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REVIEW

Legal abortion in Brazil: systematic review of the scientific production, 2008-2018

Aborto legal no Brasil: revisão sistemática da produção científica, 2008-2018

Aborto legal en Brasil: revisión sistemática de la producción científica, 2008-2018

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Abstract

Previous reviews on the subject of abortion in Brazil have estimated one million procedures per year but did not address legal abortion. This systematic review sought to update knowledge regarding legal abortion in terms of service and women's profile, student and doctor knowledge, situations of anencephaly and severe malformations. We searched MEDLINE and LILACS for articles published in all languages between 2008 and 2018. Article quality was assessed using the Joanna Briggs Institute instruments. Search, selection, quality assessment and data extraction were carried out independently by two researchers. We selected 20 articles, 11 on the knowledge and opinion of medical professionals (4 articles) and students (7 articles) revealing a less-than-ideal level of knowledge and a high degree of objection of conscience. Six studies on women who use legal abortion services found that they are young, single and that the main demand was for pregnancy resulting from rape. When women were younger and single and when the aggressor was someone close to them, there were delays in seeking care. Three studies on severe malformation found around 40% of court authorizations. In cases for which no authorization was given, the evolution of pregnancies was complicated and deliveries were done through cesarean sections. Only one article addressed legal abortion services, showing that 37 of the 68 that had been registered were active, lack of services in seven states and concentration in capitals. Knowledge regarding legal abortion is still scarce, the demand for the procedure is repressed and medical training is deficient with regard to this subject.

Legal Abortion; Reproductive Rights; Systematic Review

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Introduction

It is estimated that, worldwide, each year, there are 35 abortions for every 1,000 women aged between 15 and 44 years. In Latina America, that rate is 44/1,000 [1] and most countries in the region, with the exception of Uruguay, Guyana and Cuba, have laws restricting the practice. In Brazil, abortion is allowed for women whose lives are at risk and in situations in which the pregnancy is the result of rape and, more recently, when there is fetal anencephaly. The two first exceptions are established in Article 128 of the Penal Code [2]. The third resulted from the Supreme Court's ruling regarding Claim of Non-Compliance with a Fundamental Principle (ADPF, in Portuguese) n. 54, in 2012 [3], which was ratified that same year in a decision by the Federal Medicine Council (CFM, in Portuguese) which authorizes doctors to interrupt pregnancies of anencephalic fetuses, at the pregnant woman's request, at any point during the pregnancy [4]. In addition to these situations, court authorizations for abortions in cases of anencephaly (before 2012) and other malformations have been issued in Brazil, broadening the perspectives of legal abortion [5,6].

An extensive review of research on abortion, published in 2008, analyzed the scientific production in Brazil over a 20-year period [7]. It included articles published in journals, theses, dissertations, books, works presented at conferences and argumentative texts. Most were opinion pieces and only 20% involved the production of primary data or the analysis of secondary data. A large part focused on public hospitals and few works addressed legal abortion. Another review, specifically of Collective Health studies, also did not address investigations of legal abortions [8].

Since these two articles were published [7,8], there have been few advances regarding abortion in Brazil, except for the 2011 update of the Ministry of Health's Technical Norm (originally published in 2005) on the provision of abortion-related care [9] and the authorization of abortion in cases of fetal anencephaly in 2012 [4]. It is worth noting two other Ministry of Health norms on the subjects of harms resulting from sexual violence [10] and provision of care to pregnant women carrying anencephalic fetuses [11]. By reviewing articles on abortion in Brazil, this study seeks to update knowledge regarding legal abortion in terms of service and women's profile, student/doctor knowledge, situation of anencephaly and severe malformations, in the period of 2008 to 2018.

Methods

This is a systematic review of legal abortion and unsafe abortion in Brazil, carried out according to the recommendations of the *Preferred Reporting Items for Systematic Reviews and Meta-Analysis* (PRISMA) [12] statement. All review steps were carried out independently by two researchers (S. C. F. and R. M. S. M. D.). This article refers to the subgroup of studies on legal abortion in the country. The results regarding unsafe abortion (frequency, women's profile and complications) will be discussed in another publication.

Eligibility criteria

We included original scientific articles published between 2008 and 2018. We considered articles with a predominantly quantitative focus as eligible. We excluded studies with exclusively qualitative methods, non-systematic reviews, theoretical essays, research protocols, intervention and diagnostic studies and methodological studies. We did not include monographs, dissertations or theses.

With regard to legal abortion, which is the focus of this article, due to the small number of previous quantitative studies [8], the eligible themes were decided during the search process: (1) service profile – number and characteristics of care provision; (2) profile of women who had a legal abortion; (3) doctors/medical students' knowledge of the situations in which abortion is legally permitted; and (4) abortion in cases of malformations other than anencephaly. We chose to address doctors exclusively because, in Brazil, only these professionals are allowed to perform abortions.

Bibliographic search strategy

We searched the electronic databases MEDLINE and LILACS. The key words we used in combination are presented in Box 1. Additionally, we included references cited in the selected articles that met inclusion criteria. Electronic searches, with no language restrictions, were carried out in late 2017 and updated in March 2019.

Study selection

After manual exclusion of repeated articles, we carried out an initial triage based on titles, eliminating all those not related to unsafe abortions or legal abortion in Brazil. After reading the abstracts, the articles that did not meet eligibility criteria were excluded. Other studies were eliminated after the full articles were read, if they were confirmed to be ineligible. Once again, the decision was made by consensus.

Study quality assessment

Article quality was assessed using instruments developed by the Joanna Briggs Institute [13] and validated in the scientific literature. These instruments assess different types of studies (case series, cross-sectional studies and cohort studies) and, while respecting the specificities of each epidemiological design, value inclusion and population sampling criteria, variable measurement methods and statistical analysis. We did not exclude any study due to quality, but we present the methodological limitations we identified based on these criteria.

Result presentation

For each included study, we extracted the following data: authors, year of publication, year the study was conducted, study design, locality, study population, assessed outcome, methodological limitations and main results. In the tables, the studies are presented along with their themes: legal abortion service; women's characteristics; knowledge/behavior of doctors/medical students; malformations and legal abortion.

Box 1

Bibliographic search: descriptors and Boolean operators.

