardians should sign the consent form in the name of the patient.

India[20]	When the continuity of pregnancy represents risks for the life of the pregnant woman or causes severe injuries to her mental or physical health (The angst caused by an undesired pregnancy in the following situations presumably causes severe injury to the pregnant woman's mental health: rape or incest; failure of any dispositive or method used by a married women or her husband with the intention of limiting the number of children); when there is a substantial risk of the newborn is born with physical or mental anomalies that would make it severely impaired (up to 20 weeks)	No	In the case of minors, it is necessary the consent of a guardian.
Singapore[21]	By women's choice (up to 24 weeks) When treatment is immediately necessary to save a life or prevent severe and permanent injury to the health of the pregnant women (without explicitly defined gestational age limit	At least 48 hours should be elapsed after pre-abortion counseling before the pregnant woman could provide her written consent for the treatment.	No information
Spain[22,26,27]	By women's choice (up to 14 weeks) When there is severe risk for the life or health of the pregnant women; when there is risks of severe fetal anomalies (up to 22 weeks) When fetal anomalies that impede the survival, or extremely severe and incurable disease at the moment of diagnosis (without gestational age limit)	A period of at least three days should be observed between the counseling and execution of intervention.	In the case of women aged 16 and 17 years, consent dependsexclusively on them. At least one of the legal guardians should be informed about the decision of the women. This information will be dispensed when the minorconfirmedly reports that it will lead to severe conflicts, with risks of familiar violence, threats, coercion, mistreats or helpless situations.
Ireland[23]	By women's choice (up to 12 weeks) When there is immediate risk of life or severe injury to women's health, and the immediate interruption of pregnancy is necessary to revert this risk; when there is a fetal condition that will probably lead to its death before or within 28 days after its birth (without gestational age limit) When there is risk of life or severe injury to women (up to the limit of fetal feasibility)	An interval not inferior to three days between the first medical assessment and the execution of the procedure is necessary	Youngsters under 18 years are encouraged to involve their parents or other guardian in the decision. If the person has 15 years or less and decides not to involve an adult, the physician may offer abortion in specific circumstances. If the person has 16 or 17 years and decides not to involve an adult, the physician may offer abortion when confident about the comprehension of information and the consent is valid

more restrictive law, with only three legal permissives for abortion.[4,5] There is no prevision of mandatory waiting period, although the authorization of parents or guardians is required in order to request the procedure for minors.[8]This is a particularly sensitive topic in the country, considering the elevated incidence of pregnancies in adolescence, with a high rate of pregnancies resultant from rape in this age group.[32]

With regard to the provision of abortion care services, the WHO recommends vacuum aspiration in pregnancies of up to 14 weeks to be performed by general practitioners or specialized physicians, nurses and obstetricians, as well as other professional categories not regulated in Brazil, such as professionals of traditional and complementary medicine and associated practitioners.[1] Medical abortion in pregnancies of up to 12 weeks, on the other hand, may be performed by all of these professional categories, also by community health agents, pharmacy workers, pharmaceutical professionals and nursery technicians.

The strategy of redistribution of tasks between members of a health professional team is called "task shifting", which allows less specialized professionals to perform functions that are traditionally carried out by other professionals with higher graduation. This strategy is encouraged by WHO as a way of ensuring the right to health. It is perceived that restrictions concerning professional categories that can provide abortions are higher in countries with very high or high HDI, which probably reflects a higher availability of higher education professionals. The WHO affirms that such restrictions are inconsistent in relation to its recommendations, since they are arbitrary and not based on evidence, promoting risk of limitation of access to the procedure.[1]

In Brazil, the law describes abortion as a medical act.[4] The regulation of reference services for pregnancy interruption in cases provided for by law, on the other hand, establishes that "the multidisciplinary health team should be composed

Table 2

Aspects related to the provision of abortion services in countries that offer its execution in Primary Health Care (PHC).

