ASSEMBLEIA DA REPÚBLICA

Comissão de Parlamentar de Saúde

Petição n.º 239/XI/2.ª

"Acabar com o aborto gratuito"

(*Deputada Relatora: Conceição Bessa Ruão*)

COMISSÃO DE SAÚDE

ASSEMBLEIA DA REPÚBLICA

Comissão de Parlamentar de Saúde

RELATÓRIO[1]

I– Nota Prévia –

Da apresentação, requisitos e processo da iniciativa

Petição, à qual foi atribuída o n.º239/XII/2ª, é uma petição on-line, a qual deu entrada na Assembleia da República em 15 de Fevereiro de 2013, tendo baixado à Comissão de Saúde nesse mesmo dia.

A Petição n.º2239/XII/2.ª, foi apresentada por um grupo de cidadãos, sendo subscrita por 4 384 assinaturas.

Reúne os requisitos formais estatuídos no artigo 9.º da Lei n.º 43/90, de 10 de Agosto, com as alterações introduzidas pelas Leis nºs. 6/93, de 1 de Março, 15/2003, de 4 de Junho, e **45/2007, de 24 de Agosto.**

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[1] O presente relatório está elaborado sem observância do acordo ortográfico.

*Considerando que, nos termos do n.º 1 do artigo 21.º da Lei n.º 43/90, de 10 de Agosto, com as alterações introduzidas pelas Leis nºs. 6/93, de 1 de Março, 15/2003, de 4 de Junho, e **45/2007, de 24 de Agosto**,*

***"A audição dos peticionantes é obrigatória sempre que a petição seja subscrita por mais de 1000 cidadãos"**,*

Foi promovida a audição do seguinte grupo de peticionários: Dr. Rodrigo Faria Castro, Dr. Miguel Alvim e Comandante Carlos Fernandes.

Atento o número de peticionários, a Petição n.º 157/XI/2.ª carece, de acordo com o disposto na alínea a) do n.º 1 do artigo 24.º da Lei n.º 43/90, de 10 de Agosto, com as alterações introduzidas pelas Leis nºs. 6/93, de 1 de Março, 15/2003, de 4 de Junho, e **45/2007, de 24 de Agosto**, de ser apreciada em Plenário da Assembleia da República.

II - Do Objecto da Iniciativa

O objeto da petição está bem especificado, o texto é inteligível, o peticionário encontra-se corretamente identificado, mencionando o seu contacto e estão presentes os demais requisitos de forma e tramitação constantes dos artigos 9.º e 13.º da Lei de Exercício de Petição (Lei n.º 43/90, de 10 de Agosto, na redação que lhe é dada pelas Leis n.º s 6/93, de 1 de Março, 15/2003, de 4 de Junho e 45/2007, de 24 de Agosto).

Objectivamente, os Peticionários solicitam à Assembleia da República que[2]:

Que " *neste momento de crise nacional, com o aumento brutal de impostos, cortes de subsídios, cortes de ordenados r aumento de taxas moderadoras no Serviço Nacional de Saúde, o Governo tenta diminuir a despesa pública e aumentar a receita.*"

Entendem assim tornar-se *"ilógico haver aborto gratuito e pagamento de até um mês de subsídio de maternidade (?!) a 100% par aquém quer abortar QUANDO E QUANTAS vezes quiser, tudo isto às custas do Estado".*

Mais referem que " independentemente da posição que os signatários têm em relação ao aborto ser ou não livre, peticiona-se ao Governo e à Assembleia da República que a interrupção voluntária da gravidez (aborto) não seja financiada/ comparticipada/subsidiada pelo Estado Português."

III - Análise da Petição

Enquadramento legislativo e outros e verificação dos requisitos

A presente petição envolve duas dimensões especificas relativas à interrupção voluntária da gravidez, enunciadas pelos peticionários. A primeira directa e expressamente relacionada com a isenção de taxas moderadoras para realização a mesma.

A segunda, sobre os direitos inerentes e equiparados à situação de maternidade para as mulheres que fazem ivg.

Neste pressuposto, tentou fazer-se o enquadramento legislativo que dá base às duas dimensões das questões suscitadas.

Assim:

No sentido da regulamentação da Lei n.º 16/2007, de 17 de Abril, sobre a despenalização da interrupção voluntária da gravidez, se realizada por opção da mulher nas primeiras dez semanas, em estabelecimentos de saúde legalmente autorizados para o efeito,

foram produzidos diversos diplomas legais bem como circulares normativas da Direcção-Geral de Saúde, que tiveram como objectivo dotar o Serviço Nacional de Saúde das condições técnicas, profissionais e garantísticas necessárias para levar a cabo a interrupção da gravidez,

A Portaria n.º741-A/ 2007, de 16 de Julho definiu os preços da interrupção voluntária da gravidez, quer medicamentosa quer cirúrgica, adequando-os às novas exigências e especificidades da mesma, designadamente incluindo a obrigatoriedade de a mulher ser atendida numa consulta prévia e a possibilidade de lhe ser disponibilizado apoio psicológico e social.

O D. Lei n.º 113/2011, de 29 de Novembro - sobre o regime de taxas moderadoras no seu preambulo enuncia que *" nos termos do disposto na Base XXXV da Lei de Bases da Saúde e do n.º 2 do artigo 23.º do Estatuto do SNS , com base em:*

- *Critérios de racionalidade;*
- *Discriminação positiva dos mais carenciados;*
- *De nível de risco de saúde ponderada*
- *E ao nível de insuficiência económica"*, são consideradas diferentes situações de isenção de taxas moderadoras.

Por sua vez, o artigo 4.º do mesmo diploma legal, que enumera as diferentes situações de isenção e taxas moderadores, refere expressamente, e passo a citar:

"Artigo 4.º

Taxas moderadoras

Estão isentos de pagamento de taxas moderadoras:

a) As grávidas e parturientes
b) .....
c) ...(...)"

Também o artigo 8.º que enuncia as situações em que as taxas moderadoras são dispensados, refere, e passo também a citar:

"Artigo 8.º

Dispensa de cobrança de taxas de moderadoras

É dispensado de cobrança de taxas moderadores no âmbito das seguintes prestações de cuidados de saúde:

a) Consultas de planeamento familiar e actos complementares, prescritos no decursos destes.(...)"

Por sua vez,

A ***Circular Normativa n.º 4/ACSS de 25.07.2007*** - Regulamenta a facturação entre instituições do SNS de parte ou totalidade dos serviços inerentes à interrupção da gravidez até às 10 semanas de gestação, na falta de protocolo ou contrato de prestação de serviços, sendo regulados, consoante o caso, pelo Anexo III da Portaria n.º 110 - A/2007, de 23 de Janeiro e Portaria n.º 781-A/2007, de 16 de Julho, respectivamente

Em termos de situação e garantias de direitos, equiparáveis às situações de maternidade, temos a legislação que a seguir se enuncia:

O D. Lei n.º91/2009, de 9 de Abril fixou o novo regime de protecção social, elegendo como prioridade o incentivo à natalidade e a igualdade do género através da atribuição de prestações de natureza pecuniária que visem a substituição dos rendimentos perdidos por força da situação de impedimento para o exercício de actividade profissional.

O seu artigo 10.º prevê que o subsídio por interrupção da gravidez, impeditiva do exercício da actividade laboral, seja medicamente certificada e ocorra durante um período variável entre 14 e 30 dias.

O n.º 1 do artigo 22.º refere que o reconhecimento do direito aos subsídios previstos " (...) dá lugar ao registo de remunerações por equivalência à entrada de contribuições durante o respectivo período de concessão," sendo considerado como trabalho efectivamente prestado.

Igualmente, por força do disposto no artigo 83.°, se fixa um regime subsidiário, que determina que,

"Com a excepção do disposto no artigo 22.° em tudo o que não esteja especialmente previsto no capítulo III são aplicáveis, com as devidas adaptações, as disposições constantes do capítulo II."

Assim, a caracterização dos subsídios sociais previstas neste capítulo estão subordinados à caracterização dos correspondentes subsídios atribuídos no âmbito do sistema previdencial, com as devidas adaptações - artigo 49.°.

Também o n.° 2 do artigo 50.° considera como condições determinantes de protecção e atribuição, entre outras, a interrupção da gravidez.

Por fim refere especificamente que enquanto não for publicada a Portaria prevista no n.° 3 do artigo 84.°, a concessão de subsídios está sujeita à apresentação de requerimento e certificação médica comprovativa do período de impedimento.

IV - Diligências efectuadas pela Comissão

Nos termos do artigo 20.° da Lei de Exercício do Direito de Petição, a Comissão pode, para além de ouvir o peticionário, pedir informações, sobre a matéria, às entidades que entender relevantes. Foi deste modo que se entendeu, porque directamente

relacionadas com os direitos e saúde sexual e reprodutiva das mulheres, foram também colhidos pareceres das seguintes entidades:

Ministério da Saúde, Direcção-Geral de Saúde, Ordem dos Médicos, Ordem dos Enfermeiros; Comissão Parlamentar de Direitos Liberdades e Garantias, E.R.S - Entidade Reguladora da Saúde e ACSS - Autoridade Central em Serviços de Saúde.

No âmbito das suas diligências, foi também remetido à relatora tese de mestrado realizado pela candidata Inês Campos Matos, mestranda na London School of Hygiene and Tropical Medicine, subordinada ao tema *"Fees for a Abortion in Portugal: A "Non-Issue, a Moralizing Policy or a Matter of Justice?"*

IV.1 - Dos Peticionários - referiram " *O Governo com dificuldades em encontrar onde fazer cortes na despesa; pessoas com cirurgia em espera; o aborto tem rápida intervenção. Num contexto gravíssimo de contas públicas, não se compreende a situação em que o aborto sendo um acto de vontade não seja sujeito a taxas moderadoras.*

Há limitações e contenções no SNS para outros tipos de cirurgias, não se compreende o modo como o Estado está a financiar o não crescimento da natalidade."

Prosseguiram agora na dimensão do tratamento dado à mulher que aborta em equiparação à maternidade e referem:

" *O Estado financia o aborto com um subsídio à maternidade* "

E analisam, em termo da base de sigilo que rodeia o processo e os dados respectivos, em que a situação criada pode perfeitamente conduzir a resultados absolutamente indesejados, mas suscpetíveis de acontecer, tais como:

"Possibilidade de conluio entre a clínica e a grávida; hipotéticos abortos que podem ser cobrados e não realizados, isto por falta de fiscalização. O Estado ao criar uma base de dados sigilosa, que não permite que se cruzem dados entre as diferentes entidades, é susceptível de criar situações em que a clínica dos Arcos possa estar a financiar as clínicas em Espanha, com valores pagos pelo Estado português.

É um sinal errado que se está a dar à sociedade. Este dinheiro deveria ser aplicado em planeamento familiar efectivo, e aí sim, por questões de saúde pública."

Prosseguem:

"A lei do aborto não protege as mulheres; mata crianças e tem um impacto tremendo.

Somos o 2.º país da Europa com a menor taxa de natalidade. Isto é almoçar cianeto, com as implicações demográficas e socais que são a sua consequência directa."

Sobre a actuação do Estado, referem ainda:

" O Estado anda a cortar subsídios e pensões e com o aborto - financia-o e despenaliza-o. Portadores de doenças crónicas como os diabéticos têm de assumir, muitas das vezes e em muitas circunstâncias, as consequências da sua doença."

Relativamente à consulta de planeamento familiar, seguinte à interrupção voluntária da gravidez, referem:

"A consulta seguinte não deve ser feita pela mesma entidade. A clinica dos Arcos vende serviços. Tem de haver um ponderação do elemento volitivo. Se a mulher se arrepende, não faz aborto, logo o serviço não é vendido."

Colocados perante a questão de a mulher, se não lhe for facultada a hipótese de abortar, poder ela própria recorrer à compra de medicamentos com efeito análogo, mas relativo a medicamentos de venda livre, argumentam:

"O Estado, de facto não conseguirá nunca controlar situação de fraude; o aborto é uma coisa inventada por homens, pais, amantes e namorados. A maternidade é intrínseca à natureza da mulher; há rapariga jovens que são levadas a abortar por pressão. O Estado em Portugal tem feito o mais fácil - despenalizar, em vez de investir em educação ."

"Se fugir à taxa moderadora pode tirar as mulheres do SNS, é então preciso encontrar uma solução de controlo dos fármacos com efeitos equiparáveis."

Mais referem:

"As mulheres quando se apresentam para abortar, apresentam-se com medo; três vezes mais mulheres foram despedidas por estarem grávidas; sofrem maus tratos, discriminação racial, associados ao aborto. O Estado está a financiar isto. Isto não é bom para as mulheres.

É necessários identificar as situações e penalizar os empregadores que directa ou indirectamente obrigam as mulheres a abortar.

O aborto não é uma questão ideológica, mas biológica.

Esta questão não pode ser nem de direita nem de esquerda, mas do bem comum. "

Afirmam:

"Sentimos que estamos do lado certo da História."

Por fim, concluem:

" Num momento em que se corta e se agrava toda a situação tributária dos contribuintes; que há cortes nas pensões, nas despesas; racionalização na saúde, como se pode isentar de taxas moderadoras a prática do aborto"

Ainda, e no âmbito do documento entregue em mão à relatora, pelos primeiros peticionários, e que constará em anexo ao presente relatório, é possível colher os dados que os mesmos fazem questão que sejam evidenciados.

Assim:

"Estima-se , de acordo com o gráfico na apresentação anexa que, até 31 de Março de 2013, tenham sido realizados já 108.000 abortos legais, "por opção da mulher", portanto ao abrigo da nova lei.

Sobre os correspondentes custos do Estado há, pelo menos duas componentes:

1. *Uma relacionada com a intervenção médica em si e que está a cargo do Ministério da Saúde.*
2. *Outra a cargo do Ministério da Segurança Social relacionada com os subsídios atribuídos às mães que abortaram durante a licença e que podem ir de 15 a 30 dias (tendo em conta o valor do vencimento de base) e com o suporte das deslocações das mulheres residentes das ilhas para o*

Continente (viagens, estadias e transportes para a mãe e um acompanhante.
(...) conforme se pode inferir da resposta , o custo médio por aborto em ambulatório ronda €342,00.(...)

(...) O valor médio de 700,00 € (tendo em conta os 108.000 abortos já realizados) € 75.000.000,00 euros em custosa directos do Estado até ao final do 1.º trimestre de 2013.

Para a segunda componente (custos com subsídios durante as licenças + deslocações) não existem valores oficiais disponíveis (do Ministério da Segurança Social), mas estima-se, igualmente, um valor médio de cerca de 800,00 euros por cada aborto realizado.

A verificar-se este valor médio por aborto (e tendo em conta os 108.000 abortos já realizados) estima-se em cerca de € 80.000.000,00 euros o custo directo do Estado até ao final do 1.º trimestre de 2013.