	Search syntax
MEDLINE	("abortion, induced" [MeSH Terms] OR ("abortion" [All Fields] AND "induced"[All Fields]) OR "induced abortion" [All Fields] OR "abortion" [All Fields]) AND (safe[All Fields] OR unsafe[All Fields] OR legal[All Fields] OR illegal[All Fields] OR ("criminals" [MeSH Terms] OR "criminals" [All Fields] OR "criminal" [All Fields]) OR provoked[All Fields] OR induced [All Fields] OR ("rate" [All Fields]) OR rates [All Fields] OR trend [All Fields] OR ("trends" [Subheading] OR "trends" [All Fields])) AND ("brazil" [MeSH Terms] OR "brazil" [All Fields]) AND ("2008/01/01" [PDAT]: "2018/12/31" [PDAT])
LILACS	Tw: (aborto AND (brasil OR brazil) AND (seguro OR inseguro OR legal OR ilegal OR pesquisa OR taxas OR tendências OR induzido OR provocado) AND (instance: "regional") AND (db: ("LILACS") AND year_cluster:("2008" OR "2009" OR "2010" OR "2011" OR "2012" OR "2013" OR "2014" OR "2015" OR "2016" OR "2017" OR "2018"))) AND (instance: "regional")
LILACS (according to Brazilian state)	Tw: (aborto AND (NOME DO ESTADO) AND (seguro OR inseguro OR legal OR ilegal OR pesquisa OR taxas OR tendências OR induzido OR provocado) AND (instance: "regional") AND (db: ("LILACS") AND year_cluster: ("2008" OR "2009" OR "2010" OR "2011" OR "2012" OR "2013" OR "2014" OR "2015" OR "2016" OR "2017" OR "2018"))) AND (instance: "regional")

Results

We identified 749 eligible titles after excluding duplicates and including six publications from article references. In the initial triage, we selected 233 abstracts. Of these, 140 were excluded because they were exclusively qualitative studies (30%), theoretical essays (22.1%), analyses of other aspects of abortion (18.6%), review studies (10%), other types of publication (editorials, letters, protocols, methodological articles, theses and dissertations, representing 19.3%). We then read the remaining 93 articles in full (we were unable to access one article on unsafe abortion) and, after applying the eligibility criteria, 20 studies on legal abortion were included in this analysis (Figure 1). The articles related to unsafe abortion (n = 50) are discussed in another article.

General article characteristics

Only three articles were of national scope [14,15,16]. All others were local. The region with the highest number of studies was the Southeast (11 articles, all from the State of São Paulo), followed by the Northeast (4 articles). The Central and North regions had only one article each (Table 1).

The studies encompassed data from 1994 to 2017, especially concentrated in the 2000s. Women's and Children's Health journals predominated (with nine articles). The remaining articles were published in Clinical Medicine, Medical Training, Collective Health and Bioethics journals (Table 1).

A single article described the results of a census of legal abortion services in the country, analyzing their structure and operations, the characteristics of the women who received care at these services and the perspective of their professionals [14]; another five studies, of local scope, described the characteristics of women admitted to hospitals for abortion following a rape, the reasons for the decision to have an abortion and repercussions for personal and day-to-day relationships [17,18,19,20,21]. Most studies investigated the behavior, knowledge and opinion of agents involved in providing legal abortion care, whether they were health professionals [16,22,23,24] or medical students [25,26,27,28,29,30,31]. Three studies addressed the theme of malformations and court authorizations for abortion [15,32,33] (Table 2).

Most studies were cross-sectional and descriptive. Six were case series and a single study was longitudinal (Table 2).

As for methodological quality, following the criteria we adopted [13], we found that 6 fulfilled more than 70% of the recommended items; 9 fulfilled between 50% and 60% of items; and the remaining 5 fulfilled less than half of the items. The main limitations are presented in Table 2. Items with the greatest fragility were those related to sample representativeness and statistical analysis.

Main results

The article by Madeiro & Diniz [14] mapped the legal abortion services in the country and identified, in the 2013-2015 period, only 37 active services of the 68 registered with the Ministry of Health. These services are distributed across the regions as follows: 5 in the North, eleven in the Northeast, 3 in the Central, 12 in the Southeast and 6 in the South, concentrated in capitals and large urban centers. The interruption of pregnancy varied according to the situation: rape (most frequent reason for the demand), in all services; risk to the woman's life, in 27; and anencephaly cases, in 30. All had multi-professional teams, but not specifically for this service. Documents such as forensic reports and court orders were demanded by 8% to 14% of services. The methods available in most services were: medication, curettage and manual intrauterine aspiration. Of 5,075 demands, 2,442 legal abortions were performed in the country between 1994 and 2015. Five services (not specified, one for each region) were selected for in-depth investigation, with an analysis of 1,238 charts. With regard to sociodemographic characteristics, women were, for the most part, young (15 to 29 years), single and Catholic (43%). As for educational level, 41% had ≤ 8 years of schooling, 47% had completed secondary education and 14% had completed higher education [14]. Another study, focusing on Bolivian women who received care at a reference center for legal abortion in São Paulo, found that 40% had low educational levels [20].

With regard to age and marital status, the results from the national census [14] were similar to those observed among 1,270 women who received care at a São Paulo hospital certified for performing legal

Figure 1

Fluxograma da seleção de artigos incluídos na revisão sobre aborto legal no Brasil.