Country	Type of abortion performed in PHC	Professionals that are able to provide abortion on the first trimester	Gestational age limit for abortion in PHC
África do Sul[11]	Medical and vacuum aspiration	Registered and trained physicians, nurses or obstetricians	12 weeks + 0 days
Etiópia[12]	Medical and vacuum aspiration	Nurses, obstetricians and health officers	Medical abortion up to 9 weeks e aspirationup to 12 weeks
Moçambique[13,24]	Medical and vacuum aspiration	Physicians; Medicine technicians and mother-and-child health nurses (both mid-level practitioners)	12 weeks
Zâmbia[14]	Medical and vacuum aspiration	Trained physicians and obstetricians	12 weeks
Argentina[15]	Medical	No information	12 weeks
Colômbia[16,25]	Medical and vacuum aspiration	Only physicians	12 weeks for medical and 15 weeks for aspiration
México[17]	Medical and vacuum aspiration	Physicians and nurses	12 weeks
Bangladesh[18]	Medical and vacuum aspiration	Menstrual regulation can be done by physicians, nurses, family well-being visitors, obstetricians, paramedics, sub-assistant community physicians and mid-level providers	12 weeks when performed by physicians e 10 weeks when performed by other professionals
Camboja[19]	Medical and vacuum aspiration	Trained obstetricians, trained medical assistants, trained physicians	9 weeks for medical e 12 weeks for aspiration
Índia[20]	Medical and vacuum aspiration	Only physicians that have qualification certified by the government	7 weeks for medical e 12 weeks for aspiration
Singapura[21]	No information	Only physicians	No information
Espanha[22,26,27]	Medical and vacuum aspiration	Only physicians specialized in Gynecology and Obstetrics	14 weeks

Table 3

Aspects related to clinical management and self-management of abortion in countries that offer its execution in Primary Healthcare (PHC).

Country	Availability of medications	Ultrasound imaging as prerequisite?	Self-management at home
África do Sul[11]	Mifepristone and Misoprostol	No	Yes, up to 10 weeks + 0 days
Etiópia[12]	Mifepristone and Misoprostol	No	The medication is administered in the health unit and the woman is observed for 4 hours. If the expulsion do not occur, she should return after 2 weeks to confirm if the abortion was complete
Moçambique[13,24]	Mifepristone and Misoprostol	No	Yes, up to 9 weeks
Zâmbia[14]	Mifepristone and Misoprostol	No	Yes, up to 12 weeks
Argentina[15]	Mifepristone and Misoprostol	No	Yes, up to 12 weeks
Colômbia[16,25]	Mifepristone and Misoprostol	No	Yes, up to 10 weeks
México[17]	Mifepristone and Misoprostol	No	Yes, up to 12 weeks
Bangladesh[18]	Mifepristone and Misoprostol	No	Yes, up to 10 weeks
Camboja[19]	Mifepristone and Misoprostol	No	Yes, up to 9 weeks
Índia[20]	Mifepristone and Misoprostol	No	Yes, up to 7 weeks
Singapura[9,21]	Mifepristone and Misoprostol	No information	No information
Espanha[22,26,27]	Mifepristone and Misoprostol	Yes	Yes, up to 12 weeks
Irlanda[23]	Mifepristone and Misoprostol	No (for pregnancies with less than 10 weeks)	Yes, up to 9 weeks + 6 days

of, at least, obstetricians, anesthetists, nurses, social workers and/or psychologists".[8] That is, besides there is no express restriction of the performance of the procedure to physicians specialized in Gynecology and Obstetrics, it is necessary that this kind of professional integrates the teams of reference services.

