PREPARATION GYNECOLOGISTS MONTEVIDEO

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"I wrote the prescription; the patient did the abortion": Preparation of gynecologists for abortion services in Montevideo before and after 2004

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An abstract of

A thesis submitted to the Faculty of the

Rollins School of Public Health of Emory University

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2015

Abstract

"I wrote the prescription; the patient did the abortion": Preparation of gynecologists for abortion services in Montevideo before and after 2004

By Shira "Yonah" EtShalom

Background: Unsafe abortion causes 13% of all maternal deaths worldwide (WHO, 2011b). In Uruguay, prior to 2001, unsafe abortion caused ~30% of maternal mortality (Briozzo et al., 2004). In 2004-2012, nationwide implementation of a harm reduction model coincided with a steady reduction in abortion-related death. In 2012, 1st-trimester abortion was decriminalized with several restrictions. No data were available on the extent of gynecologist training in the abortion, to help determine the degree to which lack of training is a cause of decreased access to safe abortion under the new law.

Purpose: To determine, 18 months after the decriminalization of abortion, the extent to which gynecologists practicing in Montevideo, Uruguay are trained, willing, and confident about providing abortion services – and which kinds of abortions they are trained to provide. We also sought to measure what proportion of gynecologists have provided abortions, and to capture reasons for denial of abortion services.

Methods: Cross-sectional structured survey using convenience/snowball sampling of 40 gynecologists (37 in-person surveys, 3 via online survey) totaling 42% of gynecologists currently practicing in in the public sector in Montevideo (approx. 90). Montevideo was chosen because, as the capital city of Uruguay, its metro area is home to 51% of the country's population.

Primary Results: Of the respondents, 95% were trained in induced abortion and 97.5% in managing incomplete miscarriage; 97.5% had managed incomplete miscarriage surgically and 95% medically (using misoprostol). Eighty-nine percent of abortion providers reported having denied patients abortions due to gestational age based on legal gestational age restrictions.

Conclusions: Based on the very high prevalence of abortion training amongst respondents, it appears that lack of training is not a major barrier to access. Montevideo gynecologists appear to be trained in both medical and surgical techniques of abortion care, whether through abortion training or miscarriage management training/experience. Because 85% of respondents reported having seen an abortion patient with advanced gestational age, barriers to early access to abortion as well as to contraception should be further researched and extending the gestational limit should be explored.

Keywords: abortion, abortion training, gynecologists, Uruguay

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Chapter 1: Introduction

Context of Project

Each year, an estimated 20 to 22 million unsafe abortions take place worldwide (WHO, 2011b). These unsafe abortions cause 47,000 deaths annually according to WHO (2011b)[1], disproportionately affecting developing countries. Worldwide, 13% of maternal deaths are attributable to unsafe abortion. Maternal mortality and morbidity from unsafe abortion is costly and preventable. Besides the obvious public health issue of lives lost, the financial cost of treating unsafe abortion is substantial: an estimated $11.3 million annually for Latin America, and $11.4 million annually for Africa, two of the regions with the highest incidence of unsafe abortion (Vlassoff, Walker, Shearer, Newlands, & Singh, 2009).

The United Nations, among many authorities addressing issues of public health and economics, addressed maternal mortality and morbidity in the Millennium Development Goals. Goal 5 includes the following (from WHO, 2009):

> Goal 5: Improve maternal health
>
> Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.
>
> Target 5.B: Achieve, by 2015, universal access to reproductive health.

Target 5.B includes safe abortion in its definition of "reproductive health" (WHO, 2009), though it is not addressed in the 2015 MDG report.

Uruguay, where induced abortion has been a crime since 1938, has had periods of very high maternal mortality from unsafe abortion, and over the past fifteen years has responded by

[1] WHO also reported, elsewhere, that 68,000 deaths from unsafe abortion occur annually (2009). The lower estimate of 47,000 is quoted more widely in the literature and is directly traceable to WHO's 2011 publication of abortion trends, while their 2009 document does not include citations for the 68,000 estimate.

enacting various policies and procedures to address this, with great success. Uruguay overall has fairly low maternal mortality, particularly compared with other developing countries and with the region of Latin America. However, in the 1990s a very high proportion – 25.8%, among the highest in Latin America – of that maternal mortality was due to unsafe abortion (Briozzo et al., 2004, table 5, p. 72). An estimated 33,000 clandestine abortions took place per year prior to 2004 (Ottolenghi, 2011).

In 2001, Uruguay saw a sharp increase in maternal mortality: 19 deaths nationwide (for a maternal mortality rate of 3.7 deaths per 10,000 births), 9 (47.4%) of which were due to unsafe abortion (Ottolenghi, 2011). That proportion was even higher in Hospital Pereira Rossell, the primary public maternity hospital in Uruguay: 71.4% of the hospital's maternal mortality for 2001 was due to unsafe abortion. Overall for 1997-2001, unsafe abortion caused 25.8% of Uruguay's maternal deaths.

In light of this, clinicians developed a harm reduction model in 2004 to mitigate the risk of illegal abortion without challenging its legal status. In 2012, abortion was decriminalized in the first trimester with several restrictions.

Problem Statement

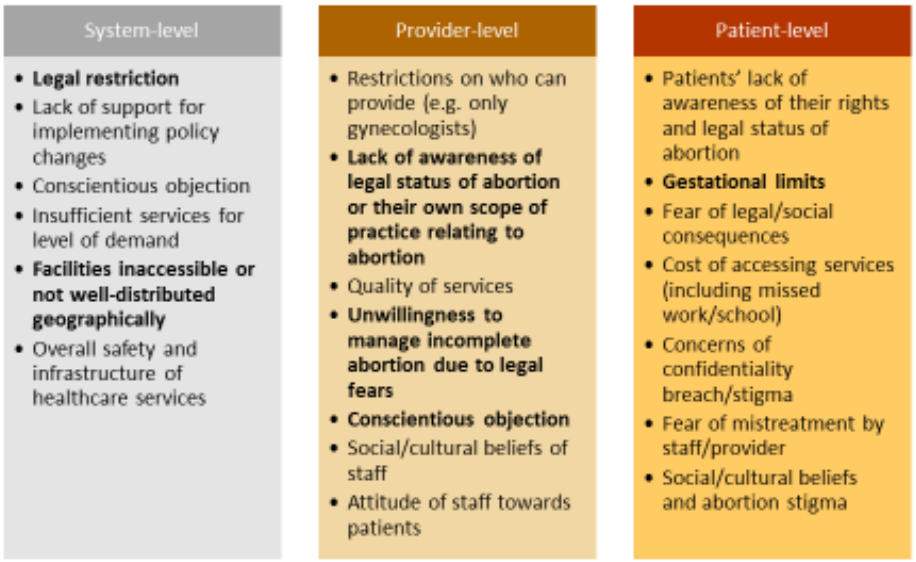
Maternal mortality from unsafe abortion is a significant problem in much of the developing world, where 55% of abortions are unsafe (Haddad & Nour, 2009). Through implementing a harm reduction response and liberalization of abortion laws (discussed in Chapter II), Uruguay has radically changed the climate of abortion provision. We have data on the effects on maternal mortality overall and specific to unsafe abortion. However, we do not have data on what barriers remain for abortion-seeking patients in Uruguay. Specifically, we do not know how prepared

gynecologists are to provide abortion amidst changes in policies and practice. We don't know about whether or how much gynecologists are trained, willing, or confident to provide abortion services post-decriminalization. We don't know the extent of denial of services.

Without this knowledge, we might assume that change in policy results in change in practice and that the multi-faceted decriminalization legislation of 2012 has in fact made elective abortion an accessible, safe option for all Uruguayans. But we have not yet established this as true, and there may be any of several barriers to translating policy to practice.

The World Health Organization describes barriers to abortion care at length in their 2011 document *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008* (2011b). We summarize these barriers (Fig. 1), with emphasis added to indicate the barriers addressed in this investigation.

Figure 1: Barriers to safe abortion (based on WHO, 2011b); emphasis indicates barriers addressed in this project



Purpose of Project

The purpose of this study is to investigate aspects of abortion access in light of the 2012 liberalization of abortion laws. We conducted a cross-sectional survey of gynecologists in Montevideo to study barriers to abortion access, focusing on the follow:

- abortion training prevalence,
- experience with managing incomplete miscarriage (which is a similar process to inducing abortion),
- history of refusal to provide abortions in the past,
- history of refusal to receive training in abortion,
- history of denial of abortion services based on legal restrictions (i.e. legal restrictions on age, gestational age, citizenship)

Significance

The results of this study are significant for two reasons. First, we learn more about the barriers to access that continue to prevent all Uruguayans from accessing safe abortion care and keeping maternal mortality and morbidity to a minimum.

Second, by identifying the strengths of Uruguay's system of safe abortion access, other countries may be able to adapt aspects of Uruguay's process to improve their own systems of abortion care and reduce maternal mortality from unsafe abortion. The harm reduction model enacted in 2004 to mitigate the risk of illegal abortion without challenging its legal status caught the attention of many other countries in Latin America and worldwide, which have since adapted this model for their own settings. These countries may benefit from continuing to learn the challenges and strengths of Uruguay's path towards eliminating maternal mortality and morbidity from unsafe abortion.

Chapter 2: Background and Literature Review

Background

Abortion as Public Health Priority

Numerous governmental and nongovernmental organizations have identified mortality and morbidity associated with unsafe abortion as priorities from perspectives of human rights, public health, and economics. The World Health Organization, amongst its many documents on the subject of safe and unsafe abortion (2011b; 2012; 2015) stated, in its document outline best practices for safe abortion, "an estimated 22 million abortions continue to be performed unsafely each year, resulting in the death of an estimated 47 000 women and disabilities for an additional 5 million women. Almost every one of these deaths and disabilities could have been prevented through sexuality education, family planning, and the provision of safe, legal induced abortion and care for complications of abortion" (WHO, 2011a, p.1). The document goes on to say, "[t]o the full extent of the law, safe abortion services should be readily available and affordable to all women" (2011a, p. 8).

In 2015, reducing maternal mortality has been one of the Millennium Development Goals (Target 5.A, UN 2015). The 1994 International Conference on Population and Development (ICPD) identified as an objective "[o]n the basis of a commitment to women's health and well-being, to reduce greatly the number of deaths and morbidity from unsafe abortion" (United Nations, 2014, p. 88). More specific to the scope of this project, the Society for Family Planning identified "[i]nvestigating…[b]arriers to care in newly decriminalized environments" as one of their top research priorities (Higginbotham, 2015, p286).

Uruguay

Uruguay is a middle-income country on the east coast of South America, bordering Argentina to the west and Brazil to the north. With a population of 3.3 million, 95.3% of the population lives in urban areas (CIA, 2015d). Over 50% of the country's population lives in Montevideo, the capital city.

Uruguay consists of 19 regions called *departamentos.* Montevideo is the name of both the capital city and the *departamento* containing the capital city and surrounding area. For the purposes of this thesis, we will be using *Montevideo* to refer to the *departamento* as a whole.

As of 2007, Uruguay provides universal healthcare coverage to all Uruguayans (Center for Reproductive Rights, 2015), though some Uruguayans use private insurance. The Ministry of Public Health (MSP) operates public hospitals and clinics, but private healthcare facilities are also available to those who can pay.

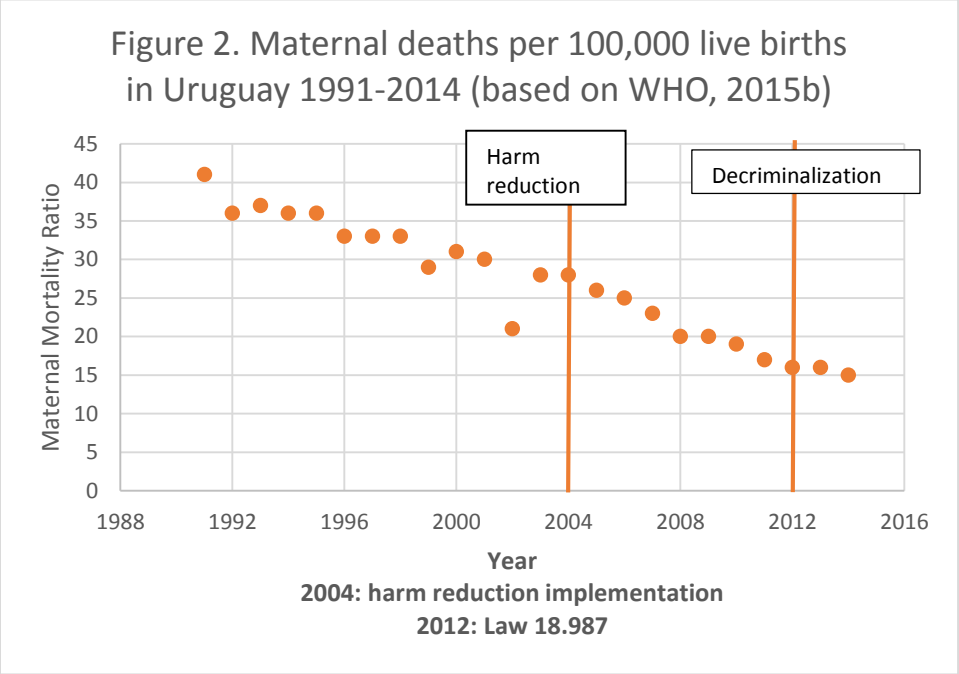
The total fertility rate (TFR) was 2.2 children per women in South America for 2008, and 2.4 for Latin America and the Caribbean as a whole (WHO, 2011b). Uruguay's estimated TFR for 2015 is 1.82, which is relatively low for a developing country, ranking 151st out of 224 countries (ranked from highest TFR to lowest) (CIA, 2015c). Neighboring countries Argentina and Brazil have TFRs of 2.23 and 1.77 respectively (CIA, 2015a; CIA, 2015b).

Uruguay's adolescent fertility rate (births per 1,000 women age 15-19) was 59 in 2010 and 2011, and 58 in 2012 (PAHO, 2014). Argentina's rate was 54-55, while Brazil's rate was 71-73 (PAHO, 2014).

For years 2011-2013, 99% or more of births in Uruguay took place in hospitals (PAHO, 2014). This is higher than the average for Latin America as a whole, where 92% of women deliver in hospitals, and in stark contrast to the 55% of women in developing countries who

deliver in hospitals (WHO, 2011b). Uruguay's infant mortality rate is 8.9 death per 1,000 live births (Population Reference Bureau, 2015).

Uruguay's maternal mortality ratio (MMR) was, in 2013, 14 per 100,000 live births – half the United States' MMR of 28 (WHO, 2014) (Fig. 2[2]).



Uruguay's history and culture differ from much of South America in several key ways that may influence the country's ability to liberalize abortion access. The Catholic Church, a powerful political player in most Latin American countries, has less influence in Uruguay, where 47.1% of the population are Roman Catholic and 17.2% are atheist or agnostic (CIA, 2015d). In contrast, 92% of Argentinians are Roman Catholic, though the CIA notes that only 20% are practicing (2015a). In Brazil, 64.6% percent of the population are Roman Catholic (2015b). Uruguay's population, while less religiously homogenous, is more ethnically homogenous, with

[2] "HR" and "Decriminalization" mark the years of harm reduction (2004) and decriminalization of abortion (2012) in Uruguay, respectively.

88% of the population defined as “white”, primarily descended from mid-19th century immigrants from Spain and Italy (CIA, 2015d).

Harm Reduction and the Path to Decriminalization

Abortion has been a criminal offense in Uruguay since 1938, with exceptions (Briozzo, Vidiella, Rodríguez, Gorgoroso, Faúndes, & Pons, 2006). Briozzo et al., writing in 2006, described the situation:

> Uruguayan law declares all voluntary abortion always illegal. Nevertheless, under extenuating circumstances, judges are authorized not to enforce penalties. In practice, however, even though abortion is not penalized when performed in extenuating circumstances (to prevent women's death or serious morbidity, extreme poverty, extra- or premarital pregnancy, or when pregnancy is the result of rape), only exceptionally are abortions carried out in public hospitals. (p222)

Inducing abortion remains a criminal offense. However, over the past 15 years the Uruguayan parliament has passed several pieces of legislation altering abortion policy and practice.

In the 1990s, Uruguayan civil society became increasingly aware of clandestine abortion as an issue of public health and social justice (Ipas, 2013). National data on maternal mortality and morbidity from unsafe abortion were not available until Dr. Leonel Briozzo et al. published their findings in 2004, but organizations like Mujer y Salud en Uruguay (discussed below) formed to address their concerns regarding the unsafe, illegal abortions occurring in the 1990s.

