

Legal abortion services in Brazil – a national study

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Abstract *This article presents the results of a mixed methods study of 68 legal abortion services in Brazil. The services were analyzed in two stages. The first stage was a census, in which all the institutions were sent an electronic questionnaire about the organization of the legal abortion services. The second stage was conducted in a sample of 5 reference services, one for each region of the country. In this stage, a form was used to collect data about the women and the abortions in the medical records, and 82 interviews with health professionals were conducted. Thirty-seven of the services informed they performed legal abortions, and the services were inactive in 7 states. Police reports, forensic reports, and court orders were required by 14%, 8% and 8% of the services, respectively. Women who underwent abortions were predominantly aged 15-29, single and Catholic. Most abortions were performed until 14 weeks in the case of rape-related pregnancy, by means of manual vacuum aspiration. According to the health professionals, the main difficulties faced in the services are the low availability of physicians to perform abortions and the insufficient training of the staff. The data reveal a discrepancy between the legal provision and the reality of the services. The implementation of more services and the strengthening of the existing services available are necessary.*

Key words *Legal abortion, Census, Health services, Rape, Sexual violence*

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Introduction

In Brazil, the Penal Code exempts abortion from punishment when there is risk of death for the woman and when the pregnancy results from rape¹. In 2012, the Supreme Court considered anencephaly as another possible condition to legally terminate a pregnancy². Although the Brazilian legislation authorized the voluntary interruption of rape-related pregnancy in the 1940s, access to health services remained unregulated for almost 50 years. In 1989, the local government of Sao Paulo city established the first service to assist women who suffered sexual violence in Hospital Municipal Artur Ribeiro de Saboya, known as 'Hospital do Jabaquara'. A woman should present a copy of the police report and the forensic report from Legal Medicine Institute to have access to the abortion³.

The national regulation of the legal abortion took place in 1999, when the Ministry of Health issued the document *Prevenção e Tratamento dos Agravos Resultantes da Violência Sexual contra Mulheres e Adolescentes*, which promoted and standardized the organization of these services⁴. The document was updated in 2005 and 2011, and exempted women from presenting a police or forensic report. According to these regulations, the only document necessary to terminate a pregnancy resulting from rape was the written consent of the woman^{5,6}. The implementation of the majority of the services gained attraction with the reissue of that document in 2005, and the official information disclosed by the Ministry of Health predicted the availability of 60 legal specialized abortion services throughout the country by 2009⁷.

Despite the advances deriving from the establishment of the services in all regions of the country, women face many difficulties to have access to abortion services. By means of questionnaires sent by mail to gynecologists and obstetricians, research conducted in 2003 observed that about 2/3's of the physicians believed court permission was necessary for legal abortion⁸. In 2012, another study conducted including gynecologists and obstetricians revealed that 81.6% of them requested a police report or some other document, such as forensic report, authorization from the hospital's ethics committee, or a court order⁹. Also, the truth about the claim of rape is often disputed, and the woman's claim is not sufficient to guarantee the termination of the pregnancy¹⁰.

Another barrier has been to find health professionals available to assist legal abortion – many doctors refuse to perform the abortion because they are afraid to be known as abortionists, believe they could be sued, or have a moral or religious conscientious objection^{9,11-13}. The document issued by the Ministry of Health assures that doctors have the right to conscientious objection to abortion, but also determines that the public services that assist victims of sexual violence should guarantee timely assistance by another professional or service. However, the right to conscientious objection is not recognized if there is no other doctor who could assist the woman in the service, if there is risk of death, or if the denial of care may cause harm⁶.

Public care services for women who suffered sexual violence in Brazil was the object of two studies in 2005. The first one evaluated 56 hospitals listed as specialized services for the legal interruption of pregnancy. The data showed that only 37 of them were enabled to provide legal abortion services, and that another 5 of the hospitals had never performed this procedure, and that, in 6 states, there was not any legal abortion service available whatsoever. Also, the data confirmed that 70% of the services were offered in the Southeast region of Brazil, and received patients from all regions of the country¹⁴. In the second study, managers and professionals from 1,395 health facilities who assisted victims of sexual violence were interviewed. The results were that of the services given, 12% had performed at least one abortion, 53% offered emergency contraception, and 45% provided for HIV prophylaxis¹⁵.

