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Gynecologist attitudes towards and practices regarding legal abortion provision in Montevideo, Uruguay

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2012

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Abstract

Gynecologist attitudes towards and practices regarding legal abortion provision in Montevideo, Uruguay

By Bethany Kotlar

In October of 2012 Uruguay passed a law decriminalizing abortion for any reason up to 12 weeks of gestational age, at 14 weeks of gestational age in cases of rape or incest, or at any point if the pregnancy poses a serious risk to the woman's health or the fetus has a malformation incompatible with life. Following decriminalization of abortion approximately one third of gynecologists have registered as conscientious objectors to abortion provision. High levels of conscientious objection to abortion have been established as a potential barrier to access to safe abortion care, yet little is understood regarding the rationale behind gynecologist objection in Uruguay. To address this knowledge gap a qualitative analysis of in-depth interviews with eleven gynecologists in Montevideo, Uruguay was conducted with the goal of determining how gynecologists decide whether to practice abortions or become conscientious objectors. Another goal was to understand what attitudes gynecologists hold towards abortion decriminalization. Gynecologist decision-making regarding abortion provision is based on several interrelated issues, including human rights, the perceived role and agency of the gynecologist, religious and moral beliefs, emotional reactions to abortion, the perceived rights of the agents in abortion, and the perceived psychological and social impact of abortion. In general, gynecologists support the decriminalization of abortion, but differ in their opinions on how the law should be implemented. Gynecologists also identify several potential barriers to safe abortion access in Uruguay. These results demonstrate the need for the inclusion of values-clarification regarding abortion provision and education regarding ethically based conscientious objection in the medical school curriculum in Uruguay and policy-based action to overcome barriers to safe abortion access.

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Chapter I: Introduction

In October of 2012 Uruguay enacted Law 18.987, one of the most liberal abortion policies in Latin America, decriminalizing (removing criminal punishments for) first-trimester abortions for any reason, up to 14 weeks gestational age in cases of rape or incest, and at any time for fetal malformations incompatible with life or to save the life of the mother (Chamber of Representatives, 2012). Although this law was meant to expand access to abortion and reduce maternal health complications associated with clandestine abortions, several potential barriers to increased access have been identified.

One serious barrier to abortion access is provider's conscientious objection to abortion. Under Law 18.987 gynecologists and health care organizations with religious or moral objections to abortion have the right to abstain from providing legal abortions. According to Uruguay's Ministry of Health, approximately 30% of gynecologists nationwide are registered as conscientious objectors to abortion provision. In some rural regions, 100% of gynecologists have registered (Presidencia de la República del Uruguay, 2013). High levels of provider conscientious objection can seriously impede patients' access to abortion services by delaying provision of services and creating other barriers such as the need to travel or to use more expensive private clinics (Chavkin et al., 2013).

Despite widespread use of conscientious objection to abortion and its potential impact on access to abortion services, little is known about gynecologists' decision-making process or rationale behind abortion provision in Uruguay. The purpose of this study is to address this knowledge gap in Montevideo, Uruguay in order to mitigate against issues arising from conscientious objection and to determine gynecologist attitudes towards legal abortion provision.

Problem Statement

Abortion is highly restricted in the majority of countries in Latin America. In part due to this restriction, the region's unsafe abortion rate is the highest in the world (32 per 1,000 women) (Guttmacher Institute, 2012). Legal restrictions on abortion are known to cause high levels of unsafe abortion and there is a proven link between unsafe abortion and maternal mortality and morbidity (Guttmacher Institute, 2012). According to the World Health Organization, 95% of abortions in Latin America are unsafe and one in eight maternal deaths in the region results from unsafe abortions (World Health Organization, 2011).

In 2001, in response to high maternal mortality from abortion, Uruguay implemented a harm reduction model to reduce abortion-related deaths and other negative health consequences caused by unsafe abortion. This model provided women with clinical counseling on the use of medication to terminate pregnancies and promoted the use of contraceptives to prevent further unwanted pregnancies (Gorgoroso, 2010). According to the Uruguayan Ministry of Public Health, in 2011 this measure had made Uruguay the only country in Latin America that had not registered any maternal deaths from unsafe abortion in three years (UNFPA, 2011).

Until the early 2000s, the only Latin American countries that allowed abortion on demand were the communist nation Cuba, a nation whose government's laws and policies are not as directly influenced by Roman Catholic positions, and Guyana, a former British colony with fewer than 800,000 inhabitants. In 2006 Colombia passed legislation allowing abortion in some limited circumstances and in 2007 Mexico City voted to decriminalize first trimester abortions (Center for Reproductive Rights, 2014).

In October 2012, Uruguay passed Latin America's most liberal abortion law by decriminalizing abortion up to 12 weeks of gestation, up to 14 weeks for victims of rape or incest, and at whatever gestational age in cases of fetal malformations incompatible with life or serious risk to the health of the mother (Center for Reproductive Rights, 2014). The implementation of this law has been lauded as an important step towards increased access to abortion in Uruguay and a potential model for other Latin American countries interested in reducing maternal mortality and morbidity from abortion (UNFPA, 2011).

Under the law gynecologists are the only healthcare providers allowed to provide abortions and are obligated to provide this service with one exception: gynecologists with moral or religious objections to abortion are allowed to register with the Ministry of Public Health and abstain from abortion provision, although they continue to be required to provide pre and post-abortion counseling and to refer patients to another provider for their abortion (Chamber of Representatives, 2012). Since October of 2012 approximately 30% of Uruguay's gynecologists nationwide have registered as conscientious objectors. In some rural regions of Uruguay 100% of gynecologists are conscientious objectors (Presidencia de la República del Uruguay, 2013).

Conscientious objection is defined as "the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs" (Chavkin et al., 2013). Conscientious objection to the provision of certain medical services is considered a right of physicians; however, unless appropriate structures are in place, it may negatively affect access to abortion services through several pathways. Global Doctors for Choice in their White Paper on conscientious objection developed a conceptual framework to illustrate the potential harms conscientious objection can cause to the health system and patients' health (see Figure 1).

Figure 1: Conceptual Framework of Harms Caused by Conscientious Objection to Abortion Provision (Chavkin et. al., 2013)

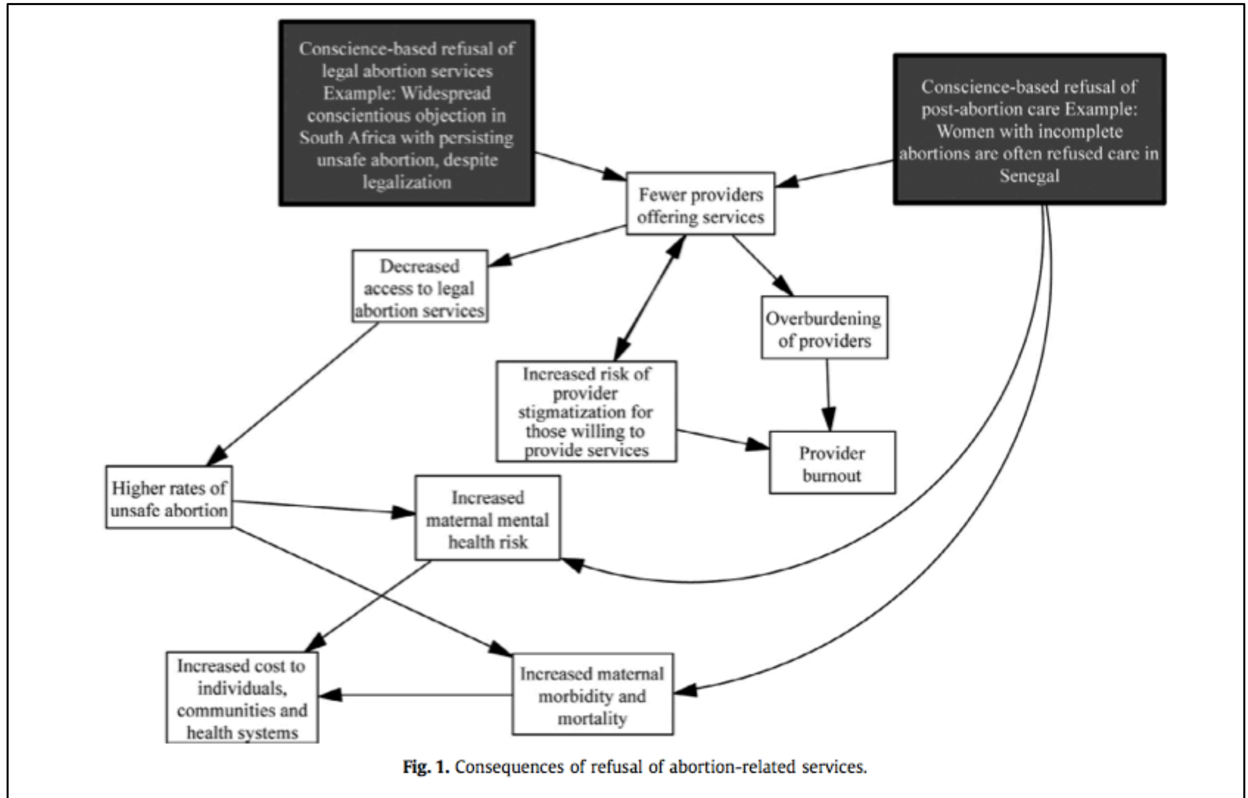

Fig. 1. Consequences of refusal of abortion-related services.

In situations where a large number of providers are conscientious objectors to legal abortion provision, there are necessarily fewer providers willing to provide services. This decreases access to providers for women and increases the potential for stigma for current and future abortion providers. Demand for abortion services could also exceed supply of clinicians willing to provide them, leading to provider burnout and decreased access to services for women. Decreased access to abortion services has been shown to increase unsafe abortion and thus risk to maternal health and cost to the healthcare system (Chavkin et al., 2013).

The rationale behind conscientious objection may influence its likelihood to cause issues for maternal health and health care. Faúndes et al., have posited that a significant portion of conscientious objectors to abortion provision in Latin America may be misusing conscientious

objection in order to avoid the stigma of abortion provision. This not only has the potential to decrease women's access to needed services, but also increase the stigma of abortion provision, thus increasing the proportion of physicians relying on conscientious objection (2013). Finally, Johnson et al., describe a similar abuse of conscientious objection, wherein physicians refuse to provide legal abortions in some cases or to some patients, but willingly provide them in others. This leads to increased inequality in access to abortion services and may especially disenfranchise low SES, rural, minority, or young women (2013).

Despite the potential harms that conscientious objection represents to maternal health and the health care system and the large proportion of gynecologists registered as conscientious objectors, nothing is currently known about the nature of conscientious objection to abortion provision in Uruguay. Elucidating Uruguayan gynecologists' decision-making regarding conscientious objection to abortion provision and their attitudes towards abortion provision would help us better understand its effects on Uruguayan health and healthcare.

Purpose

The purpose of this study is to explore the rationale behind gynecologists' decision-making regarding abortion provision in Montevideo, Uruguay and their attitudes towards legal abortion provision. The primary research questions investigated were:

1. How do gynecologists in Montevideo, Uruguay decide whether to register as conscientious objectors to abortion provision or provide abortions?
2. What role do religious, spiritual, and/or moral beliefs play in gynecologists' decision-making regarding abortion provision?
3. What are gynecologists' attitudes towards the law decriminalizing abortion in Uruguay?

