Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

_____ _____

Heidi Katharina Schroffel

Women's Satisfaction with Decriminalized Abortion Services at Uruguay's National Women's Hospital Pereira Rossell

By

Heidi Katharina Schroffel
Master of Public Health

Hubert Department of Global Health

_____

Roger Rochat, MD
Committee Chair

Women's Satisfaction with Decriminalized Abortion Services at Uruguay's National Women's Hospital Pereira Rossell

By

Heidi Katharina Schroffel

B. A., University of Malaga

2007

Thesis Committee Chair: Roger Rochat, MD

An abstract of a thesis submitted to the Faculty of the Rollins School of Public Health of Emory University in partial fulfillment of the requirements for the degree of

Master of Public Health in Global Health

2015

Abstract

Women's Satisfaction with Decriminalized Abortion Services at
Uruguay's National Women's Hospital Pereira Rossell

By
Heidi Katharina Schroffel

Uruguay decriminalized first trimester abortions in October 2012. The law requires women to undergo three consultations with different healthcare professionals, including a multidisciplinary team, to obtain the procedure, followed by an optional post-abortion visit. Since decriminalization, no survey studies have examined client satisfaction with abortion services in the Uruguayan healthcare setting. In this study, we aimed to evaluate abortion clients' satisfaction at the Pereira Rossell hospital, Uruguay's largest abortion provider. After intensive training on the country's newly decriminalized abortion services, the Principal Investigator (PI) observed 20 consultations with women obtaining pre-abortion counseling and post-abortion care. The PI also conducted a self-administered satisfaction survey with 81 abortion clients and examined differences in satisfaction by demographics and consultation type. Overall client satisfaction and perceived support of healthcare professionals were very high. Dissatisfaction was mostly due to the legally mandated five-day waiting period and scheduling delays. We infer that reducing delays would improve client satisfaction with abortion care.

Women's Satisfaction with Decriminalized Abortion Services at Uruguay's National Women's Hospital Pereira Rossell

By

Heidi Katharina Schroffel

B. A., University of Malaga

2007

Thesis Committee Chair: Roger Rochat, MD

A thesis submitted to the Faculty of the Rollins School of Public Health of Emory University in partial fulfillment of the requirements for the degree of

Master of Public Health in Global Health

2015

Acknowledgements

I would like to express my gratitude to Dr. Roger Rochat for his encouragement, support, genuine interest, optimism and sense of humor.

To the members on Iniciativas Sanitarias in Montevideo and the Sexual and Reproductive Health Services staff of the Women's Hospital Pereira Rossell, who made me feel like part of their team, provided me with valuable insights and allowed me to collect the data for this study.

To the Emory Global Health Institute and the GEMMA fund, whose generous funding made this study a reality.

To my GHI team members, Bethany Kotlar and Yonah EtShalom, who helped me prepare for and supported me during the trip to Uruguay.

And to my husband Jonathan Schroffel, my constant source of loving support without whom none of this would have been possible.

Table of Contents

List of Figures and Tables……viii

Chapter 1: Introduction……1

Chapter 2: Literature Review……4

Chapter 3: Project Content

Methods……13

Results……15

Chapter 4: Discussion, Conclusion and Recommendations……18

Figures and Tables……22

References……33

Appendix……35

List of Figures and Tables

Figure 1: The four IVE consultations in the Uruguayan healthcare system including the timeline established by the law……22

Figure 2. Examples of clients' comments…….23

Table 1. Demographic characteristics of study participants and consultation type……..24

Table 2. Distribution of total satisfaction scores – all visits…….25

Table 3. Factors associated with satisfaction……..……..25

Table 4. Satisfaction by survey item (dichotomized), all visits…….....26

Table 5. Frequency distribution of responses by question, all visits…….27

Table 6. Frequency distribution of responses by question – IVE 1……..28

Table 7. Frequency distribution of responses by question – IVE 2……..29

Table 8. Frequency distribution of responses by question – IVE 3……..30

Table 9. Frequency distribution of responses by question – IVE 4……..31

Table 10. Distribution of total satisfaction scores – by consultation type……..……..32

Chapter 1: Introduction

Access to safe abortion services prevents mortality and morbidity among women, as evidenced by the statistics from countries with access to legal, safe abortion or effective harm reduction models within restrictive legal contexts. In the United States, where abortion on request is legal within certain restrictions, only 0.6 fatalities per 100,000 legal abortions occur, compared to 50 fatalities per 100,000 unsafe abortions in Latin America (WHO, 2011). Ninety-five percent of all abortions are estimated to be unsafe in the region, mainly due to legal restrictions, with abortion-related mortality accounting for 12% of all maternal deaths (Sedgh et al.; WHO, 2011).