(...) Finalmente, devem anotar-se os prazos escandalosamente curtos de pagamento às instituições privadas que realizam abortos"

IV.2 - Ministério da Saúde

Foi o Ministério da Saúde questionado pela deputada relatora sobre o conteúdo da petição n.º 239/XII/2.ª, a qual mereceu a resposta que se transcreve:

" Relativamente à petição acima referida e ouvida a Direcção-Geral de Saúde, encarrega-me Sua Excelência o Ministro da Saúde de informar que a petição em causa refere apenas que entende não dever o ivg ser financiada/subsidiada pelo Estado. Não explicita se pretende incluir neste desiderato todas as interrupções da gravidez ou apenas as relativas à alínea e) do n.º 1 do artigo 142.º do C.Penal.

Em todo o caso cumpre distinguir dois planos:

1. *O subsídio por interrupção da gravidez previsto na alínea b) do n.º1 do artigo 4.º do Decreto-Lei n.º89/2009, de 9 de Abril é uma matéria exclusivamente relativa à Segurança Social;*
2. *A mulher grávida está isenta do pagamento de taxas moderadoras. Note-se que na primeira consulta e durante o período de reflexão a mulher está grávida, podendo desistir de efetuar ig e decidir levar a gravidez a termo, pelo que faz sentido que se inclua na exceção de pagamento de taxas moderadoras. Por outro lado, e no correr deste processo, está prevista uma consulta de revisão a realizar no prazo máximo de 15 dias após a IG. Ora, esta consulta de revisão tem dois objetivos. Um, verificar se a IG foi completa e o outro, é assegurar e disponibilizar um método anticoncepcional. Por isso, enquadra-se numa consulta de planeamento familiar e como tal também isenta de taxa moderadora. "*

IV.3 - Direcção-Geral de Saúde

No âmbito da presente Petição foi enviada comunicação à Direcção-Geral de Saúde, para a qual se pedia resposta às questões nela contida.

Foi recebida a seguinte resposta:

Assunto: Petição n.º 239/XII/2.ª - Petição contra o aborto gratuito. "Peticionam ao Governo e à Assembleia da República que a interrupção voluntária da gravidez (aborto) não seja financiada/comparticipada/subsidiada pelo Estado Português"

Relativamente às questões colocadas sobre o assunto em epígrafe, cumpre-nos esclarecer:

1ª - O Decreto-Lei n.º 113/2011, de 29 de Novembro com a redacção que lhe foi dada pelo D.lei n.º128/2012, de 21.06, regula o acesso às prestações do Serviço Nacional de Saúde (SNS) por parte dos utentes, no que respeita ao regime de taxas moderadoras e à aplicação de regimes especiais de benefícios. Na sua nova redação, as Grávidas e Parturientes estão isentas de taxa moderadora - pela condição "Gravidez e Parto."

2ª - a) Não conhecemos evidência de que a taxa de nascimentos varie em função da aplicação ou não de taxa moderadora ao aborto. Desconhecemos estudos que demonstrem que a aplicação de um co-pagamento ou taxa moderadora diminua as interrupções das gravidezes indesejadas e que este fenómeno tenha repercussão significativa na taxa de nascimentos a nível nacional.

Em Portugal, no ano de 2012 verificou-se uma diminuição do número de abortos realizados a pedido da mulher e também uma diminuição do número de nascimentos. Podemos inferir que se a taxa de nascimentos diminuiu, não foi à custa do aumento do número de abortos.

b) A preocupação sobre o risco de utilização de uma taxa moderadora nesta situação, depende do valor a ser atribuído, porque, mesmo entre as mulheres que não estão isentas por insuficiência económica, pode ser entendido como menor custo, para a própria, o recurso ao uso de fármacos em automedicação ilegal. Esta possibilidade, poder-se-ia traduzir num recrudescimento das complicações de aborto ilegal.

Iv.4 - Ordem dos Médicos

A Ordem dos Médicos acusou a recepção e agradeceu o envio da petição, mas não respondeu.

IV.5 - Ordem dos Enfermeiros

" De acordo com o solicitado, no mail rececionado nos nossos Serviços no dia 01.08.2013, venho por este meio informar que a Ordem dos Enfermeiros é de parecer que a não aplicação de taxa moderadora no aborto será , uma questão de "não opção" por parte da entidade com competência para o efeito."

IV.6 - Comissão de Assuntos Constitucionais, Direitos, Liberdades e Garantias

Relativamente à presente Petição, foi solicitado à Comissão de Assuntos Constitucionais, Direitos, Liberdades e Garantias pedido de pronúncia sobre o objecto da presente petição.

A resposta recebida, foi a que se transcreve:

"Em resposta ao ofício de V.Exª n.º 230/COM/2013, de 13 de Setembro, cumpre-me informar que o pedido de informação nele contido foi analisado por esta Comissão na sua reunião de 17 de setembro último, tendo sido considerado, por unanimidade, na ausência do PEV, não dever ter lugar uma pronúncia desta Comissão sobre a matéria que não diz respeito às suas áreas de competência, sem prejuízo de poder vir a ser chamada a pronunciar-se se vierem a suscitar, a propósito da petição, questões de constitucionalidade.

Com efeito, parecendo estar em causa, no pedido formulado pela Senhora Deputada relatora, uma apreciação acerca da questão da não aplicação de taxas moderadoras às situações de interrupção voluntária da gravidez, entende-se que esta dificilmente poderá envolver a Comissão de Assuntos Constitucionais, mesmo considerando juízos de conformidade com o princípio constitucional da igualdade, que sempre se colocarão, em maior ou menos graus, em relação a todas as opções de política ou legislativas."

IV.7 - ACSS - Autoridade Central em Serviços de Saúde

Não respondeu.

IV.8 - E.R.S. - Entidade Reguladora da Saúde

Não respondeu

IV.9 - Tese de mestrado em Saúde Pública[3], *"Fees for abortion in Portugal: A "Non-issue, a Moralizing Policy or a Matter of Justice".*[4]

Do estudo em causa, é possível extrair algumas conclusões e recomendações, sendo que uma delas é a de que,"[5]*através de entrevistas realizadas há evidências de que taxas moderadoras aplicadas sobre o aborto, em Portugal, não teriam impactos importantes na saúde ou consequências sociais."*

Mais afirma a autora do estudo:

"(...) a evidência dos dados recolhidos não me permite aconselhar a favor ou contra a introdução de taxas moderadoras no aborto em Portugal. As recomendações coligidas pretendem ajudar os decisores no processo respectivo, quando considerem a possibilidade de implementar esta medida."

As recomendações que se seguem, pela autora do estudo, serão transcritas em inglês, por questões de fiabilidade de conteúdo.

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[3] Candidate: Inês Campos Matos; Stream: Public Health, General Stream; Supervisor: John Cairns. Submitted in part fulfillment of the requirements for the degree of MScin Public Health, for academic year 2011-2012.

[4] O estudo fará parte integrante deste relatório, facto para o qual a deputada relatora está autorizada

[5] Tradução efectuada pela deputada relatora, pelo qualquer falha ou erro não deverá ser interpretada ou assumida como intencional. - Matos, Inês Campos - " Fees for Abortion in Portugal" - Pag. 30;

Assim:

Recommendation 1."Moderating fees" for abortion should be used as a way of decreasing abortion rate.

Considering the evidence collected and its application to the Portuguese context, there is no reason to believe that abortion rates wiil decrease if a "moderating fee" is applied.

Recommendation 2. "Moderating fees" for abortion should not be expected to raise birth rate.

Although evidence shows that some pregnancies are converted into births when abortion costs are high, the fact this was observed for much higher costs and that poorer women are exempt in Portugal, makes it high unlikely to happen in the Portuguese context.

Recommendation 3. The introduction of "moderating fees" for abortion should not be used as a way of modifying sexual behavior.

This is supported by evidence that shows that higher abortion costs are not related and don`t lead a more intensive contraceptive use, a lower rate of sexuality transmitted diseases or other types of sexual behavior. Also, there is no strong evidence that a higher abortion costs will lead to lower pregnancy rates.

Recommendation 4. Illegal abortion should not be a concern when considering "moderating fees" for abortion provision.

There is no evidence to support the possibility that higher abortion costs led to higher rates of illegal abortions. Also exemptions mechanism and the likely high costs of illegal abortions in Portugal make this possibility even more unlikely.

V.1 - Conclusões:

a) Estão isentos de pagamento de taxas moderadoras as grávidas e parturientes.

b) As consultas de planeamento familiar e actos complementares, prescritos no decurso de processos de interrupção voluntária de gravidez, estão isentas de taxas moderadoras.

c)O acto em que ocorre a interrupção voluntária da gravidez está igualmente isenta de taxa moderadora.

d)A Ordem dos Médicos não respondeu à solicitação feita par ase pronunciar sobre o teor da Petição.

e)A Ordem dos Enfermeiros é de parecer que *"a não aplicação de taxa moderadora no aborto será , uma questão de "não opção" por parte da entidade com competência para o efeito "*

f) A Comissão de Assuntos Constitucionais, Direitos, Liberdades e Garantias, considerou por unanimidade, com a ausência do PEV, *"não dever ter lugar uma pronuncia desta Comissão sobre a matéria que não diz respeito às suas áreas de competência(...)"*.

g) No âmbito do estudo em anexo, *"(...) através de entrevistas realizadas há evidências de que taxas moderadoras aplicadas sobre o aborto, em Portugal, não teriam impactos importantes na saúde ou consequências sociais."*

h) Ainda no âmbito do estudo, *"(...) a evidência dos dados recolhidos não me permite aconselhar a favor ou contra a introdução de taxas moderadoras no aborto em Portugal(...)"*

i) Ainda, *" As recomendações coligidas pretendem ajudar os decisores no processo respectivo, quando considerem a possibilidade de implementar esta medida."*

V .2 - Opinião da relatora

- A relatora reserva, nesta sede, a sua opinião sobre a petição em apreço, a qual é de elaboração facultativa conforme o disposto no n.° 3 do artigo 137.° do Regimento da Assembleia da República.

No entanto, sempre se dirá, que tal como aquando da apresentação do relatório sobre "A avaliação do aborto em Portugal", desde a entrada em vigor da Lei n.° 16/2007, de 17 de Abril , continua a relatora a entender que atribuir à interrupção

da gravidez por opção da mulher, em pé de igualdade, subsídios de natureza pecuniária que visam a substituição dos rendimentos perdidos por força da situação de incapacidade ou indisponibilidade para o trabalho, por motivo de maternidade, paternidade, adopção e outras causas de interrupção da gravidez, é tratar de modo igual situações antagónicas e conflituantes em matéria de interesses a proteger.

V - Anexos

Anexo I - Documento apresentado pelos Peticionários.

Anexo II - Carta resposta do Ministério da Saúde

Anexo III - Documento de resposta da Direcção- Geral de Saúde

Anexo IV - Carta da Ordem dos Enfermeiros

Anexo V - Oficio resposta da Comissão de Assuntos Constitucionais, Direitos, Liberdades e Garantias.

Anexo VI - Tese de Mestrado " Fees for abortion in Portugal: A Non-issue, a Moralizing Policy or a Matter of Justice".

VI - Parecer

Assim, a Comissão de Saúde é de parecer que:

1. *Nos termos da alínea a) do n.º 1 do artigo 24.º da Lei n.º 43/90, de 10 de Agosto, com as alterações introduzidas pelas Leis nºs. 6/93, de 1 de Março, 15/2003, de 4 de Junho, e* ***45/2007, de 24 de Agosto,*** *a Petição*

n.º157/XI/2.ª seja objecto de apreciação em Plenário da Assembleia da República;

2. Que, nos termos do n.º 2 do artigo 24.º da Lei n.º 43/90, de 10 de Agosto, a Petição n.º 157/XI/1ª. seja enviada a Sua Excelência, a Presidente da Assembleia da República, para efeitos de agendamento da apreciação a que se refere o ponto anterior, acompanhada do presente Relatório;

3. Que, nos termos legais aplicáveis, o presente relatório seja levado ao conhecimento dos representantes dos peticionários;

4. Que o presente relatório seja levado ao conhecimento do Governo, através do Senhor Ministro da Saúde.

Palácio de S. Bento, 17 de Dezembro Outubro de 2011

A Deputada Relator, A Presidente da Comissão,

(Conceição Bessa Ruão) (Maria Antónia Almeida Santos)

PARTE IV – ANEXOS

1ª Comissão. 15.2.2013

PETIÇÃO Nº 239/XII/2ª

(4384 assinat.)

Ver actuais Signatários | ASSINAR esta Petição

Petição ACABAR COM ABORTO GRATUITO

Para: Governo e Assembleia da República

Neste momento de crise nacional, com aumento brutal de impostos, cortes de subsídios, cortes de ordenados e aumento das taxas moderadoras no Serviço Nacional de Saúde, o Governo tenta diminuir a despesa pública e aumentar a receita.

Assim, torna-se incoerente e ilógico haver aborto gratuito e pagamento de até um mês de subsídio de maternidade (?!) a 100% para quem quer abortar QUANDO e QUANTAS vezes quiser, tudo isto às custas do Estado.

Independentemente da posição que os signatários têm em relação ao aborto ser ou não livre, peticiona-se ao Governo e à Assembleia da República que a interrupção voluntária da gravidez (aborto) não seja financiada / comparticipada / subsidiada pelo Estado Português.

Assembleia da República
Gabinete da Presidente

Nº de Entrada 457231

Classificação

15/02/___/___/___/

Data

15/02/2013

Os signatários

Assinar a Petição ACABAR COM ABORTO GRATUITO

Oficio N.: 4358
Data: 26-04-2013

GOVERNO DE PORTUGAL | MINISTÉRIO DA SAÚDE

Gabinete da Secretária de Estado
dos Assuntos Parlamentares e da Igualdade

Entrada N.º 2530

Data 26 / 04 / 2013

Exma. Senhora
Chefe do Gabinete da Secretária de Estado dos Assuntos Parlamentares e da Igualdade
Dra. Marina Resende

Sua referência	Sua comunicação	Nossa referência
Nº 1602	18-03-2013	Ent. 3142/2013

ASSUNTO **Petição nº 239/XII/2ª - iniciativa de Rodrigo Guedes Simas Faria de Castro "Acabar com o aborto gratuito"**

Relativamente à Petição acima referida e ouvida a Direção Geral da Saúde, encarrega-me S.E. o Ministro da Saúde de informar que a petição em causa refere apenas que entende não dever a IVG ser financiada/comparticipada/subsidiada pelo Estado. Não explicita se pretende incluir neste desiderato todas as interrupções da gravidez ou se apenas as relativas à alínea e) do n.º 1 do artigo 142.º do Código Penal.