Significance

The results of this study are significant for two reasons. First, the results of this study will contribute to the literature by exploring a little-understood issue: clinician decision-making regarding conscientious objection in Montevideo, Uruguay. A better understanding of clinician decision-making regarding abortion provision will have direct policy implications for Uruguay. Knowledge in this area can be used to establish policies to mitigate against possible abuses of conscientious objection, educate clinicians on appropriate conscientious objection, and engage medical students or residents in ethically-based conversation around abortion provision with the goal of reducing stigma towards abortion provision and thus minimizing the potential harms of conscientious objection to abortion provision on maternal health and health systems. Finally, the results of this study will determine other [facilitators and??] barriers to safe abortion access by describing provider attitudes towards Law 18.987 and its implementation.

Definition of Terms

This paper uses the ACOG definition of induced abortion as a "procedure that is done to end a pregnancy" which can include the termination of a pregnancy through surgical, medication, or household methods (ACOG, 2011). This study uses the World Health Organization's definition of unsafe abortion: "a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both" (World Health Organization, 2003). The term conscientious objection is used exclusively for conscientious objection to abortion and is defined as the refusal to provide abortions for religious, ethical, moral, or philosophical reasons or the pretense of religious, ethical, moral, or philosophical reasons.

Religion is used to refer to adherence to a particular system of faith or worship (Merriam-Webster, 2014). Thus, religion is considered a cultural system that directly influences cultural and political systems and thus public health policies. Spirituality, however, is individualistic in nature. Spirituality may affect personal health beliefs and actions, but has less influence on higher-level systems and policies. Specifically, this study uses the concept of spirituality as defined by Burkhardt:

> Spirituality is that which gives meaning to one's life and draws one to transcend oneself. Spirituality is a broader concept than religion, although that is one expression of spirituality. Other expressions include prayer, meditation, interactions with others or nature, and relationship with God or a higher power (1989).

Morality is defined as " principles concerning the distinction between right or wrong or good or bad behavior" (Merriam-Webster, 2014). Morality and moral reasoning can occur outside of and independently from religious systems or belief structures.

Chapter II: Background and Literature Review

Introduction

Abortion is a complex issue that involves ethics, human rights, religion, and maternal health. In the 2nd edition of the guidelines for safe abortion care The World Health Organization reports that worldwide each year an estimated 22 million abortions are carried out in unsafe circumstances and these abortions result in death for an estimated 47,000 women and the morbidity of an estimated 5 million women (World Health Organization, 2012).

In this chapter I will broadly summarize the major issues surrounding abortion including legal issues, ethical and moral issues, human rights issues, religious issues, and public health issues. It will then discuss abortion in the region of Latin America and the Uruguayan context including the legal history of abortion decriminalization, a broad review of the public discourse

on abortion, and the current process for legal abortion within the healthcare system. Finally, this chapter will review the literature on health providers' attitudes towards abortion.

Legal Issues in Abortion

The Center for Reproductive Rights, a global legal advocacy organization, places countries into four categories depending on that country's laws regarding abortion. Category I countries prohibit abortion entirely or allow it only in order to save the mother's life. Category II countries permit abortion only to protect a woman's life or health. The definition of potential harm that qualifies for a legal abortion varies across countries from serious or life-threatening harm to any threat to physical or mental health. Category III countries are those that permit abortions on socio-economic grounds. Finally, Category IV countries are those that permit abortions for any reason within certain gestational age limits. These countries typically extend gestational age limits for certain circumstances such as severe fetal malformations, risk to the health of the mother, or pregnancies that are the result of rape or incest (Center for Reproductive Rights, 2014).

Most of Category I and II countries are located in the Global South (Africa, South America, and Southeast Asia), while the Global North (North America, Europe, and Central Asia) have the most liberal abortion laws. Although almost 40% of women worldwide live in Category IV countries, a little over a quarter of women worldwide live in the 66 countries that prohibit abortion completely or allow it only in order to save a woman's life. A further 13.8% of women live in countries that only permit abortion to preserve health. Thus, over a third of the world's women live in countries where abortion is only legal to preserve maternal health. (Center for Reproductive Rights, 2014).

Criminalization of abortion does not decrease the proportion of women seeking induced abortions. Faced with criminal charges, women with unwanted pregnancies risk their lives and health to have abortions in unsafe conditions. Maternal mortality and morbidity is lowest in countries where abortion is legal and unrestricted. Thus, legality has a direct influence on maternal mortality and morbidity from abortion (World Health Organization, 2012).

Public Health Issues in Abortion

An unsafe abortion is "a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both" (World Health Organization, 2003). Methods for abortion include medication methods using mifepristone and/or misoprostol and surgical methods using manual vacuum aspiration or a sharp curettage (World Health Organization, 2012). Guidelines for safe abortion care have been established and generally require low-cost supplies and minimal training of health care providers. When abortions are performed by a trained provider in a safe and clean facility morbidity and mortality from the procedure are extremely low or non-existent. For example, the case-mortality rate of legal abortions performed in the United States is 0.7 per 100,000 procedures compared to 30 per 100,000 unsafe procedures performed in Latin America. Thus, morbidity and mortality from abortion are preventable occurrences (World Health Organization, 2012).

Worldwide approximately 41% of pregnancies each year were unintended (World Health Organization, 2012) and 42 million women with unintended pregnancies chose abortion (Haddad and Nour, 2009). Although the measured rate of abortion has fallen from 35 out of 1,000 women aged 15-44 in 1995 to 26 out of 1,000 women aged 15-44 in 2008, this is most likely due to the

decrease in safe abortions, which are much more difficult to measure. The proportion of abortions that are unsafe worldwide rose from 44% in 1995 to 49% in 2008 (World Health Organization, 2012).

The health consequences of unsafe abortion are high. Worldwide mortality from unsafe abortion accounts for 13% of overall maternal mortality (Haddad and Nour, 2009). Given the difficulty of measuring maternal mortality from abortion, especially in contexts where abortion is illegal, this is likely to be an underrepresentation of the true figure (World Health Organization, 2012). Complications resulting from unsafe abortion include sepsis, hemorrhage, reproductive tract infections, and trauma to reproductive and/or abdominal organs (World Health Organization, 2012).

Morbidity due to unsafe abortion is even more difficult to measure than mortality. However, each year 5 million women are hospitalized for abortion-related causes. Long-term consequences of unsafe abortion include incontinence, infertility, internal organ damage, and poor wound healing (Haddad and Nour, 2009). Women also experience psychological and economic burdens from unsafe abortion (World Health Organization, 2012).

Human Rights Issues in Abortion

Restrictions on abortion have been argued to violate several basic human rights outlined in the International Bill of Rights including the right to life, the rights to health and healthcare, and the rights to nondiscrimination and equality. By restricting abortion women are denied access to health and healthcare and driven to using unsafe measures to terminate unwanted pregnancies, thus endangering their lives. Furthermore, in many countries with restricted abortion, wealthy or well-connected women are still able to access safe procedures, leaving women without means to bear the risks (Human Rights Watch, 2014).

Beginning in the late 1960s sexual and reproductive rights began to be elaborated in the Proclamation of Teheran, the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), and the International Conference on Population and Development. Although these human rights agreements are ostensibly "abortion neutral" and do not mention abortion explicitly, several of the rights elaborated can be interpreted to include abortion (United Nations, 2014). Resolution XVIII of the Proclamation of Teheran states that

> …couples have a basic human right to decide freely and responsibly on the number and spacing of their children and a right to adequate education and information in this respect." (Resolution XVIII: Human Rights Aspects of Family Planning, Final Act of the International Conference on Human Rights. U.N. Doc. A/CONF. 32/41, p.15).

The 1994 International Conference on Population and Development extended these rights to include free decision-making regarding reproductive health stating:

> These rights rest on the recognition of the basic right of all couples and individuals to…attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents. (ICPD Programme of Action 1994, para 7.3).

Some have argued that the right to life elaborated in the International Bill of Rights applies to the embryo or fetus and that this right supersedes the rights of the mother. Only one human rights treatise puts forth the right to life from conception, all other treatises do not overtly specify that an embryo or fetus is also privy to the right to life (United Nations, 2014). Legal experts differ on their interpretation of these treaties. Some maintain that the right to life begins at conception, while others stipulate that this right begins at viability. Still others designate the beginning of human rights as the moment of birth. However the cutoff of rights is interpreted, the potential rights of the embryo or fetus must be balanced against the rights of the mother, which have been well established (Human Rights Watch, 2014).

Ethical and Religious Issues in Abortion

Ethical and religious concerns [that are opposed to abortion generally revolve around the personhood of an embryo or fetus and the morality of killing. Personhood is a complicated term that has different interpretations. Personhood could be the possession of a unique human genetic code, the possession of certain human characteristics such as a nervous system or the ability to think, or the possession of moral personhood-the ability to rationalize and reason (BBC Ethics, 2014). Whether an embryo or a fetus is defined as a person or not is one critical consideration in the morality of abortion and is complicated by the continuous development of the embryo and fetus toward viability and eventually birth. In the scientific community a human pregnancy is considered to begin not at conception, but at the implementation of a fertilized egg in the wall of the uterus (Guttmacher, 2005). The pregnancy is considered an embryo for the first eight weeks of gestation. From week nine to birth the pregnancy is considered a fetus and takes on many characteristics of life such as a developed neurological structure and independent movements (The Embryo Project, 2014). Those that do not consider an embryo or a fetus of a certain gestational age to be a human being are not as likely to consider abortion wrong (BBC Ethics, 2014).

Another key component is the morality of killing. Even those who consider that an embryo or fetus is a human being may not consider abortion as morally wrong in certain circumstances. For example, if the termination of a pregnancy would save the life of a mother, it may be considered morally justified even if the fetus is considered a person. The opposite may also be true. The argument has been made that it is inconsistent to oppose war, capital punishment, or other circumstances that end human life and to condone abortion. This position,

called the “consistent ethic of life,” contends that respect for dignity to life should apply to all life, even the life of a fetus (BBC Ethics, 2014).

Since a pregnancy naturally involves two entities, the morality of denying an abortion to a woman who wants one or one that is necessary for medical reasons is also important to consider. Many proponents of abortion access argue that it is immoral to require a woman to continue with a pregnancy for any reason or for certain reasons such as risk to the woman’s life or health, in circumstances of rape or incest, or in the face of fetal malformations (BBC Ethics, 2014).

Given the moral and philosophical implications of abortion it is no surprise that religious institutions have historically taken public positions on abortion. Due to the nature of this paper and the region of focus I will limit the discussion here to the Catholic position towards abortion. St. Thomas Aquinas, writing in the 13th century, considered that it is a sin to have an abortion once a fetus has become “animated.” Although he did not define the exact moment at which this takes place, it was generally considered to be at the point of “quickening,” or when the fetus can be felt by the mother (The Embryo Project, 2014). Although some have considered Aquinas’ writings as a potential support for abortion in the early stages of development, the Roman Catholic Church is currently and has been historically against the act of abortion. Pope Paul II in his cyclical Evangelium Vitae disseminated in 1995 reiterated the Church’s historical position against abortion citing the holiness of human life and the responsibility of the Church to protect life from conception (La Santa Sede, 2014).

The Church has also taken a stand against the use of abortion to protect a woman’s life, health, or wellbeing. In traditional Catholic theology the philosophical tradition of “double effect” is used to determine the circumstances in which abortion would be considered acceptable.

"Double effect" is a set of conditions that allow one in circumstances where an action could have both good and bad effects to determine whether that action would be a sin. In order for such an act to be morally acceptable it must satisfy all of the following requirements: the act independent of its context must be good or indifferent, the person performing the act can only intend the good effect of the act, the good effect can't be the result of the bad effect, and there must be a serious reason for permitting the bad effect of the act. Under these conditions there are only two instances in which an induced abortion is acceptable: if the pregnant woman has uterine cancer and the uterus is removed along with the fetus or if in the case of an ectopic pregnancy the fallopian tube is removed along with the fetus (Rudy, 1996).

