

Task sharing in abortion care in Latin America

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Abstract

Unsafe abortion remains a major public health and human rights challenge in Latin America, despite recent reforms that have expanded the legal grounds for abortion in several countries. A central reason for the persistent gap between law and access is the region's widespread reliance on physician-exclusive provider models, which structurally limit the availability of services, particularly in rural, Indigenous, and primary-care settings where specialists are scarce. Task sharing in abortion care should be understood not as a discretionary efficiency strategy, but as an essential component of States' obligations under legal rights to health care, equality, life, and scientific progress. A review of global evidence, a comparative analysis of legal and regulatory frameworks in 14 countries, and an in-depth examination of emerging reforms in Mexico, Colombia, Argentina, and Ecuador show that expanding provider eligibility is both clinically safe and normatively required. The conclusion outlines a regional reform agenda for aligning domestic regulations with World Health Organization standards.

KEYWORDS

abortion, health providers, human rights, Latin America, primary health care, task sharing, task shifting

1 | INTRODUCTION

Abortion is a highly safe procedure when performed following recognized clinical standards,¹ yet it continues to generate a disproportionate burden of preventable morbidity and mortality in Latin America.² The World Health Organization (WHO) estimates that more than three-quarters of abortions in Latin America are unsafe,³ and, according to the Guttmacher Institute, at least 10% of all maternal deaths in the region are attributed to unsafe abortions, with nearly 760000 women treated annually due to related complications.⁴

For decades, the primary way abortion has been regulated in Latin America has been through criminal law.⁵ In practice, this means that abortion is treated as a crime by default, which creates a "chilling effect" for everyone involved⁶ (pp. 3–8). Women, girls, and other

pregnant persons often delay or avoid seeking abortion care in the formal health system⁶ (pp. 3–5), while clinicians have strong incentives to refuse or limit these services because they fear the legal consequences of being accused of a crime⁶ (pp. 6–8). In this context, fear of prosecution and deep-rooted stigma around abortion work together to make it much more likely that people will resort to unsafe abortions.⁷

Over the last 15 years, several Latin American countries, including Uruguay,⁸ Mexico,⁹ Colombia,¹⁰ Argentina,¹¹ Chile,¹² and Ecuador,¹³ have reformed their criminal laws to liberalize access to abortion in at least some circumstances; for example, by allowing abortion in more situations (such as in cases of rape or risk to health), by extending gestational limits, or by decriminalizing abortion on request during early pregnancy. These reforms have opened important doors and have improved access to safe and legal abortion

for at least some groups of patients¹⁴ (p. 1). However, these legal changes on their own have not been enough to solve the problem of unsafe abortions. Even in countries where abortion is now partially or broadly legal, many patients still find that there is no one willing or authorized to provide it.¹⁵ In these settings, the main bottleneck is no longer whether the law recognizes a legal indication for abortion, but whether there are trained providers available and where they are located.

This gap is particularly visible in countries that reserve abortion provision exclusively to physicians, and often to obstetrician/gynecologists. Specialists tend to be concentrated in large urban centers and tertiary hospitals; they are scarce in rural regions, peri-urban settlements, and Indigenous territories¹⁶ (p. 11). Where laws insist that only these professionals may perform an abortion—even an early medical abortion—the health system structurally underproduces legal services, and the formal right to a safe procedure is transformed into a lottery: patients who cannot travel, take time off work, or afford private care in order to reach these specialized providers continue to rely on clandestine solutions, despite living in jurisdictions where abortion is “legal.”¹⁷ As the present article will show, this is the reality in most Latin American countries that recognize at least some legal grounds for abortion.

Task sharing directly addresses this disconnect between legal reform and effective access. It is a public health strategy that redistributes the tasks involved in abortion care among a broader range of health workers—midwives, nurses, pharmacists, community health workers, and others—thereby increasing the number of professionals who can safely provide abortion care¹⁸ (p. 11). This has a direct impact on service delivery:¹⁹ it reduces travel and waiting times, shifts appropriate components of care away from physicians, expands availability of services in rural and primary care settings, helps prevent unsafe self-management of abortion, and lowers overall health system costs²⁰ (p. 60).

Recognizing the public health relevance of this approach, the most recent WHO Abortion Care Guideline explicitly incorporates task sharing as a key recommendation for providing quality abortion care²⁰ (p. 3). In particular, it recommends that both medical and surgical abortion can be provided by a wide range of trained healthcare professionals (Recommendations 24, 28, 30, and 33)²⁰ (p. 60). At the same time, Recommendation 21 advises against restrictive regulations that arbitrarily limit who can provide and manage abortion care in ways that are inconsistent with these recommendations, emphasizing that such limitations are arbitrary and not evidence-based²⁰ (p. 60).

Accordingly, task sharing in abortion care should not be treated as a discretionary efficiency measure, but as a central component of States' obligations in reproductive health governance. In a region where unsafe abortion continues to contribute substantially to preventable morbidity and mortality, and where specialists are unevenly distributed and often absent from primary care and rural settings, maintaining physician-exclusive provider models is increasingly difficult to justify. The persistence of these models helps explain why liberalizing abortion laws has not translated into equitable

access to safe services, and why task sharing emerges as the “missing piece” between formal legal entitlements and the reality of care on the ground.

Methodologically, this article combines three strands of analysis. First, it draws on a review of peer-reviewed literature, policy reports, and WHO guidance on the implementation and effectiveness of task sharing in abortion care, with particular attention to the roles of midwives, nurses, and other nonphysician providers. Second, it undertakes a comparative legal analysis of abortion-related laws, regulations, and clinical protocols currently in force in 14 Latin American countries that, as of November 2025, recognize at least one legal ground for abortion, focusing on how these instruments define who is authorized to provide abortion services. Third, it examines in greater depth the legislative, regulatory, and policy debates in four countries—Mexico, Colombia, Argentina, and Ecuador—that have recently moved toward more inclusive provider frameworks, drawing on parliamentary records, explanatory memoranda, and policy documents, as well as media interviews with key reform actors where available. This article, therefore, contributes a regional legal analysis of provider eligibility rules, a dimension largely overlooked in global discussions of task sharing and essential to understanding access to abortion care in Latin America.