Uruguayan clinicians also became involved with the issue of clandestine abortion. In July 2001, a group of healthcare workers formed the organization Iniciativas Sanitarias (IS) to address maternal mortality and morbidity from unsafe abortion (Briozzo et al., 2004; Gorgoroso et al.,

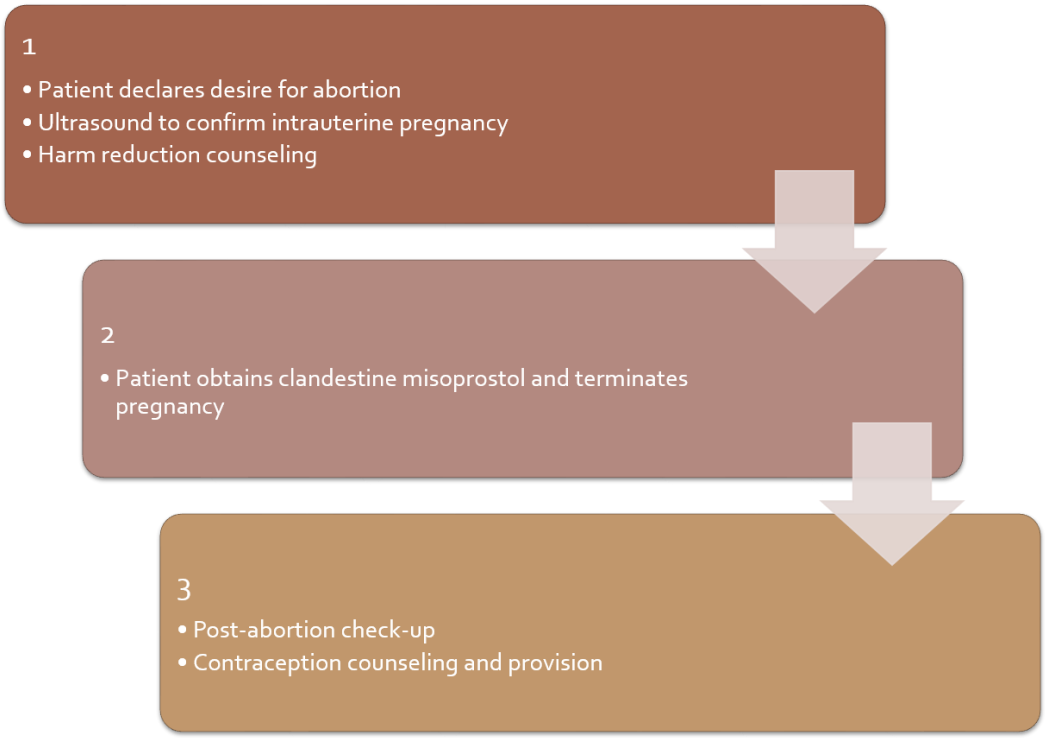
2011). IS developed a harm reduction[3] program to reduce the risk of illegal abortion. This consisted of two clinical visits:

1. Patients who wished to terminate their pregnancies, or were considering termination, had a "pre-abortion" visit. The visit included (a) an ultrasound to confirm intrauterine pregnancy and determine gestational age, and (b) options counseling and discussion of the varying levels of risk with each of the common self-termination methods used in Uruguay at the time. Clinicians included misoprostol amongst the safest methods for clandestine abortion, and described dosage, expected effects, and concerning signs and symptoms that would indicate the need to seek clinical care.
2. The "after" visit consisted of prenatal care if the patient chose to continue the pregnancy, or post-abortion care if the pregnancy ended spontaneously or due to induced abortion. At post-abortion visits, clinicians confirmed completion of abortion, offered the patient contraception, and provided psychological and social services, as desired by the patient.

The steps were as follows:

[3] "Harm reduction" is a concept recognizing that a behavior – in this case, illegal abortion – has inherent risks, and seeks to decrease the associated risks rather than seeking to eliminate the behavior itself. Harm reduction models are also used to decrease risk associated with other illegal acts such as intravenous drug use and sex work.

Figure 3. Steps in abortion services outlined in IS' harm reduction model



IS piloted the program in March 2004 at Hospital Pereira Rossell, the primary safety net hospital of Montevideo where 20-25% of Uruguayan births take place (Briozzo et al., 2006) and site of the highest proportion of maternal deaths from unsafe abortion (48% of maternal deaths in the time frame 1991-2001). IS performed ongoing monitoring and evaluation and advocated this model to the Ministry of Public Health (MSP). In August 2004, the MSP adopted the IS model and implemented it in healthcare facilities run by Uruguay's public health system. The MSP encouraged midwives, obstetricians and gynecologists working in public and private sectors to use IS' harm reduction model. This model was adopted into law in 2008 as Law 18.426. Throughout this period, misoprostol was not legally available, though it could be purchased in the underground economy including in a clandestine manner in some pharmacies.

Briozzo et al. were the first to collect nationwide data on unsafe abortion in Uruguay, and continued to publish on the harm reduction model and its success throughout this period. The national Bureau of Statistics' Mortality System and the Perinatal Information System collect relevant data, now available publicly from the MSP and Uruguay's statistics bureau.

Briozzo et al. published data in 2004 and 2006 on maternal mortality for Uruguay as a whole, along with data for Hospital Pereira Rossell (HPR) specifically due to its role as primary public maternal health center for the country.

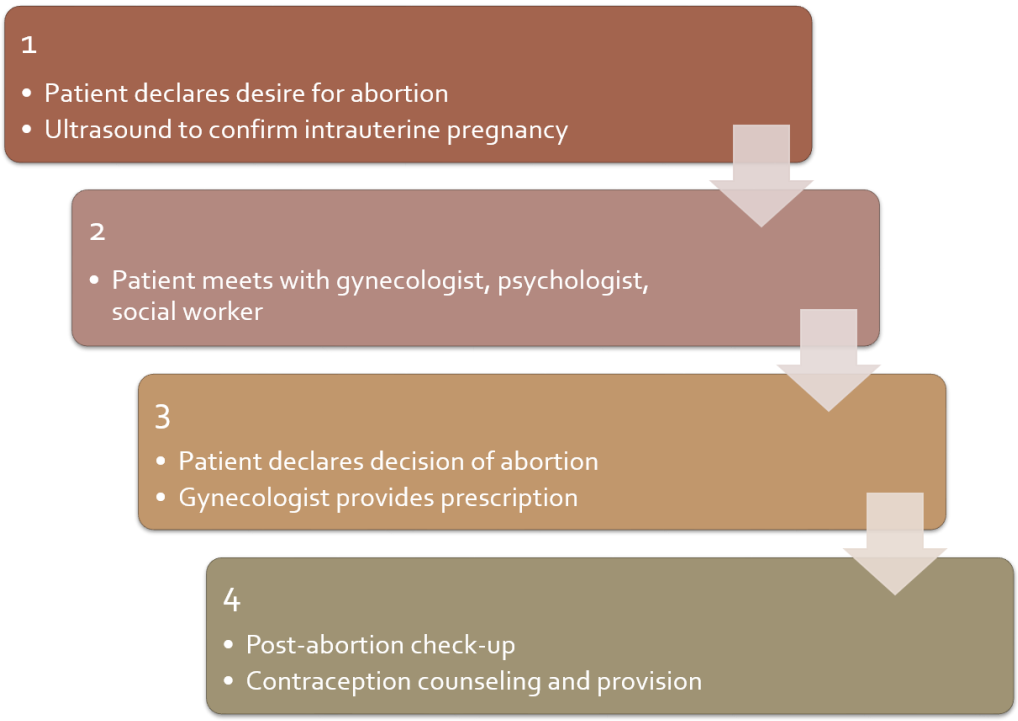
On October 23 2012, the Uruguayan parliament passed Law 18.987 (Spanish, Appendix B; English translation, Appendix C), expanding the exceptions to the established ban on abortions. This 2012 legislation, which we will refer to as "decriminalization", permits gynecologists to provide abortion services under the following circumstances:

- The pregnancy is 12 weeks gestation or earlier or, if the pregnancy was the result of rape, 14 weeks;
- After the patient tells their clinician they want to terminate a pregnancy, or they are considering a termination, the clinician coordinates a meeting with the patient, a gynecologist, a social worker, and a psychologist. At this meeting, the healthcare workers provide required information to the patient regarding pregnancy options, and ask the patient for the reason for termination. The legislation dictates that the healthcare workers do not try to influence or judge the patient's decision.
- The patient waits for five days after the above interdisciplinary meeting, at which point the patient may confirm the decision to terminate the pregnancy and request abortion services from the gynecologist.

- Patients who are under 18 years old must have parental consent or, when that is not available, must state their case to a judge.

There are no gestational limits in cases of fetal anomaly incompatible with life, nor in cases of serious threat to the pregnant patient's life or health. When a patient seek abortion after these gestational limits, and does not meet the criteria for exceptions listed above, Law 18.987 directs the gynecologist to revert to the harm reduction model. This legislation overall pertains only to those who meet residency requirements, that is, can document that they have resided in Uruguay for at least one year and/or are Uruguayan citizens.

Figure 4. Steps in abortion services delineated in Law 18.987



Healthcare institutions and individual clinicians may decline to provide abortions by registering their ideological oppositions or conscientious objection, respectively, with the MSP. Approximately 30% of Uruguay's gynecologists are registered as conscientious objectors

(MYSU, 2014). According to Law 18.987, by registering with MSP as conscientious objectors, gynecologists can abstain from the 3rd of the four visits (Fig. 4)[4].

The original text of Law 18.987 does not specify a method of termination for decriminalized abortions. However, the official manual on induced abortion with respect to Law 18.987 describes medication abortion as the method of choice (*"el procedimiento de elección"*, p. 15) for induced abortion in Uruguay, clarifying that surgical abortion should be used when necessary for medical reasons (MSP, 2012b).

Since the passage of Law 18.987, the MSP reports approximately 450 induced abortions monthly.

MYSU

Mujer y Salud en Uruguay (MYSU) was founded in 1996, and became a non-profit organization in 2004 (Ipas, 2013). MYSU performs "research, training, political influence and communication" (Ipas, 2013) towards improving sexual and reproductive health on a national scale. MYSU's work addresses gender equity, transgender rights, sexual and gender-based violence, sexually transmitted infections, and family planning. The organization focuses on promoting these issues in Uruguay, but works in a global context, collaborating with organizations throughout Latin America as well as other parts of the world including Ipas.

MYSU has been involved with addressing unsafe abortion in Uruguay since the 1990s. On September 28, 2012, in coordination with the September 28 Campaign to Decriminalize Abortion, MYSU led a protest against Law 18.987 (which was passed four weeks later). This

[4] Advocates for conscientious objection have since challenged this policy in order to expand the abortion-related services from which they may abstain, but the law had not yet been challenged at the time of this survey in 2014.

protest registered resistance to the extensive restrictions included in the then-pending legislation. Protesters dressed in orange, or disrobed and painted themselves with orange paint, with the message “Aborto legal” – “Legal abortion”.

Figure 5. © 2012 Manuela Aldabe. Photograph used with permission

For this practicum and thesis project, the field supervisor was Martin Couto at MYSU. MC and MYSU provided advocacy, guidance on survey development, and office space.

Work Settings

Analyzing the workplaces of respondents gives us information on availability of resources and possible relationships between work setting, training and experience in miscarriage management, and training in abortion care. Public, private, primary care. ASSE, universal healthcare.

Clinics A, B, and C are clinics affiliated with the Universidad de la Republica, the public university, and are teaching facilities. Clinics A and C are housed within Hospital Pereira Rossell. Hospital Pereira Rossell (HPR) is a major safety net hospital in central Montevideo, and

is the setting for 20-25% of Uruguayan births (Briozzo et al., 2006). HPR has been the center of harm reduction interventions to reduce maternal mortality from unsafe abortion in Uruguay.

Clinic B is housed in Hospital de Clinicas, another safety net hospital in downtown Montevideo.

Terminology

Induced abortion will be described as "abortion", while spontaneous abortion will be referred to as "miscarriage" for clarity.

Pregnancies can be terminated by either chemical or procedural means. Safe abortion methods are generally described in the literature and in clinical practice as *medical* or *medication* abortion and *surgical* abortion (WHO, 2011a, p. iv). We will use the terms *medication abortion* and *surgical abortion* in this thesis. Safe surgical abortion methods acknowledged by the WHO include electric and manual vacuum aspiration, dilatation and curettage, dilatation and evacuation, and sharp curettage (WHO, 2011a, p. 40-42). WHO also acknowledges medication abortion using misoprostol (chemical) as a safe method (WHO, 2011a, p. 42).

"Abortion provider" or "provider" will be used to describe respondents who report having ever provided induced abortion. We are defining "providing an abortion" as providing the patient with the means to terminate a pregnancy. This can include providing pills or prescriptions for pills, or performing surgical abortion on a patient.

We will describe the 2012 legislative changes regarding abortion law, contained in Law 18.987, as "decriminalization". Law 18.987 does not only increase exceptions to the abortion ban but also adds new restrictions to the decriminalized abortion; however, for clarity we will refer to the entire piece of legislation as "decriminalization".

We will describe the 2004 MSP adoption of IS' harm reduction model as "harm reduction" or "the implementation of harm reduction", and the period from that point until the passage of Law 18.987 as "the era of harm reduction."

Literature Review

Uruguay's maternal mortality ratio has changed dramatically in the past two decades, correlating with policy and practice changes in abortion access. The 2004 institution of harm reduction strategies to increase the safety of illegal abortion, joined with the 2012 decriminalization of first trimester induced abortion, shape the current climate of Uruguay. Gynecologists currently practicing have received their training before, during, or after the era of harm reduction (2004-2012). We do not yet know the extent of gynecologists' preparedness for the post-2012 provision of abortion services. The ultimate question is the extent to which the public health and human rights burden of unsafe abortion is alleviated by current interventions – and specifically the extent to which gynecologist experience and training affects outcomes.

Abortion Incidence

The World Health Organization estimates that 43.8 million induced abortions occur annually throughout the world (2012, based on 2008 data). As of 2008, 21.6 million (49.3%) of these abortions were unsafe (2012) – a 9.6% increase from 19.7 million unsafe abortions in 2003 (2011b). The WHO further estimates that 47,000 women died from unsafe abortion in 2008, with a maternal mortality ratio (MMR) of 30 deaths due to unsafe abortion per 100,000 live births globally (2011b). Broken down according to development, this ranges from an MMR of 0.7 per 100,000 live births in the developed world to an MMR of 40 in the developing world. In 2008, South America saw 700 deaths from unsafe abortion for an MMR of 10. In 2013, Uruguay's MMR was 14 deaths per 100,000 live births (WHO, 2014).

Safe and Unsafe Abortion

Authors describe individual abortions as safe/legal or unsafe/illegal, and national or state climates as having "restrictive" or "liberal" abortion laws. Most (but not all) "legal" abortions are safe (Cohen, 2009; Haddad & Nour, 2009; WHO, 2011). However, legalization does not always translate to access and safety (South Africa etc). "In many countries, both safe and unsafe abortions take place in substantial numbers" (Sedgh et al., 2012, Appendix A). At the same time, not all illegal or clandestine abortions are equally unsafe, and efforts to challenge the safe/unsafe dichotomy have resulted in harm reduction models like that of Iniciativas Sanitarias in Uruguay (PAHO, 2012) as well as the work of Women on Waves/Women on Web which seeks to increase access to medication abortion regardless of political or legal climate.

In 2008, of the 21.6 million unsafe abortions estimated annually worldwide, 98% occur in the "less developed" world – an increase from 97% in 2003 (WHO, 2011b). Latin America and the Caribbean had an estimated 19.4% of the world's unsafe abortions in 2008, down slightly from 19.8% in 2003 (WHO, 2011b). In comparison, 50% of unsafe abortions in 2008 took place in Asia, while 1.9% took place in Europe (WHO, 2011b). Based on 2008 data, WHO continues to estimate that 13% of maternal mortality annually is related to unsafe abortion (2011b).

The distinction between unsafe and safe abortion is valuable because the gap in case-fatality rates is so large: 0.6 per 100,000 safe, legal abortions in the US versus 220 deaths per 100,000 abortions classified as "unsafe" (WHO, 2011b).

In the literature, "illegal abortion" and "unsafe abortion" are often used interchangeably, based on the premise that illegal abortions are unsafe (Cohen, 2009; Haddad & Nour, 2009). WHO (2011) established that abortion, where generally legal, is largely safe. However, there are certainly exceptions to this dichotomy. Illegal clandestine abortion does occur in countries where

it is generally legal (e.g. in the United States), and is considered unsafe. Because abortion in Uruguay has been decriminalized, following guidelines established by the Uruguayan government, it could be considered safe and legal – or considered to be beyond the dichotomy of safe/legal and unsafe/illegal. Not all abortions in Uruguay occur under the conditions laid out by Law 18.987. Extralegal abortions in Uruguay, which have resulted in at least two deaths since 2012 (needs citation), do not meet the definition of "safe". Countries or states which legalize abortion but place restrictions on provision or access may exist in limbo between safe and unsafe as well, depending on the extent of the restriction. Sedgh et al. (2012) offer this definition:

> Countries and territories were considered to have liberal abortion laws in 2008 if (a) abortion was legal without restriction as to reason or on socioeconomic grounds, either with or without gestational limits; or (b) the law allowed for abortion to preserve the physical or mental health of the woman, and it was interpreted liberally, such that a substantial proportional of all abortions were deemed legal in 2008. All other countries are classified as having restrictive laws (Appendix Table 1, footnote 1).

As of that writing, Uruguay did not meet their definition of having "liberal abortions laws". The passage of Law 18.987 means that Uruguay does meet the definition of having "liberal abortion laws". However, the definition above does not address the nuance of Uruguay's restrictions on access: the multiple visits required, the panel of healthcare workers with whom patients must meet, five-day waiting period, and residency and age requirements. Sedgh et al.'s definition does address the question of gestational limits, indicating that Uruguay's gestational limits do not alter its access to the label of "liberal abortion laws".

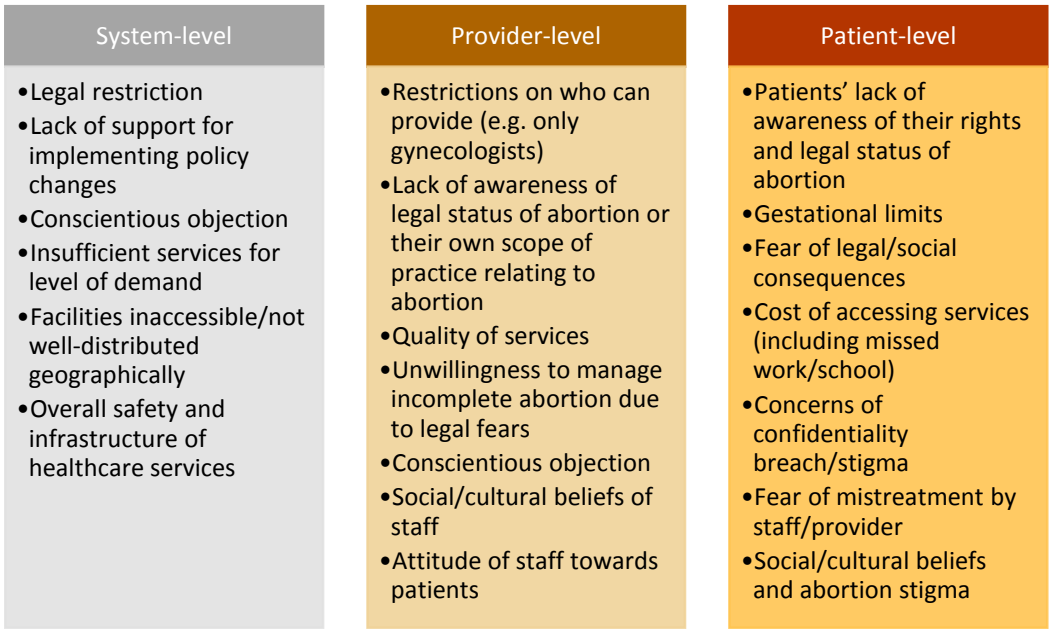
While Sedgh et al. define the national environment in which abortions exist, the World Health Organization offers a definition of "unsafe abortion" itself:

> WHO defines unsafe abortion as 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. While the definition seems to be linked to the process, characteristics of an unsafe abortion touch on inappropriate circumstances before, during or after an abortion. The following conditions typically characterize an unsafe abortion, sometimes only a few conditions prevail, and sometimes all or most of them:
>
> • no pre-abortion counselling and advice;
>
> • abortion is induced by an unskilled provider, frequently in unhygienic conditions, or by a health practitioner outside official/adequate health facilities;
>
> • abortion is provoked by insertion of an object into the uterus by the woman herself or by a traditional practitioner, or by a violent abdominal massage;
>
> • a medical abortion is prescribed incorrectly or medication is issued by a pharmacist with no or inadequate instructions and no follow-up;
>
> • abortion is self-induced by ingestion of traditional medication or hazardous substances.
>
> Further hazardous features of unsafe abortion are:
>
> • the lack of immediate intervention if severe bleeding or other emergency develops during the procedure;

• failure to provide postabortion check-up and care, including no contraceptive counselling to prevent repeat abortion;

• the reluctance of a woman to seek timely medical care in case of complications because of legal restrictions and social and cultural beliefs linked to induced abortion." (WHO, 2011b, p. 2)

Figure 6. Barriers to safe abortion (based on WHO, 2011b)



It is important to note that despite the WHO's broad definition of unsafe abortion, there is certainly a different in the relative safety of terminating a pregnancy with misoprostol under Uruguay's harm reduction regime and terminating a pregnancy by inserting a crochet hook into one's own cervix.