With the recent decision of the Supreme Court, the termination of pregnancy in case of anencephaly has become a right, with no need for court permission; therefore, legal abortion services also provide assistance in such cases. Resolution 1.989/2012, issued by the Federal Council of Medicine, set the criteria for the therapeutic early delivery of anencephalic fetuses: 'two identified and dated photographs, one with the fetus' face in sagittal position, and the other showing the cephalic pole in a transversal cut, demonstrating the absence of calvaria and identifiable cerebral parenchyma; report signed by two physicians enabled for such diagnosis¹⁶.

Even though the periodic evaluation of the services is specified by the 2011 document⁶, it does not occur regularly. A woman's access to the termination of pregnancy as the result of

rape may be hindered by geographical and institutional obstacles, or by the professionals' conscientious objection. There are no consolidated data about the qualification or composition of the staff assigned to abortion services, about the number of abortions performed by them, or about the access to abortion itself – whether it is real and facilitated. This article describes the results of a census of specialized services enabled to perform legal abortions in Brazil, and provide assistance for victims of sexual violence. The main objective is to present up-to-date data about the structure of the services and the sexual assault care, besides the woman's profile and the characteristics of the abortion.

Methods

This is a national mixed methods study that analyzed the legal abortion services in Brazil from 2013 to 2015. The 60 services listed as active by the Ministry of Health in 2009 were assessed⁷. Before the data collection, the State Health Departments and the Technical Area of Women's Health of the Ministry of Health were contacted by phone to check the creation or cancellation of any service. As a result, 8 more institutions were included in the study, which evaluated 68 services in total. Data was collected from July 2013 to March 2015, in two stages.

First, a structured questionnaire was sent by e-mail to every service, with questions about: i. year of implementation; ii. composition of the staff; iii. Approaches adopted in sexual assault care; iv. performance of the legal termination of pregnancy; v. documents required to perform the legal abortion; vi. methods for the termination of pregnancy; vii. number of women that underwent an abortion. Each service also received a letter presenting the research and the opinion of the Research Ethics Committee approving the study. The institutions themselves designated a professional to answer the questionnaire and return it to the research team.

Second, five service locations, one in each region of the country, were visited. The criteria used to choose these services included having performed legal abortion in the 5 last years and being a reference service in the region, in terms of the number of cases assisted. This stage involved two steps: analysis of the women's pro-

files and the characteristics of the legal abortion in each service, which was done by means of file research in the medical records; and interviews with the multi-professional staff. The data collected in each service were those available in the institutional file since its foundation – three services were founded in the 1990s, and two in the 2000s. To retrieve data about abortions, a standardized form was filled out based on the woman's medical records, with questions about color, age, education, civil status, religion, gestational age, reason for abortion, and method used for the termination of pregnancy. The interviews with the professionals were semi-structured and comprised of 10 questions divided into 2 analytical categories (organization of the service, and standard and difficulties for legal abortion assistance). Eighty-two health professionals were interviewed, among physicians, nurses, social workers, psychologists, and nurse technicians. The interviews were conducted by two researchers in a room provided by the hospital. The research instruments were previously tested with a service in the Southeast region of the country, where the number of abortions remained constant over the years.

The quantitative data were inserted into a spreadsheet in Microsoft Excel for descriptive analysis. The interviews were recorded and transcribed. Three researchers read and codified the interviews, and the data were organized by an instrument composed of two questions: if the service faced difficulties, and how those difficulties happened. The patterns were compared and, in the case of discrepancy, the transcriptions were revised.