The argument unfolds in four steps. Section 2 situates task sharing within broader public health and health systems debates, tracing its evolution from an emergency-response to a workforce-crisis to a systems-level strategy, and summarizing the allocation of health worker roles in WHO's Abortion Care Guideline.²⁰ Section 3 turns to Latin America and maps how existing legal and regulatory frameworks across 14 countries regulate provider eligibility for abortion, showing how physician-exclusive models conflict with WHO recommendations and function as structural barriers to access care. Section 4 examines recent reforms in Mexico, Colombia, Argentina, and Ecuador that challenge physician exclusivity, analyzing how these countries have broadened provider roles and the public health, equality, and interculturality arguments that proved most persuasive. Finally, Section 5 distills the lessons of this regional experience, proposing a reform agenda that reframes task sharing as a human rights obligation, calls for harmonization of fragmented regulatory frameworks, and highlights the importance of training, institutional culture, and service organization to ensure that expanded provider roles translate into effective, equitable access to abortion care.

2 | TASK SHARING AS A PUBLIC HEALTH STRATEGY

2.1 | From emergency response to systems thinking

Task sharing is a health workforce strategy that seeks to optimize available human resources by redistributing clinical tasks across a broader range of health professionals²¹ (p. 2). Rather than reserving key interventions to a narrow group of highly specialized providers,

task sharing trains and authorizes other cadres—such as midwives, nurses, pharmacists, and community health workers—to perform clearly defined components of care¹⁶ (p. 7). In this sense, it is related to, but not identical with *task shifting*, which typically refers to moving responsibilities downwards along a professional hierarchy²¹ (p. 2). Task sharing instead emphasizes a team-based model in which different cadres can perform overlapping tasks within their areas of competence, expanding the pool of providers without removing the task from the original group entirely.²²

This approach emerged as a pragmatic response to acute health worker shortages in resource-constrained settings.²¹ Nowhere was this more visible than in sub-Saharan Africa in the mid-2000s, when the urgency of scaling-up access to antiretroviral therapy collided with a severe scarcity of physicians and nurses.²³ In that context, national programs began to authorize nonphysician clinicians, nurses, and community health workers to initiate and monitor antiretroviral treatment, often with impressive gains in coverage and outcomes.²³ Building on this experience, the WHO, together with the President's Emergency Plan for AIDS Relief (PEPFAR) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), issued its first formal guidance on task shifting and task sharing under the “Treat, Train, Retain” initiative,²⁴ explicitly endorsing the redistribution of clinical tasks as a core strategy for addressing the health workforce crisis in HIV care.²²

As evidence accumulated, task sharing gradually moved from an emergency measure to a central element of broader health systems strengthening. Maternal and Newborn Health (MNH) became a key area of expansion.²⁵ In many low- and middle-income countries, chronic deficits in obstetricians and specialist physicians—compounded by their concentration in urban referral hospitals—have long limited access to skilled birth attendance and emergency obstetric care.²⁶ In response, health systems increasingly relied on midwives, nurse-midwives, and nonphysician clinicians to deliver comprehensive maternal care, including routine antenatal visits, intrapartum care, and the management of complications such as postpartum hemorrhage and neonatal asphyxia.²⁶ This shift was subsequently codified in WHO's OptimizeMNH guidelines to optimize health worker roles to improve access to key maternal and newborn health interventions through task shifting, which explicitly recommends redistributing key tasks to appropriately trained nonspecialist providers as a strategy to expand coverage and promote equity.²⁷

A similar evolution occurred in family planning. Task-sharing initiatives enabled nonphysician cadres to provide a broad range of contraceptive methods, from oral contraceptives and injectables to long-acting reversible methods such as implants and intrauterine devices, following competency-based training and standardized protocols.²⁷ These interventions not only increased contraceptive uptake but also diversified the points of access, allowing users to obtain methods at primary care centers, pharmacies, and community clinics rather than relying exclusively on specialist physicians.²⁷

Taken together, these developments mark a shift from viewing task sharing as a temporary response to crisis toward understanding

it as a systems-level strategy for organizing care. The underlying logic is straightforward: when services are designed around a small, scarce cadre of specialists, access will remain uneven and inequitably distributed, particularly in rural and marginalized areas²⁸ (p. E430). By contrast, when tasks are deliberately allocated across the full health team in line with evidence on safety and effectiveness, countries are better able to deliver essential interventions at the level where people actually seek care. It is within this broader evolution—from emergency response to systems thinking—that the application of task sharing to abortion care must be situated.

2.2 | WHO's Abortion Care Guideline and health worker roles

Abortion care has progressively become one of the fields in which task sharing is most clearly and systematically articulated. Building on its earlier work in maternal health and HIV, WHO began to address health worker roles in abortion more directly in its 2015 guidance on providers of safe abortion and postabortion contraception.¹⁸ That document already advanced a central proposition: safe abortion care does not inherently require specialist physicians, and many components of care—especially in early pregnancy—can be safely and effectively provided by a wide range of trained health workers.¹⁸

This approach was substantially expanded and consolidated in the 2022 Abortion Care Guideline, which now constitutes the principal global normative reference on the topic.²⁰ The guideline adopts a continuum-of-care perspective, covering preabortion information and counseling, the abortion procedure itself, and postabortion follow-up, including contraception. Across this continuum, it formulates 21 specific recommendations on who can safely perform which tasks, distributing them across 11 categories of health workers: specialist medical practitioners, generalist medical practitioners, associate and advanced associate clinicians, midwives, nurses, auxiliary nurses, auxiliary nurse-midwives, traditional and complementary medicine professionals, pharmacists, pharmacy workers, and community health workers.