Post-abortion care including contraceptive counseling is an essential part of safe abortion care (WHO, 2011a). In settings where safe abortion is difficult to access, it is essential that post-

abortion be accessible without fear of social or legal consequences (WHO, 2011a). Morbidity and mortality from unsafe abortion can be mitigated with prompt skilled management, but if patients are afraid to seek care for fear of criminal charges, breach of confidentiality, disrespect from healthcare workers, or other repercussions, such care may be inaccessible despite being available. Laws criminalizing abortion can also lead to increased morbidity and mortality from miscarriage, as miscarrying patients may fear being treated as though they have terminated their own pregnancies. At the time of this writing, nineteen women are incarcerated in El Salvador on charges of violating abortion laws, though by all accounts they have all lost their pregnancies spontaneously or suffered obstetric complications (Amnesty International, 2015).

Cost of obtaining care can also be a major barrier to safe abortion access. When abortions are legally available but cost is prohibitive, in practice this makes abortion less accessible (Cohen 2009).

Cohen describes further obstacles to safe care that must be addressed even after legalization/decriminalization: providers with training and willingness to provide care; hygienic clinical conditions (less relevant for medication abortions, the current standard in Uruguay); affordability, accessibility by transit, and other measures of logistical accessibility; and abortion stigma (2009). The World Health Organization (WHO) also names "the lack of trained providers" as a priority barrier to safe abortion and reduction in mortality and morbidity from unsafe abortion (2015, p3). WHO adds stigma, provider refusal, and "[p]olicy and regulatory barriers" as contributing to unsafe abortion (p3).WHO emphasizes that evidence-based abortion and post-abortion care should not be restricted to the scope of gynecologists or physicians in general, but to all skilled, trained healthcare workers. At the time of this study, however,

Uruguay's Ministry of Public Health restricted abortion practice to gynecologists only, so we will revisit WHO's recommendation to expand scope of practice in Discussion.

The WHO includes the following populations as having the highest risk of unsafe abortion: "rural, less educated, poor, adolescent or unmarried women" (2015, p3).

Abortion in Latin America

Latin America and the Caribbean have had, collectively, the most restrictive abortion laws second only to Africa (WHO, 2011b). In 2009, Cohen estimated that 97% of Latin American women of reproductive age (15-44 years old) were living under restrictive abortion laws. However, Cohen's data have not been updated to reflect Uruguay's 2012 decriminalization, while WHO's data also don't reflect Mexico City's legalization of abortion, regardless of reason, implemented in 2008.

Abortions take place regardless of restrictive abortion laws, as has been well-documented by Guttmacher and WHO (Cohen, 2009; WHO, 2011a; WHO, 2011b; WHO, 2012). The WHO reports an estimated 4.2 million unsafe abortions in 2008, the last year for which data are available (2011b). South America in particular has made remarkable progress in reducing unsafe abortion from over 50 per 1000 women age 15-44 in 1990 to 32 per thousand (WHO, 2011b). Latin America and the Caribbean have seen an increase in unsafe abortion per 100 live births, from 37 in 1990 to 39 in 2008, but the increase is in part due to a decreasing total fertility rate (TFR) (WHO, 2011b). The region's TFR was 2.7 in 2001 but dropped to 2.2 by 2008 (WHO, 2011b).

Abortion Training Methods

In Uruguay, where abortion has been decriminalized until 12 weeks (and further in special circumstances), the focus on abortion training is primarily regarding first-trimester abortion.

WHO recommends manual and electric vacuum aspiration and medication abortion as safe methods in this time frame (2011a). Uruguay's Ministry of Public Health published a technical guidance document to guidance abortion care under the Law 18.987 (2012). This document recommends medication as the first choice for abortion (mifepristone with misoprostol, if possible) followed by vacuum aspiration when medication abortion is not possible for medical reasons. Dilation and curettage is named as a third choice, when neither medication nor vacuum aspiration are available or possible for a given patient (MSP, 2012a).

These guidelines, freely available from the MSP's website, describe medication dosage, antibiotic prophylaxis, pain management, and interpretation for post-abortion ultrasounds. Guidance on cervical preparation for surgical abortion is present, though guidance on surgical abortion itself is not. The guidelines discuss many key teaching points for patient education, such as possible adverse effects of medications. These points are not comprehensive, however, leaving out crucial information on how much bleeding and pain patients should expect while terminating their pregnancies at home. If and when these guidelines are used for training purposes or to guide clinical care (see Resources to guide abortion care, in the Results section), they need to be supplemented either with prior knowledge or with additional resources.

Manual vacuum aspiration (MVA), also called "manual uterine aspiration", was developed in Eastern Europe post-World War II, at a time of widespread liberalization of abortion laws (Innovating Education, 2013). This low-technology method is safer than sharp curettage, the previous standard; portable, unlike the electric vacuum aspiration technology that followed; and does not rely on electricity, which is ideal for low-resource settings.

Learners may learn uterine aspiration techniques on patients, on reusable plastic models, or on papayas (Paul & Nobel, 2005). Clinical educators, particularly in low-resource settings, use papayas to teach intrauterine procedures (Innovating Education, 2013; Paul & Nobel, 2005; Steinauer, Preskill, Devaskar, Landy & Darney, 2013). Educators have shown that training clinical learners on papayas is associated with significantly decreased perceived difficulty of the procedure and increased confidence (Paul & Nobel, 2005).

Key Gaps in the Literature with Respect to Uruguay

There is no published literature regarding incidence or prevalence of abortion training for Uruguay's gynecologists since the 2004 implementation of the harm reduction model. Specifically, there are no data on the experience or training of the country's gynecologist with respect to surgical methods of uterine emptying (i.e. managing incomplete miscarriage or incomplete induced abortion, or inducing abortion).

The literature also lacks data on the characteristics of patients who are denied abortion services, whether based on residency requirement, age restriction, gestational age, or other reasons.

Estimates from the WHO are based on the most recent data available, which are from 2008. These don't reflect the impact of legislative changes such as Uruguay's decriminalization or Mexico's legalization, nor do they capture the increasing use of medication abortion as a low-risk early abortion option involving less clinical supervision than surgical options such as aspiration.

Summary

In conclusion, we know that restrictive abortion laws do not decrease abortion incidence but rather increase mortality and morbidity. We know that decreasing restriction on abortion access

decreases maternal mortality. Uruguay has taken steps to change abortion policy and practice. However, it is impossible to know how the extent to which these policies are implementable or implemented without data on gynecologists' preparation for providing abortion (measured in miscarriage management experience, abortion training, and confidence in their abilities) as well as distribution of trained providers to areas of high need.

Chapter 3: Project Content

Methodology

In June and July 2014, we surveyed gynecologists working in Montevideo. Forty such gynecologists completed the 32-question survey either on paper (n=37) or online (n=3). The survey assessed what types of training they had undergone in management of incomplete miscarriage and induced abortion; which miscarriage management techniques they had used; what obstacles they faced in accessing abortion training; and whether they had turned away abortion-seeking patients due to legal requirements (i.e. residency or age).

Study Design

We chose a cross-sectional quantitative survey design to capture, at 18 months after the passage of Law 18.987, the number and proportion of gynecologists who have been trained, regardless of when they were trained. We sought to identify the extent of training before and after decriminalization, especially after clinicians and public health workers had had the opportunity to organize such trainings and begin incorporation legalized abortion services into practice post-decriminalization.

Because we were unable to obtain a comprehensive list of all gynecologists working in Montevideo, we could not do accurate random or other probabilistic sampling. Due to the stigmatized and politicized nature of the topic, we added a snowball sampling element to our strategy in order to maximize response and reach potential participants who we might otherwise not reach.

We primarily reached respondents through workplace-based recruitment. We had initial recruits that we had connected with through MYSU's contacts, and asked them to refer us to

others in their workplaces and elsewhere. We also visited healthcare facilities and inquired about interest in our survey. In some settings, respondents recommended that we return on different days and different times of day to talk to reach maximum numbers of gynecologists at their facility.

We chose Montevideo, the capital city of Uruguay, which has 51% of the country's population.

Survey Tools

We developed a Spanish-language paper survey of 32 questions covering basic demographics of the respondent and their work environment(s), as well as their training and experience managing incomplete miscarriage and inducing termination of pregnancy, obstacles to training, and obstacles to provision of services. We surveyed gynecologists currently practicing in Montevideo.

We also developed an online version of the survey using SurveyGizmo to reduce response barriers such as scheduling or transportation problems. For example, one respondent cancelled a meeting due to illness but completed the survey online instead. This format had the same criteria for respondents as above.

Variables and factors

Primary measures include the following questions (English translation of survey questions):

- Have you received any type of training for managing incomplete miscarriage?

- Which of the following techniques have you used for the treatment of incomplete miscarriage? (Answers: medication, i.e. misoprostol; manual uterine aspiration; electric uterine aspiration; other - specify.)
- Have you received any training in carrying out abortion?
- Which of the following methods were addressed in your training? (Same answer options as above.)
- Since when have you received training in the techniques of abortion?
- Confidence after receiving training, and confidence at the time of survey, on a five-point Likert scale in the respondent's ability to provide abortion in a safe manner?
- Have you ever carried out an abortion personally?
    - In what year did you first provide/carry out an abortion?
    - How many abortions did you provide in the prior month?
- Have you ever denied a patient an abortion due to legal restrictions?
    - Gestational age past legal limits
    - Patient's age under 18
    - Patient's mental disability (unable to legally make medical decisions for oneself)
    - Patient not meeting citizenship/residency requirements

Outcome measures include "surgical management", in contrast with medication management (or expectant management of incomplete miscarriage, which was outside the scope of this survey). "Surgical" induced abortion refers to use of electric or manual vacuum aspiration and/or curettage to terminate a pregnancy and empty uterine contents; likewise, "surgical

management" of incomplete miscarriage refers to the use of any of those same techniques to manage an incomplete miscarriage. Each of these methods were unique variables. We also analyzed them in aggregate to examine training and experience with surgical methods, and contrast with training and experience in management with medication.

Another set of outcomes measures included denying induced abortion services based on legal restrictions: gestational age greater than the legal limit of 12 weeks; age less than 18; significant intellectual or other disability restricting patient from having legal medical autonomy; lack of Uruguayan residency documentation[5]. Each of these measures identify whether the respondent has ever denied abortion services to a patient based on the given restriction. We did not collect data on how many patients had been denied services based on these restrictions.

Data collection

Sampling.

We were unable to secure a comprehensive list of all gynecologists working in Montevideo, but based on clinic and facility websites we were able to identify many of the gynecologists working in the public sector (approximately 90) who were listed on those sites. Because the issue of abortion access disproportionately affects poor women dependent on public providers, we focused our data collection in the public facilities. We especially sought to reach many gynecologists working at Hospital Pereira Rossell (HPR), a safety net hospital in the center of Montevideo, at which approximately 25% of Uruguayans are born[6]. HPR was also the site of

[5] Uruguayan law requires abortion-seeking patients to have cédula, documentation proving the individual has resided in Uruguay for at least one year.

[6] Briozzo, L., Vidiella, G., Rodríguez, F., Gorgoroso, M., Faúndes, A., & Pons, J.E. (2006). A risk reduction strategy to prevent maternal deaths associated with unsafe abortion. *International Journal of Gynecology and Obstetrics, 95*: 221-226.

the highest reported maternal mortality associated with unsafe abortion (48% of their total maternal mortality) prior to the 2004 implementation of the harm reduction strategy[7], so the investigators gave it priority.

We used convenience sampling with snowball methodology to collect data. We began with initial recruits who were put in contact with our team by a leading gynecologist in Montevideo, a professional colleague of MC. We asked each respondent to refer us to other potential respondents.

We then visited hospitals, emergency departments, and clinics in Montevideo and, at each one, asked to speak with the gynecologists there and offered them the opportunity to complete surveys. We used the snowball methodology in these settings as well. We chose these facilities by first reaching out to as many gynecologists as possible at each facility where we had initial recruits. We then continued to prioritize HPR (described above).

Table 1. Selected facilities' number of births annually compared to national and citywide totals

Facility	Births per year (% of national total?)
Hospital Pereira Rossell Women's Hospital	6,836[8] (20% of national births[9], 34% of Montevideo births)
Hospital St. Bois	48[10] (0.2% of Montevideo births)
Hospital de Clínicas	1,051[11] (approx. 5.3% of Montevideo births)

Yonah EtShalom (YES) was the primary survey administrator for this survey, and was the author of the survey (with assistance from Roger Rochat, Jenny Foster, Martín Couto, and

[7] Ibid.
[8] 2014. From Administración de los Servicios de Salud del Estado (ASSE), 2015.
[9] From Instituto Nacional de Estadistica, 2014.
[10] Ibid.
[11] 2008. From Hospital de Clínicas "Dr. Manuel Quintela", 2009.

others). We also provided paper surveys to one employee and one intern of Iniciativas Sanitarias who came into contact with gynecologists and were able to solicit participation from them. YES provided the surveys to these individuals and gave them the opportunity to review the data collection tool together in order to ensure that they understood the survey and could answer any questions respondents might have.

Quality control.

Most questions on the paper survey were multiple-choice or select-all-that-apply, but some of the questions and all of the opportunities to specify responses for "other" answer choices had places for writing in answers. Survey administrator YES was present with respondents during survey completion whenever possible in order to answer clarifying questions and ask for handwriting clarification.

Declined or unable to respond.

Three gynecologists did not respond to multiple phone messages requesting meetings. Two gynecologists asked for paper surveys to be left with them during their night shift, to be completed by morning, but by end of shift the gynecologists had not completed them. At one outpatient clinic within a private hospital, front desk staff stated that the gynecologists did not have time to complete the surveys, clarifying that their reluctance was not due to the topic. Two private hospitals asked for authorization prior to surveying their employees; unfortunately we were not able to complete the authorization process prior to departing Uruguay. In total, five individual gynecologists and three institutions declined or were unable to participate.

Data analysis

We used the data gathered for descriptive statistics of the scope and depth of abortion and miscarriage training for Montevideo gynecologists. We also used Chi-square, Fisher exact, and Mann-Whitney tests to analyze the data.

Respondents who answered that they had never provided induced abortion were excluded from answering how many they had provided in the prior month, since the latter measure examines the distribution of abortion services amongst the gynecologists who are currently providing abortions .Similarly, those who answered that they had never provided induced abortion services were excluded from answering the year of their first abortion provision; the resources they used for providing services; and whether they had felt negatively judged for providing abortions. Missing data were dropped from analysis.

For independent variables regarding abortion techniques, we analyzed all surgical (non-medication) methods one at a time as well as in aggregate. For the variables regarding year of medical school graduation, we created a binary variable grouping respondents by whether they had graduated prior to 2004, the year of national implementation of the harm reduction model, or 2004 and later. The variable for "year of first abortion training" received the same treatment. We created a further variable from subtracting a respondent's graduation year from their year of first abortion training, to determine length of time in years between graduation and beginning abortion training; for some respondents, this value was negative or zero, indicating training prior to or during medical school.

Two respondents answered that they had never provided an abortion, but we recategorized them as having provided based on notes they wrote in the margins of the paper survey. One noted on the survey that they had provided prescriptions for abortion medication,

but had not provided abortions themself. The other noted the year of first abortion provision as well as resources used in abortion provision. For the purposes of analyzing data regarding attributes of those who provide abortion services, we included all respondents who met our definition of abortion provision, regardless of whether they see themselves as abortion providers.

One respondent answered that they did not know their year of medical school graduation. For analysis, we categorized this respondent as having graduated prior to 2004 based on reported year of first abortion training and abortion provision in the 1980s, and age above 50.

Ethical Considerations

Prior to data collection, Emory University's Institutional Review Board (IRB) reviewed the study proposal and deemed the study as not requiring review due to not meeting the "definition of 'research'". Uruguay does not have a national ethics review board; we took direction from MYSU regarding ethical practices and cultural norms. We maintained the privacy and security of survey respondents by not collecting identifying information or information regarding illegal abortion provision in the survey and by keeping completed paper surveys in a secure location. All data were retained on the survey administrator's password-protected laptop. Completed surveys were kept in a locked room or with the survey administrators while in-country, and were kept in a locked room after return to the US. We did not collect names. We collected email addresses for participants to receive updates on the data analysis, but kept those separate from the surveys so that they could not be matched to survey answers. We limited the collection of potentially identifying or sensitive information to what was needed to accomplish our research goals.

Results

Demographics

While all respondents worked in Montevideo, seven respondents also worked in other counties (known as *departamentos*). All but one of the respondents held multiple jobs, and 85% worked in both the public sector and the private sector.