Concerning aspects related to clinical management and self-management of abortion assessed in this study, the WHO defines mifepristone and misoprostol as essential medicines for health systems,[33] and do not recommend ultrasound exams as pre-requisites for the execution of abortions, considering that it may limit the access to the procedure in contexts that this exam is hard to be performed. It is also recommended that the self-management of medical abortion in up to 12 weeks, that is, the execution by women themselves, should be recognized as a legitimate strategy and the clinical protocols should be adapted in order to ensure this possibility.[1]

Such recommendations are observed in the great majority of assessed guidelines, with rare exceptions within the results. The situation of Brazil differs from the studied countries in several aspects: the abortion, both medical and surgical, is considered a medical procedure; mifepristone is not regulated in the Brazilian Health Regulatory Agency; and misoprostol is a medicine under special control.[34] The execution of ultrasound exams is prescribed in the procedure of justification and authorization of pregnancy interruption in cases provided for by law,[8] and in 2020 ordinances were established (already rescinded) updating this procedure, one of which established that "the health team should inform the possibility of visualizing the embryo or fetus by means of ultrasound imaging".[25]

According to what was mentioned in the beginning of the discussion, the documents should be understood as means of communication, and their authorship and context matter[28]: in this case, talking about the possibility of visualization of the fetus or embryo seems to be contradictory in relation to the assurance for women to the right of not seeing it – which is explicitly recommended in Argentinian and Irish guidelines.[15,23] At the time of release of this ordinance, Brazil had a government with authoritarian profile ruling the country, recognized by anti-gender policies.[36]

PHC and abortion: beyond the access

The access of first contact is one of the four essential attributes of PHC, denoting that this level of care should be the preferential gateway of individuals in the health system each time medical care is necessary, and this gateway should be of easy access. The inexistence of an easily accessible gateway may lead to delays or unavailability of adequate care, with consequent increase of costs and risks to health.[2] Abortion is a procedure sensitive to time – that is, the later it is performed, the higher are the associated risks – , one of the reasons that makes access such a relevant question.[1]

One of the characteristics that facilitate the access to PHC services is their geographical location next to communities. In Brazil, according to what Jacobs demonstrated, the concentration of services that perform legal interruption of pregnancy is a barrier of access,[37] however the country has conditions to solve this issue by means of the offer of the procedure in PHC services: whilst in 2021 the legal interruption of pregnancies resulting from rapes (main cause of legal aborting) was only performed in 55 municipalities, in case of the service was provided in PHC units, considering WHO recommendations, this number would be expanded to 3741 municipalities in Brazil.[7]

The benefits related to the provision of abortions in PHC services, however, are not limited to access; other essential PHC attributes also can be understood as potentialities.[38] Longitudinality presupposes that PHC services are recognizes by the population as a continued source of care over time, leading to the building of a bond and mutual confidence between patients and health professionals.[2] This sense of confidence can lead women to feel more comfortable to share the experience of sensitive situations such as a pregnancy resulting from sexual violence. Continued care is also strategic for the execution of essential actions for abortion care, such as the prophylaxis of sexually transmitted diseases and the institution of post-abortion contraception.

Comprehensiveness concerns the group of services offered in PHC, which should be broad, making possible the approach of the most frequent and relevant healthcare needs of the population. The actions offered by PHC should provide an integrative care, both in perspective of the biopsychosocial aspect of health-disease processes and the continuum of actions of health promotion, prevention, treatment and rehabilitation.[2] Abortion situations are often complex, benefiting from a integrative view on the person who demands it. Moreover, the proposition of the offer of abortion in PHC services is not limited to the mere execution of the procedure as it may signal a qualification of reproductive health care as a whole, when adding to community services the debate about health promotion and prevention in this area.

Finally, the coordination of care, the fourth essential PHC attribute, denotes the responsibility of this level of care over its users, independently of the site of the healthcare network in which they are located.[2] Naturally, not every abortion could be performed in PHC services, considering the preconized gestational age limits and situations that involve risk of life for women, in which hospital care will be necessary. Therefore, PHC would

have an essential role in the coordination of the itinerary of people in healthcare networks according to their needs, ensuring the access to the procedure by means of formal reference mechanisms.