Crucially, the guideline does not treat physicians as the default or exclusive providers. For medical abortion in the first trimester (up to 12 weeks), WHO strongly recommends that the full range of these 11 cadres may be involved in providing care, including administering medications, offering counseling, and managing routine follow-up, provided they are appropriately trained and supported (Table 1).²⁰ In other words, early medical abortion is conceptualized as a low-complexity intervention that can safely be delivered at the primary care and community levels, much like other essential reproductive health services.

For medical abortion beyond 12 weeks, the recommendations become more differentiated. Specialist and generalist physicians remain central providers, but the participation of midwives, nurses, auxiliary nurses, auxiliary nurse-midwives, and traditional and complementary medicine professionals is suggested in settings where adequate infrastructure, referral pathways, and back-up for

TABLE 1 WHO recommendations on task sharing in the provision of abortion care by type of provider and procedure.

	Specialist medical practitioners	Generalist medical practitioners	Associate/advanced associate clinicians	Midwives	Nurses	Auxiliary nurses	Auxiliary nurse midwives (ANMs)	Traditional and complementary medicine professionals	Pharmacists	Pharmacy workers	Community health workers
Medical abortion											
<12 weeks	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
≥12 weeks	✓	✓	✓*	✓*	✓*	✓*	✓*	✓*	X	X	X
Surgical abortion											
<14 weeks	✓	✓	✓	✓	✓	✓*	✓	✓	-	-	-
vacuum aspiration											
≥14 weeks	✓	✓	✓*	✓*	-	-	✓*	X	X	X	X
D&E											

Note: ✓, Recommended: A strong recommendation in favor of the intervention; ✓*, Suggested: A weak recommendation in favor of the intervention (requiring additional wording to qualify the recommendation, specifying the conditions of use); - not evaluated: The intervention has not been reviewed or addressed in the WHO's most recent guidelines on abortion care; X, not recommended: A strong recommendation against the intervention.

Source: Author's own elaboration based on recommendations from the Abortion Care Guidelines.²⁰ Adaptation inspired by the chart developed for Argentina by the Access to Safe Abortion Network (REDAAS).¹⁶ Terminology in the legends reflects the classification used by the expert group convened by WHO to determine the strength of each recommendation²⁰ (p. 32).

complications are in place²⁰ (Recommendation 30). Here, the emphasis is on ensuring that higher-risk procedures are embedded in functional networks of care, rather than on reserving them categorically to a single profession.

The guideline adopts a similarly nuanced approach to surgical abortion. For vacuum aspiration—typically used before 14 weeks—WHO recommends that specialist and generalist physicians, associate/advanced associate clinicians, midwives, and, in some contexts, traditional and complementary medicine professionals can safely perform the procedure²⁰ (Recommendation 24). Auxiliary nurses and auxiliary nurse-midwives may also play a role where they are formally integrated into basic emergency obstetric services and supported by robust referral and monitoring systems²⁰ (Recommendation 24). In contrast, dilation and evacuation (D&E) at later gestations is recommended for specialist and generalist physicians and conditionally suggested for midwives and associate/advanced associate clinicians in settings where these cadres are routinely involved in advanced maternal and reproductive health care²⁰ (Recommendation 26).

These detailed allocations of tasks across provider types pursue a dual goal. On the one hand, they offer States a practical template for expanding abortion access in a way that is consistent with clinical safety and quality standards.²⁹ On the other hand, they articulate a clear normative principle: restrictive scope-of-practice rules that confine abortion provision to specialist physicians—particularly where other qualified cadres exist and are already delivering comparable services in maternal and reproductive health—are not evidence-based. Reflecting this, the guideline explicitly states that where legislation or policy regulates who may provide or manage abortion care, such regulation should be consistent with WHO recommendations²⁰ (p. xxix).

The implication for law and policy is direct. If early medical abortion can safely be provided by midwives, nurses, pharmacists, and even community health workers, then statutory or regulatory frameworks that insist on physician-only provision are misaligned with current scientific evidence and global technical guidance. Conversely, frameworks that authorize a broader range of health workers to perform abortion-related tasks—within clear competency and supervision structures—are not experimental departures from best practice, but faithful implementations of WHO's task-sharing model. It is against this global standard that the provider eligibility rules in Latin American abortion laws and regulations must be assessed in the following sections.

3 | TASK SHARING IN LATIN AMERICAN ABORTION CARE: A MISSING PIECE

A review of the legal texts that govern abortion provision in Latin America reveals a striking contrast with WHO guidance. Among 14 countries in the region where abortion is legally permitted on at least one ground, 10 maintain a physician-exclusive model.

In Bolivia, Brazil, Chile, Costa Rica, Cuba, Guatemala, Panama, Peru, Uruguay, and Venezuela, abortion laws, penal codes, and

implementing regulations typically designate “physicians”, “medical surgeons”, or specifically “gynecologists and obstetricians” as the sole providers authorized to perform abortions. Clinical guidelines in these jurisdictions usually mirror this allocation, assigning assessment, the procedure itself, and management of complications to doctors. Nonphysician providers may participate in counseling, pre- and postprocedure care, or administrative tasks, but are rarely recognized as potential primary providers (Table 2).

In nine of these 10 countries, the restriction stems directly from legislation, most often the Penal Code itself. This has two important consequences. First, it means that physician exclusivity is not a minor technical detail but a legislative choice, often made decades ago under very different clinical standards. Second, alignment with WHO guidance will generally require parliamentary reform, which is politically and procedurally more demanding than revising ministerial guidelines. Within the region, Cuba is the only exception: there, the scope-of-practice limitation appears solely in a ministerial regulation, which is comparatively easier for the executive branch to modify.