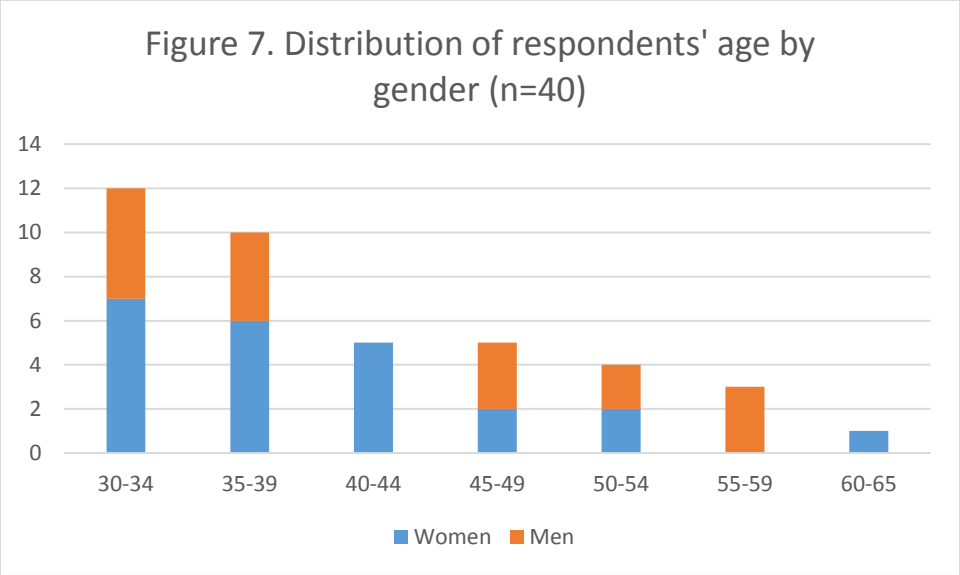
Table 2: Demographics of Montevideo gynecologist respondents

Demographics	total (n=40)
Women	23 (57.5%)
County	
Montevideo	40 (100%)
Additional Counties	
Canelones	6
San Jose	2
Flores	1
Maldonado	1
Salto	1
Work Setting	
Public + Private	34 (85%)
Public only	4 (10%)
Private only	2 (5%)
Primary care	14 (35%)
Facilities	
Pereira Rossell	25 (62.5%)
Clinica A[12]	8 (20%)
Clinica B	7 (17.5%)
Clinica C	7 (17.5%)

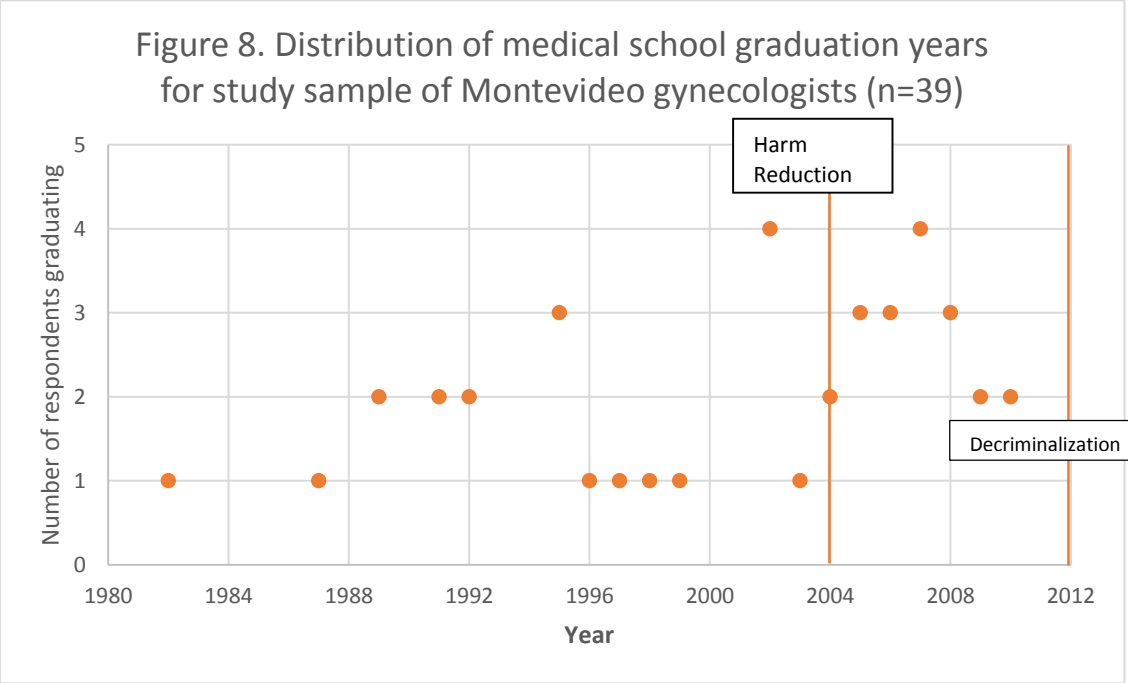
Respondents' age ranged from 31 to 63 years old (mean = 41), skewed towards younger ages. Over half (55%) of respondents were age 30-39. The distribution of men's ages was closer to normal than that of women. Although the relationship between gender and age was not

[12] All Clinica A employees and 5 of the Clinica C employees reported working at HPR.

statistically significant (Chi square, p = 0.160), females were more common below age 45 (18/27, or 2/3) than 45 and above (5/13).



Respondents ranged in medical school graduation year from 1982 to 2010 (Fig. 9), with 52.5% graduating prior to 2004 (the year the Ministry of Public Health implemented IS' harm reduction model). Median year of graduation was 2003.



Respondents reported working at a total of 30 clinical sites at the time of the survey. Table 2 lists (a) all facilities where respondents reported currently working; (b) number of respondents who reported working at that facility, if greater than 2; (c) whether the facility is private or public; and (d) whether any of the respondents working at that facility are abortion providers, indicating that abortion may be available at that site. However, because all respondents work in multiple sites, we do not know that those who have provided abortions are providing at every site where they currently work. Similarly, we know that facilities as a whole can decline to participate in abortion provision. Therefore, providers may be unable to provide abortions at certain workplaces. Because this is a convenience sample and not a census, there may be others who provide abortions at sites listed below as not having providers.

Table 3: Characteristics of Montevideo healthcare facilities employing gynecologist survey respondents, based on convenience sampling survey data

Facility (County in parentheses if not Montevideo, or if multiple counties)	# of respondents[13]	Private or Public	Abortion Providers[14]
AEPM		Private	●
Asociación Española		Private	
ASSE (Montevideo, Canelones)	3	Public	●
BCBS		Private	
BPS		Unknown	
CASMU	5	Private	●
Centro de Asistencia Periférica de DNSFFAA (Military hospital)		Public	●
Círculo Católico		Private	●
Comunitaria Hospital Saint Bois	3	Public	●
CRAMI (Canelones)		Private	●
CUDAM	3	Private	●
Hospital Pereira Rossell	25	Public	●
Antepartum			●
Emergency Department			●
Gynecology Clinic "B" MSP			●
Ultrasound			
Hospital Británico	4	Private	●
Hospital de Clínicas		Public	●
Hospital Evangélico		Private	
Hospital Flores (Flores)		Public	●
Hospital Italiano		Private	●
Medica Uruguaya		Private	●
Medicina Personalizada		Private	
Piedras Blancas		Unknown	●
"Policlínica de Mutualistas"		Private	●
Policlínica Giráldez		Public	●
Policlínica Los Ángeles		Public	●
Sanatorio Americano		Private	●
Sanatorio Mautone (Maldonado)		Private	●
Seguro Americano		Private	●
SMI	5	Private	●
SMQS (Salto)		Private	●
Summum Medicina		Private	
Universal		Unknown	●

[13] This is the number of respondents who reported working at a given healthcare facility. Numbers are only listed for facilities represented by more than 2 respondents, to maintain confidentiality of individual-level sensitive data.
[14] This column is marked for any facility at which at least one of the respondents who reported working there also reported having ever provided an abortion. This does not indicate that abortion services are provided at all of the facilities marked under "Abortion Providers", since gynecologists may be providing abortion care at some but not all of the facilities where they work.

Primary Findings

Miscarriage Management

Miscarriage management training.

B1. ¿Ha recibido algún tipo de formación para manejar los abortos espontáneos incompletos?
Have you received any type of training for managing incomplete spontaneous abortions (miscarriages)?

All but one of the respondents (97.5%) reported receiving training in management of incomplete miscarriage.

Miscarriage management experience.

All respondents reported experience in managing incomplete miscarriage. All but one respondent reported having managed an incomplete miscarriage using surgical methods, and all but two had used medication management (Table 4).

Table 4. Frequency and proportion of sample of Montevideo gynecologists reporting experience managing incomplete miscarriages by miscarriage management method.

Miscarriage management method	**n (% of 40)**	**Stratified by year of abortion training[15]**		**Stratified by year of medical school graduation**	
		Before 2004 (n=9)	2004 and after (n=27)	Before 2004 (n=21)	2004 and after (n=19)
Medication	38 (95)	100%	93%	90%	100%
Any surgical management	39 (97.5)	100%	96%	100%	95%
Either aspiration method	33 (82.5)	89%	85%	71%	95%
Manual vacuum aspiration	18 (45)	78%	37%	52%	37%
Electric vacuum aspiration	27 (67.5)	78%	70%	57%	79%

[15] This includes all 38 respondents who reported training in abortion, except for two who did not list the year of their abortion training

Other (curettage)	19 (47.5)	56%	44%	67%	26%

Using the Fisher's exact test, there appears to be a significant relationship between receiving abortion training prior to 2004 (as opposed to after) and reporting experience using manual vacuum aspiration to manage an incomplete miscarriage ($p = 0.040$).

Results of Chi-square suggested a significant relationship between graduating before, as opposed to during, the harm reduction era and reporting experience managing incomplete miscarriage with curettage (chi-square with 1 degree of freedom = 6.5128, $p = 0.011$)

Abortion Training

Abortion methods taught.

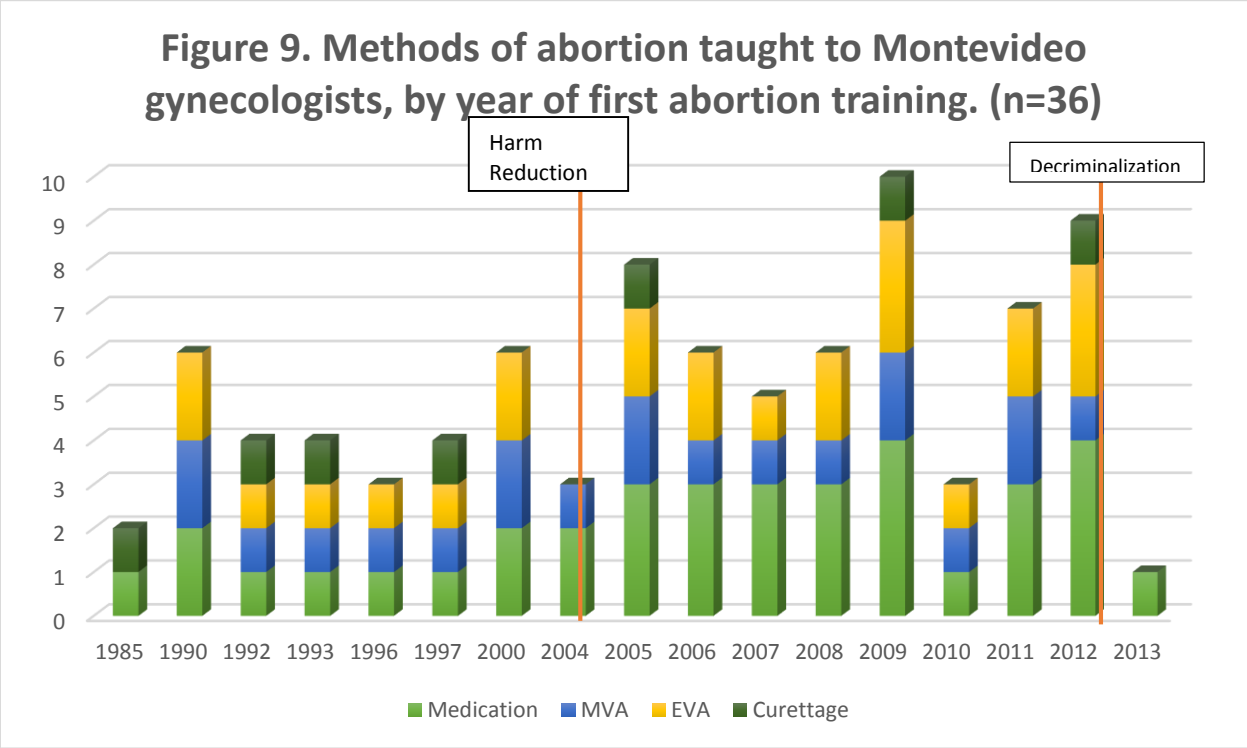
C5. ¿Cuáles de los siguientes métodos se abordaron durante su formación? **Seleccione todo lo que corresponda.**	❑ Medicamentos (misoprostol) ❑ Aspiración manual endouterina ❑ Aspiración eléctrica endouterina ❑ Otro (Especifique:_____)
Which of the following methods were addressed during your training? **Select all that apply.**	❑ Medications (misoprostol) ❑ Manual uterine aspiration ❑ Electric uterine aspiration ❑ Other (Specify:_____)

We asked gynecologists which methods they had learned in their abortion training, as well as which methods they had used in managing incomplete miscarriage. We report those data individually as well as in aggregate: all surgical or non-medication methods of uterine evacuation (Table 5). All respondents who answered that they had learned an "other" abortion method specified that it was curettage.

Table 5. Frequency and proportion of sample of Montevideo gynecologists reporting receiving training in abortion, by abortion method.

Abortion method taught	**n (% of 40)**	**Stratified by year of abortion training[16]**		**Stratified by year of medical school graduation**	
		Before 2004 (n=9)	2004 and after (n=27)	Before 2004 (n=21)	2004 and after (n=19)
Medication	38 (95)	100%	100%	91%	100%
Any surgical management	29 (72.5)	100%	70%	67%	79%
Either aspiration method	28 (70)	89%	70%	62%	79%
Manual vacuum aspiration	21 (52.5)	89%	44%	52%	53%
Electric vacuum aspiration	25 (62.5)	89%	59%	52%	74%
Other (curettage)	7 (17.5)	44%	11%	29%	5%

[16] This includes all 38 respondents who reported training in abortion, except for two who did not list the year of their abortion training



As shown in Fig. 10[17], as abortion trainings increase over time amongst the sample – notably after 2004 – MVA training stays steady at 1-2 per year, while EVA and medication increase. Receiving abortion training prior to 2004 was significantly associated with manual vacuum aspiration being addressed in the training (Fisher's exact, $p = 0.023$).

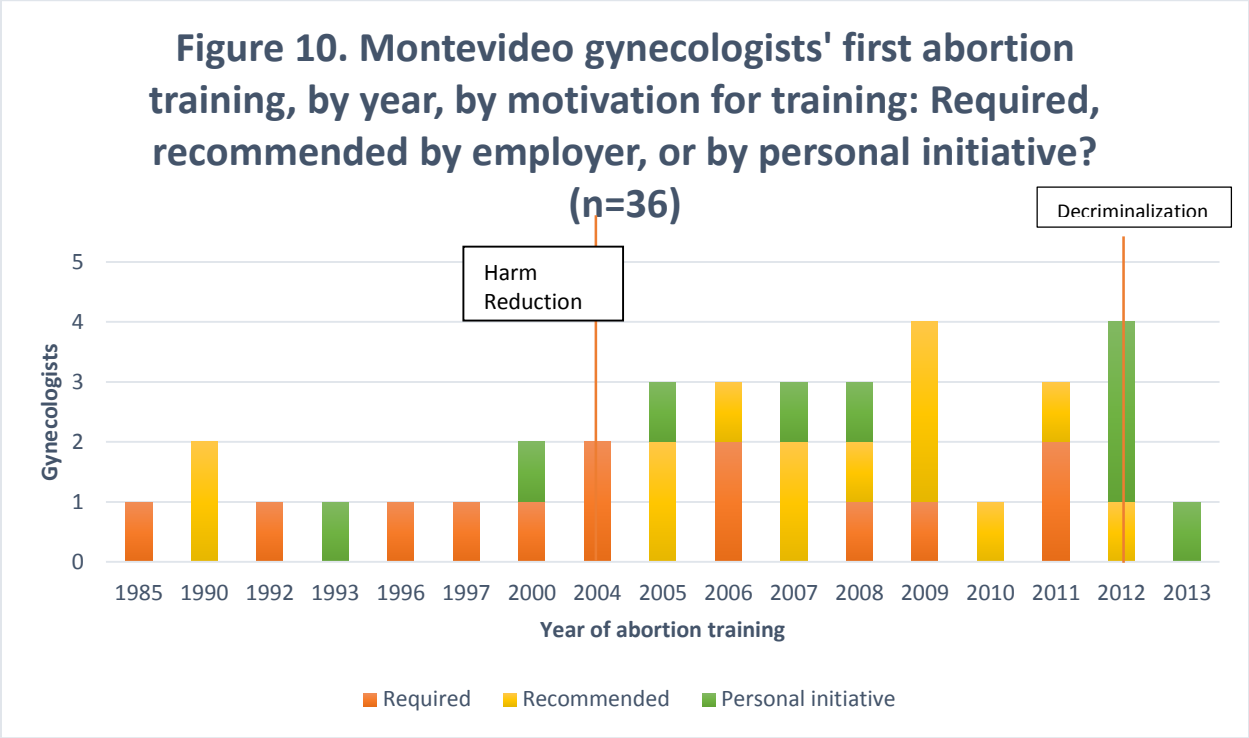
Timing of training.