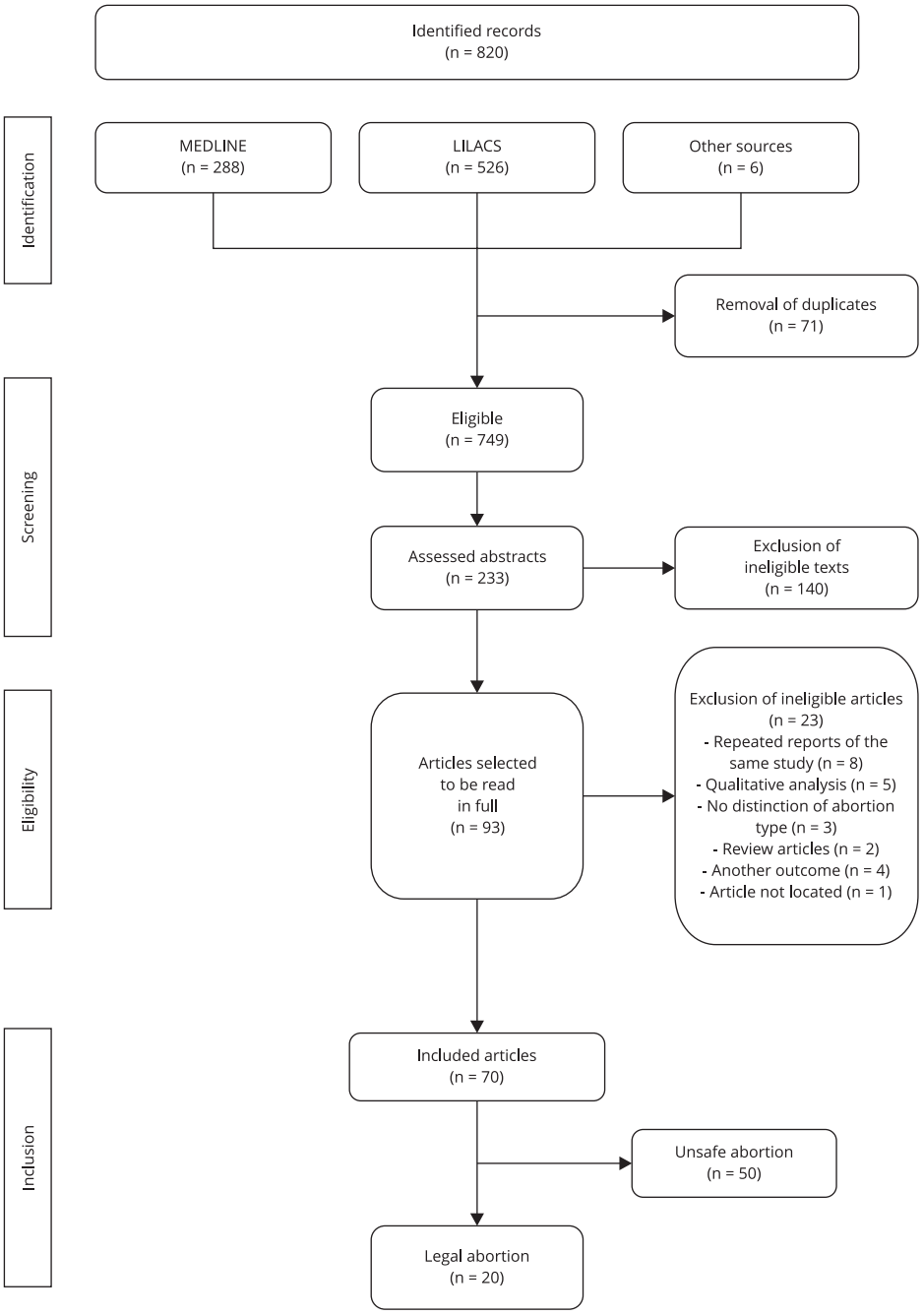

Table 1

Articles on legal abortion in Brazil, 2008 to 2018.

Article (year of publication)	Journal, location and year of study	Outcomes assessed
Madeiro & Diniz [14] (2016)	*Ciênc Saúde Colet* Brazil, 2013-2015	Characteristics of legal abortion services and of the women who use these services
Drezett et al. [17] (2011)	*Reprod Clim* São Paulo (SP), 2000-2007	Reasons for legal interruption of pregnancy in cases of rape and repercussions for personal relationships
Drezett et al. [18] (2012)	*Health Med* São Paulo (SP), 2000-2007	Reasons for legal interruption of pregnancy in cases of rape
Blake et al. [19] (2015)	*Int Arch Medicine* São Paulo (SP), 1994-2013	Reasons for delayed search for legal abortion in cases of rape
Santos et al. [20] (2015)	*Reprod Clim* São Paulo (SP), 2002-2014	Characteristics of Bolivian women who had legal abortions due to rape
Mutta & Yela [21] (2017)	*São Paulo Med J* Campinas (SP), 1994-2004	Characteristics of women who received care in a legal abortion service
Benute et al. [15] (2012)	*Rev Bras Ginecol Obstet* São Paulo (SP), DNI	Health professionals' behavior with regard to legal abortion
Diniz et al. [22] (2014)	*Reprod Health Matters* Brazil, 2012	Gynecologists-obstetricians' behavior with regard to legal abortion
Ribeiro & Fonseca [23] (2015)	*Rev Para Med* Belém (PA), 2015	Professionals' knowledge regarding the technical norm on legal abortion
Rocha et al. [24] (2015)	*Rev Bioét* Brasília (DF), 2014	Professionals' knowledge regarding ethical aspects of legal abortion
Almeida et al. [25] (2012)	*Rev Bras Educ Méd* Botucatu (SP), 2008	Medical students' knowledge regarding abortion laws
Medeiros et al. [26] (2012)	*Rev Bras Ginecol Obstet* Rio Grande do Norte, 2010	Medical students' knowledge regarding legal abortion
Faundes & Duarte [27] (2013)	*Reprod Health Matters* Campinas (SP), 2011	Medical students' opinion of legal abortion
Darzé & Azevedo [28] (2014)	*Rev Bras Ginecol Obstet* Bahia, 2012	Medical students' opinion of abortion
Madeiro et al. [29] (2016)	*Rev Bras Educ Méd* Piauí, 2012	Medical students' attitude toward objection of conscience
Motoki et al. [30] (2016)	*Clinics* São Paulo (SP), DNI	Medical students' opinion of legal abortion
Darzé & Barroso [31] (2018)	*Rev Bras Ginecol Obstet* Bahia, 2016-2017	Medical students' objection of conscience regarding abortion
Diniz et al. [16] (2009)	*Ciênc Saúde Colet* Brazil, 2008	Medical care to women pregnant with anencephalic fetuses
Nomura et al. [32] (2011)	*Rev Assoc Med Bras* São Paulo State, 1998-2010	Case series of conjoined twins and legal terminations
Westphal et al. [33] (2016)	*J Matern Fetal Neonatal Med* São Paulo State, 2010-2013	Factors associated with the termination of pregnancy with severe malformations

DF: Federal District; MG: Minas Gerais State; DNI: did not inform; PA: Pará State; SP: São Paulo State.

Table 2

Quantitative studies on legal abortion in Brazil, 2008-2018: methods and results.

Reference	Study location (year)	Study design and instrument for data production	Population	Outcome	Methodological limitations	Results
Legal abortion services						
Madeiro & Diniz [14]	Hospital census, Brazil (2013-2015).	Survey. Self-administered online questionnaire.	Census stage. Active services (37) of the 68 registered with the Ministry of Health.	Structure of legal abortion services.	No description of hospital characteristics.	37 active services were identified, providing abortion in cases of: rape (37/37), risk to the woman's life (27/37) and anencephaly (30/37). 35 also provided care for sexual violence, distributed in the regions North (5), Northeast (11), Central (3), Southeast (12) and South (6), concentrated in the capitals. Seven states have no services. Different documents demanded for abortions. Multi-professional/non-specific team. Available methods: Curettage (89%), medication (97%), aspiration (86%). Care provision: 5,057 demands vs. 2,422 procedures.
Women's characteristics						
Madeiro & Diniz [14]	Brazil (year not informed).	Case series. Chart evaluation.	Sample stage: data from charts of 1,283 women, in 5 selected services.	Profile of women who underwent a legal abortion and abortion characteristics.	Convenience sample: (available charts). Non-consecutive cases.	Age 15-29 years, (62%); white (51%) and brown (26%); single (71%); Catholic (43%) and Evangelical (26%); educational level ≤ 8 years (41%), secondary education (37%) and higher education (14%); GA ≤ 14weeks (68%). Rape 94%. Method: aspiration (45%) and misoprostol (32%).

(continues)

Table 2 (continued)

Reference	Study location (year)	Study design and instrument for data production	Population	Outcome	Methodological limitations	Results
Women's characteristics						
Drezett et al. [17]	São Paulo (2000-2007).	Case series. Phone interviews.	43 of 53 women admitted to a reference center for legal abortion following rape.	Women's profile, aggressor, characteristics of the violence, reasons for the abortion, personal conflict.	19% loss (refusal or no contact) Interview conducted a long time after the abortion. Only a descriptive analysis of cases.	Age: 19-44 years (mean 28.9); white (58%), black (27.9%) and brown (13.9%); single (65%), Catholic (46.5%) and Evangelical (25.6%); educational level ≤ 8 years(18,8%), secondary education (53,3%) and higher education (27,9%). Unknown perpetrator (65%); when known, former partner (60%). Sharing decision with family members in around 60% of cases. Reasons for abortion: rejection of pregnancy and connection with violence in around 90%; violation of the right to choose 77%. No participant regretted the abortion.
Drezett et al. [18]	São Paulo (2000-2007).	Case series. Phone interviews.	43 of 53 women admitted to a reference center for legal abortion due to rape.	Profile of women and of the violence, information regarding rights.	19% loss (refusal or no contact) Interview conducted a long time after the abortion. Only a descriptive analysis of cases.	Violence occurred on the way to work (35%) during leisure time (32.5%), at home (12%). Information regarding the right to an abortion: police unit (44%), health unit (23%).