Although the official Catholic stance on abortion is one of absolute censure, the vast majority of lay Catholics do not share these views. In the General Social Survey conducted in 2012 85% of Catholics reported approving abortion when a woman's health is at serious risk, 76% support abortion in cases of rape or incest, and 74% approve of abortion for serious health defects (Catholics for Choice, 2015).

Furthermore, a study conducted by Univision found that 76% of U.S. Catholics surveyed believe that abortion should be allowed in all or some circumstances (Catholics for Choice, 2015). There is no evidence that Catholics have fewer abortions than the secular population. In a study conducted by the Guttmacher Institute in the U.S. in 2010 28% of women who had an abortion identified themselves as Catholic, whereas only 27% of women of reproductive age identified themselves as such (Catholics for Choice, 2014).

Despite the fact that the majority of lay Catholics approve of abortion in some circumstances, the Catholic Church has wielded political power to fight the legalization of abortion, the liberalization of abortion laws or policies, or even the inclusion of abortion services

in the realm of reproductive rights. In both the Cairo and Beijing United Nations conferences the Vatican has successfully rallied more conservative nations to exclude or tone down language on abortion in reproductive rights statements and to fight against the inclusion of reproductive rights in basic human rights agreements (Fleishman, 2000). The Catholic Church is also credited with influencing more conservative laws on abortion such as those that exist in Spain (Fleishman, 2000), Nicaragua, El Salvador, Chile, and other Latin American countries where the Catholic Church has considerable influence (Pulitzer Center, 2013).

Abortion in Latin America

In fact, the influence of the Catholic Church is one of the most-cited reasons why abortion remains largely restricted in Latin America (Pulitzer Center, 2013). In Latin America, defined as the sub-region of the Americas where Romance languages are spoken (Spanish and Portuguese) that stretches from the southern border of the United States to the southernmost point of South America (Academy for Cultural Diplomacy, 2015), abortion is largely illegal or greatly restricted. Abortion is only permitted for any reason up to certain gestational limits in Guyana, Cuba, Puerto Rico, Uruguay, and in Distrito Federal in Mexico, where abortion is legislated on a state basis. In the majority of Latin American countries abortion is only permitted to save the woman's life or in cases of rape or incest. In Honduras, El Salvador, Chile, and Nicaragua total bans on abortion have been enacted making abortion illegal in all circumstances (Center for Reproductive Rights, 2014).

Due to the restrictive nature of abortion laws in the region the Guttmacher Institute reports that 95%, nearly all of the 4.4 million abortions that occurred in 2008, were considered unsafe (2012). This incredibly high level of unsafe abortion leads to excess maternal mortality.

The World Health Organization estimates that 12% of maternal mortality in Latin America and the Caribbean is due to unsafe abortion (Guttmacher Institute, 2012).

Abortion legality and access are in flux in Latin America (Kulczycki, 2011). In Central America there has been a recent trend towards enforcing legislation against abortion. In 1998 El Salvador eliminated previous legal exceptions to a ban on abortion including in instances of sex with a minor, rape or incest, severe fetal malformations, and to save the mother's life (Kilbanoff, 2013). Furthermore, in 1999 the Constitution was amended to recognize the right to life from conception (Center for Reproductive Rights, 2014). Similarly, in a legislation that came into effect in 2008, Nicaragua eliminated the exception to abortion criminalization to save the life of the mother, affecting a total ban on abortion (Center for Reproductive Rights, 2014).

In contrast, recognizing that unsafe abortion directly contributes to maternal mortality and morbidity, several countries have chosen to liberalize their abortion laws in the last several years. In 2006 Colombia reversed a total ban on abortion and passed legislation legalizing abortion in cases of rape or incest, to preserve the life or physical and mental health of a woman, or in the case of severe fetal anomalies (Center for Reproductive Rights, 2014). Similarly, in 2007 Mexico City legalized first trimester abortions and in 2008 Mexico's Supreme Court upheld the Mexico City's assembly's decision. Finally, in 2012 Uruguay passed legislation decriminalizing abortion for any reason in the first trimester, up to 14 weeks in cases of rape or incest, and at any gestational age for fetal malformations incompatible with life or a serious risk to the mother's health (Center for Reproductive Rights, 2014).

The Uruguayan Model

Uruguay is a small country on the East coast in South America bordered to the North by Brazil and to the West by Argentina. Its population is around 3.3 million, the majority of which reside in the nation's capital, Montevideo. Spanish is the official spoken language and the majority of Uruguay's inhabitants are of European descent (CIA, 2014). With a per-capita GDP at $16,600 Uruguay is at the high-end of middle-income countries. Due to the implementation of a National Health System, free quality education through university, and a well-developed social security system Uruguay ranks high on most development indicators (CIA, 2014).

Figure 2: Map of Uruguay (CIA, 2014)

In 2004, following more than two centuries of a two-party system dominated by the Colorado and Blanco parties, the left-leaning Frente Amplio Coalition won the national elections (Nolen, 2014). In 2009 José Mujica, a former guerrillero and political prisoner, was elected as President of the Republic. Mujica, affectionately known as Pepe, has used his political power to make Uruguay one of the most socially liberal countries in Latin America. It was under Pepe's presidency, in October of 2012, that first trimester abortions were decriminalized (Nolen, 2014).

Abortion became a criminal offense in Uruguay in 1938 largely based on Catholic morals that " life, once conceived, can not be eliminated licitly" (Ponte, 2007). Under this penal code induced abortion was illegal except if the pregnancy posed a serious risk to the woman's health

and life, if the pregnancy was the result of rape, if the woman lived in extreme poverty, or to defend personal honor (PAHO, 2012). Under this system women with unwanted pregnancies frequently turned to clandestine abortion clinics or home methods of abortion to terminate their pregnancies (Gorgoroso, 2010).

Unsafe abortion practices intensified in the late 1990s and early 2000s in the wake of an economic recession. Between 1995 and 1999 28% of maternal mortality in Uruguay was due to unsafe abortions. In the primary public hospital in Montevideo, which mostly served women of lower socio-economic status, 47% of maternal mortality was due to unsafe abortion (PAHO, 2012).

The issue of unsafe abortion did not go unnoticed. Political debates on the legalization of abortion intensified and legislation on the decriminalization of abortion was narrowly defeated in 2004 (Abracinskas and Gomez, 2007). In the same year concerned professionals from various health organizations in the country formed the organization Mujer Y Salud, Uruguay to defend sexual and reproductive rights including access to safe abortion care (Ipas, 2013).

Yet, while political debates and advocacy efforts continued, unsafe abortion continued to occur. In the face of maternal mortality a group of health professionals came together in 2001 to design a harm reduction strategy that would include women with unwanted pregnancies in the health care system and lead to a reduction in maternal mortality and morbidity from abortion (PAHO, 2012). In 2006 the group Iniciativas Sanitarias was formed and the harm reduction model they designed was implemented that same year (Gorgoroso, 2010).

Iniciativas Sanitarias model to improve the safety of illegal abortions was simple:

- Train physicians and midwives to counsel women on the use of misoprostol to terminate an unwanted pregnancy. Training followed the World Health Organization guidelines on the safe use of misoprostol for abortion.

- Disseminate information to the public about the availability of reproductive health services under the model.
- Provide counseling on the correct use of misoprostol as well as pre-abortion and post-abortion care and counseling on the adoption of a contraceptive method (PAHO, 2012).

Under this system women seeking an abortion would be seen by a health professional and given counseling on the use of misoprostol. Since abortion was still a criminally punishable offense, misoprostol would not be prescribed during this session. Rather, the woman seeking an abortion would procure misoprostol for herself through a pharmacy or on the black market. Post-abortion she would return to the healthcare provider to resolve any difficulties and/or receive routine post-abortion care and counseling on contraceptive methods (Gorgoroso, 2010).

The effects of this model on maternal mortality were strong. One year following the introduction of the harm reduction model maternal mortality from abortion fell to zero reported deaths in the country. Admission into the intensive care unit for post-abortion complications also fell significantly (PAHO, 2012). Largely due to the public health success of the harm reduction model it was included in the Uruguayan legal code in 2008 under Law 18.426. This law guaranteed the right of Uruguayan women to pre-abortion counseling and post-abortion care within the health care system (Gorgoroso, 2010).

Despite the success of this harm reduction model there were lingering issues surrounding the availability and safety of abortion. First, the act of abortion itself was still considered a criminal offense and although no cases were actively prosecuted, women were still reluctant to come forward. Second, it continued to be illegal for health professionals to prescribe misoprostol or for pharmacies to sell it without a prescription. Thus, women were left to procure the medication however they could with no guarantee of a fair price or the legitimacy of the medication. Finally, many civil organizations considered the legality of abortion as a basic

reproductive right and continued to lobby for this right to be recognized by the Uruguayan legislature (Ipas, 2013).

In 2008 the senate passed legislation to decriminalize abortion, but then president Tabaré Vazquez vetoed the legislation (Botinelli & Buquet, 2010). Finally, in October of 2012 Law 18.987 was passed and approved by President Mujica. Through this law abortion was removed from the criminal code up to 12 weeks of gestational age. Law 18.987 also established a clear set of protocols for abortion care as well as a set of exceptions to the gestational limit. Under the law, abortion is included within the National Health System the Ministry of Public Health is responsible for its regulation (Senate and Chamber of Representatives, 2012).

Under Law 18.987 women who seek an abortion must follow a schedule of four visits, three of which are mandatory. The first visit must be with a gynecologist to declare the intention of seeking an abortion. After this visit the gynecologist sets up a second visit, which takes place with a multidisciplinary team composed by law of a gynecologist, a social worker, and a psychologist. During this visit the multidisciplinary team counsels the woman on her options for an unwanted pregnancy as well as the process of the abortion. After this visit the law establishes a waiting period of five days. After five days a woman seeking an abortion can request a third visit during which she will receive both counseling on the use of medications to induce an abortion and be prescribed the medication. Only gynecologists can perform this visit and prescribe misoprostol. The final visit, although not mandatory, is highly recommended and includes post-abortion care and counseling on contraceptive methods (Senate and Chamber of Representatives, 2012).

Under Law 18.987 abortion continues to be allowed at any gestational age in cases of fetal malformation incompatible with life or serious risk to the health or life of the mother. The

gestational age limit is extended to 14 weeks in cases of rape or incest. In order to receive an abortion after 12 weeks for rape or incest a criminal case must have been filed by the woman against her assailant. However, the waiting periods or pre-abortion visits are not required (Senate and Chamber of Representatives, 2012).

The law does allow gynecologists as well as health care organizations that have religious or moral beliefs against abortion to be conscientious objectors to the practice. Gynecologists or organizations that decide to become conscientious objectors must register with the Ministry of Public Health through a letter stating their inability to provide abortions on moral or religious grounds. This provision only allows gynecologists to abstain from the third visit during which misoprostol is prescribed. They still have the responsibility to see a patient during the first visit and refer them to another gynecologist during the abortion process and to provide post-abortion care (Senate and Chamber of Representatives, 2012).

Although the most Uruguayans have supported the decriminalization of abortion since 1993, certain groups have historically and currently oppose abortion. One of these groups is the Catholic Church. In fact, in a poll realized in 2008 on Uruguayan citizen's opinions on abortion 55% of those who self-identified as strong Catholics were against abortion, compared to 35% of all those surveyed (Bottinelli & Buquet, 2010). Politically, the Catholic Church was outspoken in their disapproval of Law 18.987, actually excommunicating legislators who voted to approve abortion decriminalization and stating, "life is not under the control of any citizen" (El Diario, 2012).