Em todo o caso, cumpre distinguir dois planos:

1. O subsídio por interrupção da gravidez previsto na alínea b) do n.º 1 do artigo 4.º do Decreto-Lei n.º 89/2009, de 9 de abril é uma matéria exclusivamente relativa à Segurança Social;

2. A mulher grávida está isenta do pagamento de taxas moderadoras. Note-se que na primeira consulta e durante todo o período de reflexão a mulher está grávida, podendo desistir de efetuar a IG e decidir levar a gravidez a termo, pelo que faz sentido que se inclua na exceção de pagamento de taxas moderadoras. Por outro lado, e no correr deste processo, está prevista uma consulta de revisão a realizar no prazo máximo de 15 dias após a IG. Ora, esta consulta de revisão tem dois objetivos. Um, é verificar se a IG foi completa e, o outro, é assegurar e disponibilizar um método anticoncepcional. Por isso, enquadra-se numa consulta de planeamento familiar e como tal também está isenta de taxa moderadora.

Com os melhores cumprimentos,

O Chefe do Gabinete,

Luís Vitório

Gabinete do Ministro da Saúde
Av. João Crisóstomo, 9 - 6º, 1049-062 Lisboa, PORTUGAL
TEL + 351 21 330 50 00 FAX + 351 21 330 51 61 EMAIL gms@ms.gov.pt www.portugal.gov.pt

Direção Geral de Saúde – 13-8-2013

Assunto: Petição n.º 239/XII/2.ª – Petição contra o aborto gratuito. "Peticionam ao Governo e à Assembleia da República que a interrupção voluntária da gravidez (aborto) não seja financiada/comparticipada/subsidiada pelo Estado Português"

Relativamente às questões colocadas sobre o assunto em epígrafe, cumpre-nos esclarecer:

1ª – O Decreto-Lei n.º 113/2011, de 29 de Novembro veio regular o acesso às prestações do Serviço Nacional de Saúde (SNS) por parte dos utentes, no que respeita ao regime de taxas moderadoras e à aplicação de regimes especiais de benefícios. Na sua nova redação introduzida pelo Decreto-Lei n.º 128/2012, de 21 de junho, as Grávidas e Parturientes estão isentas de taxa moderadora – pela condição "Gravidez e Parto."

2ª - a) Não conhecemos evidência de que a taxa de nascimentos varie em função da aplicação ou não de taxa moderadora ao aborto. Desconhecemos estudos que demonstrem que a aplicação de um co-pagamento ou taxa moderadora diminua as interrupções das gravidezes indesejadas e que este fenómeno tenha repercussão significativa na taxa de nascimentos a nível nacional.

Em Portugal, no ano de 2012 verificou-se uma diminuição do número de abortos realizados a pedido da mulher e também uma diminuição do número de nascimentos. Podemos inferir que se a taxa de nascimentos diminuiu, não foi à custa do aumento do número de abortos.

b) A preocupação sobre o risco de utilização de uma taxa moderadora nesta situação, depende do valor a ser atribuído, porque, mesmo entre as mulheres que não estão isentas por insuficiência económica, pode ser entendido como menor custo, para a própria, o recurso ao uso de fármacos em automedicação ilegal. Esta possibilidade, poder-se-ia traduzir num recrudescimento das complicações de aborto ilegal.

Gabinete do Bastonário

Exma. Senhora
Deputada Conceição Bessa Ruão
Comissão Parlamentar de Saúde
Palácio de São Bento
1249-068 Lisboa

Mail:Comissao.9A-CSXII@ar.parlamento.pt

Nossa Refª: CD/E – 13 05421 31.10.2013
Vossa Refª:

Assunto: Petição nº 239/XII (2.ª) – Petição contra o aborto gratuito

Ex.ma Senhora Deputada,

De acordo com solicitado, no mail rececionado nos nossos serviços no dia 01.08.2013, venho por este meio informar que a Ordem dos Enfermeiros é de parecer que a não aplicação de taxa moderadora no aborto será, uma questão de "não opção" por parte da entidade com competência para o efeito.

Com os meus cumprimentos e estima,

O Bastonário

Enf. Germano Couto

GC/AS

Av. Almirante Gago Coutinho, 75 – 1700-028 Lisboa, Portugal
Tlf.: +351 218455230 / Fax: +351 218455259 / email: mail@ordemenfermeiros.pt / www.ordemenfermeiros.pt

ASSEMBLEIA DA REPÚBLICA
COMISSÃO DE ASSUNTOS CONSTITUCIONAIS, DIREITOS, LIBERDADES E GARANTIAS

EXCELENTÍSSIMA SENHORA
PRESIDENTE DA COMISSÃO
PARLAMENTAR DE SAÚDE

Ofício n.º 1085/XII/1.ª – CACDLG/2013 **Data: 18-09-2013**

ASSUNTO: Petição n.º 239/XII/2.ª – pedido de informação

Em resposta ao ofício de V. Exa. n.º 230/9.ª/COM/2013, de 13 de setembro, cumpre-me informar que o pedido de informação nele contido foi analisado por esta Comissão na sua reunião de 17 de setembro último, tendo sido considerado, por unanimidade, na ausência do PEV, não dever ter lugar uma pronúncia desta Comissão sobre matéria que não diz respeito às suas áreas de competência, sem prejuízo de poder vir a ser chamada a pronunciar-se se se vierem a suscitar, a propósito desta petição, questões de constitucionalidade.

Com efeito, parecendo estar em causa, no pedido formulado pela Senhora Deputada Relatora, uma apreciação acerca da questão da não aplicação de taxas moderadoras às situações de interrupção voluntária da gravidez, entende-se que esta dificilmente poderá envolver a Comissão de Assuntos Constitucionais, mesmo considerando juízos de conformidade com o princípio constitucional da igualdade, que sempre se colocarão, em maior ou menos grau, em relação a todas as opções de política ou legislativas.

ASSEMBLEIA DA REPÚBLICA
Divisão de Apoio às Comissões
CS
Nº Único 474635
Entrada/Saída nº 955 Data 19/09/2013

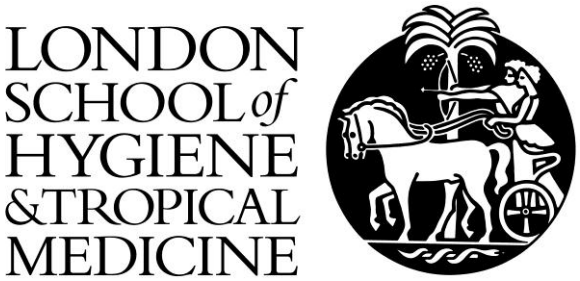
Com os melhores cumprimentos,

ASSEMBLEIA DA REPÚBLICA
Divisão de Apoio às Comissões
CACDLG
Nº Único 474635
Entrada/Saída nº 1085 18/09/2013

O Presidente da Comissão

(Fernando Negrão)

Comissão de Assuntos Constitucionais, Direitos, Liberdades e Garantias
Assembleia da República – Palácio de São Bento
1249-068 Lisboa
Tel: 21 391 95 30/21 391 96 67 **Fax: 21 393 69 41**



Fees for Abortion in Portugal: A "Non-Issue", a Moralizing Policy or a Matter of Justice?

Candidate: Inês Campos Matos
Stream: Public Health, General Stream
Supervisor: John Cairns
Word Count: 8 945

Submitted in part fulfilment of the requirements for the degree of MSc in Public Health

For Academic Year 2011-2012

Fees for Abortion in Portugal: A “Non-Issue”, a Moralizing Policy or a Matter of Justice?

Health Policy Report

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Academic year 2011-2012

Executive Summary

Abortion on a woman's request has been legal in Portugal for five years and has always been exempt from any kind of out-of-pocket payment. This goes against the general trend seen lately in Portugal of rising fees for most services provided by the National Health Service in the context of a financial crisis. A public debate has recently sparked on whether abortion should also have a fee and a decision on the issue is expected to be made by the Parliament in September 2012.

This project aimed to understand what would be the possible health and social outcomes of introducing such a fee. A literature review was performed and six semi-structured interviews with members from different parties of the Portuguese parliament and with one expert on the subject were undertaken. These were analysed using the framework approach.

The literature review showed that, in the United States of America, higher abortion costs seem to decrease abortion rates(1-11) and increase birth rates in the short term(7, 8, 12). It is also possible that pregnancy rates decrease in the long term as a result of a pregnancy avoidance behaviour motivated by higher abortion costs(8, 13). There is evidence that no association exists between higher abortion costs and illegal abortions(8, 14). There was no important evidence of other outcomes being influenced by abortion costs.

The interviews showed diverging opinions on a number of different subjects, according to each person's stance on the issue. The interviewees who agreed with the introduction of user fees for abortion argued that, because other medical services have a fee, abortion should not be exempt, and framed the issue as one of justice in relation to other medical services and of fair resource allocation. They also stressed the fact that all family planning consultations, as well as contraceptives can be acquired for free in Portugal. On the other hand, the interviewees who were against this policy, saw this proposal as a way of restricting abortion rights by people who didn't agree that abortion should be legal, saw social circumstances as a fundamental reason as to why women choose to have abortions and repeat abortions and framed this as a question of freedom and non-judgmental attitude towards women.

According to the resulting evidence, it is likely that if fees are introduced for abortion in Portugal there will be no considerable health or social consequences. The recommendations drawn from the data collected aim to help policy makers in their

decision process when considering the implementation of user fees for abortion. The recommendations were the following:

Recommendation 1. ‘Moderating fees’ for abortion should not be used as a way of decreasing abortion rate.

Recommendation 2. ‘Moderating fees’ for abortion should not be expected to raise birth rate.

Recommendation 3. The introduction of ‘moderating fees’ for abortion should not be used as a way of modifying sexual behaviour.

Recommendation 4. Illegal abortion should not be a concern when considering ‘moderating fees’ for abortion provision.

Selection of the interviewees by purposive sampling might have introduced some bias in the data collected. This research was also limited by the fact that the available data from the literature review was based on only one country – the United States of America – which has some significant differences from Portugal. Finally, my personal stance on the issue could have affected any step in the research, especially concerning the interviews (from execution to interpretation). On the other hand, it is, to the best of my knowledge, the only review of how abortion costs affect several health and social outcomes and it concerns a very up-to-date debate that is currently being held in Portugal.

Acknowledgements

To the interviewees, for their availability and supportive attitude. This would, obviously, be impossible to do without their collaboration. Hopefully this work will also be of some support to them.

To Pedro Barrias for help with putting me in contact with people who can be difficult to reach.

To my tutor and supervisor, for the guidance on how to select a topic, on what to consider when planning my project, for suggesting alternatives when problems arose and for reviewing the final drafts. I felt supported all the way through.

To my family and friends for the warming support and the opportunity to have someone to debate with when I reached an impasse. To Gillian McKay, my friend and MSc colleague, for reading a draft and for the helpful comments. Finally, to my mother: thank you for the support and continuous inspiration.

Contents

Glossary

BE	*Bloco de Esquerda* (Left Block)
CDS-PP	*Centro Democrático e Social - Partido Popular* (Democratic and Social Centre – People's Party)
ECB	European Central Bank
EU	European Union
FFL	Federation for Life
GI	Guttmacher Institute
HDG	Health Directorate General
IMF	International Monetary Fund
MeSH	Medical Subject Headings
MF	Moderating fees
MP	Member of Parliament
NHS	National Health Service
PCP	*Partido Comunista Português* (Portuguese Comunist Party)
PS	*Partido Socialista* (Socialist Party)
PSD	*Partido Social Democrata* (Social Democratic Party)
USA	United States of America
WHO	World Health Organization

Background

The debate around abortion appears to be a never-ending and often emotional one. Supporters of abortion rights argue that women's self-determination should prevail over the rights of the fetus(15) and tend to frame abortion as a public health issue(16), whereas 'prolife' supporters argue that the fetus has the same status as other human beings and tend to frame the issue as an inalienable right to life(17). There are many other possible arguments and, as interesting as the debate might be, it is not the purpose of this work to systematically review them.

Not surprisingly with such a controversial issue, the legislation around the world regarding abortion varies widely(18). Still, it is a frequent procedure, with about one in five pregnancies worldwide having ended in abortion in 2008 and an estimate of almost 50% of these having been performed in unsafe conditions(19).

Law in Portugal

In Portugal, abortion was illegal until 1984, when the law changed to decriminalize it on the grounds of risk to the woman's life, risk of physical or psychological illness, fetal malformation or pregnancies resulting from rape(20). The law only changed again in 2007, after the second referendum on abortion in Portugal, when it became legal to perform on a woman's request up to ten weeks of pregnancy.

The current law requires that abortion providers "guarantee the referral" of women who go through an abortion to a family planning consultation(21). Data from one central hospital in Lisbon show that around 40% of women who have abortions don't attend this consultation(22); however, according to the Portuguese Health Directorate General (HDG), 97% of women who had an abortion in 2011 chose a contraceptive method after the procedure(23). The law allows abortion to be provided both in public and private settings, where they are currently fully covered by the National Health Service (NHS), making them free for every woman at the point of care(22). It also ensures health workers the right to be conscientious objectors (i.e., the right to refuse to participate in abortion procedures which are performed on a woman's request). No official national data is available, but it is speculated that around 80% of gynaecologists working in Portugal have invoked conscientious objection after 2007(22). Women also enjoy the right to a sick leave, if necessary, of maximum 30 days after having an abortion(24).

In June 2012 a media report showed a journalist who, pretending to be a woman seeking an abortion after 10 weeks of pregnancy, was offered the opportunity to do so in a Portuguese hospital by paying around 400€(25).

Numbers in Portugal

Since mid-2007, when the law changed, the Portuguese HDG has published yearly reports with descriptive statistics on abortion in Portugal(26). Excluding 2007 (when the law was only put in place in July), there have been around 20,000 abortions on a woman's request per year in Portugal(23, 27-29). This places Portugal near the bottom of the list of abortion rates when compared to the rest of the 27 European Union (27-EU) member states, which had an average of 10 abortions per 1,000 women aged 15 to 49 in 2008(30).

Table 1 Abortion Rates in Portugal and Europe, from 1995 to 2011.

Year	1995	2003	2008	2009	2010	2011
Portugal * †	-	-	6.94	7.45	7.41	7.80
Europe (WHO region) ** ‡	43	25	25	-	-	-
Europe (27 member states) * †**	-	-	10	-	-	-

All data refer to safe abortion only. WHO World Health Organization * Source: Portuguese Health Directorate-General and the Portuguese National Statistics Institute **Source: Guttmacher Institute(31) *** Source: The European Society of Contraception and Reproductive Health(30) † Rates per 1.000 women aged 15-49 ‡ Rates per 1.000 women aged 15-44 – unknown

Around 97% of all abortions in Portugal since 2007 have occurred on women's request (23, 27-29). The number and proportion of women who have had one or more previous abortions has slightly risen since the law was first put in place. This effect is not surprising and has been seen in other countries after the decriminalization of this procedure (such as the United States of America (USA), where, since the *Roe vs Wade* case in 1973, repeat abortion cases rose from 3% to almost half of all abortions currently(32)). Compared to other European member states, Portugal seems to have one of the lowest rates of repeat abortion (around 30% in Italy(30), Finland(30), France(30), the United Kingdom(33) and Spain(30), 39% in Sweden(34), almost 50% in Hungary(30) and 62% in Estonia(30)).