(continues)

Table 2 (continued)

Reference	Study location (year)	Study design and instrument for data production	Population	Outcome	Methodological limitations	Results
Women's characteristics						
Blake et al. [19]	São Paulo (1994-2013).	Cross-sectional. Analysis of database based on charts.	1,270 women admitted to a reference center for legal abortion due to rape.	Association between sociodemographic factors and GA at time of abortion.	Exclusion of incomplete charts.	Age: 10-46 years (adolescents, 42%); white (58%), black (13.2%) and brown (26.1%); single (70%), Catholic (50.6%) and Evangelical (24.42%); educational level ≤ 8 years (49.4%); secondary education (45.9%) and higher education (4.7%). Unknown perpetrator (62%). Reasons for seeking abortion at a late GA (≥ 23 weeks): being a minor (OR = 1.8), being single (OR = 8.7), perpetrator was a family member (OR = 1.99), police report (OR = 1.95).
Santos et al. [20]	São Paulo (2002-2014).	Case series. Analysis of database based on charts.	38 Bolivian women who requested a legal abortion after rape at a reference center.	Women's profile, aggressor, characteristics of the violence,	No definition of consecutive cases or completeness. Only descriptive analysis of cases.	Age: 13-44 years (mean 24.0); single (23%); Catholic (55.3%) and Evangelical (13.2%); educational level ≤ 8 years (52.7%), secondary education (44.7%) and higher education (2.6%). Violence occurred at home (26.3%), during leisure time (23.7%), on the way to work (13.7%). Unknown perpetrator (63%); referral from a health unit (39.5%) and from a police unit (31.6%).

(continues)

Table 2 (continued)

Reference	Study location (year)	Study design and instrument for data production	Population	Outcome	Methodological limitations	Results
Women's characteristics						
Mutta & Yela [21]	Campinas, São Paulo State (1994-2014).	Case series.	131 women admitted for legal abortion following sexual violence. Data extraction from charts (UH).	Physical and psychological characteristics of women, the violent act and type of care offered.	No limitations.	Age 70% < 29 years, 36.6% adolescents. Single (72%); none with higher education, 45% ≤ 8 years of schooling; Low income (76.4%); 30% with no previous sexual activity; Almost 70% with no habitual CC use and 99% with no emergency CC use. Characteristics of the violent act: unknown aggressor (62%). Presented a police report (92%). Characteristics of abortion: GA < 12 weeks (63%); Method: misoprostol and curettage; Complications (2.3%); cervical laceration and uterine perforation. All wanted to terminate the pregnancy, only 35% with no psychological conflict. Adolescents were students, not previously sexually active, with no CC use, with known aggressor and more advanced GA. Adults were workers, sexually active, unknown aggressor, GA ≤ 12 weeks and low CC use (45.6%).

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Table 2 (continued)

Reference	Study location (year)	Study design and instrument for data production	Population	Outcome	Methodological limitations	Results
Awareness/behavior of doctors/medical students						
Benute et al. [22]	São Paulo (year not informed, prior to 2012).	Survey. Self-administered questionnaire.	119 of 149 Obstetrics professionals of a UH and public hospital in the São Paulo periphery.	Knowledge of Brazilian legislation.	No detailed description of participants. Total response rate of 80%, with no description by category. Limited statistical analysis.	Participants: 48.7% doctors, 33.6% nurses and 17.6% from other areas. Correct knowledge of the legislation (abortion permitted in cases of rape and risk to woman's life, at the time of the study): 67.2% of doctors, 2.5% of nurses, 4.5% of others. Favorable opinion to increasing legal cases: for fetal malformation, 62.0% of doctors, 20% of nurses and 23.8% of others; for unwanted pregnancies, doctors (53.4%), nurses (85%), others (33.3%).
Diniz et al. [16]	Brazil (2012).	Survey. Self-administered online questionnaire.	1,690 of 15,000 OBGYN members of FEBRASGO.	Doctors' behavior with regard to legal abortion following rape: knowledge of conditions for requesting an abortion and objection of conscience.	No definition of sample size. No detailed description of results according to participants. Response rate of 11.3%, no description of loss.	Participants: 53.5% women, age group < 50 years (58.5%); over 20 years of medical practice (50.9%); 50% Catholic; 13% Spiritist; 7% Evangelical and 27% with no religion; 57% from the Southeast Region; 43% with experience providing care to rape victims. Only 13.7% trusted the information provided by the woman; almost half required a document (court authorization, police report); 37% required 2 documents. In total, 81.6% required some document, creating barriers to care. Almost half would refuse to perform the procedure for non-specified reasons (only 5% for religious reasons); 21% would perform it and 18% only with a document.

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Table 2 (continued)

Reference	Study location (year)	Study design and instrument for data production	Population	Outcome	Methodological limitations	Results
Awareness/behavior of doctors/medical students						
Ribeiro & Fonseca [23]	Belém, Pará State (2013).	Survey. Face to face interviews.	33 of 58 professionals of the Legal Abortion Service of a SUS hospital.	Knowledge of the Ministry of Health's Technical Norm (*Atenção Humanizada ao Abortamento*).	No definition of strategy or sample size. Convenience sample. No detailed description of participants or results. Very limited statistical analysis. No description of losses.	Little over half of the interviewed professionals knew the Technical Norm (52%). Among those who did not know it, there were 5 nurses and 10 doctors.

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Table 2 (continued)

Reference	Study location (year)	Study design and instrument for data production	Population	Outcome	Methodological limitations	Results
Awareness/behavior of doctors/medical students						
Rocha et al. [24]	Brasília, Federal District (2014).	Survey. Self-administered questionnaire.	177 professionals (35 doctors) of a SUS reference center for legal abortion, however, not directly connected to the service.	Health professionals' perception of legal abortion.	No definition of the calculation of sample size or sampling strategy. No description of results according to category. No tables. No description of losses. Limited statistical analysis.	Participants: female sex (89.8%); age: 25-35 years (38.9%) and 36-50 (42.4%); Catholic (54.2%), Protestant or Evangelical (27.1%); Spiritist (10.2%); no religion (4.5%); 32 OBGYN (18.1%), 3 clinicians, 5 social workers (2.8%), 9 psychologists (5.1%), 8 pharmacists/ biochemists (4.5%), 68 nurses (38.4%) and 52 nursing technicians (29.4%); no *lato* or *stricto sensu* post-graduate degree (37.9%). Lack of knowledge regarding the necessary documentation (> 90%). Only 27.1% agreed with the right to termination in any situation. Of those who partially agreed, 45.8% Catholic, 41.7% Protestant and 38.9% of Spiritists are favorable to termination only in the cases established by law. As for convincing women to carry their pregnancy to term, 25% of Catholics and around 40% of Evangelicals and Spiritists would adopt a strategy of persuading women to carry a post-rape pregnancy to term.