There has been speculation that this religious climate against abortion has influenced gynecologists' decision-making regarding conscientious objection. Nationwide approximately 30% of gynecologists have registered as conscientious objectors. In some of the more rural

regions of Uruguay up to 100% of gynecologists have registered as conscientious objectors (Presidencia de la República del Uruguay, 2013). The availability of gynecologists who can perform abortions directly affects access to safe abortion services (Chavkin et al., 2013).

This is especially true for women living in more isolated regions of Uruguay. For these women access to abortion services is dependent on their ability to travel six hours to Montevideo to complete the necessary visit structure or for the Ministry of Public Health to procure a gynecologist willing to travel to the region daily or relocate permanently. With a gestational age limit of 12 weeks and a mandatory five-day waiting period, delays can mean the difference between a legal and safe abortion and an abortion occurring outside of the health system.

Literature Review

FIGO, the International Federation of Gynecology and Obstetrics, has identified conscientious objection to abortion as a serious barrier to safe abortion and post-abortion care as well as an ethical and human rights issue (Zampas, 2013; Chavkin et al., 2013). FIGO has also warned that high levels of provider objection to abortion provision have the potential to ultimately increase maternal mortality and morbidity from abortion (Chavkin et al., 2013). Thus, conscientious objection represents a serious barrier to expanded abortion access in Uruguay.

In order to minimize both the possible health consequences and human rights violations resulting from conscientious objection it is important to adequately understand the phenomenon from the perspective of health care providers (Chavkin et al., 2013; Faúndes, 2013; Díaz-Olavarrieta et al., 2012). Although few studies of conscientious objection to abortion have been conducted in Latin America, existing literature points to several rationales for refusal of abortion services including religiosity, avoidance of stigma or a burdensome practice, and an objection to

certain situations or patients (Díaz-Olavarrieta et al., 2012; Chavkin et al., 2013; Kestler, 2011; Espinoza et al., 2004; Gogna et al., 2004).

Several studies showed an opposition to abortion provision under certain circumstances and support in others. A survey administered to 3,337 members of the Brazilian Federation of Gynecology and Obstetrics Societies found that nearly all (85%) of gynecologists surveyed believe abortion should be permitted in cases of rape. However, only 50% of those surveyed responded that they would be willing to perform an abortion in that circumstance (Faúndes et al., 2007). Similarly, more than three-quarters of gynecologists working in public hospitals in Buenos Aires supported abortion in cases of a severe threat to the health of the mother, severe fetal anomaly, or rape/incest, but opposed abortion for any reason (Romero et al., 2002). A qualitative study of conscientious objection in Mexico City following decriminalization of abortion found that many gynecologists supported abortion only in certain extreme cases, such as rape or fetal anomalies (Díaz-Olavarrieta et al., 2012). In a study of Guatemalan physicians attitudes towards abortion the majority of providers disapproved of abortion for socioeconomic reasons, being unmarried, or being under 18 years of age (Kestler, 2011). Similar results were reported in a study of Nicaraguan physicians (McNaughton et al., 2002).

Physicians may be more likely to provide abortions to certain kinds of patients and refuse others. A study of Brazilian obstetrician-gynecologist's attitudes towards unwanted pregnancy found that physicians were more likely to support abortion for themselves or kin than for patients (Faúndes et al., 2004). Díaz-Olavarrieta et al., found that Mexican physicians were ambivalant towards multiple abortions and fearful that abortion would become a contraceptive method, but were more positive towards those who requested an abortion because of contraceptive failure (2012).

Stigma towards abortion provision has also been found to be a factor in conscientious objection. In a qualitative study of 30 obstetrician-gynecologists in Säo Paulo, Brazil, many participants expressed that the main reason for physician objection was stigma (Faúndes et al., 2005). Similarly, Mexican physicians reported that colleagues who are conscientious objectors had a "double discourse," refusing to perform abortions in public, but consenting in private to avoid stigma (Díaz-Olavarrieta et al., 2012). Doctors in Poland and Brazil reported reluctance to perform legal abortions because of political and cultural stigma (Zordo & Mishtal, 2011).

Finally, religiosity was cited as a contributor to conscientious objection in several studies. Two studies in the United States and one in the United Kingdom found associations between self-described religiosity and objection to abortion (Marie Stopes International, 2007) (Schrader and Belcheir, 2012) (Aiyer and Ho, 1999). Furthermore, the most-reported reasons for conscientious objection to abortion amongst interviewed physicians in Säo Paulo were religious principles and personal beliefs (Faúndes et al., 2005).

Conclusion

Uruguay has taken an important first step towards nation-wide access to safe abortion and post-abortion care. However, the registration of 30% of Uruguay's gynecologists as conscientious objectors may pose a serious barrier to patient access to services. Understanding the rationale behind conscientious objection from the physician perspective may help guide improved policies and interventions to maintain the positive health and human rights effects of abortion decriminalization.

Chapter III: Manuscripts

Title Page

"La que hace el aborto soy yo:" Gynecologists' decision-making regarding legal abortion provision in Montevideo, Uruguay

Prepared for submission to *Social Sciences and Medicine*

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Student Contribution

In the development of this thesis I, the student, was responsible for the development of research methods, the collection of data following these methods, the analysis of collected data, the development of tables and figures, and the writing of this thesis document. I received the following assistance: Martín Couto advised me on the methodology of this study and participant recruitment, Dr. Roger Rochat and Dr. Jennifer Foster provided ongoing technical and academic support throughout the research and writing stages. They also contributed in the editing of the thesis and this manuscript.

Manuscript Body

Abstract

Objective. Determine how gynecologists in Montevideo, Uruguay decide whether to provide legal abortions or to become conscientious objectors to the practice.
Methods. 11 in-depth interviews of gynecologists in Montevideo, Uruguay were carried out between June and July of 2014. The methods of Grounded Theory were used to analyze the resulting data.
Results. Gynecologist decision-making regarding abortion provision is based on the sum of positions a gynecologist takes on a combination of several interrelated issues including human rights, the perceived role and agency of the gynecologist, religious and moral beliefs, perceived social and psychological consequences of abortion, and emotional reactions to abortion. Stigma may also play a role in gynecologist decision-making.
Conclusions. Gynecologist decision-making regarding abortion provision is a complex and multifaceted issue. Including values-clarification on abortion provision and conscientious objection in the medical school curriculum in Uruguay will help gynecologists better understand their own and others' values on abortion, aiding in ethical decision-making regarding abortion provision.

Introduction

Abortion is highly restricted in Latin America. Because of this restriction, the region's unsafe abortion rate is the highest in the world (32 out of 1,000 women) (Guttmacher Institute, 2012). Legal restrictions on abortion are known to cause high levels of unsafe abortion and unsafe abortion has been linked to maternal mortality and morbidity (Guttmacher Institute, 2012). The World Health organization estimates that 95% of abortions in Latin America are unsafe, leading to high maternal mortality from abortion (World Health Organization, 2011).

Until 2001 Uruguay largely exemplified the situation described above. In reaction to high maternal mortality from abortion in 2001 Uruguay implemented a harm reduction model to reduce abortion-related deaths and other negative health consequences caused by unsafe abortion. This model provided women with clinical counseling on the use of medication to terminate pregnancies and promoted the use of contraceptives to prevent further unwanted pregnancies, but did not include abortion within the health system. Thus, women seeking abortions under the harm reduction model received medical counseling, but were left to procure

misoprostol or mifepristone (abortificiants) on the black market (Gorgoroso, 2010). Despite this restriction, the harm reduction model greatly reduced maternal mortality from abortion, making Uruguay the only country in Latin America that did not register any maternal deaths from unsafe abortion between 2008 and 2011 (UNFPA, 2011).

In October of 2012 Uruguay took further steps to increase access to abortion services by enacting Law 18.987, one of the most liberal abortion policies in Latin America. Law 18.987 decriminalized (removed criminal punishments for) first-trimester abortions for any reason, up to 14 weeks gestational age in cases of rape or incest, and at any time for fetal malformations incompatible with life or to save the life of the mother.

Although Law 18.987 was a positive first step towards expanding access to safe abortion, several potential barriers to access still exist. One potentially serious barrier to abortion access is provider conscientious objection to abortion. Under Law 18.987 gynecologists and health care organizations with religious or moral objections to abortion have the right to abstain from prescribing abortifacients. According to Uruguay's Ministry of Health approximately 30% of gynecologists in Uruguay are officially conscientious objectors to abortion provision and in some rural regions 100% of gynecologists are conscientious objectors (Presidencia de la República del Uruguay, 2013). High levels of provider conscientious objection can seriously impede patients' access to abortion services by reducing the number of accessible abortion providers, increasing stigma for current and future providers, and creating a situation where demand for abortion services exceeds supply of willing providers (Chavkin et al., 2013). Furthermore, misuse of conscientious objection, or objection for reasons other than religious, moral, or philosophical beliefs such as avoidance of stigma or personal profit, has also been posited by Faúndes et al and Johnson et al (2013). Misuse of conscientious objection can also lead to increased inequality of

abortion services that especially affects low SES, rural, minority, or young women (Faúndes,2013).

Some hypothesize that religious and moral beliefs largely drive conscientious objection (Chavkin et al., 2013). However, despite common use of conscientious objection to abortion, little is known about gynecologists' decision-making process or rationale behind abortion provision in Uruguay. The purpose of this study was to characterize gynecologists practicing in Montevideo, Uruguay's decision-making on providing abortion services and its possible association with religion. A better understanding of clinician decision-making regarding abortion provision will have direct policy implications for Uruguay as the country's health system adjusts to legal abortion provision.

Materials and Methods

Sampling

This paper reports a series of in-depth interviews conducted between June and July of 2014 with gynecologists practicing in Montevideo, Uruguay. Sampling was carried out in collaboration with members of Uruguay's National Health System. Investigators and collaborators compiled a comprehensive list of gynecologists practicing in Montevideo. Each member of this list was sent an invitation to participate in the study that described the study's research goal and provided contact information to participate in the study. Gynecologists willing to participate replied to this invitation with their telephone number. Each potential participant was then contacted by phone to reaffirm their interest in participating and to schedule the interview. Eleven gynecologists were recruited through this method, and two were lost to follow-up. Two participants were recruited through a previous participant. As a preliminary assessment of provider attitudes and practices

regarding abortion specifically in Montevideo, Uruguay, Emory's Institutional Review Board deemed the study exempt from human subjects research review.

Data Collection

Interviews were conducted by the first author in Spanish at a time and place of the participant's choosing using a semi-structured interview guide, which contained five key points a) participants' formation as a gynecologist, b) participants' personal values and religious or spiritual beliefs, c) participants' family structure and upbringing, d) participants' decision-making process regarding abortion provision or conscientious objection, e) and attitudes regarding Law 18.987. Verbal and written consent were obtained from all participants. Interviews were recorded and transcribed verbatim in Spanish and then translated to English.