From a health systems perspective, this legal inertia locks countries into a model already known to be suboptimal. Chronic shortages of doctors mean that restricting abortion provision to physicians inevitably leaves many people without access.³⁰ Quantitative indicators reveal the depth of this problem: Brazil has 2.14 doctors per 1000 inhabitants,³¹ followed by Venezuela (1.66),³² Peru (1.62),³³ Panama (1.73),³⁴ Guatemala (1.28),³⁵ and Bolivia (1.27).³⁶ These figures are low not only in absolute terms, but also relative to countries with stronger service coverage: members of the OECD average around 3.5 doctors per 1000 inhabitants,³⁷ and several European health systems exceed 4 or even 5 per 1000.³⁸ Moreover, even in the four Latin American countries with comparatively higher densities—Costa Rica (2.64 per 1000),³⁹ Chile (3.13),⁴⁰ Uruguay (4.6),⁴¹ and Cuba (9.42)⁴²—the distribution remains uneven, as physicians are heavily concentrated in urban centers, leaving rural regions comparatively underserved.^{43–45} In this context, insisting that only physicians provide abortion care entrenches inequities in access, illustrating how a seemingly neutral regulatory choice can function as a structural barrier to reproductive health.

From a human rights perspective, the implications are even broader. International monitoring bodies have repeatedly emphasized that States must not only make abortion legal in certain circumstances, but also organize their health systems so that services are available, accessible, acceptable, and of good quality.⁴⁶ When scope-of-practice rules reserve abortion provision to a small group of specialist physicians, despite clear evidence that other trained providers can safely deliver care, they undermine the “availability” and “accessibility” dimensions of the *right to health* and leave large segments of the population without any realistic option for safe services.⁴⁷

Because only women and other pregnant people need abortion care, these regulatory choices also have a distinctly gendered and classed impact. Where specialist providers are concentrated in

urban centers and private facilities, restrictive provider rules disproportionately harm those women who are poorer, younger, rural, or Indigenous, and who depend on primary care services.⁴⁸ In human rights terms, this pattern is not simply inefficient; it is a form of indirect discrimination that is difficult to reconcile with States' obligations of equality and nondiscrimination.^{49,50}

The consequences are not abstract. When the health system is structured in such a way that legal abortion services are scarce, delayed, or geographically out of reach, it becomes foreseeable that many people will resort to unsafe methods.⁵¹ In these circumstances, maintaining restrictive provider regulations, while knowing their predictable effects on unsafe abortion and maternal mortality, risks violating the positive obligation to protect life by preventing avoidable deaths.⁵² At the same time, refusing to incorporate task sharing into domestic law and policy where robust evidence supports its safety and effectiveness means withholding the benefits of scientific progress from those who most need them.⁵³ In this sense, the failure to implement task-sharing strategies in abortion care is a regulatory omission that may place States in breach of their duties *under the rights to health, equality and nondiscrimination, life, and to enjoy the benefits of scientific progress*.

Viewed in a regional perspective, it becomes evident that advances in liberalizing abortion laws have not been matched by equivalent progress in updating provider regulations to reflect WHO's task-sharing model. Task sharing remains, therefore, a missing piece in the implementation of abortion law reform in the region.

4 | EMERGING REFORMS THAT CHALLENGE PHYSICIAN EXCLUSIVITY

A small but growing number of Latin American countries have begun moving away from physician-exclusive models, embracing more inclusive provider frameworks that align better with public health evidence and human rights principles. Notably, the most progressive examples—Colombia, Mexico, Argentina, and Ecuador—have all updated their abortion regulations within the past 5 years, and these newer frameworks tend to reflect WHO task-sharing recommendations. Each adopts broader language (e.g. referring to “health professionals” rather than only doctors) and explicitly or implicitly allows mid-level providers like nurses and midwives to participate in abortion care. These positive trends in each country and the arguments that drove them are examined in the sections below.

4.1 | Mexico

Mexico offers one of the clearest examples of a shift toward more inclusive provider roles in abortion care. Recent federal jurisprudence—most notably Amparo en Revisión 267/2023, which held that federal health institutions must provide abortion on legal grounds,⁵⁴ and Acción de Inconstitucionalidad 148/2017,⁵⁵ which struck down

TABLE 2 Provider scope for abortion care in Latin America.