The project was revised by the Research Ethics Committee of the Human Sciences Institute at University of Brasilia. However, the institutional review boards of 9 services requested a new review, both in the first and in the second stage of the study. The approval of the new review took four months on average, but one of the services took 14 months to conclude the ethical revalidation. In one of them, the data in the census stage could only be retrieved by resorting to the Brazilian Law of Access to Information, because the hospital systematically refused to authorize the research. All health professionals previously agreed to be interviewed and signed the informed consent.

Results

Profile of the legal abortion services

Thirty-seven of the 68 services analyzed reported they perform the termination of pregnancy in cases of rape (37/37), risk of death of the woman (27/37), and anencephaly (30/37). Despite performing the termination of pregnancy, 2 hospitals reported they referred the case to another service when pregnancy was more than 14 weeks. Among the inactive services, 28 said they had stopped performing legal abortions, and 4 reported they had never performed abortions. Among the active services, 29 were implemented before 2005, 8 of them having been established after that, and 2 of them since 2013. The services are distributed over 20 states (5 in the North region, 11 in the Northeast, 3 in the Midwest, 6 in the South, and 12 in the Southeast), and there are no active services available in seven states (1 in the South region, 1 in the Midwest, 2 in the Northeast, and 3 in the North). Only 6 states have more than 1 service, and in 4 of them there are services outside the capital (8 cities).

All the 37 active institutions reported they had a minimal multi-professional staff (physician, nurse, psychologist, and social worker) in sexual assault care. However, 35 (95%) of them did not have specific assigned staff, and care was provided by the professionals on duty at the time. In 2 services, there was a lawyer (legal advisor) included among the staff, and in 3 of them there was a psychiatrist and an infectologist. Fifteen services reported they hired the professionals by means of a specific civil service examination to compose the legal abortion staff.

As for the first aid provided to victims of sexual violence, 35 (95%) of the 37 active services offered emergency contraception, 33 (89%) prescribed prophylaxis against non-viral sexually transmitted diseases (STDs), and 34 (92%) performed prophylaxis against viral STDs. The collection of material for an eventual identification of the aggressor was made in only 2 services. In the case of termination of pregnancy from rape, there was a request for written authorization of the woman in 34 services (92%), a police report (5/14%), a forensic report (3/8%), a court order (3/8%), an opinion from the institutional review board (4/11%), and an order from the Department of Public Prosecution (3/8%). In the case of anencephaly, 2 (6%) services also demanded a court order as a condition for the interruption of pregnancy.

The active services reported that 5,075 women who sought legal abortion were assisted, with 2,442 abortions performed. The first service was established in 1994, and the most recent, in 2014. It calls our attention that 15 services performed less than 10 abortions in the last 10 years, 4 of them located in capitals and being the only services available in the region. The methods available for the termination of pregnancy were curettage (89%), medical abortion (97%), manual vacuum aspiration (86%), and electric aspiration (3%).

Profile of the women assisted and characteristics of the legal abortion

A total of 1,283 medical records of women who had legal abortions in 5 services of each region in Brazil were analyzed. One of the services was responsible for 80% of the abortions registered. In 4 services, files included all the cases of legal abortion since their implementation; however, in one of them the files only included cases registered from the last five years. Table 1 presents the sociodemographic characteristics of the women. The majority of them are between 15 and 29 years old (62%), single (71%), and Catholic (43%), and have completed high school (37%). It should be noted that 38% of the women were still children or teenagers, 5 of them being less than 10 years old.

Table 2 shows that the main reason for abortion was rape (94%). The prevailing gestational age was between 9 and 14 weeks (41%). The therapeutic anticipation of birth in case of anencephaly led to the majority of the terminations after 20 weeks (only 5%). The most frequent abortion method used was manual vacuum aspiration (45%) and misoprostol (32%).

Difficulties faced in the services' routines: the experience of the professionals

Despite the singular characteristics of each service, two main obstacles hindering legal abortion services were generally mentioned by the professionals interviewed. First, the limited availability of professionals, mainly physicians; second, the need for better training of the staff in terms of the legislation and in the guarantee of sexual and reproductive rights. The infrastructure of the services was not considered an issue, even though the absence of specific spaces for care and the admission of the women together with puerperal mothers and newborns were mentioned.