Data Analysis

Data was analyzed using the methods of Grounded Theory (Corbin & Strauss, 2008; Charmaz, 2006). Data analysis began with data collection. The primary investigator took detailed notes of reflexive reactions and possible codes and categories throughout the collection, transcription, and translation processes. Following translation, interview documents were uploaded to MAXQDA to organize the data. The primary investigator then actively read each interview and took detailed memos using MAXQDA. Memos and interviews were re-read to develop an open codebook. The codebook contained both inductive codes (codes defined by participants during the interview) and deductive codes (codes determined important to the study through literature or the research question) (Charmaz, 2006). Once codes were developed, the investigator developed detailed descriptions of each code through both active reading and the comparison of codes across participants and sub-groups of participants. Participants were divided into subgroups depending on age, gender, conscientious objector status, whether they were romantically partnered, whether

they had children, focus of their medical practice, and self-described religious orientation. Following code description, the investigator again actively read all notes, memos, reflexive writings, code descriptions, and interviews in order to group codes into categories. These categories were then used to conceptualize the data into a cohesive visual representation and written narrative.

Limitations

During the data collection process two participants were lost to follow-up. Portions of two interview recordings were lost due to technical malfunction and were only semi-recovered from in-depth notes taken during interviews. The sampling method may have introduced some bias into the study as those who are interested in participating in the study could differ on their attitudes or practices regarding abortion, i.e. be more open to abortion provision and/or legislation and thus more willing to be interviewed. .

Results

Demographic characteristics of participants

Of the 11 gynecologists interviewed, ten were female and one was male. Interviewees ranged in age from 33 to 47, with an average age of 38. Two gynecologists were registered conscientious objectors to abortion. Four interviewees self-identified as Catholic, one self-identified as Protestant Christian, four identified as spiritual, but not religious, and two did not hold any spiritual or religious beliefs.

Respondents chose gynecology as a specialty for a variety of reasons. Many chose gynecology because of its association with largely healthy patients and positive life events. Several chose it as an alternative to surgery, which they considered a less friendly specialty towards female physicians. Despite its positive associations, more than half of interviewees

described life as a gynecologist as “exhausting” and “stressful.” The health system in Uruguay expects gynecologists to work in multiple locations and to complete 12-24 hour “on-calls,” which require their presence at the hospital or clinic. Only one gynecologist interviewed had a “fixed” job, or a position that covers only one health organization. Long hours mean little free time and generally unhealthy lifestyles, with little time for self-care. On top of these long hours several interviewees mentioned the stress of assisting patients with their health problems in the face of these patients’ often-complex personal or social issues. Abortion was mentioned specifically as a health issue that requires gynecologists to step in to a situation that they view as distressing and complex. To protect gynecologists’ identities, all names used in this paper are pseudonyms.

Gynecologist Decision-Making Regarding Abortion Provision

Although we hypothesized that gynecologist decision-making regarding abortion provision was largely based on religious and moral values, analysis of interviews showed that decision-making involves gynecologists’ perceptions and beliefs within five diverse and broad categories. These issues arose inductively, raised by gynecologists themselves during the interview process (Charmaz, 2006). They include: gynecologists’ perceived role and agency in abortion provision, gynecologists’ emotional reactions to abortion provision, gynecologists’ perceptions of the rights of the social actors involved in abortion (the gynecologist, the mother, the father, and the fetus), gynecologists’ religious and moral values, and gynecologists’ perceptions of the social and psychological consequences of abortion. Stigma may also play a role in decision-making regarding abortion provision, but gynecologists did not identify it as a factor in their decisions in this study. Within each category are multiple positions, some of which incline a gynecologist

towards abortion provision and others towards conscientious objection. These categories are described in-depth below.

Role and agency

Interviewees expressed several separate perceptions of their role in the sexual and reproductive health decisions of their patients. The majority agreed that their role as gynecologists is not to judge whether a woman's decision regarding her body is right or wrong. Gynecologists who are abortion providers highlighted the importance of patient autonomy in decision-making and described their role as an agent of support to the patient whether they agreed with that patient's decision or not:

> If I am against it or not, there are women I don't agree with but I counsel them all the same. What am I going to do? Tell her: "Leave. Leave, because I don't agree." You are a doctor and you have to do it, to do what the patient wants or what is indicated.
>
> –Marina, abortion provider

Those who provide abortions were also more likely to see their role as someone who helps the patient through a difficult situation or prevents them from harm. Even though she didn't agree with a patient's decision, Andrea, an abortion provider, stated: "I wouldn't stop counseling and accompanying a woman, because it isn't my life….If a woman asks me for help, it's not like I would leave that woman…I am here to give them information, to support them in what they want." Interviewees who are conscientious objectors saw their role as promoting the health and wellbeing of both mother and child, and although they also highlight the importance of patient autonomy, they were not willing to participate in an activity that would harm a fetus.

Gynecologists' perception of their agency in the abortion process is also of vital importance to decision-making regarding abortion provision. Those who provide abortions were more likely to minimize their role in the termination of the fetus:

The decision to interrupt a pregnancy is the woman. I'm not the one who is deciding

> whether to interrupt that pregnancy. The one who is deciding is the woman. I am the medium through which…it occurs in as less risky of a way possible. So, I don't feel that I have the responsibility of being the one who makes the decision, simply that I give that woman the tools so that…what the woman has decided can happen without any major damage to her life, to her health, and to her family.
>
> –Pablo, abortion provider

Conscientious objectors, however felt that prescribing misoprostol to a woman would be tantamount to accepting responsibility for the termination of the fetus:

> …if you counsel a patient you are doing the abortion. That's what I take on. It's not that the patient is doing the abortion on her own. No. I am doing the abortion because I am giving the medication and explaining how to use it. If I were to tell you: "To shoot yourself take a pistol and put it to your head and pull the trigger," without doubt I am the vehicle that is provoking the suicide, or the crime, or whatever. It's the same.
>
> –Cristina, conscientious objector

Emotions

Gynecologists' emotional reactions to abortion were also a major factor in their decision-making. The majority of gynecologists interviewed, both conscientious objectors and providers, expressed some negative emotional reaction to abortion in general or to specific abortion scenarios. Interviewees described abortion in general as "ugly" and "sad." Cristina, who is a conscientious objector, described the emotional impact of performing a surgical abortion early in her medical career:

> When I was a resident of gynecology…I was Christian but I wasn't as close to the Church as I am now and in that time one day we had to do a dilation and curettage….a court order came for one patient for psychiatric reasons….and we had to terminate the pregnancy and there wasn't misoprostol. So, the way to interrupt the pregnancy was dilate the cervix, insert forceps, and take out the, the amniotic sac. That day I was on call and….I did it because I didn't think about it much like I would think about it today…At that moment it seemed that….it was like passing off my responsibility to someone else and, well, if it was indicated and for the health of the woman it had to be done and I did it. Until this moment that abortion has been with me, ok? It's something that I am never going to be able to forget…. If after fifteen years I still can't forget and I think about if I go back I would have said no…. What one feels you can't, you can't just forget it.

Those that were providers of abortions also spoke of negative reactions to abortion, specifically to certain circumstances. Situations that were especially distressing were the termination of a second or third trimester fetus, women who have repeat abortions, or abortions that a gynecologist perceived as unnecessary given the mother's personal situation.

Abortion providers also expressed empathy for women who are faced with unwanted pregnancies and cited a desire to help women through a distressing and vulnerable time as a reason for providing abortions. The ability to feel empathy for a patient who was seeking an abortion was important to many who provide abortions. Interviewees discussed the necessity of putting oneself in the shoes of another and/or thinking through a scenario as if the patient was your daughter or sister. This was particularly helpful for some when they felt themselves judging a particular woman and her situation.

Perception of Rights

Many gynecologists used the language of rights to engage with the issue of abortion. Four categories of agents were identified as having rights or potentially having rights in an abortion: the mother, the father, the pregnancy and the gynecologist. The majority of interviewees agreed that a woman has the right to decide whether to continue with her pregnancy or not, regardless of their own personal feelings about the subject.

The rights of a fetus were less clear. Pablo, an abortion provider, mentioned the fetus as potentially having a right to life, but stated that the fetus' rights were subordinate to the mother's rights as the mother is a person with an established life and social network. Although no other gynecologist explicitly mentioned fetal rights to life, some did discuss whether the fetus was an independent life from that of the mother and this discussion was linked to the morality of abortion. Both conscientious objectors were adamant in their statement that a fetus is an

independent life from that of the mother from the point of conception, and thus should not be terminated. Other interviewees were ambivalent regarding fetal life. Several were unsure of when a fetus becomes an independent life, and several others placed the cut-off around the first trimester mark. Gynecologists described negative emotional reactions to abortions when discussing pregnancies in late gestation. The potential rights of a father were markedly less important to interviewees. Marina, an abortion provider, was the only one who mentioned paternal rights in an abortion and she expressed doubt as to whether a father even needs to know if the fetus has been terminated.

Most gynecologists viewed conscientious objection to abortion provision as a right of gynecologists. Several stated that conscientious objection was positive, as gynecologists who had strong religious, moral, or philosophical objections to abortion and were obligated to perform them would not give patients quality attention. However, interviewees also mentioned the existence of gynecologists who registered as conscientious objectors not because of personal belief systems, but rather to avoid having to engage with a complicated situation or to escape the stigma associated with abortion provision. Interviewees had little respect for these "false conscientious objectors" and did not think that objection under these circumstances should be a right.

Religious and Moral Values

Several gynecologists cited religious or moral reasons for providing or abstaining from providing abortions. All interviewees who identified themselves as Catholic grappled with the Catholic Church's position against abortion in some way. No one Catholic gynecologist blindly accepted the Church's position towards abortion. Instead, each interviewee engaged with and interpreted

the Church's teachings in light of their own reading of the Bible and/or their own personal experiences and belief systems.

Both conscientious objectors identify as Catholics. Although both cited the Catholic Church's position against abortion as an important factor in their decision to be a conscientious objector, both engaged with the issue at a deeper level. Each affirmed the importance of her faith, but neither agreed with every aspect of the Catholic Church's teachings. Cristina described how she arrived at her position towards abortion and contraception:

> I am convinced that contraception is not against what Christian faith says….I am Catholic because of proximity, but I am not in agreement with everything that the Catholic Church teaches… I believe that no part of the Bible says that you shouldn't use contraceptives. I believe that it does say, and perhaps that's tied up with the subject that interests you, it does say receive all of the children that come…

Despite the fact that both conscientious objectors stated that they agreed with the Catholic Church's position against abortion, they did not agree in all circumstances. Both supported abortions in the case of rape, and one supported abortion in the case of a fetal malformation incompatible with life. Both used personal belief systems beyond their faith to support these positions.

Several abortion providers also identify as Catholic. They too describe their relationship with the Catholic Church as one of active interpretation and selection. In the words of one Catholic participant:

> There are also things of the Church that I don't agree with…I counsel women that have abortions and in the Church…that is not permitted….it's like when a person has defects and even though they have defects you aren't going to leave them and that is the same [for the Church] it seems to me, no?
>
> –Marina, abortion provider

Many interviewees, both those who described themselves as religious and those that did not, cited the morality of helping others as a key factor in their decision not only to provide abortions,

but also to pursue a career in medicine. For several religious gynecologists, the morality of helping others through a difficult situation overruled any formal religious mandate against abortion.

Perceived Psychological and Social Consequences of Abortion

Gynecologists referred to a range of perceived psychological and social consequences of abortion as reasons both for and against abortion provision. Many interviewees believed that abortion provision positively impacted society by preventing the future neglect, abuse, or abandonment of unwanted children. In fact, several stated that one reason they provide abortions is because they would rather see a fetus aborted than a child in a harmful situation because they were unwanted. Many interviewees, especially those who had practiced gynecology before Uruguay's harm reduction model was implemented, indicated that providing legal abortions has positive social repercussions due to a decrease in maternal morbidity and mortality from unsafe abortion.