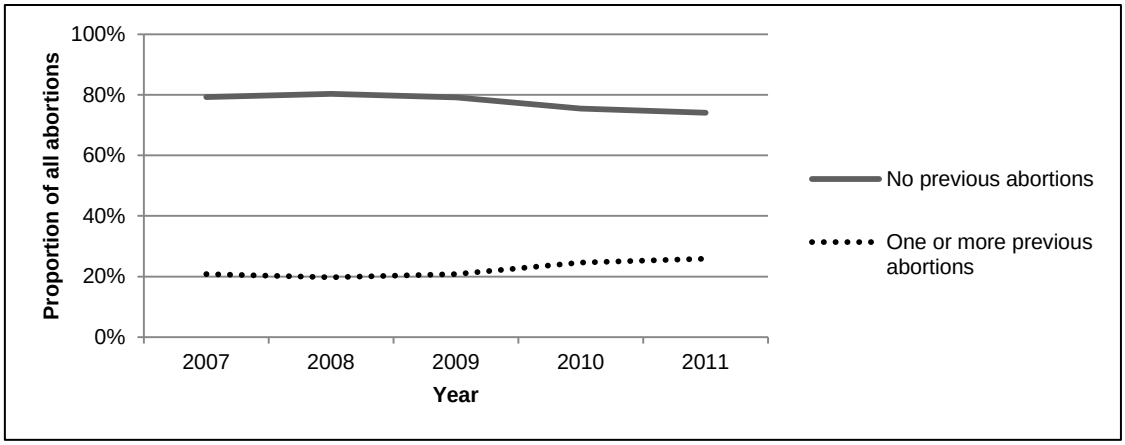

Figure 1 Proportion of first time and repeat abortions in Portugal, 2007-2011. Source: Portuguese Directorate-General

Portuguese context

Portugal is a constitutional democratic republic, operating on a unitary system. The state's main institutions are the president of the republic (also the head of state), the courts (the judiciary), the government (that holds the executive power) and the parliament (the legislature)(35).

Health policy-making is centralized in the government, more specifically in the health ministry. Portugal is also part of a number of international organizations that influence its health policies (the United Nations, the European Union (EU), the World Trade Organization, among many others)(35). The NHS was created in 1979 and World Health Organization (WHO) signaled Portugal a "leading example" for mortality reduction between 1960 and 2008(36), greatly due to its efficiency.

More recently, the Portuguese economic situation has taken a downturn. After a decade of low or negative economic growth between 2000 and 2009, the global financial crisis in 2009 placed Portugal in a delicate situation(35). Indeed, the country is now facing its worse recession since the 1970s(37) and according to Eurostat, unemployment rates have reached 15.2% in May 2012, one of the highest among European countries(38).

In May 2011 the Portuguese government signed a Memorandum of Understanding (MoU) with the International Monetary Fund (IMF), the European Commission (EC) and the European Central Bank (ECB), which guaranteed financial support to the country, provided Portugal followed a structural adjustment program and the economic policies stated in it(39). One of the measures in this agreement, regarding changes in health

care system financing, was to “review and increase overall NHS moderating fees (*taxas moderadoras*)”(39).

‘Moderating fees’ are out-of-pocket payments introduced in the Portuguese NHS in 1986, seven years after its establishment(40). They are called ‘moderating fees’ (MF) because their primary goal has been to induce moderation in health care consumption(41). In line with the MoU signed with the “troika” (name used to refer to the trio of IMF, ECB and EC), MF were raised in 2012 to as high as 50€(42) (currently the highest value permitted by law), some of them having increased by more than 100%(43). In 2010, only around 1% of the NHS revenue originated from MF while most of the remaining expenditure is funded by taxation(44). Some people – such as pregnant women, children, people with low income – and some medical services – such as family planning consultations – are exempt from payment(45). In 2012, it is estimated that around half of the Portuguese population is exempt from MF as a result of low income alone(46); low income is defined in 2012 as a per capita income lower than 628.83€ per month(46). Both contraception and emergency contraception is freely available at general practices and hospitals with family planning services(47) and sold over the counter in pharmacies(48). Abortion – be it on request or on any other grounds –, being considered part of family planning health services, is currently exempt from any type of payment.

User fees are one of the many options for health care financing. The proponents of user fees claim that they reduce demand and raise revenue that can be used to improve health services(49). However, these arguments depend on the elasticity of health care demand and can annul each other: if health care demand is inelastic, raising user fees will not have much impact on quantity demanded; if demand is elastic and diminishes because of an increase in user fees, then the benefit of raising revenue is not fulfilled(50). It has also been shown that user fees can have a detrimental effect on equity, and that the higher the proportion of health care funding originating from user fees, the greater the relative share of the burden that falls on poorer people(51). User fees can, nonetheless, help raise revenue in certain circumstances, such as when government lacks resources to fund it(49), as is claimed to be the current case in Portugal.

The WHO has recently updated its technical and policy guidelines on safe abortion, in which it is recommended that all payments for health services should happen as a form of prepayment, as opposed to the time of service provision, given that “user fees (…) can be an important barrier to services for poor women and adolescents”(52).

Recent controversies

February 2012 marked five years of abortion decriminalization on a woman's request in Portugal. This was celebrated by the Portuguese 'Federation for Life' (FFL) by presenting the statistics published by the HDG on abortion, claiming that abortion in Portugal was "common, illegal and unsafe"(53). This sparked a debate, and on that same day the president of the Portuguese National Ethics Council for the Life Sciences claimed that the absence of a fee for repeat abortions was "shameful"(54). Also on that same day, a member of parliament (MP) from the right-wing Democratic and Social Centre – People's Party (*Centro Democrático e Social - Partido Popular* (CDS-PP), Christian conservative), one of the two parties in the currently governing coalition, stated in the press that reviewing the abortion law was out of the question, but that the party was considering proposing the introduction of MF for abortion services (only for abortions on a woman's request), "specially for relapsing women" and reducing the labour benefits for these women(55).

The Social Democratic Party (*Partido Social Democrata*, PSD, centre-right liberal conservative), the other party of the governing coalition, has stated that it was time to review and evaluate the consequences of the law, and that it considers the possibility of introducing MF, but probably only to repeat abortions(56, 57). On the other hand, an advisor for the Minister of Health (who belongs to the PSD) told the media that the government was not considering any change(58).

In February 2011 the FFL had handed a petition to the Portuguese parliament to evaluate and reconsider the abortion law(59). As a result, a report on the abortion law was written by the parliament's health commission. Headed by an MP from PSD, this report recommends that abortion should not be free from MF, that the labour benefits for women who have abortions should be reconsidered and that private abortion provision services give between 2 to 5% of their profit to a social fund dedicated to children(60). Official declarations from the PSD claim that this report shows the personal opinion of the MP, not the official position of the party, that considers that user fees should only be applied when women have their second or more abortion(60). There has been some debate between the two coalition parties, that don't seem to agree on this point(61). More than one year after the submission of the petition, it was, together with the report, discussed in parliament on July 2012. This was limited to a small debate, with each party having 3 minutes to speak, and no formal law or regulatory changes arose from it.

Also, in May the same year a new movement was formed, the “Pro-referendum Life”, that is now actively collecting signatures to ask for a new referendum on abortion(62). Finally, the health ministry’s Agency for Inspection of Activities in Health also stated in their 2011 annual activities report that repeat abortion should have a MF, in order to have “a moralizing effect”(63).

Some people have spoken against these propositions. The group of Socialist Women, part of the Socialist Party (*Partido Socialista*, PS, social democratic) accused CDS of having a populist attitude and of using the context of a financial crisis to bring the subject of abortion back to the public debate(64). The two left-wing parties in parliament, the Portuguese Communist Party (*Partido Comunista Português*, PCP) and the Left Bloc (*Bloco de Esquerda*, BE) have declared their position as being against the introduction of MF for abortion provision, and accused the right-wing parties of “revenge” for having lost the referendum in 2007(65). The director of a well-known private health clinic, *Clínica dos Arcos*, the biggest private abortion provider in the country, considered that the current debate had little to do with health issues and that MF would only harm women(66). A left-wing newspaper accused the CDS of persecuting women(67).

Little is known about the public opinion on this subject, but in May this year, a national radio station had an online survey asking their audience if they agreed with the introduction of MF for abortion provision, to which 75% of the respondents answered ‘yes’(68).

Knowledge Gap

Given that MF in Portugal don’t go beyond 50€ per episode it is reasonable to believe that the introduction of MF would not have an important public health impact in the country. On the other hand, every out-of-pocket payment has the potential to create inequalities(51).

Also, several ethical considerations have arisen with this debate. Applying MF only for women who have an abortion on request can be seen as a moralizing measure (some grounds for abortion are ‘acceptable’, whereas others are ‘wrong’ and should be punished). Furthermore, applying MF only for repeat abortions can open an important precedent and be an opportunity to apply MF or other restrictions in other situations in which patient responsibility is debatable (such as for obesity or smoking related diseases).

Finally, it is important not to forget the context in which this debate is being held. Portugal is going through a financial crisis, and, drawing on Kingdon's model of agenda setting, crisis can provide windows of opportunities for new policies to be implemented(69).

This work aims to bring together the existing evidence on the subject of out-of-pocket payments for abortion services and a broad spectrum of opinions of Portuguese policy makers on this subject, in order to inform policy.

Aims and objectives

The overall goal of this project is to explore the possible health and social outcomes of introducing MF for abortions performed at a woman's request in Portugal, in order to inform policy decision. This will be achieved by analysing the existing evidence on the effects of out-of-pocket payments for abortion provision; by understanding the arguments for and against such a policy; by exploring the perspective of a range of political representatives on the issue; by consulting with an expert on the subject; and by developing recommendations directed at the Portuguese government based on the findings.

Methods

Literature Review

A review of the literature had the goal of understanding the existing evidence on the possible outcomes of out-of-pocket payments for abortion services. The databases MedLine, Embase, ScienceDirect, the Reproductive Health Library (RHL) and the Cochrane Library were used to search for the following terms: fee*, cost*, pay*, charge*, Medicaid, insurance, abortion, pregnancy interruption, interruption of pregnancy, abortion rate*, birth rate*, pregnancy rate*, contracepti*, gestational age, illegal abortion, complication*, mortality, fertility, sexually transmitted disease*. For MedLine, Medical Subject Headings (MeSH) terms were used. The exact search queries are in Annex A. The relevant papers were then used to identify further sources by reviewing the references and by searching for other papers which had cited them. The citation search was made using the search engine Google Scholar.

Papers were included in the review if they: reported original research on how abortion costs could have social and health-related consequences; were in English, Portuguese or Spanish; did not report repeated research and full text was available. There were no restrictions on study design, time frame, geographical area, age group or ethnicity.

Finally, the following data was extracted from each of the papers that met the eligibility criteria: study design, time frame, population, "intervention", controls (if applicable), outcome, analysis, limitations, control variables and other comments.

Interviews

One MP from each of the elected parties in the Portuguese parliament was interviewed. The MP's were selected purposively based on their involvement on the subject (MPs that usually handle health issues and/or that specifically spoke in the name of their party on this subject were favoured). These interviews did not attempt to gather a representative sample of opinions, but to understand a broad range of perspectives on the subject in terms of arguments and possible outcomes. A scientific expert on the subject was also interviewed, as a way of obtaining a well-informed and possibly unbiased opinion on the matter. The data from all the interviews was analysed together, without differentiating the politicians from the scientific expert, as they were all seen as "experts" on the subject.

These were semi-structured, face-to-face interviews. A topic guide was developed for the interviews (Annex B). The interviews were recorded, transcribed, and translated to English by myself.

The study received ethical approval from the London School of Hygiene and Tropical Medicine's Ethics Committee. No other ethical approval was requested. Interviewees were guaranteed anonymity and signed a consent form (Annex C). I translated the consent form to Portuguese. All the interviews took place in the month of July 2012 in the interviewees working place, on their request.

The transcripts were analysed using the framework approach (70), given that the research had a specific question, was directed at informing policy and there was no expectation of new emerging concepts. A thematic framework was developed based on the interviews' topic guide and on the data collected. The analysis followed the following stages: familiarization with the data, developing a thematic framework, indexing, sorting the data, charting and interpretation, as described by Ritchie et al (70). No special software package was used for the analysis.

Results

Literature Review

The MedLine search retrieved 144 papers, of which 18 were relevant; Embase identified 25 papers, 3 were relevant but 2 were repeated; ScienceDirect had 19 hits but did not retrieve any relevant paper; the Reproductive Health Library and the Cochrane Library did not produce any hits. Snow-balling the references identified a further 19 papers and citation search added 23 more. This identified a total of 61 papers.

One of the papers was a literature review by the Guttmacher Institute (GI) on the effect of Medicaid funding restrictions for abortion published in 2009. Medicaid is a health program for low-income people living in the USA that is federally and state funded and managed by the individual states. This means that different states cover abortion services in different circumstances. In states where this funding is restricted, it is estimated that women have to pay an average of $351 for an abortion, including direct and indirect costs(71). Out of the 61 articles retrieved, 38 were reviewed in this publication.

The GI is a well-respected experienced organization, with a vast number of publications, specifically on policy analysis. Being a high quality work, I decided to describe the GI's review's findings and complement it with the additional papers I found.

Of the 22 remaining papers (61 identified, minus the 38 already reviewed by the GI and minus the review itself), all of them reported data from the USA and were published between 1979 and 2012; data ranged from 1976 to 2008. Most focused on Medicaid funding restrictions and others on direct and indirect costs. Two focused solely on teenage girls and all others on women of reproductive age of all ethnicities. The majority of these papers relied on cross-sectional state-aggregated data, which was analysed using multiple regression. A few had a longitudinal design and looked at differences between states and within states, before and after policy changes.

Finally, ten papers studied the effect of abortion costs on abortion rates, three on birth rates, two on abortion complication rates, two on infant mortality, two on family structures, two on abortion ratio, one on contraceptive use, one on pregnancy rates, one on mortality due to illegal abortion and one on infants available for adoption.

The main characteristics of the papers are summarized in table 2.

Abortion Rate and Ratio

Probably the most studied outcome of the impact of abortion price and cost is on abortion rates. According to the GI review, it is "a reasonable estimate (…) that lack of [Medicaid] funding influences about a quarter of Medicaid-eligible women to continue unwanted pregnancies"(8). Indeed, all the papers which explored the effect of costs on abortion rates found that increases in costs were related to decreases in the rates (1-7, 9-11). Four of these built economic models and found that the price elasticity of abortion demand was relatively inelastic, estimated between -0.6 and -0.99(1, 4, 5, 72).

Abortion ratios, calculated as a ratio of the number of abortions per 1000 pregnant women, were calculated only in two papers(9, 65). This variable is a measure of the proportion of pregnancies that end up in abortion. New(65) found that Medicaid funding restrictions reduced the abortion ratio by 8% (and the rate by 9%) and Medoff(9) found that the restriction reduced the ratio by 13.1% (and the rate by 16.7).

