“Referendum on Sunday, working group on Monday”: A success story of implementing abortion services after legalization in Portugal

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Abstract
A 2007 referendum legalized abortion in Portugal. Physicians played an important role advocating for legal reform and providing services thereafter. Implementers relied on a strong public health system with many gynecologists who required minimal training, and took decisions that allowed for rapid implementation. First, they emphasized medical abortion and integrated abortion into existing hospital obstetrics and gynecologic services, where eventual complications could be managed. They also offered immediate postabortion contraception, helping prevent criticism from abortion opponents who feared women would obtain multiple repeat abortions. Finally, they established referral networks guaranteeing access despite conscientious objection. Media campaigns were not needed as Portuguese women had good access to information. Portugal’s success is largely due to key facilitators within a working group established by the Ministry of Health to implement the new law. Remaining challenges are the lack of choice between medical and surgical abortion, and some regions with relatively difficult geographic access to services.

KEYWORDS
Advocacy; Implementation; Legalization; Medication abortion; Portugal; Public health; Referrals; Safe abortion

METHODOLOGY FOR ALL CASE STUDIES
This case study is one of six comprising a comparative examination of varied countries’ approaches to the implementation of national abortion service programs, after changes in laws or policy guidelines that established or expanded access to services. In addition to Portugal, case studies were conducted in Colombia, Ethiopia, Ghana, South Africa, and Uruguay, as they had all either implemented new abortion laws or policies, or changed interpretations of existing laws or policies, within the past 15 years. Each study used the Integrated Promoting Action on Research Implementation in Health Services (i-PARIHS) framework to organize the analyses. i-PARIHS posits successful implementation to be a function of the innovation to be implemented and its intended recipients in their specific context, with facilitation as the “active ingredient” aligning innovation and recipients.1 For each country case, two types of data sources were used: an in-depth desk review and 8–13 semi-structured in-depth interviews with key stakeholders and experts in each country, selected in collaboration with in-country partners. Respondents provided written informed consent and were guaranteed confidentiality. Several respondents from each country served as in-country coauthors, in doing so giving up their anonymity as participants of the study, although no quotations provided as...
respondents are directly attributed to them. Respondents included healthcare providers, public health and government officials who had been involved in establishing or expanding the service, academics, and members of nongovernmental organizations (NGOs) and legal and feminist advocacy groups; in some countries interviewees came from the full range listed, in others, from a subset (Table 1). Interviews were performed by a Portuguese speaking physician member of the team. Quotes presented are from interviews without attribution as we promised confidentiality. Data analysis comprised a multistep iterative thematic analysis, with coding structured to follow the i-PARIHS framework. The WHO’s Research Ethics Review Committee approved this study (protocol ID A65920). A full discussion of background and methodology can be found in Chavkin et al.2

1  |  CONTEXT

Until 1984, abortion was totally illegal in Portugal. After a 1984 parliamentary debate on abortion, Law 6/84 was approved, leading Portugal to amend its Penal Code and permit abortion in cases of threats to life or health (physical or mental), rape, or fetal impairment.3 However, this law was narrowly interpreted and hardly implemented. Unlike in neighboring countries such as France and Spain, clandestine abortions remained the norm. Although the maternal mortality ratio was 15 per 100 000 live births in 1995,4 unsafe abortions continued to be one of the main causes of maternal death and accounted for thousands of yearly hospital admissions for postabortion complications.5,6 In 1998, a national referendum to allow abortion upon request up to 12 weeks of pregnancy failed to pass. In the early 2000s, a highly publicized trial against an illegal abortion provider, together with reports of deaths from unsafe abortions, brought the issue to the forefront and contributed to changing public opinion on the matter. In 2007, extensive social protests led to a second referendum in which voters approved abortion upon a woman’s request during the first 10 weeks of pregnancy.5,7 Interview respondents explained that the failure of the 1998 referendum had been disappointing as public opinion on abortion was already changing; also, by the early 2000s, Portugal remained one of the very few countries in Europe with restrictive abortion laws. For these reasons, they saw abortion reform in Portugal as “long overdue.” Physicians, feminist groups, NGOs, health professional associations, and other civil society groups played important advocacy roles leading up to the referendum, having kept the debate on legal abortion at the forefront of the political and public opinion agenda since the early 1990s. Physicians’ motivation stemmed from having experienced the consequences of illegal abortions in their clinical practices. One of the key physicians who participated in implementing the law explained:

People felt that it was very bad in their daily work. [Physicians] were tired of seeing women dying or coming in a real bad shape to the hospital […] There were four or five recognized physicians nationwide who made themselves available to carry out this campaign at the national level.