The provision of abortion in PHC services is still a poorly studied subject in Brazil, with scarce publications, making the survey in experiences from other countries relevant, which may be a model for the implementation of this practice in the country. It is worth highlighting, thus, some guidelines that may be of special interest, such as those from Latin American countries[15-17] (due to recent publications and similarities with Brazil), the guideline from India[20] (which brings a systematized proposal of qualification for new providers), from Ireland[23] (which starts with a list of recommendations based on evidence, and values the acting of multidisciplinary team in the counseling and follow-up of women, although abortion itself is only performed by physicians).

Ireland is the country with the highest number of documents of the experience of provision of abortion in PHC services in the scientific literature. After the modification of law in 2018, a model of integrative care to the existing healthcare infrastructure was developed, and abortion started to be executed in maternities and community services.[39] A multidisciplinary task force was responsible by the awareness and qualification of PHC physicians and the elaboration of technical protocols.[39] The interruption of pregnancies with less than ten weeks is performed predominantly in PHC, unless there are clinical conditions that require hospitalization, and the initial results evidenced the success of the procedure in 98,1% of cases.[40] The professionals highlight that the collaborative approach between government and medical community, as well as the financial incentive, were essential for the success of the experience.[41]

The nature of this study, carried out from the analysis of clinical guidelines, does not comprise the investigation of results originated from the practice of all included countries, the reason by which we indicate the need for a systematic review of literature about the execution of abortion in PHC services. As other limitations that may be highlighted, we mention the non-inclusion of a significant group of countries in which abortions in PHC are performed, due to the language of publication of guidelines; possible flaws of GADP platform in the detection of countries that offer the procedure in this level of attention; the several formats of PHC observed (which may impair the replication of the assistance model), and the inclusion of some guidelines published five years ago or more, for which there is no apparent regular updates.

In spite of the mentioned limitations, the analysis of international experiences makes it clear that it is possible to provide abortion in PHC services, both medical and vacuum aspiration, using the preexisting workforce and structure. There is a relative consensus on the fact that the abortion to be performed in PHC is the abortion within the first trimester, that previous ultrasound imaging is not necessary and that self-management of the procedure at home should be presented as a possibility. With this regard, international guidelines demonstrate that the WHO recommendations may be put into practice in different scenarios, considering the several realities of the countries included in the study.

Lastly, considering the Brazilian context, it is necessary to highlight that both the laws and the regulation of the procedure are retrograde compared to most countries included in this study. In the face of several initiatives for restricting even more the access to legal abortion occurred in the last years, not receding does not seem sufficient; it is necessary to advance in the assurance of this reproductive right in the country. We expect that this article, when assessing international experience of provision of abortion in PHC, may be a subsidy for this advance.

Acknowledgements

We would like to thank the Graduate Program in Public Health at ENSP/Fiocruz for funding the translation services, through the Academic Excellence Program (CAPES/PROEX).

Author's contribution

Maia MN and Pinto LW: conceptualization, data curation, formal analysis, investigation, methodology, validation, writing and review of the manuscript. All authors approve the final version of the article and declare no conflict of interest.

References

1. World Health Organization (WHO). Abortion care guideline. Geneva: WHO; 2022. [access in 2022 Mai 5]. Available from: https://apps.who.int/iris/handle/10665/3493162

2. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília (DF): UNESCO, Ministério da Saúde; 2002. [access in 2023 Mai 6]. Available from: https://unesdoc.unesco.org/ark:/48223/pf0000130805

3. World Health Organization (WHO). Safe abortion: technical and policy guidance for health systems. 1st ed. Geneva: WHO; 2003 [acesso em 2022 Mai 05]. 110 p. Available from: https://apps.who.int/iris/bitstream/handle/10665/42586/9241590343-eng.pdf?