Table 1. Sociodemographic characteristics of the women. Legal abortion services in Brazil, 2013-2015.

Characteristics	N	% ⁱ
Age (years)		
< 10	5	0,4
11-14	193	15
15-19	283	22
20-24	251	20
25-29	266	21
30-34	158	12
35-39	89	7
> 40	38	3
Education ⁱⁱ		
Illiterate	71	6
Primary education	454	35
Secondary education	471	37
University level	178	14
Civil state ⁱⁱⁱ		
Single	913	71
Married	183	14
Separated/widowed	113	9
Color/race ^{iv}		
Yellow	09	1
White ^v	648	51
Indigenous	26	2
Brown	336	26
Black	128	10
Religion ^{vi}		
Catholic	547	43
Evangelical	302	24
No religion	164	13
Other	78	6
Total	1,283	100

ⁱThe percentages have been rounded; ⁱⁱThere was lack of data in 108 cases (8%); ⁱⁱⁱ There was lack of data in 74 cases (6%); ^{iv} There was lack of data in 136 cases (11%); ^vThere was a higher number of cases analyzed in services from the Southeast and South regions, which may explain the concentration of women identified as "White"; besides, in the other services this piece of information was not registered in the medical records; ^{vi} There was lack of data in 192 cases (15%).

Most accounts express a dynamic assistance marked by care, as well as agility and resolution of the cases. In the 5 services, multi-professional staff were available for the initial care of the victim of sexual violence, with the prescription of drugs for the prevention of pregnancy and infections. For most of the professionals interviewed, the difficulties begin when the woman decides to have an abortion. According to them, the termination of pregnancy is a responsibility of the obstetricians on duty, and, if they refuse to perform the abortion, women "[...] need to wait

Table 2. Characteristics of the legal interruptions of pregnancy. Legal abortion services, 2013-2015.

Characteristics	N	% ⁱ
Reason		
Rape	1,212	94
Anencephaly	55	4
Risk of death for the woman	09	1
Other severe malformations ⁱ	07	1
Gestational age		
< 8 weeks	346	27
9-14 weeks	527	41
15-20 weeks	346	27
> 20 weeks	63	5
Method		
Manual vacuum aspiration	582	45
Misoprostol	414	32
Curettage	130	10
Misoprostol + curettage	38	3
Other	119	9
Total	1,283	100

ⁱ With court order.

for another doctor, on another day, to agree to perform the abortion. And while some anesthesiologists agree, some others don't. Sometimes, it may take a while [...]. The negotiation to assist the woman involves other professionals, as one participant said: "[...] we have to think of the nurse assistants too, so on the day of the abortion we manage the schedule so that those who won't pose any problem will be in the operating room [...]."

For the professionals interviewed, the most common reason for the objection to performing an abortion are moral or religious barriers. Very few professionals described the experience of barriers as an individual right to conscientious objection, for the majority of them noted that the woman's rights cannot be ignored, that is, that the woman "[...] could not have her request for abortion refused by all the professionals. Even if she has to come back some other day, the service must assist her [...]. Besides the religious reasons, the stigma of abortion makes professionals refuse to join the abortion staff – they are afraid of being labelled 'abortionists' by their peers. The medical team specially fears being incriminated for the termination of pregnancy not resulting from rape. The dispute over the truth of the woman's account of violence, and the request for

a police or forensic record are attempts to protect the staff against the mere word of the woman, who could allegedly lie about the violence.

Continuous training of the professionals who compose the abortion staffs was defended as a necessary tool to improve women's access to the services. According to the participants interviewed, the lack of information professionals have about current legislation and public policies creates barriers, hindering the quality of care and, sometimes, the viability of the termination of pregnancy. This is particularly true when care is provided by professionals on duty and there are not specific abortion staff assigned, "[...] it is important to take courses, training, to share experiences and difficulties. We have to implement it in the whole service [...]". The professionals interviewed also believe that the bureaucratic barriers would be reduced if they received training in concepts like "sexual and reproductive health", "gender violence", "humanization", and "human rights".