While physicians understood the human rights argument of the campaign, it was the public health argument and their professional experience that carried the most leverage for legal reform. As one physician advocate explained:

The added value in the public discussion that was generated [by physicians] at that time was [that now we had] a group of technicians who said ‘Ok, of course it’s the woman who decides, the body is hers and she has the right to decide, but there is also a health issue that is very important.’

One key group of advocates included the word “doctors” in their title because “[…] in Portugal doctors have power. And this power implies responsibility.”

The active participation of physicians was not only instrumental leading up to the referendum, but also key to the successful establishment of abortion services. As one of the gynecologists involved in the initial steps of implementation explained:

We gynecologists had years of working with women with complications from clandestine abortion, and [after the new law] we were very motivated to make things go well.

Physicians participated in a technical group convened by the Ministry of Health to decide every aspect of implementation of the law, from clinical protocols to organization of services. They were also on the ground in the public health hospitals organizing trainings and providing services almost immediately after the referendum. As one obstetrician/gynecologist recalled:

The law passed in April, [Ministry of Health] regulations were issued in June, and services began on July 15.

The existing infrastructure of the Portuguese public health system was a key element in the successful and rapid implementation of the law. Indeed, one of the earliest implementation decisions was that abortion would be integrated into the National Health System; all hospitals would be required to provide free abortion care within an established timeline (see below). Portugal’s National Health Service, established in

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**TABLE 1** Professional domains of interviewees in Portugal.

| Professional domain | Number of interviewees |
|---------------------|------------------------|
| Medical professional | 4                      |
| NGO                 | 2                      |
| Government          | 2                      |
| Other*              | —                      |

Abbreviation: NGO, nongovernmental organization.

*“Other” comprises academics, or individuals from feminist or legal advocacy groups, or UN agencies.
1979, is a universal, tax-financed system guaranteeing universal coverage of specified medical services to all citizens. The system is centrally governed by the Ministry of Health, which has jurisdiction over all hospitals, although some health services are administered at the regional level. In the last decades of the twentieth century, increases in access to and quality of health care have led to significant improvements in the general health status of the Portuguese population. Maternal and child health indicators have improved, despite some remaining regional inequalities. This strong health system already reaches a majority of the population across the national territory through far-reaching primary care centers and established reference networks to specialized services and tertiary facilities. In this context, abortion was relatively easily integrated into the existing system as an additional service provided at the hospital level within the maternal health package.

2 | INNOVATION

The 2007 Portuguese law allows abortion upon a woman’s request up to the first 10 weeks of pregnancy. Abortion is also allowed until 12 weeks to preserve a woman’s physical or mental health, up to 16 weeks if it is a result of “a crime against freedom or sexual self-determination,” up to 24 weeks in cases of serious fetal impairment, and without gestational age limit in case of a malformation incompatible with life. A woman seeking an abortion must present to a physician of her choice, who will refer her to a hospital for a preabortion consultation, which includes a physical examination and an ultrasound to confirm gestational age. This consultation must occur within 5 days of her request. If the initial physician is a conscientious objector, he or she must refer her to another physician who will then refer her within this timeline. A woman may also present directly to the hospital to request a preabortion consultation. The abortion must be provided to the woman within 5 days of this consultation. Preabortion counseling includes information on the abortion procedure and its health consequences. Women are also informed of the support available through the State during pregnancy and maternity and are offered psychological and social services. Counseling on contraceptive options is also provided. This is followed by a mandatory 3-day waiting period prior to the procedure itself, which may be medical or surgical. A second physician (different from the one who dated the pregnancy) may then perform the abortion procedure. The woman is encouraged to attend a follow-up consultation 2 weeks later, and a contraceptive method is offered to her immediately. The Portuguese national health system is obligated to provide free and timely access to abortion, and provides care largely through its own public hospitals. Private clinics that are officially recognized can also provide services but, like public health facilities, must report to a central National Health System database, which is used to compile national reports.