4. Presidência da República (BR). Decreto-Lei No 2.848, de 7 de dezembro de 1940. Código Penal. Rio de Janeiro (RJ): DOU de 31 de dezembro de 1940. [access in 2022 Mai 5]. Available from: http://www.planalto.gov.br/ccivil_03/decreto-lei/del2848compilado.htm

5. Supremo Tribunal Federal (BR). Arguição de Descumprimento de Preceito Fundamental 54. Anencefalia. Brasília (DF): 2012. [access in 2022 Mai 5]. Available from: http://www.stf.jus.br/arquivo/cms/noticianoticiastf/anexo/adpf54.pdf

6. Jacobs MG, Boing AC. O que os dados nacionais indicam sobre a oferta e a realização de aborto previsto em lei no Brasil em 2019? Cad Saúde Pública. 2021; 37 (12): e00085321.

7. Jacobs MG, Boing AC. Como a normatização sobre o serviço de aborto em gravidez decorrente de estupro afeta sua oferta nos municípios? Ciênc Saúde Colet. 2022; 27 (9): 3689-700.

8. Ministério da Saúde (BR). Portaria de Consolidação Nº 5, de 28 de setembro de 2017. Consolidação das normas sobre as ações e os serviços de saúde do Sistema Único de Saúde. Brasília (DF): DOU 3 de outubro de 2017. [access in 2022 Mai 5]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prc0005_03_10_2017.html

9. World Health Organization (WHO). Global Abortion Policies Database [*Internet*]. 2017. [access in 2022 Mai 5]. Available from: https://abortion-policies.srhr.org/

10. Ministério da Saúde (BR). Departamento de Ações Programáticas Estratégicas. Atenção humanizada ao abortamento: norma técnica. 2nd ed. Brasília (DF): Ministério da Saúde; 2011. [access in 2022 Mai 5]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/atencao_humanizada_abortamento_norma_tecnica_2ed.pdf

11. National Department of Health (ZA). National Guideline for Implementation of the Choice on Termination of Pregnancy Act. Pretoria: National Departmentof Health; 2019. [access in 2023 Abr 30]. Available from: https://www.health.gov.za/wp-content/uploads/2023/04/Termination-Pregnancy-Guideline_Final_2021.pdf

12. Federal Ministry of Health (ET). Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia (second edition). Addis Ababa: Federal Ministry of Health; 2014. [access in 2023 Abr 1]. Available from: https://platform.who.int/docs/default-source/mca-documents/policy-documents/guideline/ETH-RH-18-01-GUIDELINE-2014-eng-Safe-Abortion-Services.pdf

13. Ministério da Saúde (MZ). Diploma Ministerial n.o 60/2017: Aprova as Normas clínicas sobre Aborto Seguro, Cuidados Pós-Aborto e define as condições em que a interrupção voluntária da gravidez deve ser efectuada nas Unidades Sanitárias do Serviço Nacional. Imprensa Nacional de Moçambique; 2017. [access in 2023 Abr 1]. Available from: https://www.wlsa.org.mz/wp-content/uploads/2017/11/Diploma_Ministerial_60-2017.pdf

14. Ministry of Health (ZM). Zambia Standart Treatment Guideline (5th edition). Lusaka: Ministry of Health; 2020. [access in 2023 Abr 1]. Available from: https://www.moh.gov.zm/?wpfb_dl=32

15. Ministerio de Salud de la Nación (AR). Protocolo para laatención integral de las personas conderecho a la interrupción voluntaria y legal delembarazo: actualización 2022. 1ª ed. Ciudad Autónoma de Buenos Aires: Ministerio de Salud de la Nación; 2022. [access in 2023 Abr 1]. Available from: http://bancos.salud.gob.ar/recurso/protocolo-para-la-atencion-integral-de-las-personas-con-derecho-la-interrupcion-voluntaria

16. Ministerio de Salud y Protección Social (CO). Atención integral de la interrupción voluntaria delembarazo (IVE) enel primer nivel de complejidad. Documento técnico para prestadores de servicios de salud. Bogotá: Ministerio de Salud y Protección Social; 2014. Available from: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/PP/SM-IVE-Atencion-baja-complejidad.pdf