It is important to point out that most of these studies relied on cross-sectional state-aggregated data to perform regression analyses. Although most control for various state fixed effects (such as demographic, economic and "religiosity" characteristics of each state) and year fixed effects (such as national variations in abortion rates), most also admit that the limitations are important. These limitations are mostly biases due to variables that are not controlled for. For example, many don't consider the effect of organizations that fund abortions for poorer women who live in a state with funding or insurance restrictions; these might facilitate abortion access and the effect of costs on abortion rate might be underestimated. On the other hand, women might travel to other states to perform abortions if the state they live in is very restrictive; this might overestimate the effect of costs in studies that measure abortions performed in a specific state as opposed to abortions performed by residents of that state.

Table 2 Selected characteristics of studies identified in the literature review.

Author / Year	Geographical Area	Period	Independent Variable	Outcomes	Key Findings
Beauchamp, 2012**(73)**	US, all states	1995-2002	Removing public funding	Separation, marriage, and cohabitation following a birth	Lower abortion costs – among minors and poor women – were linked to higher proportion of single women, lower proportion of cohabitation and had no effect on marriage
Coles et al, 2010(12)	US, 30 states	2000-2005	Medicaid funding restrictions	Unintended teen birth	Teens living in states with Medicaid funding restrictions reported a higher percentage of unwanted births, only for black girls
Garbacz, 1990(1)	US, all states	1982	Medicaid funding restrictions & average cost	Abortion rate	The price elasticity of demand for abortions is -0.68; Medicaid funding restrictions did not affect abortion rates
Gober, 1997(2)	US, all states	1991-1992	State funding restrictions	Abortion rate	Medicaid funding leads to higher abortion rates
Gold and Cates, 1979**(74)**	US, all states	1977-1978	Medicaid funding restrictions	Medicaid-related illegal abortion mortality	Report 3 deaths related to illegal abortion procedures due to lack of funding
Gold, 1980(3)	US, all states	1978	Medicaid funding restrictions	Number of publicly funded abortions	Medicaid funding restrictions lead to an increase in the unmet need for abortion services
Jacobs and Stanfors, 2011**(75)**	US, all states	1995	Cost	Contraceptive use	Abortion cost was not related to intensity of contraceptive use
Kalist and Molinari, 2004**(76)**	US, all states	1978-2000	Medicaid funding restrictions	Infant homicide	Infant homicide is between 13 and 20% lower in states that fund abortion
Lichter et al, 1998**(77)**	US, all states	1980 and 1990	Medicaid funding restrictions	Proportion of women heading households	Restrictions on Medicaid funding for abortion accounted for about half of the increase in female headship among black women
Medoff, 1988(4)	US, all states	1980	Average cost	Abortion rate	The price elasticity of demand for abortions is -0.81
Medoff, 1997(5)	US, all states	1982 and 1992	Medicaid funding restrictions & average cost	Abortion rate	The price elasticity of abortion demand ranged from-0.70 to -0.99; abortion rate is also positively related to Medicaid funding

Continued…

Table 3 (continued) Selected characteristics of studies identified in the literature review.

Author / Year	Geographical Area	Period	Independent Variable	Outcomes	Key Findings
Medoff, 2008(9)	US, all states	1982, 1992 & 2000	Medicaid funding restrictions & average cost	Abortion rate & ratio	Medicaid funding restrictions reduce the abortion rate by 16.7% and the abortion ratio by 13.1%
Medoff, 2008**(78)**	US, all states	1982,1992 & 2000	Medicaid funding restrictions & average cost	Number of infants available for adoption	Higher abortion costs were related to a lower number of children available for adoption; restrictive Medicaid funding had no impact on the supply of adoptable infants
Medoff, 2010(13)	US, all states	1982,1992 and 2000	M Medicaid funding restrictions & average cost	Teen pregnancy rates	Medicaid funding restrictions reduce teen pregnancy rates
Medoff, 2010**(72)**	US, all states	2000	Medicaid funding restrictions & average cost	Nonmarital birth rate	The price elasticity of demand is -0.60; Medicaid funding restrictions reduced a state's nonmarital birthrate by 16.5%
New, 2009(10)	US, all states	1986-2003	Medicaid funding restrictions	Abortion rate	Medicaid funding restrictions reduced abortion rate
New, 2011(11)	US, all states	1985-2005	Medicaid funding restrictions	Abortion rate & ratio	Medicaid funding restrictions reduce the abortion ratio by 8% percent and the abortion rate by 9%
Rolnick and Vorhies, 2012**(79)**	US, 23 states	2001-2008	Medicaid funding restrictions	Major abortion complications	Medicaid funding restrictions were associated with lower complication rates
Selik et al, 1981(14)	US, 5 'intervention' and 5 control states	1976-1978	Medicaid funding restrictions	Legal and illegal abortion complication rates	There was no effect on the rates of complications of illegal abortions; restrictive funding policies were related to lower complication rates due to legal procedures
Sen et al, 2012**(77)**	US, all states	1983-2002	Medicaid funding restrictions	Homicide death among children under 5	No effect of Medicaid funding restrictions on child homicide
Stevans et al, 1992**(79)**	US, all states	1983-1985	Medicaid funding restriction	Abortion decision	Medicaid funding restrictions reduce the likelihood of poorer women choosing abortion
Zavodny and Bitler, 2010**(80)**	US, all states	1982-1996	Medicaid funding restrictions	Birth and abortion rates	Medicaid funding restrictions are related to lower abortion rates and higher birth rates

Birth and Pregnancy rates

Abortion price, by raising the costs of having the procedure, can raise birth rates while keeping pregnancy rates constant. Alternatively, it can serve as an incentive for a pregnancy avoidance behaviour, lowering pregnancy and possibly also birth rates. These hypotheses are both studied in some of the papers.

The GI's review hypothesises that there is a conversion from abortions to births on the short run among Medicaid-eligible women when restrictions are imposed, but that the effect on the long run is still not clear(8). Medoff found that Medicaid funding restrictions were associated to a lower non-marital birth rate in all US states in 2000(72); on the other hand, Zavodny reported an opposite effect on general birth rate(7) and Coles also found an increase but only among black teenagers(12). Once again, all these use cross-sectional state aggregated data and therefore have serious limitations.

Medoff described, in a longitudinal study using an economic model, that both Medicaid funding restrictions and abortion price reduced teen pregnancy rates(13). However, this is the only paper that specifically aimed to study pregnancy rates, and the author recognizes that there might be several unknown factors that are difficult to account for in the analysis(13).

Gestational Age

Costs can lead to a delay in abortion by forcing women to save the necessary money for the procedure. The GI's review reported some evidence that indicated that poorer women tend to delay their abortion and that raising money is an important factor in this decision(8). Whether this leads to an increase in second trimester abortions, however, was less clear(8). This can have severe consequences, given that abortion-related mortality rises steeply after 8 weeks gestation, and it has been calculated that 87% of deaths of women having abortions after 8 weeks could be avoided if the procedure was performed sooner(81).

Illegal Abortion

There is no evidence supporting the possibility that higher costs lead to increased illegal abortion rates, according to the GI's review(8), although there are some reported cases of women who had illegal abortions due to Medicaid funding restrictions(74). Selik et al(14) also found no evidence to support this possibility. Besides the problems already stated regarding the methodology of most of these papers, the issue of illegal abortion might have additional limitations given the possible reluctance of women to

share the fact that they were involved in an illegal procedure; also, not all illegal abortions have complications that lead women to a health facility, which can underestimate this association even more.

Other Outcomes

Some studies, based on the premise that children who are born from unwanted pregnancies are more likely to be abused by their caretakers, also suggest that Medicaid funding restrictions for abortion provision may adversely affect children, but the results are inconsistent (8). Sen et al(82) found an increase in child homicide to be related to more restrictive abortion policies (such as mandatory delay requirements), but not to funding restrictions; Kalist (76) found that funding restrictions lead to a 13 to 20% increase in infant homicide. Both of these papers used a cross-sectional time series design, and both controlled for very similar factors, but Sen et al used proxy variables to control for the general climate of violence of each state.

Abortion related complications may rise after a rise in costs if these lead to a higher gestational age at the moment of abortion (because of time spent gathering money) or they could be related to illegal procedures which might be characterized as 'spontaneous abortions' when the woman conceals the truth. However, both Selik et al(14) and Rolnick et al(79) found higher costs to be associated with a decrease in the proportion of legal abortion complications. According to the authors' interpretation, this may be due to a variety of reasons that may affect more restrictive states, such as a lower proportion of second trimester abortions or simply a lower number of procedures.

One study(75) tested the hypothesis that higher abortion costs lead to pregnancy avoidance behaviour through higher contraceptive use; however, no association was found between the two. Also, according to the GI's review, no effect has been found between abortion costs and sexually transmitted diseases or sexual behavior change(8).

Two studies explored broader societal consequences of higher abortion costs. Beauchamp(73) described a higher probability of marriage and cohabitation when abortion costs were higher (due to what was described as "[men's] marriage market search behavior") and Lichter et al(77) found a modest increase of single women headed households among black women.

Finally, Medoff concluded that having an abortion and giving a child away to adoption are not considered perfect substitutes by women, after finding a negative association between higher abortion costs and number of children available for adoption(78).

As before, most of these studies deal with cross-sectional aggregate data. This imposes a considerable limitation to these findings, since it is possible that unknown factors that influence the outcomes exist and are not accounted for. Also, some of them have an ecological design, which makes causality impossible to ascertain.

Interviews

The six interviews lasted between 15 to 30 minutes. Three interviewees were women and three were men. Their ages ranged from 31 to 61 years. Three interviewees stated that they believed that MF should be applied to abortion services and three others had the opposite opinion.

Since I had undertaken and transcribed all the interviews, familiarization with the data was done while identifying the key themes. A thematic framework was then built, which identified four main themes: timing, problem definition (which included context, legal issues, health issues, health services issues, social issues, economic issues, ideological perspectives, ethical issues and others), consequences and alternative solutions. The data was then indexed to the main and secondary themes on a table. Some alterations to the framework were made while indexing (annex D has the final index). A summary of the key points that were made is presented below.

Timing

Only one interviewee shared an opinion about why this issue was being debated now, and declared the petition by the FFL, that had just been discussed in parliament, as the main driver for the debate.

Problem Definition

Problem definition regards what interviewees saw as a reason to or not to debate this issue. It was separated in context, legal, health-related, health services related, social, economic, ideological, ethical and other reasons.

Context

Interpretation of current abortion epidemiologic data

Two people mentioned the fact that abortion rates in Portugal are one of the lowest in Europe, both as a means to show how they considered this is not to be a priority issue. Most interviewees also had something to say about repeat abortion. All of them knew the numbers – that around 25% of abortions in Portugal in 2011 were repeat abortions – but some considered this to be a high and others a low proportion, and, accordingly,

needing or not needing political intervention. One thought that, even though it was low, it deserved political attention. One also stated his/her belief that these numbers proved that women were using abortion as a contraceptive measure.

Current exemptions

Three interviewees believed that abortion, as part of sexual and reproductive health care, should stay exempt from payment; two disagreed, stating that it should be viewed as all other medical services and not as a privilege:

> *"I don't accept that this act is treated with a privilege regime in relation to others: to a brain tumor, to a disc hernia, to a limb fracture, to appendicitis. (…) We only want to apply to abortion the general principle, not a privilege in relation to other medical services."* (Interviewee 1)

Others

Still regarding the current context, one interviewee stressed that, while believing MF should be introduced, this issue did not intend to raise the abortion debate again. On the other hand, three interviewees accused the opposing political parties of trying to do this. As one of them put it:

> *"I think this is a non-issue, honestly. MF don't make any sense and because there is a movement that wants to go back on abortion, and because they don't want to admit they want to go back, they introduce anything (…) to block the application of the law to show us one day that the law didn't work because meanwhile it was blocked. (…) MF are hooded with an ideological movement."* (Interviewee 3)

Legal Issues

One interviewee, who disagreed with MF in any situation, argued that they go against the principles of the Portuguese constitution, which states that health care should "tend to be free". Another person, who had an opposite stand on the issue, emphasised that current exemption regulations would protect poorer women, since they would be free from payment anyway.

Health issues

One interviewee mentioned several times the importance of the negative health consequences that repeat abortion had on women, as an additional argument for the introduction of MF. No other health issues were mentioned by any other interviewee.

Health services issues

One interviewee saw the fact that family planning services are free as a fundamental argument to introduce MF for abortion:

> *"This is incomprehensible (…) in a country in which the pill is given for free in family planning consultations; in a country where in family planning*

consultations people have access to male condoms; so there is no reason for abortion to be a contraceptive method." (Interviewee 6)

Another interviewee, although supporting MF for abortion, mentioned (s)he believed that repeat abortion was a sign of a complete failure of public health services, but didn't go into more detail.

Social Issues

Interviewees who were against the introduction of user fees frequently mentioned the importance of social circumstances that lead women to choose an abortion as an argument for their case. Most of these were related to unemployment, lack of resources and social fragility. One person mentioned difficult access to health care in the context of the current cuts in the health services and the discrimination that pregnant women might face at their jobs (when in flexible contracts, women might not be able to renew them if their boss finds they are pregnant).

Economic Issues

Only one interviewee (who disagreed with the MF) mentioned the possible financial gains that this policy might bring to the NHS, stating that they were minimal. One other person, with a different stance on the issue, mentioned the issue of payments that the State makes to private health providers for abortion services as "senseless".

Ideological Perspectives

The three interviewees who were for the introduction of MF for abortion all stated that they were in favor of decriminalized abortion, as they believed the criminalization of women is not a good solution. Two of the others stated they were completely against MF, whatever the procedure, stating inequities as the main argument against.

Ethical Issues

Ethical issues were by far the most frequently mentioned arguments to argue both for and against this policy. Interviewees who argued for it, mentioned mainly principles of justice, equity and equality:

"How do you explain to people that for an abortion (…) on a woman's request people are always exempt from payment? It makes no sense. A person thinks "but I have a brain tumor, why am I not exempt? Or I had a limb fracture, why not…" It is very difficult. And why is it difficult to explain? It's very difficult to explain to people when in the origin they have injustice or inequities." (Interviewee 1)

Interviewees who had a different opinion on the subject mentioned the freedom to choose and accused people with the opposite stance of judgmental and disrespectful attitudes towards women:

> *"I want to tell you that I think there is in this proposal a sense of punishment to women who have an abortion. I think that is socially and morally unfair and unacceptable because abortion means we assume, consciously and freely, that we accept that others decide for their lives (…) and therefore we should not make them pay for a decision they make freely and consciously. I find that unacceptable."* (Interviewee 2)

Another interviewee stated that:

> *"They talk about women who perform abortions as – and some even say it – as if it was a contraceptive method, that is, as if a woman would have an abortion (...) lightly, as if she was doing something else. It's not true, no! (…) Treating women this way as if they were irresponsible and as if they didn't have the competence to make their own decisions, I think it's very disrespectful and it doesn't value women's own dignity."* (Interviewee 4)

Consequences

This theme regards what interviewees speculated would be the consequences of introducing MF for abortion.