(continues)

Table 2 (continued)

Reference	Study location (year)	Study design and instrument for data production	Population	Outcome	Methodological limitations	Results
Awareness/behavior of doctors/medical students						
Almeida et al. [25]	Mid-sized city in São Paulo (2008).	Survey. Self-administered questionnaire.	151 of 180 medical students in the first (74/90) and sixth years (77/90) at a public university.	Knowledge regarding Brazilian legislation on abortion.	No detailed description of participants. No description of results according to category. Response rate of 79.5%. No description of losses. Limited statistical analysis.	Participants: women (60%), from smaller cities in São Paulo (> 50%); Catholic majority. Knowledge of situations for legal abortion (at the time: rape, risk to the woman's life) considered to be median (48% of correct answers) in all years of the course. Disciplines which addressed the subject: 49.3% Embryology; 29.9% Genetics, 47.8% Public Health, 68.7% Gynecology/ obstetrics, and 44.8% medical ethics. High ignorance (> 90%) of non-requirement of documents such as police reports.
Medeiros et al. [26]	Rio Grande do Norte State (2010).	Survey. Self-administered questionnaire.	52 + 73 (125) medical and law students (seniors) at a federal university.	Knowledge regarding legal abortion (permitted situations at the time) and opinion regarding expanding legal situations.	Convenience sample. No information on sample size. No detailed description of participants. Response rate of 56.5%. No description of losses. Limited statistical analysis.	Participants: male sex (62.4%); high income (> 70%). Knowledge of the situations permitted by law higher among medical students ($p < 0.05$); 100 and 87.5% for rape; 94.2 and 87.5% for risk to woman's life. Opinion on increasing legally permitted situations: Higher for cases of anencephaly (73%), for any severe malformation (34.6%); harm to the pregnant woman's physical health (40.4%); for other situations (< 10%). For unrestricted increase of legal abortion: 17.3%.

(continues)

Table 2 (continued)

Reference	Study location (year)	Study design and instrument for data production	Population	Outcome	Methodological limitations	Results
Awareness/behavior of doctors/medical students						
Faúndes et al. [27]	Campinas, São Paulo State (2011).	Survey. Self-administered questionnaire.	874 medical students from 3 universities.	Opinion regarding conditions for legal abortion and regarding the criminalization of abortion.	No information on sample size. No description of results according to characteristics. Response rate of 69.5%. No detailed description of losses. Limited statistical analysis.	Participants: 82% < 24 years, 59% women, 96.3% single, 71.8% follow some religion. Only 15% of students agree with legal abortion in all circumstances, but 85% oppose imprisonment of women who have had abortions.
Darzé & Azevêdo [28]	Bahia State (2012).	Survey. Self-administered questionnaire.	174 students from several phases of the School of Medicine and Public Health of Bahia medical course.	Knowledge of and opinion on abortion.	Convenience sample; Inadequate sample strategy and size. No description of participants. No quantitative or qualitative description of losses. Limited statistical analysis.	Participants: women (63%), single (93.7%), follow some religion (73.6%). Knowledge of legislation: 48.9% (higher among students in the second half of the course, $p < 0.001$). Discomfort in conducting the procedure: 54.6%. Favorable opinion to increasing legal abortion cases: 86.5%, especially for cases of lethal malformations. For terminations due to personal reasons: 29.9%.

(continues)

Table 2 (continued)

Reference	Study location (year)	Study design and instrument for data production	Population	Outcome	Methodological limitations	Results
Awareness/behavior of doctors/medical students						
Madeiro et al. [29]	Piauí State (2012).	Survey. Self-administered questionnaire.	1.174 students of all medical schools in Piauí.	Objection of conscience in the permitted situations for legal abortion and ethical responsibility associated with the objection.	Response rate of 67%. No qualitative description of losses. Limited statistical analysis.	Participants: 21-25 years (68%); men (52%); 1/3 in each period of the course (1st/2nd , 3rd/4th, 5th /6th years). Percentage of objection of conscience according to legal reason: - Rape: 50.8% with no differences according to age, sex and year; religious (55%) *vs.* non-religious (32.6%) – p = 0.000. - Anencephaly: 31.6%, no differences according to age, sex and year; religious (36.4%) *vs.* non-religious (10.8%) – p = 0.000. - Risk of death to the pregnant woman: 13.2%, no differences according to age, sex and year; religious (15.4%) *vs.* non-religious (4.1%) – p = 0.000. Ethical responsibility (justifying, explaining, referring): - Would not justify the refusal – only 4.9%. - Would not explain options – 38.8% (72.5% for rape) - Would not refer – 28% (54% rape). No differences according to age, sex and year. For the non-religious, percentages of non-ethical responsibilization were lower ($p < 0.05$).

(continues)

Table 2 (continued)

Reference	Study location (year)	Study design and instrument for data production	Population	Outcome	Methodological limitations	Results
Awareness/behavior of doctors/medical students						
Motoki et al. [30]	São Paulo (Year not informed, after 2012).	Survey. Self-administered questionnaire.	201/±350 students in the first (100) and sixth years (101) of the São Paulo University, School of Medicine.	Respect to pregnant women's choices and need to protect the fetus in other situations.	No information on sample size. No description of results in tables. No description of losses. Limited statistical analysis.	Participants: 1st year (mean 19.5 years; 56.4% men; 76% white; 11% Asian; 11% brown; 2% black); 6th year (mean 26 years, 58% men, 73% white; 16% Asian; 8% brown; 3% black). Position regarding the legalization of abortion: no differences according to course year. Around 40% approve legalization in any circumstances, 4% would ban it in all circumstances and the remaining would approve in some situations. Current rules of legal abortion: Knowledge: 80.2% among first year students *vs.* 94% in sixth year students. Agreement: 64% among 6th year students *vs*. 48% among 1st year students; non-significant difference (p = 0.08).
Darzé & Barroso Júnior [31]	Bahia State (2016-2017).	Survey. Self-administered questionnaire.	120 students in the ninth semester at the Bahia School of Medicine	Objection of conscience.	Undefined sampling strategy. Limited statistical analysis.	Participants: mean age 24.35 years; women (75%); white (62%); some religion (80%). The more religious, the higher the objection (reaching 71%). Knowledge regarding ethical principles of objection varied between 74.2 and 85%.