17. Secretaría de Salud (MX). Lineamiento técnico para la atención del Aborto Seguro en México. Secretaría de Salud; 2022. [access in 2023 Mai 26]. Available from: https://www.gob.mx/cms/uploads/attachment/file/779301/V2-FINAL_Interactivo_22NOV_22-Lineamiento_te_cnico_aborto.pdf

18. Ministry of Health and Family Welfare (BD). Woman-centered Menstrual Regulation and Postabortion Care Services: Reference manual. 3rd ed. Dhaka: Ipas Bangladesh; 2021. [access in 2023 Abr 1]. Available from: https://dgfp.gov.bd/sites/default/files/files/dgfp.portal.gov.bd/miscellaneous_info/9c3b06a2_ff40_4214_a6f5_6cc640abdfa2/2023-08-17-08-05-954637373118126b93f89e3d8cd0ddda.pdf

19. Ministry of Health (KH). National protocol Comprehensive Abortion Care. Phnom penh: Ministry of Health; 2010 [access in 2023 Abr 26]. Available from: https://nmchc.gov.kh/en/national-protocol-comprehensive-abortion-care-2010/

20. Ministry of Health and Family Welfare (IN). Comprehensive abortion care: Training and service delivery guidelines. New Delhi: Ministry of Health and Family Welfare; 2018 [access in 2023 Abr 28]. Available from: https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/CAC_Training_and_Service_Delivery_Guideline.pdf

21. Ministry of Health (SG). Guidelines on termination of pregnancy. Ministry of Health; 2015 [access in 2023 Abr 27]. Available from: https://www.moh.gov.sg/docs/librariesprovider5/licensing-terms-and-conditions/revised-guidelines-on-termination-of-pregnancy-(dated-17-apr-2015).pdf

22. Servicio Canario de la Salud (ES). Protocolo de actuación - Aborto inducido - Comunidad Autónoma de Canarias. Gobierno de Canarias; 2012 [access in 2023 Mai 18]. Available from: https://www3.gobiernodecanarias.org/sanidad/scs/content/ee23ad48-0327-11e3-8241-7543da9dbb8a/ActuacionAbortoInducido.pdf

23. Royal College of Physicians of Ireland. Interim Clinical Guidance: Termination of pregnancy under 12 weeks. Dublin: Institute of Obstetricians & Gynaecologists; 2018 [access in 2023 Abr 1]. Available from: https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/interim-clinical-guidance-termination-of-pregnancy-under-12-weeks-2018-.pdf

24. Assembleia da República (MZ). Lei n.o 24/2019: Lei de Revisão do Código Penal e revoga o artigo 2 do Decreto-Lei n.o 182/74, de 2 de Maio e o Código Penal aprovado pela Lei n.o 35/2014 de 31 de Dezembro. Imprensa Nacional de Moçambique; 2019. [access in 2023 Abr 1]. Available from: http://www.ts.gov.mz/images/Lei_24-2019_-_Lei_de_Revisao_do_Codigo_Penal_1.pdf

25. Corte Constitucional (CO). Comunicado 5: Febrero 21 de 2022. Sentencia C-055-22. Corte Constitucional de Colombia; 2022. [access in 2023 Abr 1]. Disponível em: https://www.corteconstitucional.gov.co/comunicados/Comunicado%20de%20prensa%20Sentencia%20C-055-22%20-%20Febrero%2021-22.pdf

26. Jefaturadel Estado (ES). LeyOrgánica 2/2010, de 3 de marzo, de salud sexual y reproductiva y de lainterrupción voluntaria delembarazo. Madrid: Boletín Oficial del Estado; 2010. [access in 2021 Mai 22]. Available from: https://www.boe.es/eli/es/lo/2010/03/03/2/con

27. Ministerio de Sanidad y Política Social (ES). Real Decreto 831/2010, de 25 de junio, de garantía de la calidad asistencial de la prestación a la interrupción voluntaria del embarazo. Madrid: Boletín Oficial del Estado; 2010. [access in 2023 Jun 15]. Available from: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2010-10154