The consensus amongst gynecologists was that abortion was necessarily a negative psychological experience, one that was difficult to live through and to be avoided if possible. Cristina, a conscientious objector, specifically mentioned distress and regret post-abortion as reasons not to provide abortion services. However, abortion was represented as having positive psychological effects if the abortion was a result of rape or incest or in certain cases of fetal malformations.

Stigma

Although several gynecologists described episodes of stigma arising from abortion provision in their private lives, no one cited stigma as a factor in their decision to provide abortions or to become conscientious objectors. However, interviewees did describe stigma as a factor in *other* gynecologists' decision to register as a conscientious objector

The Scale Model of Gynecologist Decision-Making Regarding Abortion Provision

To illustrate and summarize our preliminary findings regarding gynecologist decision-making regarding abortion provision in Montevideo, Uruguay we have developed the model represented in Figure 3. Gynecologist decision-making regarding abortion provision is likely based on the combination of the five broad concepts described above and potentially others not found in this preliminary study. Within the five concepts described are multiple beliefs that fit within three categories: beliefs supporting provision, beliefs supporting conscientious objection, and neutral beliefs. A gynecologist can hold multiple beliefs in each concept. The beliefs a gynecologist holds in each concept weigh the scale towards one direction and the sum of beliefs in each concept ultimately tips the scale towards abortion provision or conscientious objection. For an overview of concepts and their corresponding beliefs including supporting quotes from participants see Table 1.

To illustrate this model we will walk through one participant's decision-making process regarding abortion provision. Pablo is a male gynecologist who provides abortions. He believes that his primary role as a gynecologist is to help patients carry out their reproductive decisions in the safest way possible. He does not feel that prescribing misoprostol to a patient makes him the agent responsible for the termination of the fetus. Although he sometimes has negative emotional

reactions to certain abortion cases, he also feels a great deal of empathy for patients facing unwanted pregnancies. He affirms the right of a woman to decide whether or not to have an abortion; he also feels a fetus in gestation has certain rights. Finally, he believes gynecologists have the right to abstain from performing abortions if they are morally or religiously opposed to the practice. Pablo is not very religious, but believes strongly in the morality of helping others. He believes that access to abortion prevents that child from being abandoned or mistreated in later life and that abortion could have positive psychological consequences in cases of rape, incest, or fetal malformations. Although Pablo had beliefs that support conscientious objection as well as beliefs that support provision, the majority of his beliefs surrounding abortion support provision, resulting in a cohesive narrative supporting abortion provision.

Discussion

Results indicate that gynecologist decision-making regarding abortion provision is a complex and multi-faceted issue based on a variety of beliefs belonging to five main concept areas. No single belief or category is the primary basis of decision-making regarding abortion provision, rather a combination of the beliefs in each concept area combine to form a cohesive narrative of a gynecologist's decision to provide abortions or to register as a conscientious objector. Furthermore, concept areas influencing decision-making were more diverse than originally expected, covering emotions, human rights, religion and morality, psychological and social consequences of abortion, and a gynecologist's perceived role and agency in abortion.

Gynecologist decision-making regarding abortion provision was influenced by personal religious beliefs and morality, gynecologist role and agency, emotions, perception

of human rights, and perceived psychological and social consequences of abortion. Gynecologists did not take Official Catholic teachings on abortion by at face value, but rather used their own experience, other non-religious beliefs, and personal interpretation of religious texts. Thus, only personal religious beliefs, not official positions of any one religion, affected participant decision-making regarding abortion. The only moral value that was important to gynecologist decision-making was the moral value of helping others. This was almost universally proclaimed to be an important factor in provider's decision-making processes. Spiritual beliefs were not found to influence gynecologist decision-making.

The chief strength of this study is that it is the first study of gynecologist decision-making on abortion in Montevideo, Uruguay and thus serves to greatly enlighten the subject and serve as a point of entrance for other subsequent studies. The limitations of this study are: 1) It is based solely on a convenience sample of gynecologist in Montevideo and only included two gynecologists who were conscientious objectors to abortion provision. Thus, the results may not be maximally representative of the population. 2) The results of this study cannot be used to make any claims on the causality of gynecologist beliefs on decision-making. Since interviews were conducted after gynecologists had decided whether to register as conscientious objectors or to provide abortions, any statements as to the decision-making process could be post-decision rationalization. Rather, the results of this study should be interpreted as an overview of the various factors that can influence gynecologists' decisions regarding abortion provision and how they interact.

This study is meant to be a preliminary exploration of gynecologist decision-making regarding abortion provision. Although this study has described five concepts important to gynecologist decision-making, it has also identified several areas of future research. First, it is important to further explore the issue of stigma and its influence on gynecologist decision-making. Although stigma was not found to be a factor for decision-making for any of this study's participants, several participants speculated that stigma was a factor in the decision-making process of some of their colleagues. Future studies should address stigma surrounding abortion provision and its role in decision-making regarding conscientious objection. Second, future studies should focus more directly on the decision-making process of registered conscientious objectors to determine whether there are any more concept areas influencing this population specifically. Finally, it will be important to explore decision-making regarding abortion provision in other areas of Uruguay, specifically those that have a higher proportion of registered conscientious objectors than the national average.

Conclusion

Gynecologist decision-making regarding abortion provision is a complex and multifaceted issue. As medical students specializing in gynecology prepare themselves for a career in gynecology, they need the space and opportunity to engage with the multiple concepts influencing abortion provision. In light of these results, this study's authors recommend that education regarding the concepts influencing abortion provision and discussion or values-clarification sessions in which future gynecologists can engage with these concepts be included in the medical school curriculum in Uruguay.

Figure 3: Scale Model of Gynecologist Decision-Making Regarding Abortion Provision in Montevideo, Uruguay

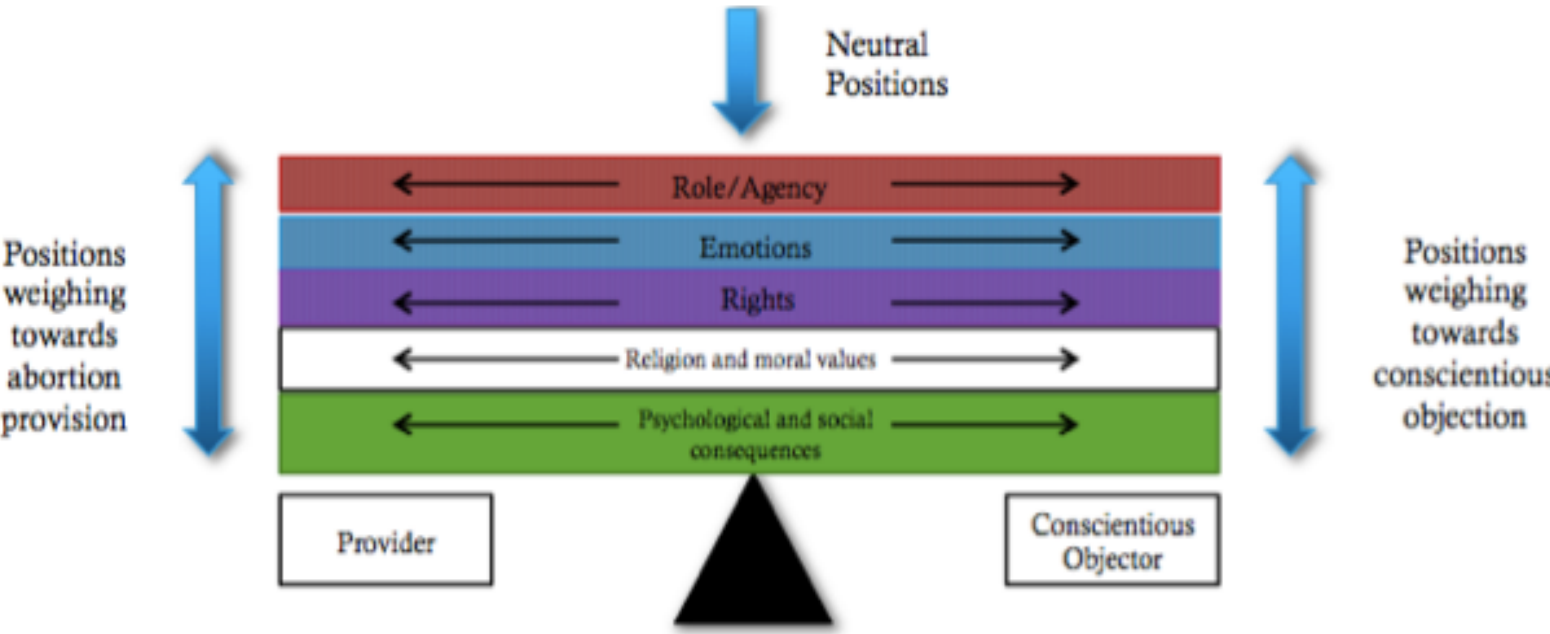

Table 1: Quotes Supporting Gynecologist Positions Towards Abortion in Each Category

	Refusal to Provide	Neutral	Provision
Role/Agency	"I didn't want to be the vehicle through which the pregnancy is terminated….If you counsel a patient you are doing the abortion. It's not the patient who is doing the abortion on her own. No. I am doing the abortion…" –Cristina, conscientious objector	"Like I said, I don't judge them. I can have my personal opinions, but…I keep them to myself."- Lucia, provider	"It is the patient that asks for it….It is her decision and I don't feel very bad." – Flavia, provider
Emotions	"I don't like abortion…In reality, it makes me sad…" – Andrea, provider		"…one has to have the peace of being able to help people in extreme situations that come in one of the worst moments of their life to look for counseling, or a helping hand…" –Pablo, provider
Rights	"There's the right of that new life in gestation…" –Pablo, provider	"Yes, I think that conscientious objection is a right that we as health professionals have…." –Maria, provider	"There's the right of that new life in gestation…" –Pablo, provider I see it as a right. I mean, right of the, of the woman and the partner, but above all the woman, to decide if she wants or doesn't want the pregnancy." –Vanesa, provider
Religion and moral values	"I believe that [the Bible] does say, and perhaps that's tied up with the subject that interests you, it does say receive all of the children that come…" – Cristina, conscientious objector		She believes in God, but sometimes she is in opposition to the positions of the Church. She believes in God, but she understands the situation of the woman. She tries not to involve her faith in her practice. She tries to do things in the best way possible. She might go to hell, but she doesn't think so. –Notes from interview with Paula, provider
Psychological and social consequences	"A lot of times a woman sees the abortion as a solution to that problem that she doesn't know how to resolve, but I have seen many women after the abortion that really end up really upset…" –Cristina, conscientious objector		"So, I prefer that they terminate the pregnancy than that they leave the children drenched, thrown into the street or that they mistreat them... It's ugly to say it, but I prefer that they terminate the pregnancy…" – Marina, provider "Yes, I think that yes, for the woman that suffers through a situation like [rape] I think that having to endure the entire pregnancy and a child in those situations is very difficult."- Andrea, provider

Title Page

Gynecologists' attitudes towards decriminalization
of abortion in Montevideo, Uruguay

Prepared for submission to the Pan-American Health Organization

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Student Contribution

In the development of this thesis I, the student, was responsible for the development of research methods, the collection of data following these methods, the analysis of collected data, the development of tables and figures, and the writing of this thesis document. I received the following assistance: Martín Couto advised me on the methodology of this study and participant recruitment, Dr. Roger Rochat and Dr. Jennifer Foster provided ongoing technical and academic support throughout the research and writing stages. They also contributed in the editing of the thesis and this manuscript.