The 10-week gestational age limit is restrictive, and implementers recognized this, but were motivated to establish the best possible access within the confines of the law. According to several of them, a series of strategic decisions were key to ensuring the effective implementation of the law. One of these was to focus on medical, outpatient abortions rather than on surgical ones. In Portugal, this was seen as a more cost-effective route in that the method required fewer technical skills, less equipment and facilities, and it allowed for easier participation of nursing staff. As one physician described:

*We had a well-studied medical abortion technique with low complication rates, which allowed us to establish an outpatient service. The biggest secret is to get an outpatient service, because if we had to admit all these patients and take them to aspirations, this would not go well.*

The knowledge of a reliable medical abortion protocol came from existing international protocols such as those from the WHO, and also from the experience of other countries, particularly France. One respondent recalled:

*Our best option was to prepare ourselves for medical abortion in the ambulatory setting on a large scale. So [...] we learned the French protocols [...] and we adapted the protocol to Portugal.*

Medical abortion was also seen as less likely to generate objection; as one physician explained:

*[Surgical abortion] would increase the number of objectors essentially because of the workload, because we must involve the anesthetist, a room and surgical material—so in this aspect I think it would have been impossible, from the start [...] to implement interruption of pregnancy in Portugal in such a simple and fast way.*

Another strategic decision was to provide abortion within hospital maternity wards rather than at the primary care level. This was initially debated as Portugal has a strong network of primary health centers that reaches a majority of the population. While some respondents felt that providing services at the healthcare center level would be ideal, key decision makers explained that there were not enough resources and not enough clinical expertise at the primary healthcare level, and there was fear of being unable to manage complications. As one physician explained:

*The Commission didn’t want the health centers to do the terminations. I agreed to that. Why? Because if anything, especially at the beginning, went wrong in the health center, who would be to blame? [...] people would say ‘they are not experts at doing this, etc.’*

While there were some exceptions, providing abortion at the primary care level was not seen as a viable strategy, as a respondent explained:

*We tried to [provide abortions] in some health centers, but there are general practitioners, no specialists, no ultrasounds, no laboratory.*
The decision to provide abortions at the hospital level was thus a matter of human and physical resources, but also a political strategy—implementers knew that abortion opponents would look for complications and be ready to argue against abortion on the grounds of safety, and therefore tried to anticipate and prevent this from happening.

Another essential component of the Portuguese approach was to include contraception as part of abortion services. Respondents described this as a key strategy to reduce the number of unplanned pregnancies in general and of repeat abortions in particular. During the debate leading up to the 2007 referendum, opponents of abortion had raised the concern that women would start using abortion as contraception, and have multiple abortions. Early implementers responded to this concern in two ways: the first was to collect data on women seeking abortions to establish whether these were first-time or repeat abortions; and the second was to integrate contraceptive counseling into the very structure of abortion care. The data demonstrated that most women were having abortions for the first time, and that they were not using abortion as a form of contraception. One respondent who participated in designing the data collection tool used by the Ministry explained:

There were reports of [the same] women having terminations every 6 months [so we decided] to turn this into a yearly report, because people always want to know numbers. It was always there, that line of attack against the abortion system, the issue of numbers. And it was a good thing that we had a register, because we can say, clearly, when people say most women use abortion as if it is contraception, that's a lie.

The results of this strategic decision are remarkable: according to the 2016 report of abortions in Portugal, 70% of women had an abortion for the first time, and 96% used postabortion contraception, with 38% choosing long-acting reversible methods.13

Finally, a key component of the Portuguese implementation model was the regulation of conscientious objection. According to the 2007 law, only those directly involved in the provision of abortion may object, and must submit a written declaration to their hospital director specifying the specific components of law to which they object. As previously described,14 most respondents explained that conscientious objection is not a barrier to obtaining abortions in Portugal because in most hospitals there are sufficient willing staff who provide services. While there are some hospitals where all providers are objectors, the law requires that hospitals guarantee access to services, and hospitals have found a variety of solutions to fulfill this obligation. As one interviewee explained:

Conscientious objection is permitted, according to our Law and is an individual act. [...] What happens is that there are hospitals where all the staff is a conscientious objector and they don't have the human resources to offer this type of service. [...] the State, in accordance with our law, requires that the institution arrange or organize in a way their users’ access to health is not impaired. And there are several models: there are hospitals that have contracted gynecologists to come 2 or 3 hours a week; there are hospitals that refer to private clinics and others that refer to other hospitals.

Thus, an important aspect of the Portuguese strategy was to guarantee that services be provided despite conscientious objection, and to allow hospitals to organize their response in a variety of ways to fulfill this obligation.