Country	Legal framework	Authorized provider	Relevant norms
Argentina	Mixed (on request up to 14 weeks; then life or health risk; rape)	Varies by state In most, only physicians are authorized National guidelines use “healthcare professional” broadly, potentially allowing expanded roles	Law No. 27.610 on Access to Voluntary Interruption of Pregnancy and Postabortion Care (2020); Comprehensive Health Care Protocol for People Entitled to Legal Termination of Pregnancy (ILE) and Voluntary Termination of Pregnancy (IVE) (2023)
Bolivia	Grounds-based (rape, incest, life or health risk)	Physicians (as per Penal Code), despite broader references in health protocols	Penal Code Art. 266; Comprehensive Care Model for Victims of Sexual Violence (2015); Technical Procedure for the Provision of Health Services under the Plurinational Constitutional Court Ruling 0206/2014 (2015)
Brazil	Grounds-based (life, rape, anencephaly)	Clinical doctor, general surgeon, gynecologists obstetrician	Penal Code Art. 128; Ordinance No. 1508 (2005) Technical Guidelines for Humanized Abortion Care (2014)
Chile	Grounds-based (life, fetal inviability, rape)	Medical surgeons	Law No. 21.030 Regulating the Decriminalization of Voluntary Termination of Pregnancy on Three Grounds (2016)
Colombia	Mixed (on request up to 24 weeks; then 3 grounds)	Health professionals	Court Ruling T-128/2022; Resolution 051/2023
Costa Rica	Grounds-based (life, health risk)	Physicians based in hospital settings; midwives only when physicians are not available	Penal Code Art. 121; Technical Norm for the Medical Procedure Related to Article 121 of the Penal Code (2019)
Cuba	Mixed (on request up to 12 weeks; medical grounds after)	Certified gynecologists, Certified anesthesiologists, Certified residents under supervision	Methodological Guidelines for the Implementation of All Types of Voluntary Termination of Pregnancy (2011)
Ecuador	Grounds-based (life or health risk; rape)	Physician or other trained healthcare professional (as per Penal Code) The Abortion Law in cases of rape explicitly includes midwives and Indigenous health practitioners with ancestral knowledge, provided they are properly trained.	Penal Code Art. 150; Law Regulating Voluntary Termination of Pregnancy in Cases of Rape (2022); Clinical Practice Guideline for Comprehensive Health Care in Voluntary Termination of Pregnancy in Cases of Rape (2023)
Guatemala	Grounds-based (life risk)	Physicians	Penal Code Art. 137; National Guidelines on Hemorrhage and Postpartum Management (2011)
Mexico	Varies by state (federal law: total decriminalization)	Medical personnel, Nursing personnel	Amparo in Review 267/2023 Action of Unconstitutionality 148/2017 Official Mexican Norm NOM-046-SSA2-2005
Panama	Grounds-based (rape, life or health risk)	Gynecologists and obstetricians	Penal Code Art. 144 Resolution No. 0277 on Methodological Guidelines for the Implementation of All Types of Voluntary Termination of Pregnancy (2022)
Peru	Grounds-based (life or health risk)	Physicians	Penal Code Art. 119; Standardization of the Procedure for the Comprehensive Care of Pregnant Women Under Therapeutic Indication for Pregnancy Termination Before 22 Weeks with Informed Consent (2014)
Uruguay	Mixed (on request up to 12 weeks; Then health risk; fetal malformation; rape)	Gynecologists	Law 18.987 on Voluntary Termination of Pregnancy Act (2012); Decree No. 375/2012 regulating the Law on Voluntary Termination of Pregnancy (2012)
Venezuela	Grounds-based (life risk)	Physicians (‘facultativos’)	Penal Code Art. 435

state-level barriers that impeded access—confirmed that abortion services may be performed by either medical or nursing personnel. This interpretation builds on the Official Mexican Standard NOM-046-SSA2-2005, updated in 2016, which expressly authorizes trained nurses to provide abortion in cases of sexual violence.⁵⁶ The 2022 Safe Abortion Guidelines issued by Mexico's Ministry of Health further reinforce this framework by requiring all institutions within the National Health System to ensure sufficient nonobjecting both medical and nursing staff to guarantee timely access, acknowledging that both types of professionals are qualified to provide these services.⁵⁷

This trajectory has recently expanded to include professional midwives. The adoption of NOM-020-SSA-2025 formally recognizes midwifery within the national health system and, in clause 3.22, explicitly incorporates the provision of abortion services within the competencies of certified midwives.⁵⁸ Although state-level regulatory heterogeneity persists, these federal norms collectively establish a national foundation for task sharing that legitimizes the participation of nurses and midwives in abortion care. Early evidence from jurisdictions that have decriminalized abortion already shows increasing involvement of nursing personnel in medical abortion provision, signaling the gradual consolidation of task-sharing practices within Mexico's decentralized health system⁵⁹ (pp. 30–31).

4.2 | Colombia

Colombia offers another leading example of regulatory openness to task sharing in defining who is legally authorized to perform abortion procedures. Since the landmark judicial ruling C-355/2006, which, for the first time, partially decriminalized abortion,⁶⁰ the regulatory framework has explicitly allowed nonspecialist physicians in primary care facilities to provide first-trimester abortions—both medical abortion up to 10 weeks and manual vacuum aspiration up to 15 weeks—reserving specialist obstetrician/gynecologists mainly for later gestations and complicated cases⁶¹ (p. 11). Following the terminology employed by the Constitutional Court when it decriminalized abortion on request up to 24 weeks (C-055/2022),⁶² Resolution 051 of 2023 goes a step further by referring generically to “health professionals” as the cadre responsible for abortion care and by requiring only “at least one competent professional” to guarantee access to the procedure⁶³ (section 4.2.2; Author's translation).

In practice, this consolidates general practitioners as the primary abortion providers and opens normative space for a future expansion of roles to other cadres where evidence and training permit.

Empirical evidence from dedicated sexual and reproductive health services in the country, such as Oriéntame and Profamilia, confirms this partial task-sharing model: nurses and even auxiliary health workers are now participating in the provision of medical abortion within their authorized scope of practice⁶¹ (p. 15). Their experience reflects assessed evidence suggesting that task sharing in comprehensive safe abortion care with nonphysician health workers is being safely integrated into service delivery in Colombia.⁶⁴

4.3 | Argentina

Argentina also embraces a broad provider definition at the federal level. Law 27.610, which legalized abortion on request up to 14 weeks and maintained indication-based access thereafter, refers to “health professionals” as those authorized to provide abortion care, rather than limiting service provision to physicians⁶⁵ [Author's translation]. Likewise, the National Protocol for the Comprehensive Care of People Entitled to Legal Termination of Pregnancy encourages provinces to adopt task-sharing models, explicitly citing WHO guidance that “different types of health workers can safely, effectively, and satisfactorily perform some or all tasks related to the provision of abortion care”⁶⁶ [Author's translation].