(continues)

Table 2 (continued)

Reference	Study location (year)	Study design and instrument for data production	Population	Outcome	Methodological limitations	Results
Malformations and legal abortion						
Diniz et al. [15]	Brazil (2008).	Survey. Self-administered questionnaire.	1,814 OBGYNs (of a total of 15,000).	Medical care to women pregnant with anencephalic fetuses.	No description of participants. Response rate of 12%. No description of losses. Limited statistical analysis.	Of responding doctors, 83.3% followed at least one woman pregnant with an anencephalic fetus. Of these, 84.8% wanted to terminate their pregnancies and it is estimated that 43.7% were able to obtain a court authorization.
Nomura et al. [32]	Reference Hospital, São Paulo (1998-2010).	Case series. Data extraction from charts.	Thirty cases of conjoined twins without post-natal viability.	Court authorization for abortions.	No limitations.	Twin profile: thoracopagus (> 70%) and cardiac malformations (100%). Mean GA at diagnosis: late (24 weeks). Cases of abortion requests (63%) with lower GA ($p < 0.001$). 5/19 cases did not receive authorization. Of these, four NB died < 24h and one died after 28 days.
Westphal et al. [33]	Reference center in São Paulo (2010-2013).	Retrospective cohort. Data extraction from charts.	Initial N = 166. N = 94 pregnant women and fetuses with lethal malformations. Hospital (HU).	Factors associated with the request for court authorization. Complications from pregnancy, abortion and delivery.	No limitations.	Mean age 27 years; white (52%); high school (54%); Catholic (62%); single (62%). Court requests: 43.6%; Associated factors: CNS malformation (OR = 18.6) or thoracoabdominal malformation (OR = 16) and living children (OR = 0.45). Women who did not terminate their pregnancies had complications (86%) and all had cesarean sections.

CC; contraceptives; CNS: central nervous system; FEBRASGO: Brazilian Federation of Gynecology and Obstetrics Associations; GA: gestational age; NB: newborns; OBGYN: obstetricians-gynecologists; OR: odds ratio; SUS Brazilian Unified National Health System; UH: University Hospital.

abortions between 1994 and 2013 [19] , and among 131 women who had legal abortions after suffering sexual violence in Campinas, at the University Hospital, between 1994 and 2014 [21]. Considering all three studies, the percentage of adolescents who demanded a legal abortion was higher than one third of all women [14,19,21]. However, with regard to educational levels, the São Paulo and Campinas studies [19,21] had a less favorable profile than the national study [14].

In both studies, the aggressor was unknown in around 70% of cases [19,21]. However, the Campinas study found that, among adolescents, these percentages were inverted, with around 60% of aggressors being known to the victims [21].

With regard to characteristics of sexual activity, adolescents in Campinas [21] reported very low use (12.5%) of contraception and, for some, the violent event had been the first sexual relation. Among adults, despite most having an active sex life (91.6%), only 45.6% used contraception [21]. Gestational age at the time of the abortion was higher than 12 weeks in 43.8% of adolescents, practically double that of adult women (22.5%) [21].

In the studies carried out in the São Paulo reference hospital, the reasons for the decision to have an abortion and the delays to the procedure were investigated for rape cases [17,18,19]. The decision to have the procedure was mainly motivated by rejection of the pregnancy (88.4%) and its connection to the violence (86%). Two other reasons also had high percentages: violation of the right to motherhood and fear of social and psychological damage to the child's future, 76.7% and 44.2%, respectively [17,18]. Delayed demand for care, that is, after 22 weeks of pregnancy, was found among 6% of the 1,270 patients [19] and was associated with age under 20 years, being single, rape committed by a partner or family member, and occurrence of a police report [19].

In Campinas, a high presence (close to 70%) of psychological conflicts with regard to the decision to terminate the pregnancy was found, regardless of age [21]. On the other hand, women who were interviewed months after the procedure at the São Paulo reference center did not report having regrets [17,18].

Of the studies on health professionals, three were conducted specifically in hospitals with legal abortion services [22,23,24] while the fourth was a online survey of all doctors in the country who are members of the Federation of Gynecology and Obstetrics [16]. Despite their small number, these studies reveal a high ignorance of the fact that documents are not required (86% to 92%) and a high percentage (between 43.5% and 60%) of objection of conscience, that is, the refusal to provide or participate in the provision of abortion due to religious and/or moral reasons, especially in cases of demands for legal abortion due to rape. The study by Diniz et al. [16] showed that 43.5% of interviewed doctors would not perform an abortion due to rape, only 10% because of religious reasons, and the others with no explicit justification. The study by Rocha et al. [24] mixed doctors and other health professionals. More than half of participants invoked the objection with no argumentative basis, while 16% claimed it for religious reasons. In that same study, one third of participants stated that the objection is a right of professionals and can be invoked in any situation, while another third was unable to define the concept [24].

Studies on medical students found a median knowledge of the situations for which abortions are legally permitted (around 50%) in Botucatu (São Paulo State) [25] and in Bahia State [28], and a high knowledge (> 80%) in Rio Grande do Norte State [26] and in São Paulo State [30]. These studies found low support for broadening legal abortion, varying between 15% and 40% for unrestricted permission [26,27,28,30]. Approval of current rules regarding legal abortion varied between 48% and 90% [27,30]. Objection of conscience was frequently invoked, varying between 4.1% and 71.4%, depending on reason for the abortion and religiousness [29,31]. It was higher for cases of rape (50.8%) [29] and among the more religious (71.4%) [31]. Aspects of ethical responsibilization connected to objection, such as providing guidance and referring the woman to another professional, were unknown to around 25% of students [31], or would be denied, depending on the reason for the abortion [29]. The refusal to provide guidance was more common for cases of rape (72.5%) than for those in which the pregnant women's life was at risk (17.3%) [29], and more common among religious students (40.7%) [31].

As for the need to present legal documents, the study by Almeida et al. [25] showed near complete unawareness (> 90%) of the fact that neither police reports nor court orders are required for the procedure. Faúndes et al. [27] explored opinions regarding the criminalization of abortion and found low approval (9.9%) for imprisoning women who have had abortions, especially among older, non-religious students. Being religious was the factor most closely associated with restrictive positions [27,29,31].

A 2008 survey of gynecologists-obstetricians members of the Brazilian Federation of Gynecology and Obstetrics Associations (FEBRASGO, in portuguese) had a 12% response rate and showed that 83.3% of responding doctors had provided care to women pregnant with anencephalic fetuses [15]. According to these professionals, 85% wished to terminate the pregnancy and 43.7% obtained a court authorization [16]. Two articles addressed cases of congenital malformations other than anencephaly and assessed the requests for court authorization made by women followed at reference centers for non-viable conjoined twins [32] and lethal fetal malformations [33]. Between 43% [33] and 63% [32] of pregnant women requested a termination and the factors that were positively associated with the request were an earlier gestational age [32] and type of malformation (especially those of the central nervous system) [33], while having living children reduced the probability of the request [33]. Authorizations were granted to 63% [32] to 100% [33] of requests. In both studies, the malformations were confirmed after birth. All women who did not terminate their pregnancies underwent cesarean sections, with a high percentage of complications (86.8%) related not only to the duration of the pregnancy, but to the malformations as well, such as polyhydramnios and dystocia [33].