Manuscript Body

Abstract

Objective. Determine gynecologist attitudes towards legislation decriminalizing abortion and its implementation in Montevideo, Uruguay.
Methods. A qualitative descriptive study including 11 in-depth interviews of gynecologists in Montevideo, Uruguay were carried out between June and July of 2014.
Results. Participants largely support the decriminalization of abortion, but have varied attitudes towards the technical details of its implementation. They reported the following potentially serious barriers to safe abortion access: mandatory five-day reflection period; failure to include fetal malformations compatible with life, but with serious negative prognoses within the gestational age exception; misuse of conscientious objection to abortion provision; difficulty of following the counseling structure in a timely manner in rural areas of Uruguay; and the requirement to file criminal charges to access a later-term abortion in cases of rape or incest . Moreover, they identified two other areas for improvement: the low number of women who attend the post-abortion counseling session and the limitation of abortion to medical abortions.
Conclusion: The barriers to abortion access identified in this paper should be studied further and acted upon to reduce issues with access.

Introduction

Abortion has historically been highly restricted in Central and South America. This restriction contributes to the region's high unsafe abortion rate, which is the highest in the world at 32 out of every 1,000 women (Guttmacher Institute, 2012). High levels of unsafe abortion have been linked to maternal mortality and morbidity. In Latin America, one in eight maternal deaths are the result of unsafe abortions (World Health Organization, 2011).

Until recently, the only Latin American countries where abortions were allowed at certain gestational ages for any reason were Cuba and Guyana. In 2006 Colombia passed legislation allowing abortion in some circumstances and one year later Mexico City decriminalized first-trimester abortions (Center for Reproductive Rights, 2014). In 2001, in light of the disproportionate role of unsafe abortion in maternal mortality, Uruguay launched a harm

reduction model to reduce these harmful effects. This model provided counseling by health providers on the use of misoprostol for induced abortions and the uptake of contraceptives post-abortion (Gorgoroso, 2010). By 2011 Uruguay was the only country in Latin America with no registered deaths from unsafe abortion procedures for the preceding three years (UNFPA, 2011). In October of 2012 Uruguay passed Law 18.987, which decriminalized (removed criminal punishments for) first-trimester abortions for any reason; until 14 weeks of gestational age in cases of rape or incest; and at any gestational age for serious risks to maternal health or in cases of fetal malformations incompatible with life. Regulation of abortion services was placed under the authority of the Ministry of Public Health.

Under Law 18.987 a woman seeking an abortion must attend three counseling sessions. The first session occurs with a gynecologist. During this session a woman communicates her intention to seek an abortion. Following this visit the gynecologist schedules an ultrasound to determine the gestational age of the pregnancy, runs blood tests, and schedules the second counseling session. This session must be assisted by a multidisciplinary team composed of a psychologist, a social worker, and a gynecologist and/or midwife. During the second counseling session a woman is counseled on her options, including abortion, continuing with her pregnancy and keeping or putting her infant up for adoption. If the woman decides to terminate her pregnancy she must go through a five-day waiting period before the third counseling session, during which a gynecologist prescribes the woman misoprostol, a synthetic prostaglandin analog that thins the cervix and causes uterus contractions. The gynecologist then counsels the woman seeking an abortion on how to use misoprostol After the woman takes misoprostol and terminates the pregnancy a fourth counseling session is recommended, during which a gynecologist determines whether the abortion was complete and counsels the woman on

contraceptive use. If a woman comes in past the gestational age limit, she is still entitled to the first three counseling sessions, including counseling on the proper use of misoprostol and its risks, but cannot be prescribed misoprostol.

Following the implementation of this law several potential barriers to access safe abortion procedures have been postulated by local reproductive health organizations. The three mandatory counseling sessions and the five-day waiting period may impede access to abortion services. Furthermore, under Law 18.987 gynecologists who are religiously, morally, or philosophically opposed to abortion provision can register with the Ministry of Public Health as a conscientious objector to abortion provision. Conscientious objectors are exempt from the third counseling session, in which misoprostol is prescribed, but they are not exempt from the first, second, and fourth sessions. They are also required to refer patients who come to them seeking an abortion to another gynecologist for the third counseling session.

The Ministry of Public Health estimates that approximately 30% of gynecologists nationwide are conscientious objectors and in some rural areas of Uruguay up to 100% of local gynecologists are registered as conscientious objectors. A significant proportion of conscientious objectors amongst gynecologists may impede patients' access to legal abortion services by decreasing the number of providers capable of performing abortions. Decreased access to services has been shown to increase the number of abortions performed in unsafe circumstances (Chavkin et al., 2013).

The purpose of this paper is to describe the attitudes of gynecologists' (both those who are providers and those who are conscientious objectors) towards Law 18.987 and its implementation. As the only health care providers who are authorized to perform abortions in Uruguay, gynecologists have a unique perspective as well as first-hand experience in safe

abortion provision. Thus, gynecologists can identify barriers to accessing safe abortion as well as areas for improvement in legislation regarding abortion, its implementation, and its regulation

Essentially nothing is known regarding gynecologists' attitudes towards the new decriminalization law. This paper reports the findings from this study undertaken by one member of a research team of public health, nursing, and divinity graduate students from Emory University over a two-month period.

We used a qualitative, descriptive approach with semi-structured, individual interviews to elicit information from gynecologists practicing or living in Montevideo, Uruguay. In collaboration with members of Uruguay's National Health System we used a combination of convenience and snowball sampling methods to sample gynecologists between June and July of 2014. Investigators and collaborators compiled a list of gynecologists practicing in Montevideo. We sent gynecologists on this list an invitation, which included the study's research goal and provided contact information to participate in the study. We telephoned gynecologists who replied with their phone number to schedule the interview. We recruited eleven gynecologists and lost two to follow-up. A previous participant also recruited two additional participants. We submitted the study protocol to Emory's Institutional Review Board who determined it was not human subjects research and was exempt from IRB review.

The first author conducted interviews in Spanish at a time and place of the participant's choosing. A semi-structured interview guide with questions regarding aspects of Law 18.987 and its implementation was used. Verbal and written consent was obtained from each study participant. Interviews were recorded and transcribed verbatim and then translated to English at which point all data was de-identified.

During data collection, transcription, and translation the primary investigator took detailed notes of reflexive reactions and possible codes and categories. Interview documents were then uploaded to MAXQDA. The investigator actively read each interview and took detailed memos. These memos were used to develop an open codebook containing both inductive codes (codes defined by participants during the interview) and deductive codes (codes determined important to the study through literature or the research question). Codes pertaining to gynecologist attitudes to Law 18.987 were then identified and described in detail.

During the data collection process two participants were lost to follow-up. Parts of two interview recordings were lost due to technical malfunction and had to be recovered from written notes taken during the interview.

Results

Demographic characteristics of participants

Nearly all of the 11 study participants were female (10) and abortion providers (9). One participant was male and two participants were conscientious objectors to abortion. Participants ranged in age from 33 to 47 years old with an average age of 38 years. Pathways to medicine and specialization in gynecology varied. Some chose to specialize in gynecology because of its perceived association with healthy patients and positive life events. Several chose gynecology as an alternative to surgery, which was perceived as unfriendly to female doctors. Although gynecologists stated that they enjoy the specialty, life as a gynecologist was also described as "exhausting" and "stressful." Gynecologists who are in the early stages of their career are expected to work in multiple health organizations and to complete 12-24 hour "on-call" shifts. Gynecologists described long work hours as a barrier to a healthy lifestyle. Furthermore, many

gynecologists mentioned the stressful nature of assisting patients living through complex personal or social issues, especially those faced with an unplanned pregnancy. In the following description of gynecologist attitudes towards abortion decriminalization and its implementation all names are pseudonyms to protect the interviewees identities.

Participants' attitudes towards Law 18.987 and its implementation

In general, interviewees supported decriminalization of abortion because it led to a decrease in maternal mortality and morbidity, equal access to safe abortion procedures, and included women with unplanned pregnancies within the health system. However, the majority of gynecologists interviewed did not agree with all or some of the technical details of the law and its implementation. Still, they differed in which details should be changed and what that change should be. Those who provide abortion services felt that the technical details of the law are too rigid, that certain aspects of the law set up barriers to safe abortion services, and that certain circumstances for seeking abortion are not adequately addressed by the law. Conscientious objectors stated that the law takes abortion too lightly and doesn't attempt to prevent repeat abortions. These attitudes are described in further detail below.

Gestational age limit

Law 18.987 establishes a gestational age limit of 12 weeks for women seeking abortions with exceptions for cases of rape or incest, fetal malformations incompatible with life, and serious risk to maternal health. All gynecologists interviewed agreed with a first-trimester gestational age limit, citing the lower risk of a first-trimester abortion to maternal health. Several also referred to fetal development as a justification for a first-trimester gestational age limit. Pablo, an abortion provider, explained:

> I am in agreement with the restriction on gestational age…I think there are various arguments, but the two strongest [are] I think that until twelve, fourteen weeks we're

> talking about an embryo that still doesn't have the development from the physical viewpoint to have some biological processes that make that embryo have human nature. There isn't a central nervous system and a ton of things…The second is that I think that the woman is obligated in that situation to make a decision in time for the practice of abortion will be less risky for her.

The gestational age limit also seemed to reassure gynecologists who were uncomfortable with later-term abortions:

> The fact is that…the law has twelve weeks gives me spiritual peace too. It takes the weight off of having to decide about a bigger pregnancy. Since it is written in law, there it is. The law says. A bigger pregnancy is…that puts a lot at play, no? When the fetus starts to move or you start to see visible changes there it is wrapped up in whether there is life, no? I think that the gestational age [limit] is good.
>
> –Andrea, abortion provider

Several interviewees, however, argued that the delays that can arise from the mandatory waiting period and counseling process (discussed in more detail below) may cause women to pass the gestational age limit. Interestingly, even in light of these potential delays as well as the limited ability to diagnose a fetal malformation before 12 weeks of gestational age only one gynecologist suggested an extension of the gestational age limit, and even then only by one or two weeks.

Mandatory reflection period

Several interviewees suggested the elimination of the five-day mandatory reflection period, which must take place following the second counseling session. Gynecologists described the five-day reflection period as "agonizing" for women who have definitively decided to terminate their pregnancies. Marina, an abortion provider, alleged that some women choose to have an unsafe abortion outside the health system just to avoid the reflection period. As mentioned above, the reflection period can also complicate the process for women who are nearing their second trimester. Women may come in seeking an abortion, but pass the gestational limit during the process and be forced to seek an unsafe abortion.

On the other hand, some women come into the first and second appointment without having made the final decision to terminate:

> After the [harm reduction model] that we had before…the one that establishes counseling in which we counseled the woman before the abortion and after the abortion, but it wasn't…legalized…I worked in service here in this institution and…women arrived with the decision much more meditated, much more thought out because they knew…that the abortion was penalized…now what happens a lot is that they come with a decision that isn't very thought out. What's more there are women that find out that they are pregnant in the morning and they come in the afternoon to have an appointment and part of the process of assisting them is exactly to calm them down…so that the woman can make the decision the most meditated and rational as possible.
>
> –Pablo, abortion provider

These women may benefit from a reflection period, which gives them a structured timeline to make their final decision. In light of these conflicting needs, interviewees disagreed over whether the reflection period should be eliminated or extended. Several suggested making the reflection period dependent on the individual case.