Discussion

Rape is one of the most perverse expressions of gender violence. Due to the physical, psychological, and social consequences of sexual violence, the consensus is that the health system should have adequate infrastructure and a trained staff to provide women with complete care. Pregnancy is unbearable for most of the victims. One of the main elements of such care in Brazil is the possibility to terminate pregnancy, if the woman decides so. Law n. 12.845/2013 determines that hospitals provide victims of sexual violence with multidisciplinary care. Also, it prescribes "prophylaxis against pregnancy" and "information to the victims about their legal rights"¹⁷. However, the results of this study show that there are still many barriers hindering adequate assistance to women who seek legal abortion in the country. The fact that most services are located in capitals and large cities, as well as their unavailability in 7 states, reveals the access barrier faced by many women willing to legally terminate their pregnancy. When we compare this study with the most recent evaluation of the legal abortion services, taken in 2005, we find no advancement in the implementation of other services, mainly in small cities. In 2005, 37 health services were authorized to perform legal abortion, and 6 states had no active services¹⁴. Currently, there are still

37 active services, but 7 states do not offer them.

The composition of the professional staff is still an obstacle to most of the services researched. On the one hand, the presence of multidisciplinary staff attests to the commitment to offer complete care for women who have suffered sexual violence. On the other hand, the unavailability of designated specific abortion staff delays the assistance and, sometimes, precludes abortion. Other studies involving health professionals who perform legal abortions demonstrated that the lack of technical preparation, ignorance of the law, and emotional suffering are common among the staff^{18,19}. Both the inclusion of the theme in the academic curricula and the continuous training of professionals in the health services are strategies that increase their participation in legal abortion services^{20,21}.

Between 20% and 30% of women who suffer sexual violence seek medical care, and among those, only 10% to 30% comply with treatment and follow-up care^{22,23}. The quality of the health services is one of the main factors influencing adherence to follow-up care, including both the availability of trained professionals and confidential and quick assistance, offered in the same hospital^{22,24}. As for the offer of emergency contraception and prophylaxis against infectious diseases, the data in this study demonstrate the services have improved from those offered in the 2000s^{14,15}. While prophylaxis against viral diseases (especially HIV) is unavailable in 4 services, 25% of the services reported they referred the woman to another hospital due to lack of trained staff, mainly infectologists, for the prescription of antiretrovirals. The consensus is that, after unprotected sexual activity and when the aggressor's serologic status is unknown, prophylaxis against HIV should be started as soon as possible, within 72 hours after the rape²⁵. It should be noted that around 5% (2) of the services reported they did not offer emergency contraception. It is unknown if this is due to lack of availability of specific drugs in the services, to lack of technical knowledge, or to moral and/or religious objections of the professionals. In other countries, only 50% of physicians inform women who suffered rape about emergency contraception and prescribe it²⁶. Doctors who did not receive specialized training and who treated a limited number of cases of sexual violence prescribe emergency contraception less frequently^{26,27}. Given that 5% of the women are at risk to get pregnant by rape and that this chance is reduced 85% when emergency contraception

is taken in the first 72 hours^{22,25,26}, this should be considered a priority in sexual assault care.

The bureaucratic demands made by the services to perform an abortion have decreased considerably since the evaluation conducted in 2005, when 70% of the hospitals requested a police report¹⁴. In this study, 14% of the active services still make as a condition of assistance the presentation of the police report by the woman. This study did not question the reasons for requests for documents not mentioned or required in the guidelines or legislation issued by the Ministry of Health; however, previous research in similar contexts have noted that common reasons are the lack of knowledge about the legal framework regulating abortion and the fear of legal consequences^{8,9,28}. Despite the services' willingness to assist women, the recommendations of the Ministry's document are not followed by all of them.