3 | RECIPIENTS

One element that contributed to the successful implementation of the new Portuguese law was that the healthcare professionals ultimately responsible for providing abortion services were primarily obstetricians/gynecologists. As “recipients” of the new law, they were first and foremost readily available in the context of Portugal’s health system; they were also well prepared to implement the law, as they already possessed the clinical skills required to provide abortions. One obstetrician/gynecologist explained:

We are obstetricians, right? We were accustomed to dealing with spontaneous abortion and therefore there is not much difference between spontaneous and induced abortion and this is very much part of what we are trained to do as specialists [...] it is not like the general practitioner and family doctor who must be trained in that area.

General practitioners, who played an important role in advocating for legal change and serve as an entry point into the health system, were not included in initial training efforts. This reduced the amount of clinical training to be organized in the initial phases of implementation.

There were isolated efforts to train specialized nurses to assist in some components of abortion provision. In the largest maternity ward in Lisbon, for example, specialist nurses were trained to perform dating ultrasounds and to provide counseling to women seeking abortion (under the supervision of a physician). This allowed the facility to respond to a larger number of requests for abortions. While this strategy worked well in this particular hospital, it did not appear to have been replicated in other facilities, perhaps because the volume of services requested was not sufficient to require the same level of participation from providers other than physicians.

Portuguese women are the ultimate “recipients” of the new law. Our respondents explained that Portuguese women had certain characteristics that allowed for easier implementation of the law. A majority had received sexual education, was using contraception, and was sufficiently familiar with the signs and symptoms of pregnancy that a 10-week gestational age limit was not a significant barrier to access. As one respondent summarized, “most women in Portugal are contraception users and have a perception of contraceptive failure.” Portuguese women also had excellent access to information through
a variety of media sources and the internet, which made it unnecessary to organize expensive, population-level campaigns about the new services. Word of mouth also played an important role in disseminating information about the newly available services. As one respondent explained:

The law was wanted for many years and the campaign for it was something that I think no one could be unaware of [...] and later on, women talked to each other and passed on the information.

Another respondent added: “You don’t need to advertise [abortion], because a person who wants to terminate a pregnancy goes looking for an answer.”

4 | FACILITATION

The most important facilitating factor that emerged from our interviews was the Ministry of Health’s immediate establishment of a technical working group to regulate the law and plan its implementation. Respondents explained that they knew the law would not result in access to services unless an active effort was made to regulate and implement it; this was a lesson they had learned from the 1984 experience. As one member of the technical group explained:

The [Ministry] created a working group not only with people from the [Ministry], but they invited people who were on the ground, people of reference, to do this regulation [...] most of them gynecologists and obstetricians, who were on the ground [...] the referendum was on Sunday, and the working group was assembled on Monday morning.

The General Directorate of Health, a central agency of the Ministry of Health, transformed this group’s recommendations into normative guidelines to be followed by public hospitals and private clinics. Political will was thus relatively easily translated into action. As one respondent summarized:

This is proof that when there’s political will things happen [...] there was a lot of effort here not only from the State, but also from a group of professionals that were very motivated to start and I think one of the gains was to […] get the regulation right away—because a law which isn’t regulated can’t be easily implemented. And the regulation came out very quickly and it was very precise and very surgical and the resources that would be available were surveyed.

The group’s work was not limited to the initial moments of implementation. Rather, the Ministry continues to organize annual reports and annual meetings of stakeholders in which the progress and remaining challenges in implementation are reviewed. Respondents describe these meetings as helpful in tracking the progress of implementation, but also as a source of support and problem solving for abortion providers.

Another facilitating element was that the Ministry organized the inspection of facilities throughout the national territory to ensure that they were complying with their obligations to provide services. While the lack of compliance did not necessarily result in sanctions, respondents explained that inspections led hospitals to make changes to correct certain situations and ensure that their users had access to services—whether directly through the hospital itself or through a referral or partnership in the case of hospitals with a majority of objectors. As one respondent who organized these inspections explained:

My inspections were always seen as something to improve, they were never punitive. And this creates a trust with colleagues and I never had problems.

5 | REMAINING CONCERNS

Most respondents described Portugal’s implementation of the 2007 law as a success story. It has led to a significant decrease in maternal morbidity and mortality due to unsafe abortion, without increasing the overall abortion rate.$^{13,15}$ When asked about remaining concerns, some pointed to the lack of choice in method of abortion as the public sector provides mostly medical abortions and the private sector provides predominantly surgical.

As one respondent explained:

In the public sector, most abortions are medical; and in the private, most are surgical. If these are the same women, there is something here that doesn’t seem to be right in terms of their choice.