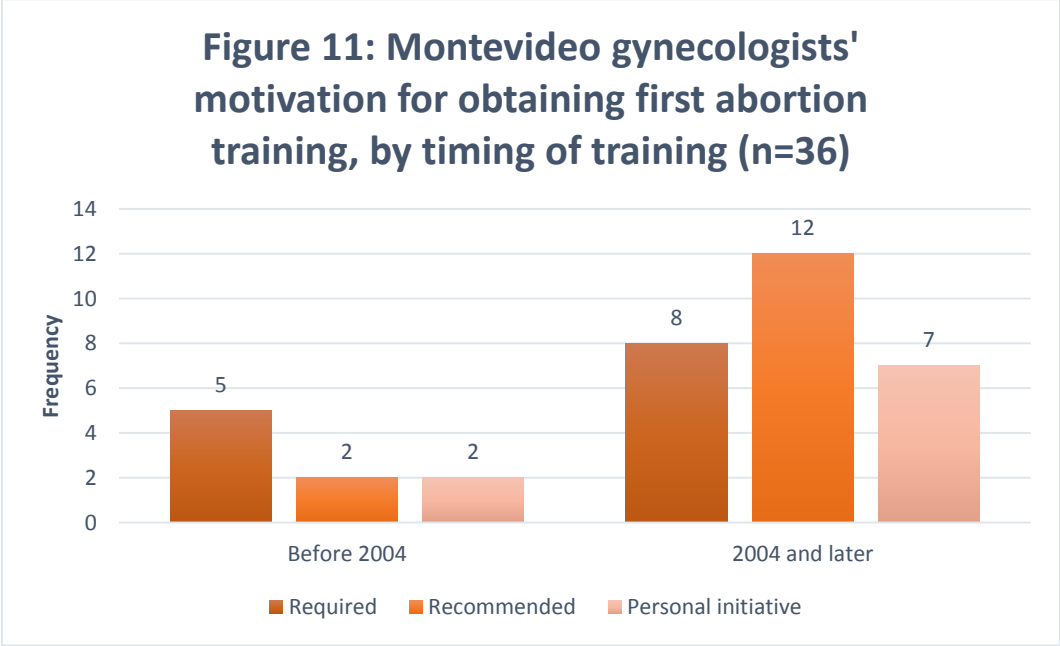
Respondents reported learning abortion provision as early as 1985; the average year was 2005. Four (11%) answered that they were first trained in abortion prior to graduating from medical school, while 11 (31%) had their first abortion training two years after graduating.

[17] Two respondents who did not report the year of their first abortion training were excluded from this figure.

No respondents reported receiving abortion training in residency prior to 2002. Gynecologists reported receiving abortion training on the recommendation of their employers as early as 1990, and being required to train in abortion as early as 1985 (Fig. 11).

Twelve (86%) of the 14 employer-recommended trainings and 62% of required trainings occurred during harm reduction (Fig. 12). Those who graduated during harm reduction were significantly more likely to receive abortion training during residency (Fisher's exact, $p = 0.002$) than those who graduated before 2004. A greater proportion of pre-harm reduction graduates received abortion training during medical school (33%) than later graduates (16%), but this difference was not significant by Fisher's exact ($p = 0.181$).





Access to abortion training.

Each respondent noted that they were familiar with law 18.987. Nearly all respondents (95%) received training in both abortion and miscarriage management. The two respondents who

denied receiving abortion training noted that they did not take advantage of some training opportunities. One answered that it was either not interesting or not relevant to their job; the other noted that they were personally opposed to abortion and also a conscientious objector.

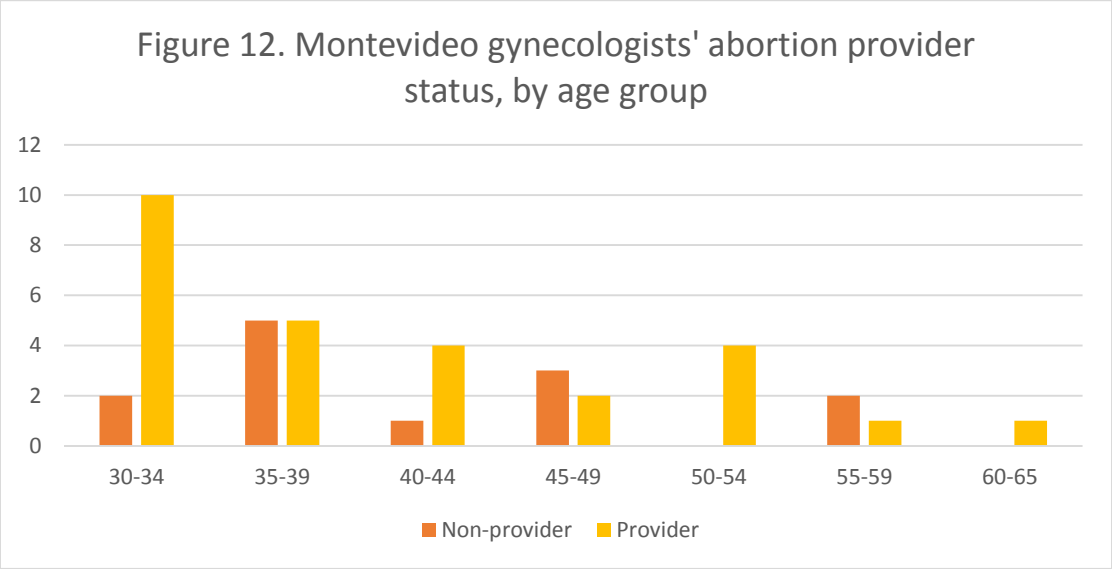
In total, 59% (23) of respondents answered that they didn't take advantage of some training opportunities. Four answered that it was unnecessary, noting that they had already been trained. Others marked that they did not participate due to financial reasons (1), lack of interest or relevance to job (5), lack of time, including that trainings overlapped with work commitments (12), they didn't know about the trainings at the time (1), or their personal opposition to abortion (5). No respondents cited concern about others' judgement or legal concerns as barriers.

Abortion Provision

Demographics of providers.

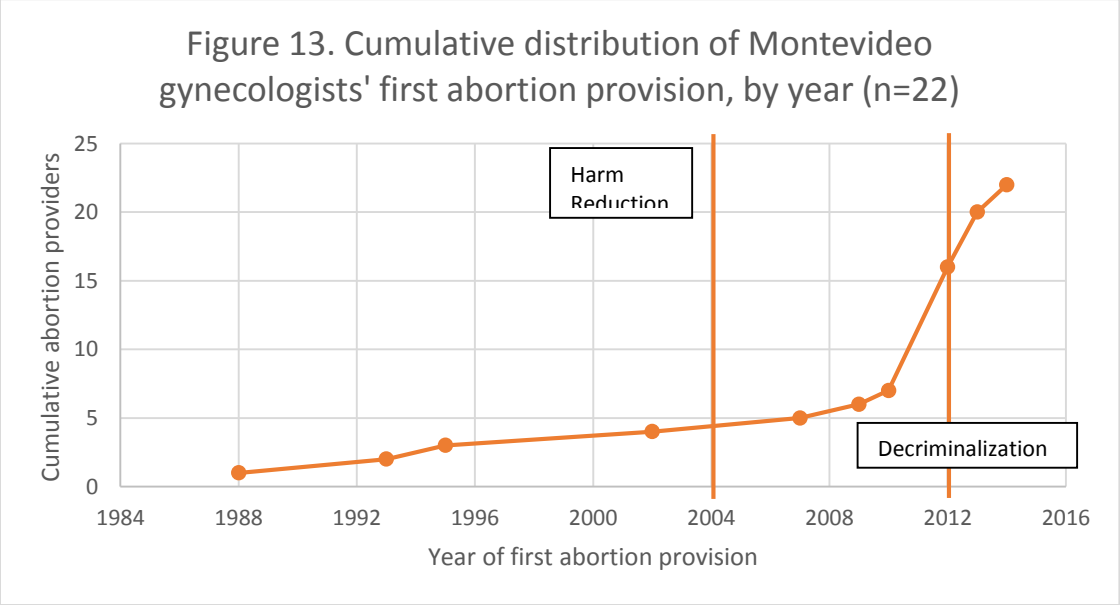
Twenty seven (67.5%) of the 40 respondents report having ever provided an abortion[18]. Seventy percent of female respondents and 65% of females reported providing abortions at some point. Provision varied by age (Fig. 13).

[18] 25 answered "yes" to this question; 2 who answered "no" commented elsewhere in their surveys that they had provided abortion prescriptions, which meets our definition of abortion provision. See "Data Analysis" above for more discussion on this.



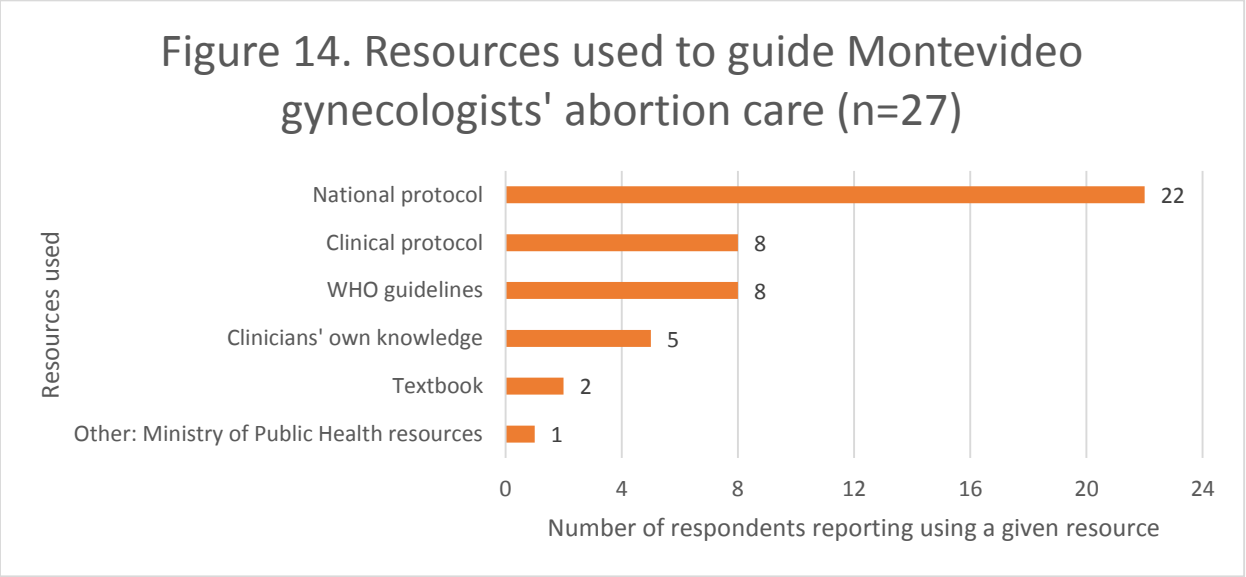
Timing of first abortion provision.

Five of the 27 providers did not give the year of first abortion provision. A sharp increase in gynecologists providing their first abortions is notable between 2011 and 2012 in Fig. 14. Respondents reported providing abortions as early as 1988, with 2009 as the mean first year of provision.



Resources to guide abortion care.

When asked what resources they had used to guide their abortion care, most (88% of those who have ever provided abortions) reported using national protocols (Fig. 15[19]). WHO guidelines and clinic-specific protocols were also commonly reported.



Confidence in abilities.

We analyzed the self-reported confidence levels of abortion providers based on volume of abortions provided in the prior month. Twenty four of the 27 providers answered the question "In the past month, approximately how many times did you provide an abortion?" (see Appendix A for full survey in Spanish). Of these 24 providers, seven provided ten or more abortions in the prior month. The other 17 reported fewer than ten, with six of these reporting no abortions provided in the prior month.

[19] Only abortion providers were included in this analysis, though non-providers did report using several of these resources. See "Discussion" for more. One provider declined to answer this question.

Those who provided ten or more abortions reported, on a five-point Likert scale, being "moderately" (n=1) or "very" (n=6) confident in their current ability to provide an abortion in a safe manner. In response to the question "How confident did you feel in your capacity to provide abortion in a safe manner *right after your first abortion training*?", this group of providers answered the same way.

Amongst those who provided fewer than ten abortions in the prior month, 82% (14) reported high confidence at the time of the survey; 6% (1) reported moderate confidence; and 12% (2) reported neutral, the mid-point on the 5-point scale. When asked how confident they had felt right after their first abortion training, 71% (12) reported high confidence, 18% (3) reported moderate confidence, and 12% (2) reported a neutral level of confidence.

Table 6. Self-reported level of confidence in ability to safely provide abortion care amongst providers reporting < 10 abortions in prior month (n=17)

	Not at all confident	Not very confident	Neutral	Moderately confident	Very confident
After first abortion training	0	0	2 (12%)	3 (18%)	12 (71%)
At time of survey	0	0	2 (12%)	1 (6%)	14 (82%)

Table 7. Self-reported level of confidence in ability to safely provide abortion care amongst providers reporting 10 or more abortions in prior month (n=7)

	Not at all confident	Not very confident	Neutral	Moderately confident	Very confident
After first abortion training	0	0	0	1 (14%)	6 (86%)
At time of survey	0	0	0	1 (14%)	6 (86%)

Distribution of provision.

D4. ¿En el último mes, *aproximadamente* cuántas veces ha realizado un aborto?
In the last month, *approximately* how many times did you provide an abortion?

Twenty four of the 27 providers in our sample answered this question, ranging from zero to 50 in the prior month. Of these, 7 (29%) reported providing more than 10 in the month prior; we will refer to these as "higher-volume providers". The average for these 24 providers was 7.9 abortions in the prior month (standard deviation = 12.2); it should be noted that respondents, particularly those reporting higher volume of abortions, may have provided estimates rather than precise numbers.

Our respondents reported a total of 190 abortions for the prior month. Over half (55%) of the abortions were done by 3 people (12.5% of the 24 providers who gave a number of abortions provided in the prior month). Seven gynecologists provided 85% of the abortions reported by all respondents for that month.

All but one of the respondents reported having been asked for abortion services at some point. Twenty seven of those have provided abortions. Of the twelve who did not provide abortions to patients who asked, two reported that they were conscientious objectors; eight had denied services based on gestational age beyond the legal restrictions; and four of these had also denied services due to residency restrictions. Two respondents gave no explanation, but answered (a) that a patient had asked them for abortion services, (b) that they had never provided an abortion, (c) that they had never denied someone an abortion that would have been permitted under the law, and (d) that they had never denied someone an abortion because of gestational age, residency restrictions, age under 18, or lack of medical autonomy (e.g. due to severe intellectual disability or developmental delay).

Six (75%) of the 8 respondents who work outside Montevideo are abortion providers, compared with 21 (65.6%) out of the 32 respondents who work only in Montevideo. This was not significant using Fisher's Exact (p=0.479). Only one (16.7%) of the providers working outside Montevideo reported 10 or more abortions in the past month, compared with 33.3% of the providers working only in Montevideo. This difference was not significant using Fisher's Exact (p = 0.414).

Four respondents (14.8% of providers) reported feeling negatively judged for providing abortions. All four reported that this judgement came from other healthcare workers and no other sources. These four were all women. We did not find a significant relationship between respondent age and reporting judgement (Mann-Whitney, p = 0.4896). Two of them work at Clinica B. All had received abortion training during their professional careers. There was no significant relationship between reporting judgement and receiving abortion training in any specific method using Fisher's exact tests. Forty three percent of the seven higher-volume providers (greater than 10 abortions for the prior month) reported feeling negatively judged, as opposed to 5.9% of the lower-volume providers (p = 0.059 by Fisher's exact).

"I wrote the prescription; the patient did the abortion."

Providers wrote the following notes in the margins of the paper surveys:

- *"Ha hacer receta, procedimiento medicamento, no procedimiento quirúrgico."*
    - Translation: "I have done prescriptions, medication procedure, no surgical procedure."
- *"No he realizado aborto; he indicado la medicación, la paciente se realiza el aborto"*

  - Translation: "I have not done abortion; I have indicated the medication [written the prescription], the patient did the abortion."
- *"No he realizado quirúrgicamente. Si con medicación aprox. 24."*
  - Translation: "I have not carried out surgically. Yes with medication approx. 24."

Additional respondents, discussing the survey question asking whether the respondent had ever carried out an abortion, told the survey administrator that they had not carried out abortions but provided medication for patients to do so.

Denial of services.

No gynecologists reported having turned a patient away due to age (under 18) or due to the patient's status as incapable of making her own medical decisions. Eighty-nine percent of providers reported having denied clinical abortion services to a patient who didn't meet legal gestational age limits[20]. Forty-one percent of providers had denied abortion services to a patient who didn't meet citizenship/residency requirements.

Table 8. Frequency and proportion of sample of Montevideo abortion providers reporting having ever denied abortion services based on legal restrictions on abortion

	n (% of 27[21])	**Stratified by year of abortion training**		**Stratified by year of medical school graduation**	
		Before 2004 (n=7[22])	2004 and after (n=19)	Before 2004 (n=13)	2004 and after (n=14)
Beyond gestational limits	24 (89)	100%	84%	92%	86%
Did not meet residency requirements	11 (41)	43%	37%	31%	50%

[20] See Background for Uruguay's policies for patients whose pregnancies are beyond these limits, which differ greatly from those of the US.
[21] Non-providers dropped from this analysis.
[22] One provider was dropped from this analysis because they did not list the year of their first abortion training

When asked if they had ever refused to provide an abortion that was permitted under the law, 4 (10%) of respondents answered that they had. Three of these cited being a conscientious objector; the fourth cited "lack of resources" and "patient was too clinically complex".

Overall, though we did not ask this question specifically, four respondents (10%) noted that they were conscientious objectors somewhere on the survey.

Relationship between Abortion Training and Provision

Table 9. Descriptive statistics on timing intervals between medical school graduation, first abortion training, and first abortion provision, in years

Training and Provision	Median	Mean	Min	Max
Interval between medical school graduation and first abortion training[23] (n=35)	2	4.6	-6	30
Interval between first abortion training and first abortion provision (n=21)	3	4.5	-2	21
Interval between graduating medical school and first abortion provision (n=21)	6	7.9	-3	25

We compared reported medical school graduation year, year of first abortion training, and year of first abortion provision. Overall respondents reported an average of 4.5 years between graduating medical school and receiving the first abortion training, and an average of 4.6 years before providing the first abortion after receiving such training.