In effect, due to the country's federal structure, the regulation of scope-of-practice competencies remains under provincial jurisdiction. In most provinces, abortion provision continues to be restricted to physicians, and the scope of practice for nurses and midwives typically excludes direct involvement.⁶⁷ However, a clear countertrend has emerged in recent years. Three provinces—Neuquén, Mendoza, and Jujuy—have explicitly authorized licensed midwives (obstétricas) to perform key components of abortion care, including the prescription of medical abortion.⁶⁸ Neuquén led this shift in 2023 with Disposition DI-2023-465-E-NEU-SSL#MS, which expressly empowers licensed midwives to prescribe misoprostol and mifepristone.⁶⁹ Mendoza followed with Decree 2088/2024, updating its provincial Vademécum Obstétrico to include abortion medications and authorizing obstetric midwives to prescribe them in the context of comprehensive counseling.⁷⁰ Most recently, in March 2025, Jujuy adopted Resolution 082/2025, revising its obstetric formulary to incorporate misoprostol and mifepristone and enabling midwives to indicate and provide first-level abortion services.⁷¹ These developments mark the first provincial-level regulatory moves toward a task-sharing approach in abortion care.

4.4 | Ecuador

Ecuador has also taken important steps toward inclusivity in abortion care. In 2022, the National Assembly enacted the Organic Law Regulating Voluntary Termination of Pregnancy in Cases of Rape (LORIVE, by its Spanish acronym), which explicitly established that “the health personnel authorized to perform abortion in cases of rape includes midwives and other members of Indigenous communities, communities, peoples, and nationalities who administer ancestral knowledge within these groups and who are duly trained and have complied with the requirements established in the pertinent norms”⁷² (Art. 23) [Author's translation]. This statutory language represents one of the clearest recognitions in the region of both midwives and ancestral health practitioners as lawful abortion providers. In parallel, the Clinical Practice Guideline for Comprehensive Health Care in Voluntary Termination of Pregnancy in Cases of Rape further defined the cadres authorized to provide abortion care, specifying that trained health professionals eligible to deliver abortion

services include gynecologist/obstetricians, family and community physicians, general practitioners, comprehensive general physicians, and midwives, in accordance with their competencies and professional training.⁷³

The legislative debates leading up to these reforms underscored Ecuador's cultural and geographic realities.⁷⁴ In many rural and Indigenous areas, ancestral midwives and community health workers are the first—and often the only—point of contact for pregnant women.⁷⁵ The law therefore mandates culturally acceptable care, including the provision of information in Indigenous languages⁷² (Art. 24.2), and formally recognizes ancestral health knowledge and practices related to abortion⁷² (Art. 14.3). It also directs health authorities to integrate ancestral midwives into the national health system as providers and companions throughout the abortion process⁷² (Art. 14.4). Taken together, these developments explicitly legitimize both mid-level and traditional providers in abortion care, aiming to expand access in underserved areas while respecting the country's ethnic and cultural diversity.

4.5 | Why provider expansion is advancing in the region

Across these country experiences, the arguments that ultimately proved persuasive were framed primarily in public health and health systems terms rather than in the language of broad human rights obligations. Reform advocates and policy-makers converged around a core intuition: increasing the number and types of authorized health professionals expands the supply of services and therefore improves accessibility, in line with the approach endorsed in the WHO Abortion Care Guideline.²⁰ Task sharing was thus presented, first and foremost, as a pragmatic strategy to improve accessibility, strengthen the first level of care, and make existing legal entitlements to abortion effectively deliverable in practice.

In Argentina, the debates surrounding Neuquén's 2023 reform make this logic explicit. The provincial Minister of Health directly justified authorizing midwives to prescribe misoprostol and mifepristone as a measure to “increase the number of trained personnel” able to guarantee timely abortion care, noting that until then these drugs could only be prescribed by physicians⁷⁶ [Author's translation]. A similar access-oriented rationale appears in Mendoza's subsequent reform of its obstetric formulary. The explanatory memorandum to the Decree emphasizes that licensed midwives are often the only sexual and reproductive health professionals consistently present in first-level facilities.⁷⁰ Granting them explicit authority to prescribe essential medications in obstetric emergencies and in perinatal, sexual, and reproductive health was, therefore, justified as a way to bring services closer to communities and to ensure that legal abortion is available beyond urban referral centers.

The Colombian experience reflects the same concern with preventing human resource shortages from becoming de facto barriers to legal abortion. Resolution 051 of 2023 explicitly states that the

absence of particular specialist cadres “cannot become an obstacle” to providing the service, and accordingly organizes abortion care around the presence of “at least one competent professional” rather than prescribing a specialist-only model⁶³ (Art. 14.4) [Author's translation]. The winning argument here is again a systems one: if the law allows abortion, the health system must be structured so that patients do not go without services simply because a specific type of specialist is unavailable.

In a similar vein, the provisions in the preamble of Mexico's midwifery norm justify “the effective incorporation of professional midwives, obstetric nurses, and the recognition of traditional midwifery as part of public health priorities” as a necessary step “to reduce maternal mortality”⁵⁶ [Author's translation]. A parallel logic appears in the legislative report accompanying Ecuador's LORIVE, which recognizes a broad group of health professionals as lawful abortion providers⁷² (Art. 23). The report acknowledges that “maternal mortality, adolescent pregnancy, and unsafe abortion constitute urgent public health problems” and on this basis justifies the reform⁷⁴ (p. 40) [Author's translation]. By explicitly linking the integration of mid-level providers to the reduction of maternal mortality, lawmakers in both countries frame provider expansion as an essential public health intervention rather than as a purely professional or corporatist reform.

Within this broader health systems frame, equality arguments emerged in two distinct ways. The first concerned equality within health teams themselves. In Neuquén, for example, the provincial Minister of Health who promoted the 2023 reform explained that the goal was to “move beyond a physician-centric model so that different health workers can progressively add competencies, broadening the landscape of who provides care”⁷⁶ [Author's translation]. In the same vein, clinical leaders involved in drafting the reform stressed that midwives had historically been treated as “mere assistants” to physicians, despite their university training and their central role in reproductive health⁷⁶ [Author's translation]. Recognizing their authority to prescribe abortion medications was therefore framed not only as a measure to expand service capacity but also as a corrective to entrenched internal hierarchies that undervalued midwives and nurses. On this view, task sharing is as much about updating outdated professional structures as it is about improving access.