One person mentioned (s)he didn't believe MF would lower abortion rates, even though (s)he was for the policy. One other, with the same stance on the issue, politely refused to answer this question.

Two, who were against the policy, mentioned illegal abortion as a concern and possible outcome; two others, for the policy, argued that MF were too low to push women into illegal procedures, adding that illegal abortions cost a lot more than the current 50€ cap for MF.

The topic of confidentiality arose in almost all interviews, when discussing the possibility of MF for repeat abortions. Most people saw this as an unsurpassable problem, although one suggested that a registry should be built with all the abortions that were performed, in order to apply the fee to women who repeated the procedure

Alternative solutions

Alternative solutions were outlined by policy objectors, most of whom mentioned better and more accessible family planning services, sexual education at schools and broader parental rights to help decrease the abortion rate and/or repeat abortion proportion.

Discussion

The literature review was quite diverse regarding timespan, studied outcomes and the likely personal opinion of the author – whereas, for example, one paper was published

in a catholic journal(64), the GI declares the right to choose abortion as one of its guiding principles(83).

On the other hand, papers were very similar on the type of analysis they did: most used cross-sectional state-level aggregated data and performed multiple regressions. Using aggregated data in one moment in time can have major shortcomings, the most important being that a causal relationship between abortion costs and the outcomes cannot be assessed with confidence. However, all of these papers controlled their results for a variety of socioeconomic variables that allow some conclusions to be made. Also, there were no papers that analysed data from any country other than the USA. This can be an important obstacle, given that the USA and Portugal are so different in a variety of features; also, the evidence was on the impact of having to pay around 300$ for an abortion, as opposed to a maximum of 50€ in Portugal. This is yet another important obstacle when trying to apply the evidence to the Portuguese context.

Nonetheless, considering these limitations, cost, including but not limited to out-of-pocket payments, seems to be an important determinant of abortion demand. Evidence showed that, in the USA, both abortion rate, ratio and birth rate seem to be affected by abortion costs: at least on the short term, women choose to take their pregnancies to term when they would otherwise have had an abortion if costs were lower(1-11). Although weaker, evidence also points to the possibility of a decrease in pregnancy rates, albeit on a longer term – possibly the result of pregnancy avoidance behaviour when faced with higher abortion costs(8, 13). On the other hand, evidence points to a lack of association between higher abortion costs and illegal abortion(8, 14), even though there have been some reported cases of illegal abortions due to high costs of the legal procedure(74); this, however, is far from being enough to conclude that illegal abortion is an important problem when abortion costs are high. There is no other evidence of health or social outcomes being related to higher abortion costs.

Abortion in Portugal does not seem to be an important public health issue: rates of legal abortion are low and the proportion of repeat abortion is also not dramatically high. Nonetheless, ‘moderating fees’ are seen as a possible strategy to tackle this issue. It is still unclear whether their introduction will happen in Portugal: there has been some public discussion, the parliament has debated it briefly and two political parties have stated that they will present formal proposals for the introduction of fees for abortion in September 2012. As is common with abortion, the debate has focused on ethical arguments and is sometimes very emotional.

I believe the interviews allowed a broad range of opinions to be collected: half were against this policy and half were for, and arguments were more diverse than those usually shared by MPs in the media.

The interviews showed that there is disagreement on some fundamental aspects of this issue. To begin with, there isn't even agreement on whether this is a real problem or not: one interviewee called this a 'non-issue', others agreed that there is a problem but MF are not the solution whereas others believed this was an appropriate solution. In fact, looking at the same numbers, rates and proportions, people had different interpretations of the magnitude of the problem. People also seemed to have different interpretations of the reasons that lead women to have abortions: if half of the interviewees mentioned social issues as a fundamental factor, the other half stressed that contraception and family planning services being free was a major factor for women to be able to control their fertility.

No interviewee believed that this policy would have an important impact on NHS revenue. This is not surprising, given the low value of MF and, consequently, the low proportion of the revenue that they add to the NHS(44).

Ethically, the views were interestingly diverse. If the ones who agreed with the policy tended to frame it as an issue of justice, equity, equality and fair distribution of scarce resources, the ones who disagreed mentioned women's freedom, a non-judgmental attitude and respect for women as their main concerns. Interestingly, interviewees were very unsure as to what consequences this policy might have. Although some mentioned a concern for illegal abortion and one believed it wouldn't have any consequences on abortion rates, no other outcomes were brought up. As would be expected, the interviewees who were against the policy suggested some alternative measures that they believed should be the focus of the debate: effective sexual education at schools and family planning services accessible to everyone were the main focus.

The particular issue of applying fees only for repeat abortions was an interesting one. Noted by some as a particularly judgmental way of making policy and by others as the consequence of an NHS whose solidarity does not have to be unbound, it raised practical issues that most people agreed would be unsurpassable. Indeed, building a registry to allow charging women who had had an abortion before would possibly cost more than the revenue that such fees would collect.

Applying the evidence collected to the Portuguese setting is a difficult challenge. Indeed, the findings of the literature review refer to a number of 'natural experiments' that occur in the USA, where women have to pay around 350$ for an abortion(71). This is a considerable difference from Portugal, where MF have a cap of 50€, a visit to the emergency department of a general hospital costs 20€ and a visit to the general practitioner costs 5€(46). No suggestions have been made on how much the MF for abortion should be, but while it is a certainty that it will not be higher than 50€, it is also unlikely that it will be this high.

Of course, costs are relative, but even considering that the Gross National Income per capita in the USA was 48,450 US dollars in 2011(84), as opposed to 21,250$ in Portugal in the same year(84), 350$ is still proportionately a higher cost than any value up to 50€.

Adding to this, half of the Portuguese population was exempt from MF in 2011 due to low income(46), which essentially means that it is likely that a considerable proportion of the women who will have an abortion are also exempt from payment.

It is, therefore, reasonable to assume that, given the relatively low cost of MF and the fact that poorer women are exempt from payment in Portugal, the introduction of MF for abortion on a woman's request would not have an impact in abortion rate or ratio, birth rate or pregnancy rate. Adding to this, the cost of illegal abortion in Portugal is very likely to be considerably higher than the MF(25), which makes it reasonable to assume that that the introduction of MF is very unlikely to lead to a rise in illegal abortions.

Limitations

One important limitation is that selecting interviewees who are involved and interested in the subject might lead to a bias regarding the importance given to the issue. That is, people who have spoken on this subject and/or are usually involved in health issues in parliament will probably tend to consider it an important issue that should be addressed. It is possible that most MPs do not agree with this, and would consider this to be a minor issue.

A serious limitation that has already been mentioned is the sole availability of evidence from only one specific context. This seriously restricts the interpretation of the findings and their application to a different context. Nonetheless, I believe that with caution it is possible to draw some conclusions safely.

Qualitative research has a special susceptibility to the researcher's way of applying the methods, interpreting and reporting the data. This work is, obviously, no exception. I hold a strong personal view on this issue that, hopefully, has not been apparent either in writing or during the interviews. However, albeit not being clear to the interviewees, I believe I did a more intense questioning of those I didn't agree with, even though I felt I was able to empathize with all of them. Also, my interpretation of the data, from building the thematic framework, to what I chose to summarize and the final recommendations, were probably influenced by my point of view on the topic. Nevertheless, I believe I tried to overcome this and being aware of this limitation is an important step in doing so.

Also, interviewees can have different answers depending on the interviewer. I cannot ignore the fact that certain characteristics about myself like my gender, age and background might have affected their responses.

I also believe my inexperience in carrying out interviews for a research project affected the results: there were some points where had I probed an answer I might have obtained richer data.

Finally, another important limitation relating to the interviews is that I believe I didn't always have, as I aimed to, a personal opinion from the interviewees. Two interviews were held in rooms with more people around and, even though the others were held more privately, appointments almost always were scheduled through secretaries. All of this seriously compromises the feeling of anonymity that interviewees would ideally to have. I believed this lead to a series of 'political' answers as opposed to personal views. Nonetheless, I believe most of these would have been coincident.

Strengths

This is a unique study in that it is the first – to my best knowledge – to review the evidence on the possible outcomes of raising abortion costs for women who want to have the procedure. It is also especially relevant given that the debate is being held right now in Portugal and an official decision will probably be made by the parliament in September 2012.

Also, I believe the literature search method was able to identify not only a high number of papers, but also from a broad range of authors (with different opinions). In fact, one of the reviewed papers had been published in a Catholic Journal while others were written by researchers who are known to be 'pro-choice'.

Recommendations

The findings from the literature review and from the interviews seem to show that if moderating fees were applied to abortion services in Portugal there would not be important health or social consequences.

No scientific work can aspire to neutrally solve an ideological dispute, and the evidence collected does not permit me to advise for or against the introduction of user fees for abortion in Portugal. The recommendations drawn from the data collected aim therefore to help policy makers in their decision process when considering the possibility of implementing this policy.

Recommendation 1. 'Moderating fees' for abortion should not be used as a way of decreasing abortion rate.

Considering the evidence collected and its application to the Portuguese context, there is no reason to believe that abortion rates will decrease if a 'moderating fee' is applied.

Recommendation 2. 'Moderating fees' for abortion should not be expected to raise birth rate.

Although evidence shows that some pregnancies are converted into births when abortion costs are high, the fact that this was observed for much higher costs and that poorer women are exempt from payment in Portugal, makes it highly unlikely to happen in the Portuguese context.

Recommendation 3. The introduction of 'moderating fees' for abortion should not be used as a way of modifying sexual behaviour.

This is supported by evidence that shows that higher abortion costs are not related and don't lead to a more intensive contraceptive use, a lower rate of sexually transmitted diseases or other types of sexual behaviour change. Also, there is no strong evidence that higher abortion costs will lead to lower pregnancy rates.

Recommendation 4. Illegal abortion should not be a concern when considering 'moderating fees' for abortion provision.

There is no evidence to support the possibility that higher abortion costs lead to higher rates of illegal abortions. Also, the exemptions mechanism and the likely high costs of illegal abortions in Portugal make this possibility even more unlikely.

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Annexes

Annex A: Search Queries

MEDLINE

("Fees and Charges"[mh] OR "Medicaid"[mh] OR "Cost sharing"[mh] OR "Financing, personal"[mh] OR "Financing, government"[mh] OR "insurance"[mh] OR "health services/economics"[mh:noexp] OR "Health Services Accessibility/economics"[mh:noexp]) AND ("Abortion, Legal"[mh:noexp] OR "Abortion, Induced"[mh:noexp]) AND ("Abortion, Legal/mortality"[mh:noexp] OR "Abortion, Legal/trends"[mh:noexp] OR "Abortion, Legal/statistics and numerical data"[mh:noexp] OR "Abortion, Legal/utilization"[mh:noexp] OR "Abortion, Legal /adverse effects"[mh:noexp] OR "Abortion, Induced/mortality"[mh:noexp] OR "Abortion, Induced/statistics and numerical data"[mh:noexp] OR "Abortion, Induced/trends"[mh:noexp] OR "Abortion, Induced/utilization"[mh:noexp] OR "Abortion, Induced/adverse effects"[mh:noexp] OR "Abortion, Criminal"[mh:noexp] OR "Abortion, Criminal/adverse effects"[mh:noexp] OR "Abortion, Criminal/trends"[mh:noexp] OR "Abortion, Criminal/statistics and numerical data"[mh:noexp] OR "Abortion, Criminal/mortality"[mh:noexp] OR "Birth Rate"[mh:noexp] OR "Birth Rate/trends"[mh:noexp] OR "Maternal Mortality"[mh:noexp] OR "Maternal Mortality/statistics and numerical data"[mh:noexp] OR "Maternal Mortality/trends"[mh:noexp] OR "Contraception/utilization"[mh] OR "Contraception/trends"[mh] OR "Contraception/statistics and numerical data"[mh] OR "Pregnancy Rate"[mh:noexp] OR "Pregnancy Rate/trends"[mh:noexp] OR "Gestational Age"[mh:noexp] OR "Sexually Transmitted Diseases"[mh:noexp] OR “Fertility”[mh:noexp]) AND ("Female"[mh:noexp] OR "Humans"[mh:noexp])

EMBASE

(exp abortion/ AND (illegal abortion/ OR mental health/ OR maternal mortality/ OR sexually transmitted disease/ OR contraception/ OR gestational age/ OR pregnancy rate/ OR female fertility/ OR birth rate/ OR health care need/) AND (*fee/ OR *medicaid/ OR *health care access/ OR *health insurance/ OR *health economics/ OR *funding/ OR *health economics/))

Science Direct

("fee*"[Title] OR "charge*"[Title] OR "out-of-pocket"[Title] OR "pay*"[Title] OR "cost*"[Title] OR "insurance"[Title] OR "medicaid"[Title] OR "fund*"[Title] OR "access"[Title]) AND ("abortion"[Title] OR "pregnancy interruption"[Title/abstract]) AND ("abortion rate*"[Title/abstract] OR "birth*"[Title/abstract] OR "pregnancy"[Title/abstract] OR "maternal mortality"[Title/abstract] OR "maternal mortality rate*"[Title/abstract] OR "illegal"[Title/abstract] OR "contracept*"[Title/abstract] OR "gestational age"[Title/abstract] OR "abortion complication*"[Title/abstract] OR "fertil*"[title/abstract]) AND ("female"[All Fields] OR "human*"[All Fields] OR "woman"[All Fields] OR "women"[All Fields])

Annex B: Interview Topic Guide

i. Why do you believe the issue of MF for abortion is being debated now?
ii. What are, in your opinion, the main ethical issues with this debate?
    a. More egalitarian/extra revenue for the NHS/moralizing/precedent for other health care services

b. Should MF differ depending on the grounds on which women have abortions and depending on the number of abortions they've had before?

iii. Do you believe there will be health-related consequences if the MF are applied on abortion services?
   a. Illegal abortions/ use of contraceptives/lower abortion rate/higher birth rate/others

Annex C: Consent Form

London School of Hygiene and Tropical Medicine

Public Health MSc

User fees for requested abortions in Portugal: what would be the consequences?

Informed Consent Form

This informed consent form is for the interviewees who are invited to participate in the study "User fees for requested abortions in Portugal: what would be the consequences?", a research on the use of moderating taxes for requested pregnancy terminations in Portugal. This investigation is being done by [redacted] as part of a Public Health MSc in the London School of Hygiene and Tropical Medicine.

This Informed Consent Form has two parts:

Part I: Information Sheet (to share information about the study with you)

Part II: Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form.

Part I: Information Sheet

Introduction

This research project is taking place as part of a Public Health MSc in the London School of Hygiene and Tropical Medicine. The aim of the research is to identify the possible Public Health impact of moderating taxes in elective pregnancy termination in Portugal.

You are being invited as a member of parliament in your political party / as a recognized expert on the subject to take part in this study as an interviewee. Other individuals, from each of the other political parties in parliamentary representation, will be invited as well. The interview is anonymous and serves the purpose of better understanding what your personal views are on the subject of moderating taxes for elective pregnancy termination.

This participation as an interviewee is voluntary and you can choose to terminate the interview and/or not be part of the research at any moment.