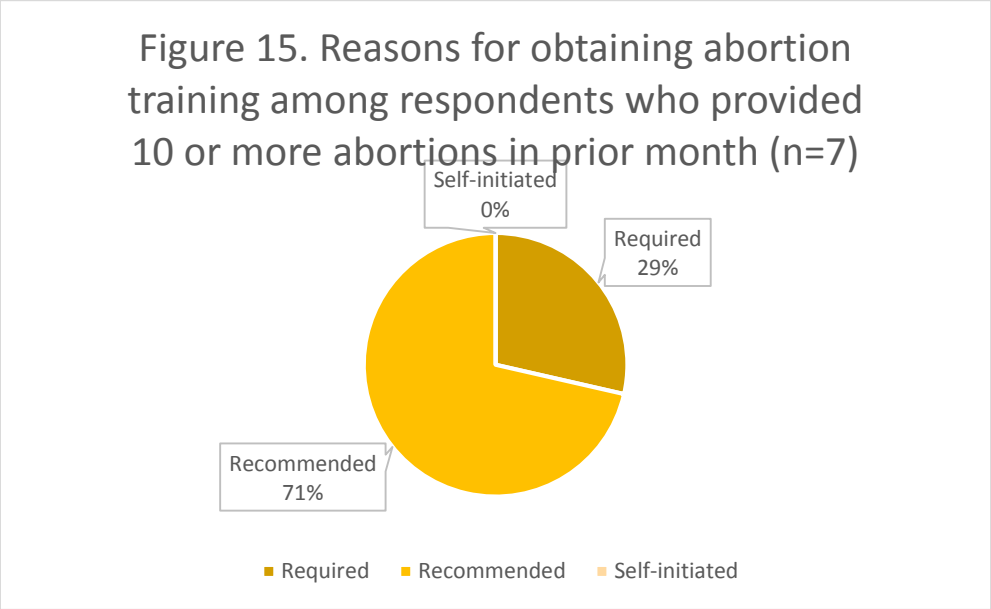
When stratified by quantity of abortions provided in the prior month, however, this education interval was distinctly different for each group though not significantly using Mann-Whitney ($p = 0.0749$) (Table 5). Providers also reported a shorter average education interval

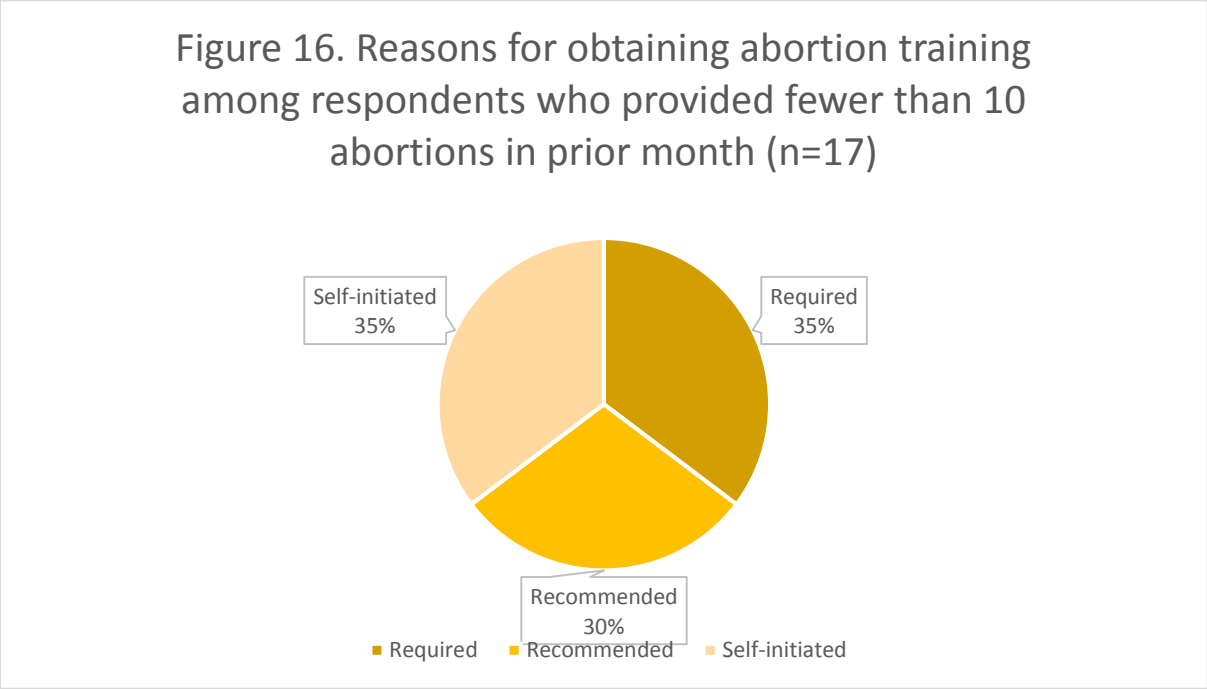
[23] Respondents who were trained in abortion prior to graduating medical school had a negative value for this.

compared with non-providers, though again this relationship did not appear significantly (Mann-Whitney, p = 0.2495) (Table 10).

Table 10. Mean interval between graduating medical school and first abortion training, by abortion provision status and quantity	
Non-providers	7.9 years
Providers	3.3 years
Fewer than 10	3.9 years
10 or greater	-0.6 years

Of the providers who did 10 or more abortions in the prior month, none of them had obtained training on their own initiative (Fig. 16); training was either recommended or required by their workplace. One such provider noted that they were in a specialized program that required abortion training. Those who provided fewer than 10 abortions in the prior month (Fig. 17) were evenly distributed between receiving training based on requirement, recommendation, or personal initiative.





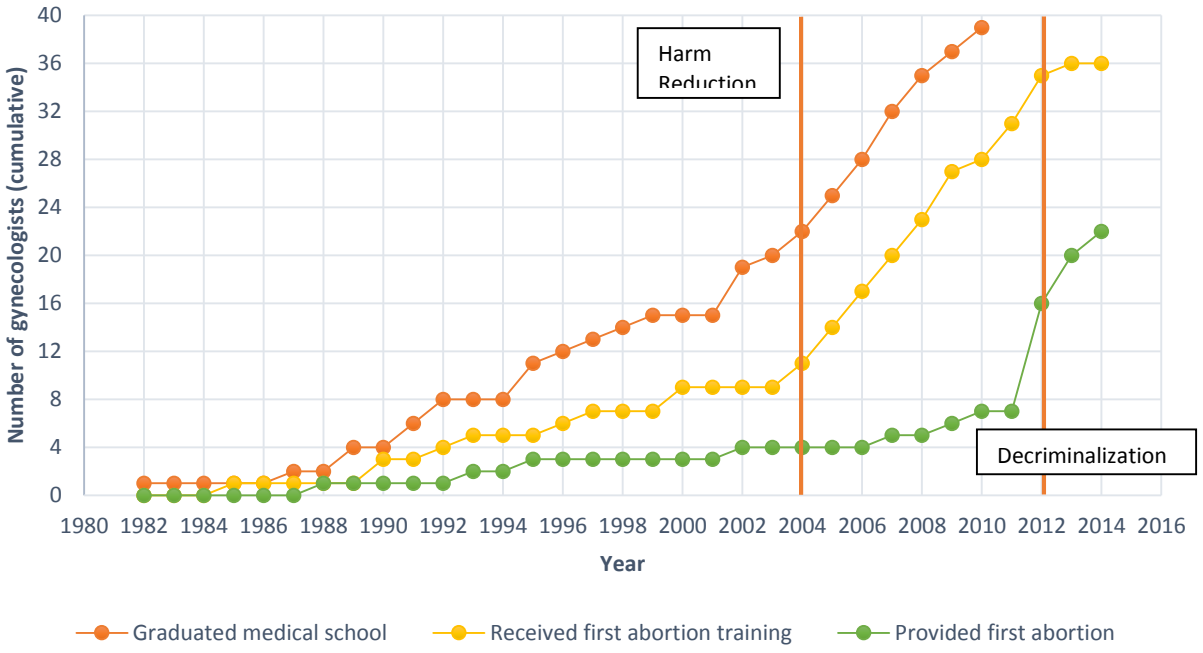
We looked at the interval between medical school graduation and first abortion training, in years, stratified by medical school graduation era (before 2004 vs. during harm reduction)[24] (Figure 10). Those who graduated prior to 2004 had a mean gap between graduation and first

[24] This analysis used 35 observations, though 38 reported receiving abortion training: 1 was excluded because graduation year was missing, and 2 because year of first abortion training was missing.

abortion training of 7.6 years (standard deviation: 9.1), while those who graduated during harm reduction had an average of 1.5 years in between graduation and first abortion training. This relationship appears significant using the Mann-Whitney test ($z = 2.182$, $p = 0.0291$). Using the Fisher's exact test, we found that those who graduated medical school in 2004 or later were significantly more likely to receive abortion training during residency ($p = 0.005$).

When stratified by volume of abortions provided (fewer than ten vs. ten or greater in the prior month), the lower-volume providers (n=17) had an average medical school graduation year of 2005, while the higher-volume providers who provided a graduation year (n=6) had an average graduation year of 2001. This difference was not significant using Fisher's exact ($p = 0.819$).

Figure 17. Cumulative distribution of medical school graduation, first abortion training, and first abortion provision as a function of time



Chapter 4: Discussion, Limitations, and Conclusions

Discussion

Demographics

Nearly all of our respondents (85%) reported working in both public and private facilities, and represent thirty healthcare facilities in Uruguay. Skewed young, these respondents have more working years ahead of them than older respondents; their characteristics will matter for the coming decades of maternal health in Uruguay.

We collected the age of respondents because age indicates years until retirement and because age may affect political views (particularly with relation to living through the dictatorship). Two gynecologists over 40, while filling out surveys, told survey administrators that they opposed abortion, but were supportive of abortion access because they did not believe that a woman's class or wealth should dictate whether she can access safe care.

Based solely on our respondents and the facilities where they report working, 100% of the public facilities have at least one abortion provider working there, compared with 77.8% of the private facilities. Because those who rely on public facilities have fewer resources to seek care in other facilities, it is more important that they be able to receive abortion care on request then those who seek care at private facilities.

However, regarding abortion providers, we can see the sites where they work but not which of those sites they provide abortions at. They may provide at all of their workplaces or as few as one of them. They also may have only provided abortions, or first provided abortions, at a site they no longer work at and therefore did not list. Some also did not name all of their sites.

Miscarriage Management: Training and Experience

Respondents were widely trained and experienced in managing incomplete miscarriage – significant because these skills are so applicable to induced abortion provision. Regardless of how much or little training or experience gynecologists have in surgical methods of induced abortion, their experience using surgical methods to manage incomplete miscarriage prepares them to use those same techniques to end an undesired pregnancy.

Though we found the surgical experience in miscarriage management to be prevalent, we did not measure the safety and efficacy of respondents' skill sets. Notably, sharp curettage was frequently reported as a technique used in miscarriage management or, less commonly, taught in abortion trainings. This technique is considered "obsolete" by the WHO (2011a). However, reporting experience with managing miscarriage with curettage was significantly associated with graduating prior to harm reduction ($p = 0.012$), which may indicate that this practice is not used as much in recent years.

Abortion Training

Results indicate that gynecologists are widely trained in abortion, and – though only two thirds have provided abortion services – are experienced in managing miscarriage.

Abortion methods taught.

Notably, 100% of those who received first abortion training prior to harm reduction (2004) received content on both medication and surgical abortion, while only 70% of those trained 2004 or later received surgical abortion content. Along the same lines, the significant relationship between receiving abortion training prior to 2004 and having been trained in manual vacuum aspiration abortion indicates a possible move away from this method.

With the increased legality and practice of clinical medication abortion, there may be less coverage of other methods. However, induced abortion after 12 weeks requires different care, and thus different training, than first trimester abortion. Medication abortion requires additional doses of misoprostol after 12 weeks (WHO, 2011a, p. 43), and different dosing after 14 weeks though clear evidence on dosing after 14 weeks has not yet been established. Uruguayan law does allow for pregnancy termination without gestational limits under certain circumstances, so gynecologists need to be prepared to provide abortions after the first trimester.

With the high reporting of surgical methods of abortion (aspiration, curettage), it is notable that medication is the primary method for induced abortion for Uruguay. The difference in provision of these services – medical versus surgical – is not only the training clinicians receive, but in the infrastructure of clinical facilities. Though some facilities require medication abortion patients to remain inpatient until their abortions are complete, many abortion patients take their misoprostol dose outpatient. In order to be safe, surgical abortion, however, requires a clean space in a clinical facility for the procedure itself; possibly ancillary staff to assist in procedure; and a bed and nursing care in a recovery room.

Timing of training.

The delay between medical school graduation and first abortion training becomes shorter over time amongst our sample. If this trend continues, this will keep training prevalence high over time as gynecologists receive training increasingly sooner after graduating medical school.

In analyzing those who provide abortions had a shorter interval between medical school graduation and first abortion provision, and that interval is shorter for those who provided more abortions in the prior month despite the training being either recommended or required

Access to abortion training.

Though 59% of respondents noted that there were training opportunities they did participate in, the only respondents who did not receive any abortion training cited reasons pertaining to personal choice rather than external barriers. This indicates that, though there were some respondents citing financial or other logistical barriers to training, overall gynecologists were able to obtain *some* training – and these barriers were preventing providers from receiving *multiple* trainings.

Abortion Provision

Resources to guide abortion care.

Since 81.5% of abortion providers responded that they had used national protocols to guide their abortion services, we might infer that national protocols are available and accessible to those who may need them, and that (perhaps most importantly) providers choose to use them. We lack information on how providers found out about these protocols; whether these protocols match other listed resources (i.e. WHO guidelines, clinic-specific protocols); or the extent to which clinicians understand and/or adhere to these protocols.

Several respondents who denied ever providing abortions also answered these questions, noting that they used clinical or national protocol, textbooks, or WHO guidelines to inform their abortion practices. They may have been referring to using these resources to inform peri-abortion care, such as that provided in visits 1, 2, or 4 of the four-visit abortion process instituted in 2012 (see Chapter II, Figure 3).

Distribution of provision.

The 190 abortions reported by our respondents for the prior month amounts to 26.8% of the 708 abortions that Uruguay's Ministry of Public Health estimated per month nationwide in 2014 (MSP, 2015). An estimated 425 of those 708 abortions took place in Montevideo. Respondents who reported working only in Montevideo reported a total of 133 abortions for the prior month, which is 31.3% of the estimated total abortions in Montevideo for the month. This would indicate that our sample represents 31.3% of the abortion provision in Montevideo; this number is conservative, since some of the higher-volume providers work outside Montevideo but may provide abortions in Montevideo as well.

A greater proportion, though not significantly greater, of gynecologists working outside Montevideo have provided abortions. This may raises the question of whether these gynecologists are working in more distant *departamentos* in order to fill a gap in abortion access. This is unlikely, however, since only one of the providers working outside Montevideo reported more than 10 in the prior month.

The majority of providers do not appear to be providing abortions in high volume (71% reporting fewer than ten in the prior month). When clinicians do a procedure less frequently, they often benefit from periodic training to keep their skills up – particularly if they are doing surgical abortions, which is skill-based rather than knowledge-based as medication abortion is. One opportunity for further study is to investigate whether low-volume abortion providers are performing surgical abortion, and what ongoing training or evaluation they receive.

"I wrote the prescription; the patient did the abortion."

The multiple respondents writing comments in the margins to the effect of "I didn't carry out abortions; I just wrote a prescription for medications" implies a mental separation of the clinician

from the act of abortion. This may be interpreted as a patient-centered perspective, as in "it's the patient's choice, I'm facilitating it but the patient is at the center of the experience." Alternately, with such a stigmatized topic it could be interpreted as putting the moral weight of abortion solely on the patient and absolving the clinician is absolved of moral responsibility in their own eyes or in the eyes of society.

With Law 18.987's passage occurring in a climate of harm reduction, clinicians may continue to think of abortion services as methods of mitigating the risk of patients' own choices to terminate rather than providing a healthcare service to patients like any other.

Denial of services.

Nearly all (89%) abortion providers reported denying a patient abortion services due to gestational age beyond legal restrictions. Though these patients still receive pre- and post-abortion counseling per the harm reduction model, should they choose to terminate, their self-induced terminations are illegal. These patients will be given information about using misoprostol regimens at home, but (as discussed above), after 14 weeks gestation there is no strong evidence to guide misoprostol dosage (WHO, 2011a).

Almost half of providers (41%) reported denying abortion services to patients who did not meet residency requirements. Those who graduated during harm reduction had a higher ratio of having had a patient who didn't meet residency requirements (57%) than those who graduated before 2004 (18%). This was not statistically significant (Fisher's exact = 0.058). One possible reason for this difference is that newer graduates may be working in underserved areas, with more prevalence of new Uruguayans, while more established gynecologists may have sought out more comfortable jobs. However, all respondents 50 years old and older reported working at Rossell, the safety net hospital, so this theory is unlikely.

While 4 (10%) respondents reported being conscientious objectors, and three of these reported denying a patient abortion services based on this, it is not clear if this objection prevents patients from receiving abortion care or merely prolongs, complicates, and perhaps increases the cost of obtaining abortion.

The single respondent who cited a lack of medical resources and a high level of patient complexity as reasons for denying abortion services noted that this occurred shortly after Law 18.987 was passed. It is unclear, and an opportunity for further research, the extent to which clinical facilities have developed the infrastructure necessary to provide abortion care to patients with complex health issues.

It does not appear from our survey that patients' age or medical autonomy is an epidemiologically significant barrier to care, as no respondents reported denying services based on these characteristics.

Strengths and Limitations

Our study provides the first data on key barriers to abortion access since decriminalization, and on the prevalence of abortion training amongst Montevideo gynecologists. With 38 respondents working in the public sector, the study captures data from approximately 42% of the gynecologists working in Montevideo's public sector in 2014. Respondents represented a wide variety of workplaces and ages, and while our focus was on Montevideo we were able to collect data from eight providers working in the interior of the country as well.

However, this study has several limitations. First, these results cannot be generalized to all gynecologists working in Montevideo since it was a convenience sample, and not probabilistic. We also cannot generalize to gynecologists working outside Montevideo.

The survey tool itself had not been externally validated, nor based on previously used surveys. Despite pilot-testing and revisions, some questions were worded in ways that were misinterpreted by respondents.

Possibly the most significant language ambiguity was with the terms *IVE* or *interrupción voluntaria del embarazo*, *aborto*, and *aborto provocado*, which all have distinct meanings. IVE generally refers to abortions newly decriminalized under the 2012 law; aborto is any termination of pregnancy, induced or spontaneous; and *aborto provocado* refers specifically to induced abortion, whether induced medically or surgically. Along with this, the language *realizar aborto* asks whether the respondent had carried out an abortion. However, some respondents indicated their belief that a gynecologist who prescribes misoprostol is not performing an abortion, but rather making it available to a patient who then performs it herself by self-administering the pill. Regardless, the language used in the survey led to some confusion amongst respondents. Some respondents asked for clarification from survey administrators, and three respondents noted in the margins some version of "I have not done abortions surgically, but I have prescribed misoprostol." However, others may have not asked or clarified, and may have marked zero for "number of abortions performed".