Abortion in cases of fetal malformation

Currently under Law 18.987 fetal malformations incompatible with life can be legally terminated at any gestational age following diagnosis by a gynecologist. All gynecologists interviewed, including those who are conscientious objectors to abortion provision, agreed with the law's exception for fetal malformations incompatible with life. However, interviewees also highlighted that the law does not include fetal malformations compatible with life, but with a negative prognosis within the exception. Thus, women who are pregnant with a fetus that is determined to have a malformation, but that malformation is deemed compatible with life, cannot legally terminate their pregnancy after the twelve week gestational limit, even if the prognosis for that fetus is very negative. Several gynecologists suggested including these cases within the fetal malformation exception to prevent these women from seeking illegal and unsafe abortions.

Abortion in cases of rape or incest

Uruguay's legislation extends the gestational age limit to 14 weeks in cases of rape or incest and waives the mandatory reflection period and counseling structure, but requires that women utilizing this extension file a formal charge against their assailant. All gynecologists interviewed, including those who are conscientious objectors to abortion provision, personally agree with a woman's ability to terminate a pregnancy that is the result of rape or incest. The implementation of this exception, however, may not be running as smoothly as hoped. Pablo, an abortion provider, suggested that the requirement of charging the assailant with sexual assault could create problems and delays, and should be eliminated.

Counseling process

The counseling process involves three mandatory sessions and one optional post-abortion session. Following this counseling schedule can be difficult in rural areas, where few doctors provide abortion services. Because of this shortage of gynecologists, some rural areas have to send patients to the public hospital in Montevideo in order to provide a requested abortion within the gestational age limit. Despite these issues, many interviewees saw the counseling structure as a positive part of the law. The second counseling session, composed of options counseling, was described as being especially important in order for the woman to be able to make the decision in the most free way possible, knowing all of her options. The fourth counseling session, in which the post-abortion check-up and counseling on contraception options occur, was also considered important. However, Josefina, who provides abortions, asserted that few women come back for the fourth session, leaving them without a contraceptive method and thus at risk for subsequent unwanted pregnancies. In fact, within the time between the passage of Law 18.987 and this study, some interviewees had witnessed patients returning for a second or even third abortion.

Multidisciplinary team

Interviewees described the mandatory assistance of the multidisciplinary team positively. The assistance of the psychologist was considered especially helpful, both to women seeking abortions and the gynecologists themselves. Those interviewed highlighted the importance of the assistance of a psychologist in helping the woman seeking an abortion through a distressing situation as well as providing support post-abortion if needed. Several also described how a psychologist helped them to process especially difficult cases.

Gynecologists interviewed had mixed opinions regarding the mandatory assistance of the social worker. Although some felt that the social worker could be helpful to women seeking abortions, others regarded their presence as a prejudice of the legislators who crafted Law 18.987. Maria explained:

> The fact that a social worker is in the consult is a little patriarchal. It makes a judgment about the situation of the woman seeking an abortion. It assumes that she is from a lower socio-economic class, or is poor….That's a prejudice of the legislators. The social work is really variable; it isn't necessary in many cases.
>
> –Maria, abortion provider

Unsafe abortion

The reduction of unsafe abortion was one of the main reasons behind the harm reduction model implemented in 2001 and the legislation decriminalizing abortion passed in 2012. Unfortunately, several interviewees stated that despite the current legislation unsafe abortions still occur. According to these interviewees, some women choose to have abortions in illegal clinics to avoid the five-day reflection period and rigid counseling structure. Others are forced to seek unsafe abortions because they fall outside the gestational age limits and exceptions. Although women

that fall outside of the requirements for legal abortion are still entitled to options counseling, they cannot be prescribed misoprostol.

Conscientious Objection

Although the majority of gynecologists interviewed expressed the opinion that conscientious objection to abortion provision is a necessary right of gynecologists, several also described a sub-section of “false conscientious objectors.” These “false conscientious objectors” abstain from abortion provision for reasons other than religious, moral, or philosophical beliefs against abortion:

> I think that conscientious objection should exist, but it has to be a real conscientious objection…what I have seen is that here many times conscientious objection…doesn’t reach the roots….For example, there are those who say that they did conscientious objection because they don’t agree with the law, that the law seems to them too restrictive, that they don’t agree with the five days….There are people…that do conscientious objection for a question of appearances and because in their place of work it’s not good to be seen associated with that subject and in fact in private life, they don’t stop inducing abortions sometimes outside of the law. So, it’s a problem.
>
> –Maria, abortion provider

Type of Procedure

Currently most abortions performed in Uruguay are medical abortions using misoprostol. According to Maria, while medical abortions have their advantages namely privacy and the avoidance of stigma, some women would prefer to have both surgical and medical abortion options. However, both Maria and Flavia admit that for the gynecologist the act of performing a medical abortion is much different from the act of performing a surgical abortion:

> [Performing a medical abortion] I feel more like I am helping her, and accompanying her and protecting her so nothing bad happens to her…that I am not doing something to terminate a life…If I had to do, for example, a dilation and curettage….I don’t think I could do it. I think that I would feel very bad. I don’t think that I could do it.
>
> –Flavia, abortion provider

Maria expressed the opinion that many gynecologists would not be willing to perform a surgical abortion at this point in time, but stated that she hoped it would be a possibility in the future.

Discussion

Most of the 11 gynecologists agreed with the decriminalization of abortion. However, nine disagreed with one or more aspects of its implementation. They assert that potentially serious barriers to safe abortion access for Uruguayan women include the mandatory five-day reflection period; the failure to include fetal malformations compatible with life, but with serious negative prognoses within the gestational age exception; misuse of conscientious objection to abortion provision; the difficulty of following the counseling structure in a timely manner in rural areas of Uruguay; and the requirement to file criminal charges to access a later-term abortion in cases of rape or incest.. Gynecologists highlighted issues such as the low number of women who attend the post-abortion counseling session and the limitation of abortion to medical abortions.

The study's limitations include its limited scope and potential selection bias. Future studies with a larger, representative sample should include a continued focus on gynecologists' experience with abortion provision as well as the experiences of social workers and psychologists who form part of multidisciplinary teams. Finally, studies should explore patient experiences and satisfaction with diverse aspects of Law 18.987 and its implementation. Despite the limitations, we believe that as barriers to safe abortion access are identified, the Ministry of Public Health and Uruguay's legislative body would fulfill the intent of the law if they reduced or eliminated the barriers identified through this study and future research.

Chapter IV: Conclusions and Recommendations

Important Findings

This study's findings suggest that gynecologist decision-making regarding abortion provision is complex and multi-faceted, involving five broad and diverse concepts including emotional reactions to abortion, human rights, religious and moral views, perceived social and psychological consequences of abortion, and perceived role and agency in the abortion process. Within each category are multiple beliefs. These beliefs are either aligned with conscientious objection, with abortion provision, or are neutral. A gynecologist can hold one or more beliefs within each category and it is the combination of all beliefs and categories that describe the reasoning behind a gynecologist's decision to provide abortions or to become a conscientious objector to abortion provision.

This study was also able to describe gynecologists' attitudes towards Law 18.987 and its implementation. Respondents supported the decriminalization of abortion based on its potential to reduce unsafe abortions, its inclusion of women with unwanted pregnancies in the health system, and equal access to abortion procedures regardless of socio-economic status. However, gynecologists differed on their opinions of the technical details of Law 18.987 and its implementation. Interviewees considered the following aspects of the law as positive: the gestational age limit of twelve weeks, the mandatory assistance of a psychologist, exceptions regarding abortion in cases of rape or incest and fetal malformations incompatible with life; and the counseling structure, especially the second counseling session, which includes options counseling and the fourth session, which includes counseling on contraceptive methods to prevent subsequent abortions.

Although gynecologists reported general satisfaction with the law, they identified several barriers to legal abortions including the mandatory five-day waiting period; exclusion of fetal malformations compatible with life, but with very negative prognoses within the gestational age exception; the requirement to file criminal charges to qualify for a gestational age exception in cases or rape or incest; difficulties following mandatory counseling sessions in rural areas; and misuse of conscientious objection. Gynecologists also described low attendance at post-abortion appointments and restriction to medical abortions as potential areas for improvement.

Comparison to the Literature

In combination with the studies undertaken by my colleagues Yona EtShalom and Heidi Schroffel, who were part of the multidisciplinary team funded by the Global Health Institute, this study is one of the first undertaken to examine barriers to safe abortion access in Uruguay following the decriminalization of the procedure in 2012. This study preliminarily describes gynecologist decision-making regarding abortion provision as well as gynecologists' attitudes towards Law 18.987 and its implementation.

Conscientious objection to abortion provision has been identified as a barrier to safe abortion access by Global Doctors for Choice (Chavkin et al., 2013). Of the studies examining conscientious objection decision-making, many include only preliminary speculations (Faúndes et al., 2013) (Johnson et al., 2013). None of these studies has explored gynecologist decision-making regarding abortion provision in Uruguay. Similarly, although many studies have examined barriers to abortion access and gynecologist attitudes towards abortion provision, this is the first study to date that describes gynecologist attitudes towards the implementation of legislation

Limitations

Although this study has described several important aspects of gynecologist decision-making, its results should be interpreted as preliminary. First, this study relies on a convenience sample and may not be representative of the population. Second, since this study only included gynecologists who have already decided either to object to abortion provision or to provide abortions their description of their decision-making process may have been based on a posteriori rationalization of their decision rather than their actual decision-making process. Nevertheless, this study contributes to our understanding of gynecologist decision-making regarding abortion provision in Montevideo, Uruguay and also highlights several areas for future research.

Recommendations

First, we recommend continued research into both conscientious objection to abortion provision and potential barriers to abortion access in Uruguay. Stigma may influence gynecologist decision-making in ways not found in these interviews. Although stigma was not found to be a factor for decision-making for any of this study's participants, several participants speculated that stigma was a factor in the decision-making process of some of their colleagues. Future studies should address stigma surrounding abortion provision and its potential role in decreasing access to legal abortion services. Second, future studies should focus more directly on the decision-making process of registered conscientious objectors to determine whether other concept areas influence this population specifically. In order to explore decision-making regarding abortion provision as it occurs, at least one study should be conducted with gynecologists as they are entering the field of gynecology. Finally, it will be important to explore

decision-making regarding abortion provision in other areas of Uruguay, specifically those that have a higher proportion of registered conscientious objectors than the national average.

Based on the results presented in this paper we can recommend the following. As medical students specializing in gynecology prepare themselves for a career in gynecology, they require space and opportunity to engage with the multiple concepts influencing abortion provision presented here. This study's authors recommend that education regarding the concepts influencing abortion provision and discussion or values-clarification sessions in which future gynecologists can engage with these concepts be included in the medical school curriculum in Uruguay and any other countries implementing similar legislation.

This study also explored gynecologists' attitudes towards abortion decriminalization and its implementation. As the only medical professionals who are legally allowed to perform abortions in Uruguay, gynecologists have both a unique perspective of abortion provision and first hand experience with the implementation of Law 18.987. Their perspective may be especially useful in identifying aspects of abortion policies and provision that may be adverse to health outcomes and which can be used to improve legislation or policies regarding abortion provision.

Further research is needed to both adequately describe potential issues surrounding abortion provision in Uruguay and to formulate potential solutions to these issues. Future studies should include further research into gynecologists' experience with abortion provision. These studies should be both qualitative and quantitative in order to fully capture both the breadth and depth of gynecologist opinions and suggestions. Furthermore, research must be conducted into patient experiences and satisfaction with abortion provision. This is especially important as patients have a unique perspective to abortion provision. Finally, studies should explore the

attitudes of other professionals associated with abortion towards abortion provision and its shortcomings. In light of these preliminary findings, this study's author recommends that the Ministry of Public Health and the legislative branch of Uruguay take whatever measures necessary to address the issues described by these findings and future research and to implement any policy recommendations that have the potential to increase access to safe abortion services.

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