Procedures

The interview will last between thirty and sixty minutes and will occur in a place that you agree to. If you do not wish to answer any of the questions during the interview, you may say so and I will move on to the next question. No one else but me will be present unless you would like someone else to be there. The information recorded is confidential, and no one else except me will access to the information documented during your interview. The entire interview will be recorded and the recording will be kept in a pen drive under my supervision. These recordings will be deleted after six months after the end of the study (i.e., they will be deleted in March 2013).

Reimbursements

You will not be provided any incentive to take part in the research.

Confidentiality

The interview will be anonymous: no information about you other than your party affiliation will be stated in the final study.

Sharing the Results

The knowledge that the research yields will be shared with you when the final paper is written. This final paper will then be the ownership of the London School of Hygiene and Tropical Medicine.

Who to Contact

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact me in any of the following ways: by email ([redacted]@lshtm.ac.uk) or by phone (+351 919617377).

The proposal for this study has been reviewed and approved by an Ethics Committee from the London School of Hygiene and Tropical Medicine.

You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?

Part II: Certificate of Consent

I have read the foregoing information and I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction.

Print Name

Signature

Date

I have, to the best of my ability, made sure that the participant understands what will be done.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

I also confirm that the data retrieved from this interview will be used only for the purposes of the stated study and that the only person who will have access to the recordings and their transcriptions will be me.

A copy of this informed consent form has been provided to the participant.

[redacted]

Signature

Date

This informed consent form was written based on the World health Organization's Informed Consent Form templates, available at: http://www.who.int/rpc/research_ethics/informed_consent/en/.

Annex D: Thematic Framework

1. Timing
2. Problem Definition
    - 2.1. Context
        - 2.1.1. Interpretation of current abortion epidemiologic data
        - 2.1.2. Current exemptions
        - 2.1.3. Others
    - 2.2. Legal issues
    - 2.3. Health issues
    - 2.4. Health services issues
    - 2.5. Social issues
        - 2.5.1. Social reasons to have abortions
        - 2.5.2. Access to services
        - 2.5.3. Discrimination of pregnant women
    - 2.6. Economic issues
        - 2.6.1. Income to the NHS
        - 2.6.2. Resource allocation
    - 2.7. Ideological perspectives
        - 2.7.1. Moderating fees
        - 2.7.2. View on abortion
    - 2.8. Ethical issues
        - 2.8.1. Freedom / non-judgment / respect
        - 2.8.2. Justice / equity / equality
3. Consequences
    - 3.1. Illegal abortion
    - 3.2. Abortion rates
    - 3.3. Medical confidentiality
4. Alternative solutions
    - 4.1. Sexual education
    - 4.2. Family planning services
    - 4.3. Parental rights

Annex E: CARE Form

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

Combined Academic, Risk assessment and Ethics (CARE) approval form for MSc Project Reports

This form must be completed electronically. For detailed guidance, please refer to the **Project Handbook for your course.*

SECTION 1 – STUDENT AND COURSE INFORMATION	
MSc DETAILS AND DEADLINES (deadlines to be communicated by Course Director)	
Academic Year	**2011-12**
MSc course (and stream, where applicable)	**MSc Public Health, general**
Deadline for Supervisor approval	**Friday 16th March 2012**
Deadline for Course Director approval	**Monday 19th March 2012**
Deadline for submission to Ethics Committee	**Friday 23 March 2012**
Target for approved form to be passed to TSO	**Friday 11 May 2012**
STUDENT AND SUPERVISOR DETAILS (to be completed by student)	
Full name of student	
Student email address	
Year of study (part-time students only)	☐ First Year ☐ Second Year
Supervisor name	John Cairns
Supervisor email address	John.cairns@lshtm.ac.uk
Supervisor institution/organisation	LHSTM
Supervisor status (at time of this version of the form being completed)	☒ Confirmed ☐ Provisional ☐ Still to be identified
Name of personal tutor (where Supervisor is still to be identified)	

SECTION 2 – APPROVAL AND SUBMISSION STATUS
***Students please note:** It is a requirement of your LSHTM degree that you obtain all required approvals before beginning your project work. Your Supervisor and Course Director must specifically give Risk Assessment approval. Ethics approval must also be obtained where necessary (answers in Section 5 will help determine if this is required or not).*

STUDENT DECLARATION (to be completed for all projects)	
I agree to conduct my project on the basis set out in this form, and to consult staff (initially, my Supervisor) if making any subsequent changes – especially any that would affect the information given with respect to ethics approval.	☒
I agree to comply with the relevant safety requirements, and will submit a separate request for LSHTM travel insurance where relevant.	☒

Where seeking ethics approval for a study involving human subjects, please also attach copies of any information sheets, consent forms, and other relevant documents.	
Date of declaration	14th March 2012

Please save the electronic file of this CARE form in the format

"[MSc title]_[Year of Submission]_[Surname]_[Forename]_CARE"

You will also be required to submit a copy of this CARE form with your final written-up project. This should be anonymised, i.e. with your name and email address removed.

STAFF APPROVAL

***Staff please note:** Sections 3 and 4 of the form should be completed by the student before you give approval. Rather than 'sign' this form, you should email the student and explicitly confirm approval, e.g. stating "In my role as supervisor, I approve the attached form". The student is then responsible for updating the form and passing it on to any other staff.*

*However if you would answer 'no' to any of the 'Yes/No' questions below, or disagree with any of the statements given, or have any other concerns, then you should **not** give approval. Instead, please contact the student immediately to inform them of your concerns and discuss changes which they may need to make before you may be willing to give approval.*

Please also be aware that in the exceptional case of a request to undertake a project in a country or region to which the Foreign & Commonwealth Office advise against travel, the student would need to fill out a separate form which will then need further School-level approval by the Safety Manager and Secretary & Registrar.

SUPERVISOR'S APPROVAL (required for all projects – this approval should be given first)	
Supervisor has agreed that Section 3 of this form is a reasonable summary of the proposed project.	☒ Yes ☐ No
Supervisor has agreed that responses in Section 4 of this form address the main risks connected with a project of this nature.	☒ Yes ☐ No
Supervisor has agreed that responses in Section 5 of this form correctly indicate whether or not ethics approval will be required.	☒ Yes ☐ No
Name of Supervisor (if not yet identified, personal tutor or Course Director should approve)	John Cairns
Date of approval	15 March 2012

COURSE DIRECTOR'S APPROVAL (required for all projects – should follow Supervisor approval)	
Course Director has agreed that the proposed project's academic content, set out at Section 3 of this form, is suitable for this MSc.	☒ Yes ☐ No
Course Director has agreed that responses in Section 4 of this form address the main risks connected with a project of this nature.	☒ Yes ☐ No
Name of Course Director (or nominee)	Jennifer Gosling
Date of approval	16.3.2012

FACULTY SAFETY SUPERVISOR'S APPROVAL (only required if project involves working with pathogenic organisms, human blood or radiochemicals – should follow Supervisor approval)	
Faculty Safety Supervisor has agreed that the proposed project, as set out in this form and particularly Section 4, may proceed.	☐ Yes ☐ No
Name of Faculty Safety Supervisor (or nominee)	

Date of approval	

ETHICS APPROVAL (required for all projects involving human subjects or human data, except for public domain data that cannot enable the identification of living people – NB that Supervisor approval **must** have been received before the application is submitted to the Ethics Committee)	
The Ethics Committee has approved the project proposal set out on this form.	☐ Yes ☐ No
Date of approval	
Ethics Committee application number assigned	

SECTION 3 – APPLICATION FOR ACADEMIC APPROVAL

**All students should complete all sub-sections (3.1, 3.2 and 3.3). If particular questions are not applicable to you then please write 'N/A'.*

3.1 PROJECT OUTLINE (should not normally exceed 750 words total)

Proposed project title: (should not normally exceed 20 words)

User fees for requested abortions in Portugal: what would be the consequences?

Proposed project type:

**See course-specific section of Project Handbook for details of project types permitted for each MSc. Be aware that restrictions may apply for individual courses.*

Health Policy Report

Proposed project length:

**For almost all students, this will be 'Standard'. Extended projects are only available for MSc IID; they have a different schedule and allow a slightly greater word count.*

☒ Standard ☐ Extended

Background: (about 200 words)

**Indicate why this topic is of interest or relevance.*

**If the project involves work with a specific organisation please give details.*

**Please give any other details specifically relevant for consideration by the Ethics Committee, e.g. related to purpose.*

Five years after Portugal decriminalized abortion on a woman's request following a national referendum in which voters called for a change in law, several organizations, political parties and institutions, with varied perspectives, are starting to draw a balance and suggest further changes to the law. Some of these interest groups have proposed the introduction of user fees for elective abortions, namely for repeat abortions. The ministry of health has officially stated that the issue is off the government's agenda, even though the current governing party, the Social Democratic Party, has stated that the issue needs to be evaluated.

At the same time, since May 2011, the Portuguese government has been acting in accordance with a Memorandum of Understanding with the European Commission, the European Central Bank and the International Monetary Fund. This memorandum states that moderating fees (user fees in Portugal are called "moderating fees", since they're said to induce moderation in health care use) for healthcare should increase, a policy that has already been brought forward for many other health care services.

The current feeling of need for increased user fees and the ongoing debate about abortion in Portugal makes this a likely issue for public debate in the near future, hence the strong need for an analysis of its possible public health consequences.

Hypothesis: (about 30 words, where applicable)

N/A

Overall aim of project: (about 30 words)

To explore the possible public health consequences of introducing user fees for requested abortions in Portugal.

Specific objectives of project: (about 70 words)

To understand the arguments for and against user fees for health care.

To describe the known public health consequences of user fees in Portugal.

To describe existing evidence on the introduction of user fees and other forms of restrictions on requested abortions.

To understand the perspective of different interest groups on the introduction of user fees for requested abortions in Portugal.

Proposed methods: (about 200 words)

Please summarise methods, and include **any relevant details for consideration by the Ethics Committee such as numbers of participants and procedures to be performed.*

A review of the literature will be made on the subject. This will rely mainly on published, peer-reviewed sources, but also, to a smaller extent, on grey literature (such as reports from the Portuguese government on the epidemiology of requested abortions).

To obtain an insight on the different range of opinions that exist regarding the subject of moderating fees for requested abortions, several interviews will be carried out. These will be semi-structured, face to face interviews, recorded and transcribed. Interviewees will be given the choice to remain anonymous, non-identifiable or to be identified.

The interviewees will preferably be members of parliament, ideally one from each of the six parties currently represented. These individuals will be selected based on convenience and availability. In case it is not possible to interview some members of parliament, organizations that are active on the issue will be approached in order to find another possible interviewee with similar perspectives on the subject.

One expert on the subject – the current president of the National Ethics Council for the Life Sciences – will also be interviewed.

References: (max 150 words)

**List any key references which will shape the project, including for methods to be used. It should not normally be necessary to quote more than 5 references.*

(1) Buse K, Mays N and Walt G. Making Health Policy [e-book]. Open University Press; 2005 [cited 2012 Feb 11]. Available from: MyiLibrary. http://lib.myilibrary.com.ez.lshtm.ac.uk?ID=95094.

(2) Sedgh G, Singh S, Shah IH, Ahman E, Henshaw SK, Bankole A. Induced abortion: incidence and trends worldwide from 1995 to 2008. Lancet. 2012. Epub 2012/01/24.

(3) The reproductive health report: The state of sexual and reproductive health within the European Union. The European journal of contraception & reproductive health care : the official journal of the European Society of Contraception. 2011;16 Suppl 1:S1-70. Epub 2011/09/09.

(4) Ritchie J and Spencer L. Qualitative data analysis for applied policy research. In: Bryman A and Burgess RG. Analysing Qualitative Data. 1994. London: Routledge.

(5) Figueras J, M.M., Mossialos E and Saltman RB. Funding Health Care: Options for Europe. European Observatory on Health Care Systems. Buckinhgham;Philadelphia. 2002.

Prior work: (only where relevant; max 100 words)

**Indicate any previous work you have done related to this project topic, including student work, professional work, or publications.*

N/A

3.2 FEASIBILITY (about 100 words total – but can write more or write less if appropriate)

What could stop this project from succeeding, or prevent you from achieving your objectives?

**Please indicate any aspects of your proposed approach which could potentially experience difficulties, e.g. delays with permissions, data collection or storage problems, lack of sufficient comparable information, etc. You may also wish to mention any wider matters which could affect your project, e.g. civil unrest, natural disasters, transport availability.*

Lack of opportunity for interviews. Civil unrest in Portugal due to the current financial situation.

What alternative plans do you have in case you encounter any of the potential problems you have identified?

In case I am unable to perform any interviews, be it for lack of opportunity or civil unrest, I will base my project on existing literature.

3.3 DATA SOURCES, INTELLECTUAL PROPERTY AND PERMISSIONS

If you expect to use existing data, how will you obtain it?

**Indicate who holds the data, who specifically you will contact, and by when. Any contact so far, especially anything confirmed in writing, should be mentioned.*

Existing data will be retrieved from published and grey literature, none of which require any special permission.

If you expect to use any public domain data, please give further details.

**Make clear who owns the data and how you will gain access (giving a link if possible). Public domain data must be available to any member of the public, without any restrictions or requirement for special permission, and must not enable the identification of living people.*

Data on abortions in Portugal is accessible via the Directorate General for Health's website (http://www.dgs.pt/). All the data I will use regarding abortions performed in Portugal is available online, without restrictions or special requirements, and it does not enable the identification of people.

Will any specific data rights permissions or usage limitations be required regarding data to be used or collected in the project? If 'Yes', please describe further. **Remember that local ethics or research governance requirements (see Section 5.2) may entail specific data rights limitations.*	☐ Yes ☒ No

Will any copyright agreements or intellectual property rights (IPR) agreements be required regarding data to be used or collected in the project?

**Please tick all boxes that apply, and attach copies of any forms/agreements (even if in draft).*

No specific IPR, copyright or permissions issues should apply to this project (student retains copyright and a claim to related IPR)

IPR to be retained by LSHTM (specific LSHTM form to be completed)

Copyright to be transferred to LSHTM (specific LSHTM form to be completed)

IPR, copyright or other agreements/permissions required with external parties/organisations

Please give any further relevant details about IPR, copyright or other permissions.

SECTION 4 – APPLICATION FOR RISK ASSESSMENT APPROVAL

**All students should answer all questions in sub-section 4.1; this will make clear which of the subsequent sub-sections you need to complete.*

Ensuring safety during project work is the responsibility of <u>each individual student</u>, and not of LSHTM or LSHTM staff. **Please see the Project Handbook for further guidance.*

4.1 TYPE OF RISK (to be completed by all students)

Where will the project be carried out? (please tick all that apply)

**Note that work away from LSHTM or outside the UK means <u>any</u> form of work for your project, not just primary data collection. Some courses may have specific restrictions on this.*

☐ **All work will take place either at LSHTM, in libraries in the UK, or at my personal residence in the UK.** [If so, you do not need to complete either section 4.2 or section 4.3]

☐ **Some work will take place in the UK that is away from LSHTM sites in London, is non-Library-based, and is not at my personal residence.** [If so, section 4.2 on 'Work away from LSHTM' must be completed]

☐ **Some work will take place at my personal residence outside the UK** [If so, section 4.3 on 'Work outside the UK' must be completed]

☒ **Some work will take place outside the UK that is not at my personal residence** [If so, <u>both</u> sections 4.2 and 4.3 on 'Work away from LSHTM' and 'Work outside the UK' must be completed]

Will the project involve working with or handling any of the following materials?