There may have been a language issue with the question regarding receiving abortion training in medical school as well. Ten respondents answered that they had received abortion training in medical school, but eight of these listed their year of first abortion training as *after* the year they graduated medical school. Due to this high proportion of contradictory responses, we believe it is likely that respondents did not interpret the question regarding training in medical school the way that it was intended.

The primary survey administrator, YES, was functional but not fluent in Spanish, which may have led to respondents asking clarifying questions and still not fully understanding. Respondents also handwrote

Missing data limited our analysis as well. For example, 3 of the 27 providers did not answer how many abortions they'd provided in the prior month. Two respondents answered that they had had a patient request an abortion but had never provided one, nor had they refused to provide a legally permitted abortion, nor had they refused due to any of the four restrictions we asked about (gestational age, patient age, residency, or "mental capacity").

Our study was further limited by the questions we didn't ask. We did not ask for conscientious objector status, though four respondents indicated this in other parts of the survey. Most respondents worked in multiple sites. For those who work in multiple locations and provide abortions, the survey did not have a way of identifying in *which* location(s) they provide abortions – and in which location(s) they feel judgement from their colleagues.

Similarly, the survey did not collect data on where respondents attended medical school or residency. That information could have helped identify which programs are teaching abortion, which methods of teaching, and which methods of abortion.

Finally, we didn't ask, for those who have never provided an abortion and are not registered conscientious objectors, whether they would provide an abortion to a patient who requested one in the future.

Regardless of these limitations, our study contributes important data for understanding barriers to gynecologists' role in providing abortions to abortion-seeking patients in Uruguay.

Conclusions

Based on these findings, we believe that key barriers to safe abortion access in Uruguay include the following:

- Gestational limits: Uruguayan federal government and civil society have acknowledged, en masse, the reality of abortion before 12 weeks, and addressed this reality with changing policy. Abortion beyond 12 weeks is also a reality, based on the high prevalence of respondents denying abortion based on gestational age. These second-trimester abortions need to be addressed in an evidence-based manner. Because there is no substantial evidence for medication abortion dosage past 14 weeks (WHO, 2011a), surgical methods need to be available and accessible. The same logic applies to an abortion at 15 weeks as it does at 8 weeks: if a patient wants to terminate a pregnancy, they will do so whether it is legal and accessible and safe or not.
- Residency: With 41% of providers reporting denying abortion services based on residency requirements, these requirements are acting as a barrier to access for new and transient Uruguayans.
- Conscientious objection: Because conscientious objectors have a legal obligation to refer abortion-seeking patients to another clinician, conscientious objection may be assumed to not be a barrier to care. However, being referred to another clinician adds steps to the process – steps that can amount to additional time, effort, and financial cost.

On the other hand, it appears from our study that training is prevalent and increasing in prevalence over time. Though we did not measure the quality of training or respondents' knowledge, we know that all respondents have managed incomplete miscarriage and nearly all

have used both medical and surgical techniques for this. This information points towards a higher level of preparedness for abortion provision.

Recommendations

Based on this, we recommend further research on the identified barriers to safe abortion care. This includes identifying obstacles to accessing early abortion services, such as lack of information about where to obtain services, the mandatory five-day waiting period and other logistical obstacles in the process outlined in Law 18.987.

We recommend investigating the effects, if any, of conscientious objection on accessibility and timeliness of abortion care, such as delays in care and increases in financial and other costs.

We further recommend investigating the feasibility and acceptability to patients, providers, and other stakeholders of incorporating surgical techniques into provision. Because such a high proportion of our sample reported experience with surgical methods of uterine evacuation, we know that they have a familiarity with these methods. We do not yet know the extent or distribution of providing surgical abortions, which methods patients might prefer, or how clinical infrastructure could support these procedures.

With regard to policy changes, we recommend extension of 12-week gestational limit, removal or decrease of the required 5-day waiting period, and removal of residency requirements.

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Appendix A

Paper Survey

Conocimientos y prácticas relacionados a la práctica de la interrupción voluntaria de embarazo (IVE) por parte de ginecólogos en el país de Uruguay

Instrucciones:

- **Para respuestas numéricas, llene los espacios en blanco, rellenando un digito por cada espacio.**
- **Para todas las demás preguntas, marque el cuadro de la respuesta. Solo marque más de un cuadro en caso de que las instrucciones lo indiquen.**

Gracias por su participación en esta encuesta. Yo, Yonah EtShalom, soy una estudiante de maestría en la escuela de salud pública de la universidad de Emory en Atlanta en los Estados Unidos. Estoy recolectando datos con respecto a los conocimientos y las prácticas relacionadas con la interrupción voluntaria del embarazo en Uruguay. Aunque la participación en esta encuesta no le beneficiará directamente en este momento, nosotros utilizaremos esta información para entender los puntos fuertes y las limitaciones de los programas actuales de formación, al igual que para la formación futura para atender mejor las necesidades de los médicos y las pacientes.

La encuesta tomará entre 10-15 minutos. Su participación es muy valiosa para nosotros. Sin embargo, es completamente voluntaria. Usted puede negarse a responder a cualquier pregunta y puede terminar la encuesta en cualquier momento. No hay ningún tipo de consecuencia negativa si no desea participar. Sus respuestas y su identidad permanecerán completamente confidenciales.

Comunique cualquieras dudas sobre la encuesta o las preguntas que tenga usted a la investigadora.

Fecha: _ _/_ _/_ _ (Día/Mes/Año)

La encuesta comienza en la página 2.

Sección A. Para empezar, quisiera hacerle algunas preguntas sobre usted mismo/a.	
Pregunta	**Respuesta**
A1. ¿Usted es ginecólogo?	❑ No ❑ Sí
A2. Marque su género.	❑ Mujer ❑ Hombre ❑ Otro (Especifique:_____)
A3. ¿Cuántos años tiene?	_ _ _
A4. ¿En cuál departamento practica Ud.?	❑ Montevideo ❑ Otro: _____
A5. ¿Trabaja en las instituciones públicas, o privadas?	❑ Públicas ❑ Privadas (Especifique:_____) ❑ Ambas
A6. ¿Dónde practica usted? **Marque todo lo que corresponda.**	❑ Hospital Pereira Rossell ❑ Primer nivel (Especifique:_____) ❑ Clínica A (Facultad) ❑ Clínica B (Facultad) ❑ Clínica C (Facultad) ❑ Otra (Especifique:_____)
A7. ¿En qué año se graduó de la facultad de medicina?	_ _ _ _ (año) ❑ No se

Sección B. Ahora, quisiera hacerle algunas preguntas con respecto a su formación profesional.	
Pregunta	**Respuesta**
B1. ¿Ha recibido algún tipo de formación para manejar los abortos espontáneos incompletos?	❑ No ❑ Sí ❑ No se
B2. ¿Alguna vez ha actuado frente a una situación de un aborto espontáneo durante su carrera profesional?	❑ No → **Pase a la Sección C** ❑ Sí
B3. ¿Cuáles de las siguientes técnicas ha utilizado usted para el tratamiento de abortos espontáneos? **Marque todo lo que corresponda.**	❑ Medicamentos (misoprostol) ❑ Aspiración manual endouterina ❑ Aspiración eléctrica endouterina ❑ Otras (Especifique:_____) ❑ No se

Sección C. Como sabe, en algunos casos en los que ocurre un embarazo no deseado la mujer puede realizar una interrupción voluntaria del embarazo. Para ello debe buscar la ayuda de un profesional. La sección que sigue consiste de preguntas acerca de su formación profesional en ese aspecto si es que la ha obtenido.	
Pregunta	**Respuesta**
C1. Para empezar, ¿está usted informado sobre los recientes cambios en la ley que despenaliza la IVE?	❑ No ❑ Sí
En el 2012, Uruguay despenalizó la IVE durante el primer trimestre con algunas restricciones.	
C2. ¿Ha recibido usted formación en realizar al aborto?	❑ No → **Pase a la Pregunta C9** ❑ Sí
C3. ¿Cuándo recibió usted esa formación? **Seleccione todo lo que corresponda.**	❑ Facultad de medicina ❑ Residencia médica ❑ Durante la carrera profesional ❑ Otra
C4. ¿De qué manera se impartió esa formación? **Seleccione todo lo que corresponda.**	❑ Información impresa ❑ Información audiovisual ❑ Observando una demostración en persona ❑ Practicado con un modelo (papaya, maniquí) ❑ Practicado con un paciente ❑ Otra (Especifique:_____)
C5. ¿Cuáles de los siguientes métodos se abordaron durante su formación? **Seleccione todo lo que corresponda.**	❑ Medicamentos (misoprostol) ❑ Aspiración manual endouterina ❑ Aspiración eléctrica endouterina ❑ Otro (Especifique:_____)
C6. ¿Esa formación, fue obligatoria para usted, se le recomendó durante sus estudios o fue por iniciativa propia?	❑ Obligatoria ❑ Recomendada ❑ Por iniciativa propia ❑ Otro
C7. ¿Desde cuándo ha recibido formación en las técnicas del aborto?	_ _ _ _ (año)
C8. Una vez completada su formación, e independientemente de su opinión personal acerca del procedimiento, ¿qué tan confiado/a se sintió en su capacidad de realizar un aborto de manera segura?	❑ Para nada confiado/a ❑ No tan confiado/a ❑ Neutral ❑ Moderadamente confiado/a ❑ Muy confiado/a ❑ No se
C9. En este momento, e independientemente de su opinión personal acerca del procedimiento, ¿qué tan confiado se siente ahora en su capacidad de realizar el aborto de manera segura?	❑ Para nada confiado/a ❑ No tan confiado/a ❑ Neutral ❑ Moderadamente confiado/a ❑ Muy confiado/a ❑ No se
C10. ¿Ha tenido usted oportunidades de formación acerca del aborto a cualquier punto en su carrera en la que no participó?	❑ No, participé en todas las capacitaciones. → **Pase a la Sección D** ❑ Sí, hubo capacitaciones en las que no participé. ❑ No se

C11. ¿Cuáles fueron las razones por las que no tomó las oportunidades de formación mencionadas? **Seleccione todo lo que corresponda.**	❑ No estaba interesado/a o no tenía que ver con mi trabajo ❑ Por razones económicas ❑ Por oposición personal al aborto ❑ Por preocupación a la oposición de otras personas (como la familia, amigos, compañeros de trabajo) ❑ Por preocupaciones legales ❑ Otro (Especifique:_____)

Sección D. La próxima sección de preguntas es sobre su experiencia con pacientes que han venido para obtener servicios del aborto, antes y después de la ley.	
Pregunta	**Respuesta**
D1. ¿Alguna vez una paciente le dijo que quería interrumpir su embarazo?	❑ No → **Pase a la Pregunta D8** ❑ Sí ❑ No se
D2. ¿Alguna vez ha realizado un aborto personalmente?	❑ No → **Pase a la Pregunta D8** ❑ Sí
D3. ¿En qué año usted realizó un aborto por primera vez?	_ _ _ _ (año) ❑ No se
D4. ¿En el último mes, *aproximadamente* cuántas veces ha realizado un aborto?	_ _ _
D5. ¿Qué tipo de recursos utilizó usted para orientarse en la realización de un aborto? **Seleccione todo lo que corresponda.**	❑ Mi propio conocimiento ❑ El protocolo de la clínica ❑ Directrices / protocolo nacionales ❑ Directrices de la Organización Mundial de la Salud ❑ Libro de texto ❑ Otro (Especifique:_____) ❑ No se
D6. ¿Se ha sentido juzgado negativamente por otras personas por realizar abortos?	❑ No → **Pase a la Pregunta D8** ❑ Sí
D7. ¿Quiénes lo han juzgado? **Seleccione todo lo que corresponda.**	❑ Otros profesionales de la salud ❑ Otros usuarios/usuarias ❑ Autoridades ❑ Familia ❑ Amigos ❑ Otro (Especifique:_____)
D8. ¿Ha negado servicio a una paciente que solicitaba una IVE permitida por la ley?	❑ No → **Pase a la Pregunta D11** ❑ Sí ❑ No se

D9. Puede que usted se haya encontrado con esta situación varias veces. Si es así, piense en la última situación que esto ocurrió. ¿Cuáles fueron las razones por las que usted no proporcionó el servicio del aborto a la paciente? **Seleccione todo lo que corresponda. Si se da una sola razón, pase a la Pregunta D11.**	❑ 1. Falta de formación suficiente ❑ 2. Falta de recursos (por ejemplo, los medicamentos necesarios) ❑ 3. Porque soy objetor de conciencia ❑ 4. Por preocupación a la oposición de otras personas (como la familia, amigos, compañeros de trabajo) ❑ 5. Por preocupaciones legales (porque antes era prohibido) ❑ 6. La paciente tuvo comorbilidades/fue un caso clínico demasiado complejo ❑ 7. Otras (Especifique:_____)
D10. Por favor, elige e indique el orden de importancia de no más de tres razones más importantes según el impacto que hayan tenido en su decisión. **Rellene los espacios con el número que corresponda de la pregunta D9.**	1. __ 2. __ 3. __
D11. ¿Alguna vez no pudo realizar un aborto a una usuaria por una de las siguientes razones? **Seleccione todo lo que corresponda.**	❑ Edad gestacional demasiado avanzada ❑ Una mujer menor de 18 años ❑ Una mujer con incapacidad ❑ Una mujer sin célula Uruguaya ❑ Ninguno de estas

Estas son todas las preguntas para usted. Muchas gracias por su participación. Sé que su tiempo es muy valioso y apreciamos mucho su voluntad de dedicarnos un poco de su tiempo. Si tiene interés en conocer los resultados de nuestra colección de datos, o si tiene preguntas sobre esta encuesta, puede contactar la investigadora usando los datos colocados abajo:

Yonah.EtShalom@Emory.Edu

Gracias de nuevo.

Appendix B

Ley 18.987 (en Español)

Source: República Oriental del Uruguay, Poder Legislativo. (2012). *Ley No 18.987: Interrupción voluntaria del embarazo.* Montevideo: 22 October 2012. Retrieved from http://www.parlamento.gub.uy/leyes/AccesoTextoLey.asp?Ley=18987&Anchor=

Ley Nº 18.987

INTERRUPCIÓN VOLUNTARIA DEL EMBARAZO

NORMAS

El Senado y la Cámara de Representantes de la República Oriental del Uruguay, reunidos en Asamblea General,

DECRETAN:

CAPÍTULO I

CIRCUNSTANCIAS, PLAZOS Y REQUISITOS

Artículo 1º. (Principios generales).- El Estado garantiza el derecho a la procreación consciente y responsable, reconoce el valor social de la maternidad, tutela la vida humana y promueve el ejercicio pleno de los derechos sexuales y reproductivos de toda la población, de acuerdo a lo establecido en el Capítulo I de la Ley Nº 18.426, de 1º de diciembre de 2008. La interrupción voluntaria del embarazo, que se regula en la presente ley, no constituye un instrumento de control de los nacimientos.

Artículo 2º. (Despenalización).- La interrupción voluntaria del embarazo no será penalizada y en consecuencia no serán aplicables los artículos 325 y 325 bis del Código Penal, para el caso que la mujer cumpla con los requisitos que se establecen en los artículos siguientes y se realice durante las primeras doce semanas de gravidez.

Artículo 3º. (Requisitos).- Dentro del plazo establecido en el artículo anterior de la presente ley, la mujer deberá acudir a consulta médica ante una institución del Sistema Nacional Integrado de Salud, a efectos de poner en conocimiento del médico las circunstancias derivadas de las condiciones en que ha sobrevenido la concepción, situaciones de penuria económica, sociales o familiares o etarias que a su criterio le impiden continuar con el embarazo en curso.

El médico dispondrá para el mismo día o para el inmediato siguiente, la consulta con un equipo interdisciplinario que podrá ser el previsto en el artículo 9º del Decreto 293/010 Reglamentario

de la Ley Nº 18.426, de 1º de diciembre de 2008, el que a éstos efectos estará integrado al menos por tres profesionales, de los cuales uno deberá ser médico ginecólogo, otro deberá tener especialización en el área de la salud psíquica y el restante en el área social.

El equipo interdisciplinario, actuando conjuntamente, deberá informar a la mujer de lo establecido en esta ley, de las características de la interrupción del embarazo y de los riesgos inherentes a esta práctica. Asimismo, informará sobre las alternativas al aborto provocado incluyendo los programas disponibles de apoyo social y económico, así como respecto a la posibilidad de dar su hijo en adopción.

En particular, el equipo interdisciplinario deberá constituirse en un ámbito de apoyo psicológico y social a la mujer, para contribuir a superar las causas que puedan inducirla a la interrupción del embarazo y garantizar que disponga de la información para la toma de una decisión consciente y responsable.

A partir de la reunión con el equipo interdisciplinario, la mujer dispondrá de un período de reflexión mínimo de cinco días, transcurrido el cual, si la mujer ratificara su voluntad de interrumpir su embarazo ante el médico ginecólogo tratante, se coordinará de inmediato el procedimiento, que en atención a la evidencia científica disponible, se oriente a la disminución de riesgos y daños. La ratificación de la solicitante será expresada por consentimiento informado, de acuerdo a lo dispuesto en la Ley Nº 18.335, de 15 de agosto de 2008, e incorporada a su historia clínica.

Cualquiera fuera la decisión que la mujer adopte, el equipo interdisciplinario y el médico ginecólogo dejarán constancia de todo lo actuado en la historia clínica de la paciente.

Artículo 4º. (Deberes de los profesionales).- Sin perjuicio de lo dispuesto en el artículo anterior, los profesionales integrantes del equipo interdisciplinario deberán:

A) Orientar y asesorar a la mujer sobre los medios adecuados para prevenir embarazos futuros y sobre la forma de acceder a éstos, así como respecto a los programas de planificación familiar existentes.

B) Entrevistarse con el progenitor, en el caso que se haya recabado previamente el consentimiento expreso de la mujer.

C) Garantizar, dentro del marco de su competencia, que el proceso de decisión de la mujer permanezca exento de presiones de terceros, sea para continuar o interrumpir el embarazo.

D) Cumplir con el protocolo de actuación de los grupos interdisciplinarios dispuesto por el Ministerio de Salud Pública.

E) Abstenerse de asumir la función de denegar o autorizar la interrupción.