Discussion

This review sought to update information regarding research on legal abortion in Brazil [7,8]. Despite being a regular topic of discussion in the national media [34], we found few quantitative studies, generally restricted to the local level. Only one presented data on legal abortion services in the entire country. This study revealed few advances when compared to a report produced, over a decade earlier, by the organization Catholics for the Right to Choose, in terms of the number and concentration of services in capitals and large urban centers [35]. The invisibility of services remains even in the hospitals where they operate. Most have equipment and professionals trained for manual intrauterine aspiration, the most recommended method; however, there is a high use of curettage and misoprostol. There is a caveat regarding gestational age, since, for terminations between 13 and 22 weeks, intrauterine aspiration is not technically applicable and the recommended method is a medication abortion using misoprostol [9].

We therefore find a long-term insufficiency of the supply of legal abortion services in the country. Barriers remain to performing abortions in the (already highly-restrictive) cases established by law, with demands for unnecessary documentation in cases of pregnancy resulting from rape. The number of abortions that are performed is inferior to women's demands. The expansion and consolidation of abortion services in the country cannot be delayed, especially in the states that still lack these services, nor can the reduction of barriers to accessing the procedure wait any longer, at least for women who fit the conditions established by law.

The women who choose to have abortions following a rape are similar in terms of educational levels, religion or race/color, but there was a high percentage of adolescents [14,17,18,19,20,21]. Studies from the 1990s showed a higher percentage of lower educational level among these women, compared to data from more recent years, which may reflect the change in educational profile of Brazilian women [36].

The rejection of pregnancies resulting from violence was nearly unanimous, as was the lack of regret following the procedure [17,18]. Delays in seeking care revealed vulnerabilities, especially among younger and single women and those abused by partners and/or family members [19]. Despite their small number, young Bolivian migrants with low educational levels were another population vulnerable to post-rape pregnancies [20].

Studies showed lack of knowledge among both medical students and, more concerning, doctors, regarding the situations in which abortion is allowed and the ethical recommendations for handling these cases. Undue demands for police reports and other documents for accessing legal abortions persist [16,25,37]. The recent incorporation of fetal anencephaly into the list of permitted situations was little known and, although an ordinance (*Ruling n. 1,145*, issued on 07/Jul/2005) [38] excluded the demand for police reports when accessing legal abortion, this and other unnecessary documents are demanded from women, increasing their distress and hindering access. That is, despite being legal in only 3 instances, barriers persist and the procedures that are carried out are inferior to women's demands. A qualitative study carried out in Campinas had already signaled low awareness

among female victims of rape regarding the right to legal termination and the services for victims of sexual violence [39].

We did not identify, in the period we analyzed, any studies on non-performance of terminations, whether due to women's wishes or ineligibility resulting from a gestational age over 22 weeks, with the exception of an unpublished Master's thesis. This thesis examined the profile and reasons for not having an abortion, even following authorization, in a Reference Hospital in São Paulo [40]. Religiousness, among more highly educated women, and knowing the aggressor stand out as factors associated with giving up the decision to have the abortion. Knowing the aggressor had already been shown by Blake et al. [19] to be a reason for a delayed demand for the procedure, corroborating the relevance of this factor in women's trajectories.

Objection of conscience continues to be invoked by students and doctors, whether effectively due to religious reasons or, as suggested by some authors [41,42], as a subterfuge. In the latter case, the objection is invoked so doctors can excuse themselves from providing care, not due to religious or moral reasons, but for fear of suffering discrimination or as result of prejudices, since the objection is most commonly invoked in cases of rape [41,42]. Though undeclared, prejudice and lack of trust on the information provided by women permeate these opinions, reflecting an inappropriate condemnatory stance by health professionals and a reinforcement of the social stigma surrounding abortion [41,43,44,45,46]. In the words of Diniz et al. [44] (p. 293), there is a "*shared regime of suspicion regarding women's narratives of rape*". In the international literature, authors emphasize the need for more studies on stigma associated with abortion and its effects on women's health, as well as on interventions that reduce these effects, which are even more scarce [47,48].

Objection of conscience is known to be an important barrier to access to abortion, even in countries where it is legal, in the face of women's spontaneous requests, in which pregnancies need not have been the result of rape or put the women's lives are at risk. The result is an increase in risks to women's health and their rights, especially for more vulnerable groups [48,49]. Data on the average time interval between initial contact with the service and the provision of abortion in the legal abortion services are still largely unknown [14]. It would be important to know what is the impact of objecting doctors' refusal on delays to the procedure in these services. It is likely that the stigma associated with the procedure affects the provision of legal abortion care in the country, with a curtailing of women's legal rights which, despite being restricted, have been assured for over 70 years [2].

Comparing these results with a review of studies on health professionals, from 2000 to 2011, we find the continuation of lack of professional preparedness and of moralist positions, leading to discriminatory care provided to women [50]. We need investments in health professionals' training, whether in university curricula or in continuous training for professionals already employed in health services. Uterine aspiration must be offered as a method for emptying the uterus instead of curettage, whenever pertinent. Internships in legal abortion services must be part of health professionals' training. In this manner, we will broaden the debate on women's sexual and reproductive rights and on good practices in abortion care.

But the context of stigma is wide-reaching and deep [41,45]. It involves not only health professionals, but society and the women who have abortions themselves, who often internalize prejudice and have difficulty making the decision and/or revealing the procedure, making this moment even more conflicted and solitary [41]. A study of 43 women in São Paulo showed that 42% decided to have the procedure on their own, without sharing the decision with family members, partners or friends [17], while another study, with 1,270 participants, found that being single was strongly associated with a delay in seeking care [19]. Additionally, studies found that one third of women who demanded abortions in cases of rape were adolescents, corroborating the vulnerability of this age group, both for sexual violence and for the experience of abortion [49,51,52]. These results reinforce the need for multi-disciplinary teams that are qualified to provide care.

Considering the repercussions for women's reproductive health, two situations stand out. The first refers to the higher number of complications among women whose fetuses had malformations and who did not have abortions, either due to religious reasons or because their demands were rejected. These complications are, in part, to be expected due to the exposure to longer gestational periods. However, other complications are associated with the congenital malformation itself, such as the occurrence of polyhydramnios and dystocia, which increase maternal morbidity. As for the form

of delivery, among women who terminated their pregnancies, there was a high proportion of vaginal resolution, while 100% of those who did not terminate required cesarean sections [33]. Brazil is one of the countries with the highest proportion of these surgeries, with an estimated one million unnecessary cesarean sections taking place each year [53,54]. Carrying the pregnancy to term, with a mandatory cesarean section, exposes women to risks associated with this procedure, with no benefits to their health or the health of their babies, since the malformations were incompatible with life. In addition, it increases the probability of obstetric complications in future pregnancies, as well the repetition of a cesarean section, compromising these women's reproductive future [55].

Another situation is the use of uterine curettage as a method for emptying the uterus, even among those who had previously used misoprostol, something that goes against studies on the medication's effectiveness [56,57], as well as against World Health Organization recommendations [58]. The high frequency of curettage in Latin America had been found in a study of medication provision through telemedicine in the entire world [59]. It is also worth encouraging a reflection regarding the inclusion of mifepristone in the list of medications available in Brazil, considering the greater efficacy and safety of the combined use of this medication with misoprostol in the initial phase of inducing abortions [60].