The second equality dimension relates to territorial and social disparities in access. In Mendoza, the preamble to Decree No. 2088 emphasizes that midwives are “indispensable resources” in the first level of care, particularly “in challenging contexts”⁷⁰ [Author's translation]. Enabling them to provide safe abortion was presented as a way to narrow the gap between patients who live near tertiary-level facilities and those whose only point of contact with the health system is a primary care post. A similar logic animates Mexico's midwifery norm, whose preamble calls on the State to reduce maternal mortality by strengthening the participation of midwives, “especially in rural areas”⁵⁶ [Author's translation]. In this way, the recognition of midwives is explicitly tied to safeguarding equality of access in regions where specialist physicians are rarely available.

Finally, interculturality introduces an additional line of reasoning that supports provider expansion in countries with significant Indigenous populations, most notably Mexico and Ecuador. Rather than focusing solely on workforce shortages or service distribution, these reforms draw on constitutional commitments to intercultural health and the recognition of Indigenous medical traditions. In Mexico, this has meant affirming traditional midwifery as a legitimate component of the health system and directing public institutions to work alongside, rather than in opposition to, community-based midwives.⁵⁶ Ecuador's LORIVE follows a comparable logic: by acknowledging ancestral midwives as lawful providers and requiring information and care in Indigenous languages, the law seeks to bridge longstanding cultural and linguistic gaps between health institutions and the communities they serve.⁷² In this view, expanding the range of recognized providers is not only a pragmatic response to service deficits but also a way of ensuring that abortion care is delivered in forms that are culturally meaningful and trusted, particularly for Indigenous and rural populations whose first contact with health services often occurs outside formal medical settings.

Taken together, these experiences suggest that the arguments most effective in advancing task sharing in abortion care in Latin America have been those that translate human rights concerns into concrete health system challenges: shortages of specialist physicians, territorial inequities in service distribution, the absence of legal protections for midwives and nurses, and the marginalization of Indigenous providers who are essential for reaching underserved populations. With the partial exception of interculturality—where constitutional rights to Indigenous health practices provided a genuinely rights-based foundation—most reforms have been justified not as implementations of human rights obligations but as pragmatic responses to these persistent access gaps. This framing has opened important pathways for expanding provider roles, yet it also points to an underused opportunity: grounding these reforms more explicitly in States' duties under international human rights law could strengthen their normative authority and enhance their resilience in the face of political backlash.

5 | LESSONS FOR A REGIONAL REFORM AGENDA

The regional picture that emerges from this analysis is double edged. On the one hand, a growing group of countries has begun to expand provider roles in abortion care, often in ways that are remarkably aligned with WHO's task-sharing recommendations. On the other hand, these changes remain fragmented, vulnerable, and still framed primarily as technocratic responses to service gaps rather than as measures required by constitutional and international human rights obligations. A forward-looking reform agenda for Latin America needs to build on the practical successes described above, while at the same time shifting how task sharing is understood: from an optional efficiency strategy to a core component of States' duties in reproductive health governance.

5.1 | Reframing task sharing as a human rights obligation

The first lesson is conceptual and builds directly on the human rights analysis developed above. If, as shown, restrictive provider regulations undermine the availability and accessibility of lawful abortion services, disproportionately harm poorer, rural, and Indigenous women, and foreseeably push many people toward unsafe methods, then the failure to implement task-sharing strategies in abortion care cannot be treated as a neutral policy choice. In contexts where unsafe abortion continues to contribute significantly to preventable morbidity and mortality, and where robust evidence demonstrates that midwives, nurses, and other nonphysician providers can safely deliver care, maintaining physician-exclusive models amounts to a regulatory omission that sits uneasily with States' obligations under the rights to health, equality and nondiscrimination, life, and to enjoy the benefits of scientific progress.

Constitutionally, most Latin American countries now recognize justiciable rights to health, equality,⁷⁷ and in several cases, sexual and reproductive rights.⁷⁸ At the same time, all States in the region are parties to core human rights treaties—such as the International Covenant on Economic, Social and Cultural Rights (ICESCR),⁷⁹ the International Covenant on Civil and Political Rights (ICCPR),⁸⁰ and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)⁸¹—and are therefore bound by the interpretive guidance of UN treaty bodies and Inter-American organs on the rights to health, equality and nondiscrimination, life, and to enjoy the benefits of scientific progress. As discussed in Section 3, these rights are significantly compromised by physician-only models of abortion delivery, particularly where such restrictions foreseeably perpetuate inequities and prevent access to safe, lawful services.

Reframing task sharing as a human rights obligation, therefore, has concrete implications for a regional reform agenda. First, it opens avenues for litigation challenging physician-only scope-of-practice rules as incompatible with this body of constitutional and international human rights norms. Second, it strengthens advocacy directed at ministries of health, legislatures, and professional councils by grounding demands for provider expansion in binding obligations rather than in discretionary policy preferences. Finally, it provides a principled interpretive lens: where abortion laws and protocols refer broadly to “health professionals”, a human rights-consistent approach should resist administrative or institutional readings that narrow this category in practice and effectively reintroduce physician exclusivity.

5.2 | Harmonizing fragmented regulatory frameworks

A second lesson is regulatory. The analysis in this article has centered on abortion-specific laws, penal codes, and clinical protocols. Yet in every country examined, the authority of midwives, nurses, and other providers to prescribe medications, perform procedures,

or lead clinical management is also governed by separate bodies of law: professional practice statutes, licensing regulations, and internal rules of health institutions.