Artículo 5º. (Deberes de las instituciones del Sistema Nacional Integrado de Salud).- Las instituciones del Sistema Nacional Integrado de Salud deberán:

A) Promover la formación permanente del equipo profesional interdisciplinario especializado en salud sexual y reproductiva para dar contención y apoyo a la decisión de la mujer respecto a la interrupción de su embarazo.

B) Estimular el trabajo en equipos interdisciplinarios cuya integración mínima en cuanto a número y calidad será la dispuesta en el artículo 3º de esta ley.

C) Interactuar con instituciones públicas u organizaciones sociales idóneas que brinden apoyo solidario y calificado, en los casos de maternidad con dificultades sociales, familiares o sanitarias.

D) Poner a disposición de todos los usuarios mediante publicaciones en cartelera, boletines de información periódica u otras formas de información, la lista del personal de la institución que integra los equipos interdisciplinarios a que hace referencia la presente ley.

E) Garantizar la confidencialidad de la identidad de la mujer y de todo lo manifestado en las consultas previstas en el artículo 3º de esta ley, así como de todos los datos anotados en su historia clínica, aplicándose en lo pertinente las disposiciones de la Ley Nº 18.331, de 11 de agosto de 2008.

F) Garantizar la participación de todos los profesionales que estén dispuestos a integrar los equipos interdisciplinarios, sin discriminaciones de ninguna naturaleza.

Sin perjuicio del cumplimiento de lo dispuesto en el literal b), numeral 2 del artículo 4º de la Ley Nº 18.426, de 1º de diciembre de 2008, y de cualquier otra disposición reglamentaria que disponga el Poder Ejecutivo a este respecto, los directores técnicos de las citadas instituciones dispondrán controles periódicos del estricto cumplimiento de lo establecido en los artículos 3º, 4º y 5º de la presente ley.

Artículo 6º. (Excepciones).- Fuera de las circunstancias, plazos y requisitos establecidos en los artículos 2º y 3º de esta ley, la interrupción del embarazo solo podrá realizarse:

A) Cuando la gravidez implique un grave riesgo para la salud de la mujer. En estos casos se deberá tratar de salvar la vida del embrión o feto sin poner en peligro la vida o la salud de la mujer.

B) Cuando se verifique un proceso patológico, que provoque malformaciones incompatibles con la vida extrauterina.

C) Cuando fuera producto de una violación acreditada con la constancia de la denuncia judicial, dentro de las catorce semanas de gestación.

En todos los casos el médico tratante dejará constancia por escrito en la historia clínica de las circunstancias precedentemente mencionadas, debiendo la mujer prestar consentimiento informado, excepto cuando en el caso previsto en el literal A) del presente artículo, la gravedad de su estado de salud lo impida.

Artículo 7º. (Consentimiento de las adolescentes).- En los casos de mujeres menores de 18 años no habilitadas, el médico ginecólogo tratante recabará el consentimiento para realizar la interrupción del embarazo, de acuerdo a lo establecido en el artículo 11 bis de la Ley Nº 17.823, de 7 de setiembre de 2004, en la redacción dada por el artículo 7º de la Ley Nº 18.426, de 1º de diciembre de 2008.

Cuando por cualquier causa, se niegue el asentimiento o sea imposible obtenerlo de quien debe prestarlo, la adolescente podrá presentarse con los antecedentes producidos por el equipo médico actuante ante el Juez competente. El Juez deberá resolver en un plazo máximo de tres días corridos contados a partir de la presentación ante la sede, respecto a si el consentimiento ha sido expresado en forma espontánea, voluntaria y consciente. A tal efecto, el Juez convocará a la adolescente y al Ministerio Público, para oírla y recabar su consentimiento para la interrupción del embarazo, conforme a lo previsto en el artículo 8º del Código de la Niñez y la Adolescencia (Ley Nº 17.823, de 7 de setiembre de 2004). El procedimiento será verbal y gratuito.

Son jueces competentes para entender en las causas que se sustancien por la aplicación del presente artículo, los Jueces Letrados de Familia Especializados en Montevideo y los Jueces Letrados de Primera Instancia con competencia en materia de familia especializada, en el interior del país.

Artículo 8º. (Consentimiento de mujeres declaradas incapaces).- Si se tratara de una mujer declarada incapaz judicialmente, se requerirá el consentimiento informado de su curador y venia judicial del Juez competente del domicilio de la incapaz que –previa vista al Ministerio Público- evaluará la conveniencia del otorgamiento de la misma, respetando siempre el derecho de la mujer a procrear si el motivo de su incapacidad no le impidiere tener descendencia.

CAPÍTULO II

DISPOSICIONES GENERALES

Artículo 9º. (Acto médico).- Las interrupciones de embarazo que se practiquen según los términos que establece esta ley serán consideradas acto médico sin valor comercial.

Artículo 10. (Obligación de los servicios de salud).- Todas las instituciones del Sistema Nacional Integrado de Salud tendrán la obligación de cumplir con lo preceptuado en la presente ley. A tales efectos, deberán establecer las condiciones técnico-profesionales y administrativas necesarias para posibilitar a sus usuarias el acceso a dichos procedimientos dentro de los plazos establecidos.

Las instituciones referidas en el inciso anterior, que tengan objeciones de ideario, preexistentes a la vigencia de esta ley, con respecto a los procedimientos de interrupción voluntaria del embarazo que se regulan en los artículos anteriores, podrán acordar con el Ministerio de Salud Pública, dentro del marco normativo que regula el Sistema Nacional Integrado de Salud, la forma en que sus usuarias accederán a tales procedimientos.

Artículo 11. (Objeción de conciencia).- Los médicos ginecólogos y el personal de salud que tengan objeciones de conciencia para intervenir en los procedimientos a que hacen referencia el inciso quinto del artículo 3º y el artículo 6º de la presente ley, deberán hacerlo saber a las autoridades de las instituciones a las que pertenecen.

La objeción de conciencia podrá manifestarse o revocarse en forma expresa, en cualquier momento, bastando para ello la comunicación a las autoridades de la institución en la que se desempeña. Se entenderá que la misma ha sido tácitamente revocada si el profesional participa en los procedimientos referidos en el inciso anterior, con excepción de la situación prevista en el último inciso del presente artículo.

La objeción de conciencia como su revocación, realizada ante una institución, determinará idéntica decisión respecto a todas las instituciones públicas o privadas en las que el profesional preste servicios.

Quienes no hayan expresado objeción de conciencia no podrán negarse a realizar los procedimientos referidos en el primer inciso del presente artículo.

Lo dispuesto en el presente artículo, no es aplicable al caso previsto en el literal A) del artículo 6º de esta ley.

Artículo 12. (Registro estadístico).- El Ministerio de Salud Pública deberá llevar un registro estadístico de:

I) Las consultas realizadas en los términos previstos por el artículo 3º.

II) Los procedimientos de aborto realizados.

III) Los procedimientos previstos en los literales A), B) y C) del artículo 6º.

IV) El número de mujeres que luego de realizada la entrevista con el equipo interdisciplinario deciden proseguir con el embarazo.

V) Los nacimientos y cualquier otro dato sociodemográfico que estime pertinente para evaluar en forma anual los efectos de la presente ley.

Las instituciones del Sistema Nacional Integrado de Salud deberán llevar sus propios registros de acuerdo a lo establecido en el presente artículo. El Poder Ejecutivo reglamentará los datos que

incluirán tales registros, la forma y la periodicidad en que las citadas instituciones comunicarán la información al Ministerio de Salud Pública.

CAPÍTULO III

DISPOSICIONES FINALES

Artículo 13. (Requisito adicional).- Sólo podrán ampararse a las disposiciones contenidas en esta ley las ciudadanas uruguayas naturales o legales o las extranjeras que acrediten fehacientemente su residencia habitual en el territorio de la República durante un período no inferior a un año.

Artículo 14. (Derogaciones).- Deróganse todas las disposiciones que se opongan a lo dispuesto en la presente ley.

Artículo 15. (Reglamentación y vigencia).- Atento a la responsabilidad cometida al Estado y a los efectos de garantizar la eficacia de lo dispuesto en la presente ley, la misma entrará en vigencia a los treinta días de su promulgación, plazo dentro del cual el Poder Ejecutivo la reglamentará.

Sala de Sesiones de la Cámara de Senadores, en Montevideo, a 17 de octubre de 2012.

DANILO ASTORI,
Presidente.
Hugo Rodríguez Filippini,
Secretario.

MINISTERIO DE SALUD PÚBLICA
MINISTERIO DEL INTERIOR
MINISTERIO DE DEFENSA NACIONAL
MINISTERIO DE EDUCACIÓN Y CULTURA

Montevideo, 22 de octubre de 2012.

Cúmplase, acúsese recibo, comuníquese, publíquese e insértese en el Registro Nacional de Leyes y Decretos, la Ley por la que se establecen normas relacionadas con la interrupción voluntaria del embarazo.

JOSÉ MUJICA.
JORGE VENEGAS.
EDUARDO BONOMI.
ELEUTERIO FERNÁNDEZ HUIDOBRO.
RICARDO EHRLICH.

Appendix C

Law 18.987 (English translation)

Source: Center for Reproductive Rights. (2012). Uruguay's abortion provisions. Retrieved from http://www.reproductiverights.org/world-abortion-laws/uruguays-abortion-provisions

Law Nº 18.987, Voluntary Interruption of Pregnancy, Establishing Rules (2012)

Law Nº 18.987

VOLUNTARY INTERRUPTION OF PREGNANCY

Establishing Rules

The Chamber of Representatives of the Eastern Republic of Uruguay, in today's session, has sanctioned the following Bill:

CHAPTER I

CIRCUMSTANCES, DEADLINES AND REQUIREMENTS

Article 1°. (General Principles).- The State guarantees the right of conscious and responsible procreation, recognizes the social value of maternity, guardianship of human life and promotion of the full exercise of sexual and reproductive rights of the entire population, in accordance with those established in Chapter I of Law No. 18.426 of Dec. 1, 2008. The voluntary interruption of pregnancy, which is regulated by this law, does not constitute an instrument of birth control.

Article 2°. (Decriminalization).- Voluntary interruption of pregnancy will not be penalized and accordingly, articles 325 and 325 bis of the Penal Code will not be applicable for women who comply with the requirements established in the following articles and provided that the interruption takes place within the first twelve weeks of pregnancy.

Article 3°. (Requirements).- Within the established timeframe in the previous article of this law, the woman must attend a medical consultation before an institution of the National Integrated Health System, in order to inform the physician of circumstances arising from conditions that have befallen the pregnancy, situations of economic penury, social, familial, or age range hardship that by her criteria impede continuing the ongoing pregnancy.

The physician will arrange for the same-day or next-day, the consultation with an interdisciplinary team that may be that provided by the article 9 of Decree 293/010 Regulation of Law No. 18.426 of December 1, 2008, which for this purpose shall consist of at least three professionals, one of which shall be a gynecologist, another shall have a specialization in psychological health and the remaining one in a social area.

The interdisciplinary team, acting together, should inform the woman of what is established in this law, of the characteristics of terminating the pregnancy, and of the inherent risk in this practice. Also, it will inform her about the alternatives to induced abortion including available programs for social and economic support, as well as regarding the possibility of putting her child up for adoption.

In particular, the interdisciplinary team should become a psychological and social support system for the woman, in order to help her overcome the causes that can lead to termination of pregnancy and to guarantee that she has the information for making a conscious and responsible decision.

From the meeting with the interdisciplinary team, the woman shall have a reflection period of at least five days, after which, if the woman still wishes to terminate the pregnancy before the gynecologist treating her, the gynecologist will immediately coordinate the procedure, in accordance with available scientific evidence, and direct her on how to diminish risks and damages. The ratification of the applicant will be expressed by informed consent, according to the provisions in Law No. 18.335 of August 15, 2008, and incorporated in her medical history.

Whatever decision the woman makes, the interdisciplinary team and the gynecologist will record the whole process in the patient's medical history.

Article 4°. (Professionals' Duties).- Without prejudice to the previous article, the professionals of the interdisciplinary team must:

A) Guide and advise the woman about suitable means for preventing future pregnancies and about how to access them, as well as regarding existing family planning programs.

B) Interview with the parent, if they have previously sought express consent of the woman.

C) Guarantee, within the framework of its competence, that the woman's decision making process be free from pressure from others, whether to continue or terminate the pregnancy.

D) Comply with the protocol of performance of those interdisciplinary groups established by the Ministry of Public Health.

E) Refrain from assuming the function of denying or authorizing the termination.

Article 5°. (Duties of the institutions of the National Integrated Health System). The institutions of the National Integrated Health System must:

A) Promote the permanent formation of a professional interdisciplinary team specializing in sexual and reproductive health in order to give contention and support for the woman's decision regarding termination of her pregnancy.

B) Stimulate the work in interdisciplinary teams who must at minimum be made of the number and quality provided in article 3 of this law.

C) Interact with the public institutions and suitable social organizations that provide solidary and qualified support in cases of maternity with social, familial or health difficulties.

D) Make available to all users through publications in billboard, periodic information bulletins, and other forms of information, a list of institution staff that are part of the interdisciplinary teams referenced in this law.

E) Guarantee the confidentiality of the woman's identity and everything expressed in the consultations in article 3 of this law, as well as all of the data recorded in her medical history, appropriately applying the provisions of Law No. 18.331 of August 11, 2008.

F) Guarantee the participation of all of the professionals who are willing to participate in interdisciplinary teams without any kind of discrimination.

Without prejudice to the compliance of the provisions of paragraph b), numeral 2 of article 4 in Law No. 18.426 of December 1, 2008, and any other regulatory provisions that has Executive Power in this regard, the technical directors of these institutions will have periodic checks for strict compliance with the provisions in articles 3, 4, and 5 in this law.

Article 6°. (Exceptions).- Outside the circumstances, deadlines, and requirements established in articles 2 and 3 of this law, termination of pregnancy may only be carried out:

A) When the pregnancy involves a grave risk to the health of the woman. In these cases one should try to save the life of the embryo or fetus without endangering the life or health of the woman.

B) When there is a verified pathological process that causes malformations incompatible with life outside the womb.

C) When pregnancy was the product of a rape consistent with judicial denunciation, within fourteen weeks of pregnancy.

In all cases the medical treatment record will be placed on record by writing in the medical history the circumstances mentioned above, the woman must give informed consent, and except in cases described in A) of this article, the severity of the state of the woman's health condition prevents it.

Article 7°. (Consent of adolescents). In cases of women below 18 years of age without authorization, a treating gynecologist will seek consent to perform the termination of pregnancy in accordance with the provisions of article 11 bis of Law No. 17.823 of September 7, 2004, in the wording given by article 7 of Law No. 18.426 of December 1, 2008.

When for whatever cause, one refuses to assent or it is impossible to obtain it from the proper person, the adolescent can present the background produced by the medical team before the competent Judge. The Judge must decide in a maximum of three calendar days following the presentation whether the consent is spontaneous, voluntary, and conscious. For this purpose, the

Judge will convene the adolescent and the Public Prosecutor to hear her and to gather her consent for the termination of pregnancy, as provided in article 8 of the Code of Children and Adolescents (Law No. 17.823 of September 7, 2004). The procedure will be verbal and free.

There are competent judges to understand the causes that are substantiated by the application in this article, the Family Law Specialization Judges in Montevideo and Judges of First Impression with competence in material of family specialization, within the country.

Article 8°. (Consent of women declared incompetent).- If it were about a woman judicially declared incompetent, informed consent of her caretaker is required and a judicial authorization from a competent judge from the disabled woman's district that – after hearing the Public Prosecutor – evaluates the appropriateness of granting the abortion, always respecting the woman's right to procreate if the reason for her incapacity does not prevent her from having children.

CHAPTER II

GENERAL PROVISIONS

Article 9°. (Medical act). Terminations of pregnancy within the terms established in this law will be considered medical acts without commercial value.

Article 10°. (Obligation of health services). - All institutions of the National Integrated Health System will have the obligation to comply with the provisions in this law. To that effect, they should establish professional-technical and administrative conditions necessary to allow users to access these procedures within the established timeframes.

The institutions referred to in the preceding paragraph, that have ideological objections existing prior to the enactment of this law, with respect to termination of pregnancy procedures as regulated in the previous articles may make an agreement with the Ministry of Public Health, within the framework that regulates the National Integrated Health System, the form in which their uses will access such procedures.

Article 11°. (Conscientious Objection). - Gynecologists and health personnel that have conscientious objections in participating in the procedures referenced in the fifth paragraph of article 3 and article 6 of this law, should notify the authorities of the institutions they belong to.

The conscientious objection can be made or revoked in an expressed form, at any moment, sufficient for communication of the objection to the authorities of the institution in which he serves. It will be understood to have been tacitly revoked if the professional participates in the procedures referenced in the prior paragraph, with the exception of the situation provided in the last paragraph of this article.

The conscientious objection, like its revocation, made before an institution, will determine identical decisions with respect to all public or private institutions, in those where professionals provide services.

Whoever has not expressed conscientious objection will not be able to refuse to provide the procedures referenced in the first paragraph of this article.

The provisions in this article are not applicable to the case provided in numeral A) of article 6 of this law.

Article 12°. (Statistical Record). - The Ministry of Public Health shall keep a statistical record of:

I) The consultations made under the agreed terms in article 3.

II) Abortion procedures performed.

III) Procedures provided in subparagraphs A), B), and C) of article 6.

IV) The number of women that after going through the interview with the interdisciplinary team decide to continue their pregnancy.

V) The births and any other socio-demographic data that it deems pertinent to annually evaluate the effects of this law.

The Integrated National Health System institutions shall keep their own records of agreement as established in this article. The Executive Power will regulate the data that will include such records, the manner and frequency in which the aforementioned institutions will communicate the information to the Ministry of Public Health.

CHAPTER III

FINAL PROVISIONS

Article 13°. (Additional requirements). -The provisions contained in this law can only be relied upon for natural or legal Uruguayan citizens or foreigners with convincing evidence of habitual residence in the territory of the Republic for a period of no less than one year.

Article 14°. (Repeals). - Repeal all provisions contrary to the provisions of this law.

Article 15°. (Regulation and enforcement). – Attentive to the responsibility of the State and to the effects of guaranteeing the effectiveness of the provisions in this law, the provisions will come into effect thirty days after their enactment, within which period the Executive will regulate it.

Meeting Room of the Chamber of Senators, in Montevideo, 17th of October 2012.