28. Flick U. Utilização de documentos como dados. In: Flick U. Introdução à pesquisa qualitativa. 3rd ed. Porto Alegre: Artmed; 2009. p. 230-7

29. Programa das Nações Unidas para o Desenvolvimento (PNUD). Relatório do Desenvolvimento Humano de 2021/2022. Nova Iorque: PNUD; 2022 [access in 2023 Jun 9]. Available from: https://hdr.undp.org/system/files/documents/global-report-document/hdr2021-22overviewpt1pdf.pdf

30. World Health Organization (WHO). Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2023 [access in 2023 Jun 10]. Available from: https://www.who.int/publications-detail-redirect/978924006875929.

31. Taylor L. How South America became a global role model for abortion rights. BMJ. 2022; 378: o1908

32. Goes EF, Ferreira AJF, Meira KC, Myrrha LJD, Reis APD, Nunes VGDA, Santos JMS, Pinto NR, Santos MES, Oliveira HCG, Ramos DO. Desigualdades raciais nas tendências da maternidade adolescente e no acesso ao pré-natal no Brasil, 2008-2019. Res Soc Dev. 2023; 12 (1): e8312139404.

33. World Health Organization (WHO). Web Annex A. World Health Organization Model List of Essential Medicines – 23rd List, 2023. In: The selection and use of essential medicines 2023: Executive summary of the report of the 24th WHO Expert Committee on the Selection and Use of Essential Medicines, 24 – 28 April 2023. Geneva: WHO; 2023. [access in 2024 Jan 2]. Available from: https://iris.who.int/bitstream/handle/10665/371090/WHO-MHP-HPS-EML-2023.02-eng.pdf?sequence=1

34. Paro HBMS, Rosas CF. Posicionamento Oficial da Rede Médica pelo Direito de Decidir: Pela manutenção dos serviços de aborto legal no Brasil em tempos de pandemia. 2020 [access in 2023 Jun 11]. Available from: https://globaldoctorsforchoice.org/wp-content/uploads/Nota-GDC-Covid-19-abortion_Portuguess.pdf.pdf

35. Ministério da Saúde (BR). Portaria Nº 2.282, de 27 de agosto de 2020. Dispõe sobre o Procedimento de Justificação e Autorização da Interrupção da Gravidez nos casos previstos em lei, no âmbito do Sistema Único de Saúde-SUS. Brasília (DF): DOU 28 de agosto de 2020. [access in 2023 Jul 11]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2020/prt2282_28_08_2020.html

36. Diniz D. Maternal mortality: when a pandemic overlaps with the anti-gender crusade [Editorial]. Dev World Bioeth. 2020; 20 (3): 116-7.

37. Jacobs MG, Boing AC. Travel as a barrier to abortion provided by law access. Brazil, 2010-2019. Rev Bras Saúde Materno Infant. 2022; 22 (4): 853-61.

38. Giugliani C, Ruschel AE, Belomé da Silva MC, Maia MN, Pereira Salvador de Oliveira DO. O direito ao aborto no Brasil e a implicação da Atenção Primária à Saúde. Rev Bras Med Fam Comunidade. 2019; 14 (41): 1791.

39. Murphy C. A Irlanda desde a revogação da Oitava Emenda. Cad Saúde Pública. 2020; 36:e00211119.

40. Horgan P, Thompson M, Harte K, Gee R. Termination of pregnancy services in Irish general practice from January 2019 to June 2019. Contraception. 2021; 104: 502-5.

41. Mishtal J, Reeves K, Chakravarty D, Grimes L, Stifani B, Chavkin W, Duffy D, Favier M, Horgan P, Murphy M, Lavelanet A. Abortion policy implementation in Ireland: Lessons from the community model of care. PLoS ONE. 2022; 17: e0264494.

Received on September 5, 2023
Final version presented on August 3, 2024
Approved on August 14, 2024

Associated Editor: Melânia Amorim