These layers may not always be coherent, and this misalignment can create legal uncertainty for providers, thereby limiting the practical impact of reforms. Indeed, even where abortion norms nominally allow midwives or nurses to participate, ambiguous professional regulations can generate fear of disciplinary sanctions or malpractice claims. In this sense, scope-of-practice rules that ignore task sharing function as a subtle but powerful brake on implementation.

A regional reform agenda should therefore prioritize harmonization across the full regulatory ecosystem. This involves, at minimum, four steps. First, abortion-related norms—laws, decrees, and clinical protocols—should explicitly adopt broad categories such as “trained health professionals”, or specify the relevant competencies in accordance with WHO task-sharing recommendations. Second, professional practice statutes for midwives, nurses, and other cadres should be revised to recognize abortion-related tasks—particularly medical abortion and first-trimester procedures—as within their lawful scope, consistent with WHO guidance. Third, institutional policies at the level of hospitals and primary care networks should be updated to reflect these changes, ensuring that job descriptions, service portfolios, and quality indicators align with task-sharing models. Finally, oversight bodies, including professional councils and health system regulators, should monitor compliance with these updated scopes of practice, not only to prevent overreach but also to avoid unjustified restrictions on legally authorized cadres.

5.3 | Moving beyond law: training, knowledge, and institutional culture

A third lesson is that legal and regulatory reforms are necessary but not sufficient. Experience from countries that have widened provider roles shows that training, professional culture, and institutional incentives play a decisive role in whether task sharing actually takes root.

First, midwives, nurses, general practitioners, and other cadres must receive high-quality, competency-based training in abortion care.⁸² Without this, formal authorization remains largely symbolic. Training needs to cover not only the technical aspects of medical abortion and early surgical procedures, but also values clarification, stigma reduction, and clarity about the legal framework.¹⁶ Providers who are unsure whether abortion is lawful in a given circumstance, or whether they have institutional backing, are unlikely to exercise their full scope of practice, regardless of what the law allows.

Second, the perception that abortion is an inherently high-risk or exceptional procedure continues to undermine task sharing⁶¹ (p. 15). The evidence summarized in WHO guidance and in this article points in the opposite direction: when performed with recommended methods and protocols, abortion—particularly early medical abortion—is a low-complexity intervention that can safely be provided at the first level of care. A reform agenda should therefore invest in reshaping institutional narratives about abortion, embedding it within

routine sexual and reproductive health services rather than treating it as an isolated or quasi-criminal intervention.

Third, institutional design matters. Ensuring that at least one competent professional is available, as Colombia's Resolution 051/2023 requires,⁶³ is not only a legal mandate but an operational challenge. It entails scheduling, task allocation, and workload management, especially in under-resourced primary care settings. Strategies such as telemedicine-supported task sharing²⁰ can play a role, but they require deliberate planning and budgetary support. A regional agenda should thus integrate task sharing into broader health system reforms, including human resources planning, financing, and performance evaluation.

6 | CONCLUSION

The evidence reviewed in this article shows that restrictive provider regulations remain a central—and often overlooked—obstacle to safe and equitable abortion care in Latin America. Even where countries have liberalized their criminal laws, physician-exclusive models continue to constrain service availability, particularly in rural, Indigenous, and primary care settings where specialists are scarce. WHO guidance makes clear that a wide range of health workers can safely provide key components of abortion care, yet most regulatory frameworks in the region remain misaligned with this evidence. Importantly, this is not a challenge unique to Latin America: recent comparative work in Asia similarly demonstrates that restrictive provider eligibility rules—combined with under-resourced public health systems—systematically undermine the implementation of the WHO Abortion Care Guideline and disproportionately burden marginalized populations.⁸³ The emerging reforms in Mexico, Colombia, Argentina, and Ecuador illustrate that expanding provider roles is both feasible and effective, and that it directly addresses the structural inequities that undermine access.

A regional reform agenda must therefore treat task sharing not as an optional innovation but as a normative requirement where legal entitlements to abortion exist. Aligning domestic regulations with WHO recommendations, revising professional practice statutes, and investing in competency-based training are essential steps to ensure that expanded provider roles translate into real access on the ground. Ultimately, broadening the range of authorized providers is a pragmatic, evidence-based, and rights-affirming strategy that can help close the persistent gap between the legality of abortion and its actual availability. In a region where unsafe abortion remains a preventable cause of morbidity and mortality, failing to implement task-sharing approaches is no longer a neutral policy choice; it is a missed obligation to safeguard the rights to health, equality, life, and to enjoy the benefits of scientific progress for those seeking abortion care.

AUTHOR CONTRIBUTIONS

DR is the sole author: conceived, drafted, and reviewed the manuscript.

ACKNOWLEDGMENTS

I am deeply grateful to Professors Rebecca Cook and Bernard Dickens for their attentive reading of this manuscript and for their generous guidance and encouragement throughout the development of this article. Their insights on reproductive health law and human rights greatly strengthened the clarity and analytical rigor of this work. I am also indebted to Professor Lisa Forman, who reviewed an early draft of this paper and encouraged me to pursue this line of inquiry in the context of her course on International Human Rights Law and Global Health at the Dalla Lana School of Public Health, which I had the privilege to take as part of my LLM in Health Law at the University of Toronto. I am additionally grateful to Linda Hutjens, PhD, Coordinator at the International Reproductive and Sexual Health Law Program, for her careful proofreading and assistance with citation management. As English is not my first language, I used ChatGPT and Grammarly solely as language editing tools to refine grammar and fluency; all substantive analysis, arguments, and conclusions are entirely my own.

CONFLICT OF INTEREST STATEMENT

None declared.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new datasets were generated or analysed. All materials examined are publicly available sources (laws, regulations, clinical guidelines, policy documents, and published literature) cited in the reference list.

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How to cite this article: Repka D. Task sharing in abortion care in Latin America. *Int J Gynecol Obstet*. 2026;172:1810-1822. doi:10.1002/ijgo.70795