Pathogenic organisms	☐ Yes	☒ No
Human blood	☐ Yes	☒ No
Radiochemicals	☐ Yes	☒ No

[If 'Yes' to any of the above, Sections 4.4 and 4.5 must be completed]

Are any other potentially hazardous activities likely to be carried out during the project?

☐ Yes ☒ No

[If 'Yes', Section 4.5 must be completed]

Do any special requirements (e.g. disability-related issues) or other concerns need to be taken into account for either you as a student, study participants or colleagues?

☐ Yes ☒ No

[If 'Yes', Section 4.6 must be completed]

4.2 WORK AWAY FROM LSHTM (to be completed if any work will be done away from LSHTM, other than at your home or at libraries elsewhere in the UK)

Will the project be based in an established hospital, college, research institute, NGO headquarters, field station or other institutional site? If 'Yes', please give the name and location of the site(s); describe approximately what proportions of your project will be spent there; and state name and role of person who has confirmed willingness to support you at each site (indicating extent of correspondence, especially what they have confirmed in writing).	☐ Yes ☒ No
Will you have an 'external supervisor', co-supervisor or other main advisor, or be working with any specific organisation(s), during your work away from LSHTM? If 'Yes', please indicate the name, role, contact details, and level of support that any such external advisors are expected to provide, and give details about any organisations you will be working with.	☐ Yes ☒ No
Will the project involve personal visits, interviews or interactions with	☒ Yes

people in their homes, workplaces, community settings or similar? If 'Yes', please give details, including approximately what proportion of your project this will involve.	☐ No
A large proportion of my project will be based on interviews. I plan to interview seven different people separately, six of them members of parliament and one a medical doctor who is the president of the National Ethics Committee. The interviews will probably take place in the individual's workplaces.	
Will the project involve lone/isolated work or significant travel? If 'Yes', please give details, including approximately what proportion of your project this will involve, and state how you can be contacted while working or travelling.	☐ Yes ☒ No
What arrangements are proposed for contact with your main supervisor while you are away from LSHTM? Indicate expected ease and frequency of contact, and communication methods to be used.	
Most communication will happen via email. At least two in-person contacts will take place before handing in the final project.	
Please tick to confirm:	☒ **I have read the LSHTM Code of Practice on off-site work.**

4.3 WORK OUTSIDE THE UK (to be completed if any work will be done outside the UK)	
What form of project work will be undertaken outside the UK? (please tick all that apply)	
Work at my family home or personal residence only **Work at an established hospital, college, research institute, NGO headquarters, field station or other institutional site** **Work away from my personal residence or an established site** **Note that for either the second or third options, you should also have completed Section 4.2.*	
Name the country/countries and region(s) in which work will be undertaken:	
Country or countries: Portugal **Region(s) :** Lisbon	
Do the Foreign & Commonwealth Office's (FCO) Travel Advice Notices (www.fco.gov.uk/en/travelling-and-living-overseas/travel-advice-by-country) **advise against travel to the regions(s), country or countries involved?** **Note that if 'Yes', the School will not normally permit such travel for project work. In **exceptional circumstances only**, requests may be considered by the Safety Committee and require approval by the Safety Manager and Secretary & Registrar.*	☐ Yes ☒ No
Please tick to confirm:	☐ **I will seek specific travel health advice before any international travel as part of my project.** **Free travel health advice is available, along with anti-malarials, vaccinations and medication, from the School's approved providers – please see details in the project handbook.*
Please tick to confirm:	☐ **I understand that travel insurance is required when travelling internationally for project purposes.** **Free LSHTM travel insurance can be applied for using a separate form – provided the travel is for location-specific project purposes.*

4.4 WORK WITH HAZARDOUS SUBSTANCES (to be completed if the project involves any work with pathogenic organisms, human blood or radiochemicals – NB that this will require approval by the Faculty Safety Supervisor)
Name the organism or organisms to be used:

Identify all potential routes of infection:
Name the radiochemical or radiochemicals to be used:
List laboratories where work with pathogens or radioisotopes will be carried out:
List disinfectants to be used, and describe arrangements for disposal of used material:

Will or might Health Surveillance be required for you or any staff working with you? If 'Yes', please give details.	☐ Yes ☐ No

4.5 PRECAUTIONS AGAINST HAZARDS (to be completed if any potentially hazardous activities are likely to be carried out during the project. Refer to Project Handbook and School safety documentation for further information. Faculty Safety Supervisor's approval may be further requested where felt appropriate by project Supervisor.)
Indicate any procedures, activities or aspects of the proposed project which may entail hazards (including work with hazardous substances as per Section 4.4, or anything else relevant). Please set distinct hazards out separately, in a numbered list.
Indicate the precautions you will take to prevent or mitigate such potential hazards. Please number these to refer to the specific hazards identified in the preceding question.

4.6 SPECIAL REQUIREMENTS (to be completed if the project involves any special requirements, e.g. disability-related issues, or other concerns that need to be taken into account for either you as a student, study participants or colleagues)
What special requirements or concerns need to be taken into account?

Do these need to be considered in planning arrangements? If 'Yes', please give details.	☐ Yes ☐ No
Do these impact on supervision arrangements? If 'Yes', please give details.	☐ Yes ☐ No
Does the project location need to be considered in relation to these? If 'Yes', please give details.	☐ Yes ☐ No
Do arrangements for access to specialist medical treatment need to be considered? If 'Yes', please give details.	☐ Yes ☐ No

SECTION 5 – APPLICATION FOR ETHICS APPROVAL

All students should **answer all questions in sub-sections 5.1 and 5.2. Answers to 5.1 will make clear whether approval by the LSHTM Ethics Committee is necessary, and which later sub-sections you may need to complete. Section 5.2 covers any external approvals required.*

Further detailed guidance about completing this section, and what to do next if formal LSHTM ethics approval is required, is given in **Chapter 6 of your Project Handbook.*

NB that supervisor approval must be obtained **before an application is submitted to the Ethics Committee.*

5.1 SCOPE OF STUDY (to be completed by all students)

Which of the following applies to your project? (please tick one option only)

**Note – the term 'human data' includes any documentary data, datasets or biological samples.*

☐ **Project does not involve any human subjects or any human data.** [If so, formal LSHTM ethics approval is not required and you do not need to complete Sections 5.3 or 5.4]

☐ **Project involves human data, but all this human data is fully in the public domain.** [If so, formal LSHTM ethics approval is not required and you do not need to complete Sections 5.3 or 5.4]

**Public domain human data must be: available to any member of the public without special permission; to which access is not restricted in any way; and which does not enable the identification of living people, either directly or by linking to other data.*

☐ **Project involves some non-public-domain human data, all of which was previously collected in another study or studies.** [If so, formal LSHTM ethics approval is required and Section 5.3 must be completed]

☐ **Project involves some additional collection of data, further to an ongoing or previously completed study or studies.** [If so, formal LSHTM ethics approval is required and Section 5.4 must be completed]

☒ **Project is a completely new study which will involve human subjects or human data.** [If so, formal LSHTM ethics approval is required and Section 5.4 must be completed]

5.2 LOCAL ETHICS APPROVAL OR RESEARCH GOVERNANCE APPROVAL (to be completed by all students)

As well as approval from the LSHTM Ethics Committee, projects may require specific approval from other involved or responsible bodies. For example, in the UK you may need specific authorisation to work in an NHS facility, or to work with vulnerable groups such as patients or children. Outside the UK a wide range of requirements may apply e.g. from local or national Ethics Committees, government departments etc. **Students must investigate all potential local approval required for your project work. Failure to check or gain any necessary external approval may invalidate LSHTM approval.*

Is local approval required for the work being done (whether this approval is still to be obtained, or has already been granted)? **This should include any forms of ethics approval, research governance approval or other specific permissions that may apply.*	☐ Yes ☒ No

If 'Yes', give details of local approval to be obtained (this must be in place before commencing fieldwork) or which has already been granted.

**Please name all bodies whose approval is required, or indicate where work is expected to take place using permissions already granted for a 'parent' project. Where approval has already been granted, quote approval reference numbers and if possible give web links to documents.*

If 'No', explain why formal local approval is not required, and describe any less formal permissions, invitations or support you are being given for this work.

**If you will be working away from LSHTM with human subjects or human data, but cannot identify a local Ethics Committee or believe that no formal approval is required, then please give details and explain what you have done to check this. In such cases, if you do not have formal approval you should always demonstrate appropriate local support, such as correspondence with local government officials or an involved Non-Governmental Organisation.*

Interviewees will be members of the Portuguese parliament and the president of the National Ethics Committee. Each will be asked to sign a consent form stating that they understand the circumstances in which they are participating.

**If any specific data rights permissions or usage limitations will be required regarding data to be used or collected in the project (e.g. as a result of local ethics or research governance requirements), this should be spelt out in Section 3.3 earlier.*

5.3 PROJECTS USING ONLY PREVIOUSLY-COLLECTED HUMAN DATA (to be completed if project involves non-public-domain human data, datasets or biological samples previously collected in another study or studies; if collecting any new data, complete Section 5.4 instead)

Summary of purpose and methods of the original study or studies: (max 100 words)

Give details of all approvals under which the original study or studies took place:

**Please quote names of Ethics Committees and approval reference numbers (required if previous approval was from LSHTM); if possible give web link to original study application.*

Proposed study: Ensure that the project outline given in Section 3.1 states the purpose, methods and procedures of the new work to be done in your project, and describes how this builds on the previous study or studies (for which participants will already have been recruited, data or samples collected, and procedures performed). Do not reproduce here.

Will your analyses be for purposes not covered by the original application detailed above? If 'Yes', indicate how you will obtain (i) permission to use the data from the principal investigator responsible for each original study; and (ii) retrospective consent, where appropriate, from the participants in each original study.	☐ Yes ☐ No
Does the project involve analysis of documentary information and/or data already collected from or about human subjects? If 'Yes', specify analyses briefly.	☐ Yes ☐ No
Does the project involve laboratory analysis of human biological samples already collected, or new or additional analysis of stored samples? If 'Yes', specify the laboratory analyses or tests to be performed.	☐ Yes ☐ No

Specify how confidentiality will be maintained. Where data will be anonymised, specify how this will be done. When small numbers are involved, indicate how possible identification of individuals will be avoided.

State how your data will be stored and what will be done with it at the end of the study.

5.4 PROJECTS COLLECTING ANY NEW HUMAN DATA (to be completed if project involves collection of human data, datasets or human biological samples – either as a completely new study, or collecting additional data further to an ongoing or previously completed study)	
<u>Proposed study:</u> Ensure that the project outline given in Section 3.1 contains sufficient detail (inc. purpose, methods, procedures for both new data collection and any work building on previous studies), so as to allow the Ethics Committee to make an informed decision without reference to other documents. Do not reproduce here.	
Is your project an intervention study? For LSHTM ethics approval purposes, 'interventional studies' include all trials based on random allocation of interventions, and also non-randomised interventions where participants or groups of participants are given treatments (of whatever nature) that they would not otherwise be receiving in the ordinary course of events and which are allocated by the investigators.	☐ Yes ☒ No
Will any human biological samples be collected? If 'Yes', specify details.	☐ Yes ☒ No
Will any human biological material be stored at LSHTM for more than 24 hours? If 'Yes', specify which samples and how and where they will be stored. ***Further guidance is given at*** http://intra.lshtm.ac.uk/support/research/humantissueact.html	☐ Yes ☒ No
Specify the number - with scientific justification for sample size – age, gender, source and method of recruiting subjects for the study.	
Members of parliament will be selected on the basis of convenience and availability. Six individuals will be interviewed, one from each party in the Portuguese parliament. One more person will also be interviewed, for being considered an expert on the subject.	
State the location and likely duration of new or additional human data collection, and the extent to which this will be carried out by you alone, or in collaboration with others, or by others.	
The interviews will probably take place in the interviewees' workplace and should take between thirty to sixty minutes. All the interviews will be done by me.	
State the potential distress, discomfort or hazards, and their likelihood, to which research subjects may be exposed (these may include physical, biological and/or psychological hazards). What precautions are being taken to control and modify these hazards?	
I don't believe there is any considerable possibility of causing distress, discomfort or any kind of hazard; having said that, my approach to the subject will be as neutral as possible in order not to cause any psychological distress to interviewees whose opinions differ from mine.	
Specify how confidentiality will be maintained. Where data will be anonymised, specify how this will be done. When small numbers are involved, indicate how possible identification of individuals will be avoided.	
All interviewees will have the option of remaining anonymous, non-identifiable or to have their identity stated in the study. Their party affiliation will be stated in the study but other than that, the final report will only include information the interviewees agree to. The expert will be identified as an expert on the subject, and no more will be stated in case he chooses to remain anonymous.	

State how your data will be stored and what will be done with it at the end of the study.
Interviews will be recorded and transcribed. Both the recordings and the transcriptions will be kept in a pen drive for six months after the end of the study, and then permanently deleted.
State the manner in which consent will be obtained from subjects. Written consent is normally required. Where not possible, explain why and confirm that a record of those giving verbal consent will be kept. Where appropriate, please state if and how the information and consent form will be translated into local language(s).
The interviewees will be asked to sign a written consent form before the beginning of the interviews. The attached consent form will be translated by me to Portuguese. Interviewees will also be given a signed statement in which I declare that all the information I am given during the interview will only be used for the purpose of this study, and nothing else.

Please tick to confirm:	☒ **I have attached copies of the information sheet(s), consent form(s), and other relevant documents related to work with human subjects.**

As well as collecting new data, will your project also make use of any human data or biological samples collected in a previous study or studies? If 'Yes', summarise the purpose and methods of the original study or studies – for which participants will already have been recruited, data or samples collected, and procedures performed. (max 100 words)	☐ Yes ☒ No
Give details of all approvals under which the <u>original study or studies</u> took place: **Please quote names of Ethics Committees and approval reference numbers (required if previous approval was from LSHTM); if possible give web link to original study application.*	
Will your analyses be for purposes <u>not covered</u> by the original ethics approval detailed above? If 'Yes', indicate how you will obtain (i) permission to use the data from the principal investigator responsible for each original study; and (ii) retrospective consent, where appropriate, from the participants in each original study.	☐ Yes ☒ No

Annex F: Ethical Approval

May 16, 2012 5:11 PM

Dear [redacted] ,

Thank you for your revised consent and CARE forms. These are now approved for the MSc Ethics Committee.

Regards,

Ursula Gompels.

MSc Ethics Committee

Dr UA Gompels

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