According to the 2016 Direção-Geral da Saúde (DGS) report, 97% of abortions provided in public hospitals were medical, and 95% of those provided in private clinics were surgical abortions performed under general anesthesia.$^{13}$ While most respondents said that ideally a woman should be able to choose which method she prefers, they also reported that a majority of women did not have a strong preference as long as they could get an abortion one way or another. One interviewee put the problem into perspective:

What I think is that the woman must have her problem solved in one way or another [...] theoretically, I prefer that women have both options, but honestly, knowing the terrain, I prefer that they have at least one option.

Respondents also expressed that while most women in Portugal have excellent access to abortion, there are some geographic areas in which access remains relatively limited. One respondent cited the example of the situation in the Azores:
...there are only two colleagues who are not objectors, so if one of them is on vacation or sick leave, it’s not possible to get an abortion [...] in my opinion this is absurd because there is no other technical act in which two signatures are required for the same thing.

While this very restrictive component of the law is not a barrier in most settings, in can become an insurmountable one in rural or isolated areas with few providers. According to a majority of our respondents, this is “one of the changes to be made to the law, now!”

Finally, some respondents expressed concern about the future of abortion in Portugal. Access to abortion is never guaranteed. As one respondent said:

On this matter [abortion], we think we should never rest assured. Look at Spain, where there was an attempt to make a large setback for the interruption of pregnancy. And that was not expected to happen. We have a leftist government today, but we don’t know what will happen in the future [...] We are not free from future setbacks, [we must continue to] move forward in altering mentalities, changing mindsets, and investing in the new generations.

Respondents also questioned future generations’ commitment to ensuring access to abortion, particularly among young physicians, who did not have the same exposure to unsafe abortion as the older generations. One respondent added:

One thing that worries me is the new generation, because I always fight for the residents or interns of the specialty to also go through the [abortion] consultation and I do not know if they do.

Integrating abortion into the medical education curriculum to train and inspire young physicians to replace the many advocates who are close to retirement remains a challenge.

6  |  LESSONS LEARNED

An immediate, Ministry of Health-led response was essential in quickly regulating and implementing the new abortion law in Portugal. This translation of political will into action started with the establishment of a multidisciplinary working group that strategically approached every aspect of implementation.

Integrating abortion within the existing public health system rapidly resulted in near-universal access to services. The decision to provide abortions at the tertiary care level was controversial but deemed necessary to meet equipment and personnel requirements, and manage potential complications. The almost exclusive focus on medical abortion within the public health sector came from a perception that surgical procedures would cause more provider objection and require more training and more resources, such as operating rooms, anesthesia, and highly skilled providers. This resulted in a lack of method choice for Portuguese women. However, it is known that surgical abortions can be provided in the outpatient setting by midlevel health providers, and that anesthesia, operating rooms, and ultrasound are not absolute requirements as local anesthesia and conscious sedation have been successfully provided in outpatient facilities elsewhere.12,16 Thus, alternative personnel and logistical solutions that have worked well in resource-limited settings could be explored to increase the range of available options for safe abortion.

Strategies to prevent backlash from abortion opponents included establishing a comprehensive registry of abortions performed and integrating contraception into abortion services. These resulted in excellent postabortion contraceptive coverage and few repeat abortions.

Despite an overall successful implementation, remaining concerns exist about relatively poor access to abortion in certain regions. Even in a country with high rates of specialist physicians, provider-related preabortion steps such as the two-physician authorization create barriers to access that disproportionately affect women in rural and remote areas. This has been recognized in other countries such as the UK, where concerns were raised that the two-signature requirement caused delays in obtaining abortions and did not have any safety benefit.17 WHO discusses third party authorization as a barrier in its Safe Abortion Guidance.12 Where possible, such requirements should be avoided.

Finally, integrating abortion into medical education curricula is an important step to ensure that newer generations of physicians remain committed to providing abortion services.

AUTHOR CONTRIBUTIONS

BMS: Contributed toward initial proposal, interview instrument, conducted Portugal interviews, wrote first draft of paper, and collated edits and reviews. DV: Advised on interview instrument, interviewee, served as in-country point person, provided information and details while writing, and reviewed, corrected, and edited the manuscript at multiple points. LV: Interviewee, served as in-country point person, provided information and details while writing, and reviewed, corrected, and edited the manuscript at multiple points.

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CONFLICTS OF INTEREST

DV and LV functioned as in-country partners, were interviewed, and are coauthors of this case study. The authors have no conflicts of interest to declare.
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