A doctor's refusal to perform an abortion, frequently justified by a moral or religious barrier, was mentioned by professionals themselves as one of the main barriers in the services. A study involving gynecologists and obstetricians conducted in Brazil in 2003 showed that 85% of them agreed with a woman's right to abortion in the case of a pregnancy resulting from rape, but only 50% were available to perform it²⁹. In 2012, another research involving gynecologists and obstetricians revealed that 43% of them declared a conscientious objection if they were uncertain the woman was telling the truth about the rape⁹. The reason for the refusal to perform the abortion was not to protect their moral or religious beliefs, but the fear of facing negative legal and social consequences related to the stigma of abortion^{13,18,30}.

In this study, the main reason for the abortion was rape, which is compatible with the profile of the victims of sexual rape that seek the service: mainly young, single, and educated women, as described by other studies^{22,23,31}. The number of abortions for anencephaly was low, and remained constant over the years in the services, which suggests no increase after the Supreme Court's decision². Manual vacuum aspiration, the most frequent abortion method used in the cases analyzed, corroborates with the recommendations of the World Health Organization (WHO) for uterine evacuation³². Manual vacuum aspiration should be the preferred method of abortion up to 12 weeks of pregnancy, because it can be done with local anesthesia, involves less risks of complications, costs less, and is as efficient as cu-

retage. Furthermore, pain management is easier and waiting time is shorter with manual vacuum aspiration^{32,33}.

This study leaves some questions unanswered about the services that are currently offered. First, less than half of the women who requested legal abortion services had their demands answered. We do not know if this happened because they requested the services after 20 weeks of pregnancy, and did not meet the legal criteria for the interruption of pregnancy (rape, anencephaly or risk of death for the woman), because there were bureaucratic or moral barriers imposed by the professionals, or because they voluntarily left the service. Second, we do not know the average time a woman faces from their initial care until the abortion. Third, we do not know if the services provide follow-up care after an abortion or what type of care they offer. Future investigation may shed light on these gaps about how the services work.

Final considerations

The data of this study show that there still is a gap between the provisions of public health policies and the reality of the legal abortion services offered. Though willing to offer adequate care, the services still fail to follow the recommendations of the official norms. In the active services, the quality of the initial care offered to women improved, with more frequent prophylaxis against STDs and emergency contraception. As well, the request for unnecessary documents, which often constitute barriers to healthcare, was made less frequently than in previous studies. The implementation of other services is a must, when considering several states have yet to establish structured units and because the services are scarce in smaller cities.

Legal abortion requires the diligence of the State to increase and consolidate services, to train the professional staffs, and to perform continuous evaluation. According to the National Program on Human Rights, established in 2010, it is the responsibility of the Ministry of Health and the Department of Policies for Women to propose "mechanisms to monitor the services of legally authorized abortion, guaranteeing their realization and ease of access"³⁴. However, this government commitment has been marked by backlashes over the last number of years, including the reduction in the number of legal abor-

tion services, and the repeal of Ministry Decree 415/2014³⁵. The decree included the register of legal abortions in the list of procedures offered in the Unified Health System, and would have facilitated the notification of cases and rule the guarantee of this reproductive right already provided by Brazilian legislation.

Brazilian public policy guarantees healthcare to women who have suffered sexual violence, including the possibility to terminate pregnancy. For women to have full and complete access to legal abortion, there must be good health services available, which respect and answer their reproductive choices. Periodic evaluation of the services, as conducted by this study, should be seen as part of the strategies to strengthen legal abortion services. Evidence-based political decisions devoted to the guarantee of women's reproductive rights could solidify just legal abortion care.

Collaborators

AP Madeiro and D Diniz designed the research project, collected data, and wrote and revised the article.

Acknowledgements

The authors thank FEBRASGO for mediating contact with several legal abortion services and the Special Department of Policies for Women for funding the study.

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Article submitted 13/6/2015

Accepted 19/6/2015

Final version submitted 21/6/2015