A gap results from the near non-existence of investigations into care provision for the other two exceptions established by law, besides pregnancies resulting from rape. In this review, only three studies assessed terminations due to fetal malformation, one on anencephaly and the others, of local scope, on severe malformations incompatible with life for which there is no jurisprudence. Little is known about the country as whole or about the itineraries women follow, from diagnosis to termination. For anencephaly, termination can occur at any gestational age, but for other malformations, gestational age may weigh on court decisions and/or those of pregnant women.

We did not find studies evaluating the provision of care to women whose lives are at risk. Although one of studies which assessed professionals' knowledge and perception verified a greater response regarding ethical responsibilization and less objection of conscience in cases in which the pregnant woman's life is at risk [29], we found no studies calling into question what doctors have interpreted as "risk to life", nor on women's and doctors' position regarding the decision to terminate a pregnancy. It is likely that a minority of cases of imminent risk during pregnancy and delivery are being resolved in an adequate and timely manner, with no dissent regarding the termination of pregnancy. However, in other cases, this may not be so clear. Given the importance of indirect causes in maternal mortality, it is worth questioning how professionals deal with cases of women with previous morbid conditions who are left in a gray zone: these are not cases with immediate or imminent risk to life, but can the pregnancy expose them to risks to their lives? These aspects have not been called into question in studies, though they may be documented in discussions of maternal mortality committees. Only in the study with members of the FEBRASGO do the authors discuss how the decision to terminate a pregnancy is ultimately an exclusive responsibility of doctors, who define at which level of risk of death women are entitled to an abortion, without this being discussed with the women themselves or their family members [61].

Studies that seek to gauge attitudes toward expanding the cases in which abortion is legal show that results depend on how questions are formulated. For example, when asked directly, the percentage of individuals who would accept severe malformations or women's socioeconomic and emotional conditions are reasons for abortions is low, whether among students and health professionals or laypeople, although most oppose imprisoning women [27]. However, in a study of judges and prosecutors in 2005-2006, 78% of interviewees were in favor of expanding the cases in which abortion is legal or even decriminalizing abortion, and opinions were frequently associated with variables related to religion [62]. Religion was also a factor associated with more restrictive positions among students [27,29,31]. However, an opinion poll carried out 2005 showed broad support among Brazilians, especially those who are Catholic, to the public provision of care in the legal abortion services and the offer of emergency contraception in health services, in clear opposition to the Catholic hierarchy in Brazil [35].

Lastly, it is worth discussing this study's limitations. We did not register the review protocol. As with any work based on bibliographical search, we cannot dismiss the possibility of a publishing bias. The search was limited to electronic sources, MEDLINE and LILACS, and to references of the identified articles. In this review, predominantly-quantitative works that are accessible through traditional

bases are represented. Although we used many combinations and key words, related articles, indexed with a different terminology, may have escaped the search. One conditioning factor is related to the profile of the instruments we used (checklists), which had strengths and weaknesses, as any quality assessment instrument. The independent assessment, reviewed by consensus, sought to minimize common biases in this type of assessment. Several studies had small samples and, therefore, are limited in terms of the generalization of their findings because they refer to very specific populations [63].

Despite these limitations, we believe the production of knowledge qualifies the debate and the political struggle for women's reproductive rights.

Contributors

S. C. Fonseca and R. M. S. M. Domingues contributed to study conception, data acquisition, analysis and interpretation, writing, critical review and final approval of the published version. M. C. Leal, E. M. L. Aquino and G. M. S. Menezes contributed to data interpretation, writing, critical review and approval of the final version.

Additional informations

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Resumo

Revisões anteriores sobre o aborto no Brasil estimaram um milhão de procedimentos anuais, porém, não abordaram o aborto legal. O objetivo desta revisão sistemática foi atualizar o conhecimento sobre o aborto legal, quanto ao perfil dos serviços, das mulheres atendidas, conhecimento de estudantes e médicos, situação de anencefalia e malformações graves. A busca de artigos foi via MEDLINE e LILACS, de 2008 a 2018, sem restrição de idiomas. A qualidade dos artigos foi avaliada com instrumentos do Joanna Briggs Institute. Busca, seleção, avaliação de qualidade e extração de dados foram feitas independentemente por duas pesquisadoras. Selecionaram-se 20 artigos, 11 sobre conhecimento e opinião de profissionais médicos (4 artigos) e estudantes de Medicina (7 artigos), revelando conhecimento aquém do ideal sobre o aborto legal e objeção de consciência elevada. Seis estudos sobre as mulheres atendidas identificaram que elas são jovens, solteiras e a principal demanda foi a gravidez decorrente de estupro. A demora em procurar atendimento ocorreu dentre as mais jovens, solteiras e quando o agressor era alguém próximo. Três estudos sobre malformações graves mostraram autorização judicial em torno de 40%. Nos casos sem autorização, a evolução da gravidez foi complicada e o parto foi cesáreo. Apenas um artigo abordou os serviços de aborto legal, apontando 37 dos 68 cadastrados em atividade, inexistência em sete estados e concentração nas capitais. O conhecimento sobre o aborto legal ainda é escasso, a demanda do procedimento é reprimida e a formação médica é deficiente no tema.

Aborto Legal; Direitos Sexuais Reprodutivos; Revisão Sistemática

Resumen

Revisiones anteriores sobre el aborto en Brasil estimaron un millón de procedimientos anuales, sin embargo, no abordaron el aborto legal. El objetivo de esta revisión sistemática fue actualizar el conocimiento sobre el aborto legal, en cuanto al perfil de los servicios, de las mujeres atendidas, conocimiento de estudiantes y médicos, situación de anencefalia y malformaciones graves. La búsqueda de artículos fue vía MEDLINE y LILACS, de 2008 a 2018, sin restricción de idiomas. La calidad de los artículos se evaluó con instrumentos del Joanna Briggs Institute. La búsqueda, selección, evaluación de la calidad y extracción de datos fueron realizadas independientemente por parte de dos investigadoras. Se seleccionaron 20 artículos, 11 sobre conocimiento y opinión de profesionales médicos (4 artículos) y estudiantes de Medicina (7 artículos), revelando conocimiento inferior al ideal sobre el aborto legal y la objeción de conciencia. Seis estudios sobre las mujeres atendidas identificaron que se trata de jóvenes, solteras y la principal demanda fue el embarazo ocasionado por una violación. La tardanza en buscar atención se produjo entre las más jóvenes, solteras y cuando el agresor era alguien cercano. Tres estudios sobre malformaciones graves mostraron una autorización judicial en torno a un 40%. En los casos sin autorización, la evolución del embarazo fue complicada y el parto fue por cesárea. Solamente un artículo abordó los servicios de aborto legal, apuntando 37 de los 68 registrados en actividad, inexistencia en siete estados y concentración en las capitales. El conocimiento sobre el aborto legal todavía es escaso, la demanda de la intervención está reprimida y la formación médica es deficiente en el tema.

Aborto Legal; Derechos Sexuales y Reproductivos; Revisión Sistemática

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