In Uruguay abortion was criminalized until 2012. Here, unsafe abortions were the leading cause of maternal mortality during the 1990s, representing 28% of all maternal deaths. In 2001, Uruguay implemented a successful harm reduction model for abortions, eleven years before the procedure was decriminalized (PAHO, 2012). Despite the fact that abortion remained illegal, within a decade the Uruguayan Ministry of Health was able to announce that Uruguay was the only country in Latin America that had not recorded a single maternal death caused by unsafe abortion in three years (UNFPA, 2011). Since 2012, Uruguay has been providing legal abortions through a system largely based on an extension of their harm reduction model.

Barriers to quality abortion services can also exist where abortion is legal. This includes lack of accurate information, mandated waiting periods, parental consent requirements, lack of respectful, conscientious objection, non-judgmental treatment by healthcare professionals and delays in receiving care (United Nations, 2011).

Problem statement

Broad and easy access to abortion services that meet clients' needs is necessary to eliminate the risk of unsafe abortions. Clients should receive non-judgmental, compassionate care that reduces barriers to timely resolution wherever possible. However, these circumstances are often not given in illegal or even legal settings and as a consequence care may remain unavailable, inaccessible, untimely or substandard. One way to evaluate quality of care is to determine how satisfied women are with the services provided, a strategy often used to improve healthcare delivery (Committee on Quality of Health Care in America, 2001).

An extensive literature review did not identify any published survey data on client satisfaction with abortion services in Uruguay since the decriminalization of the procedure in 2012. In Uruguay, the 2012 abortion law has drawn much criticism from women's rights groups and the general public because of the five-day mandated waiting period and the required consultation with the multidisciplinary team, often referred to as a 'panel' in the media, which is considered a barrier to access by some. This study aims to shed more light on the clients' experience at this early stage of implementation of the law at the national women's hospital Pereira Rossell (Complejo Hospitalario Pereira Rossell, CHPR) in Montevideo, Uruguay's largest provider of abortion services (Médecins du Monde, 2014). Data on client satisfaction with abortion services here will provide the opportunity to address areas for improvement within the organization.

Purpose statement

The purpose of this paper is to investigate how satisfied women are with abortion services provided at CHPR one and a half years after the decriminalization of the procedure. While satisfaction surveys for abortion clients were conducted while Uruguay's harm reduction model was in place (Briozzo et al., 2010), no survey data exist on client satisfaction after legalization. The paper aims to determine where the reasons for dissatisfaction lie and how they may be distributed across the different types of visits so that the findings can be addressed by the administration of the Sexual and Reproductive Health Services at CHPR.

Research questions

This paper aims to answer the following research questions:

- How satisfied are women with abortion services provided at CHPR 20 months after the decriminalization of the procedure?
- What are the factors that influence satisfaction or dissatisfaction with abortion services at CHPR?

Definition of terms

- IVE (Interrupción Voluntaria del Embarazo) – Voluntary termination of pregnancy, official term for legal abortion provided within the Uruguayan healthcare system.
- Misoprostol – Medication used to prevent gastric ulcers, treat missed miscarriage and induce labor or abortion.
- Mifepristone – Medication used to terminate a pregnancy. Frequently used with misoprostol in a two-step process of inducing abortion.

Chapter 2: Literature Review

Abortion in Latin America

Latin America is home to some of the most restrictive abortion laws in the world. With exception of the Vatican and Malta, all countries whose penal code makes no exceptions to the prohibition of abortion, not even to save a woman's life, are in Latin America: Chile, El Salvador, Dominican Republic, Honduras and Nicaragua (United Nations, 2013). Even where exceptions to abortion bans are in place, women often face challenges to identify their right to an abortion or legally demand it. As a result, those exceptions are in many cases not available to them or delays in authorization may cause women to exceed the legal gestational age. Abortion on request (without restriction as to reason) is only available in three of the 20 countries in Latin America: Cuba (since 1965), Guyana (since 1995) and Uruguay (since 2012) (Center for Reproductive Rights, 2014). Mexico's capital, the Federal District, decriminalized abortions up to 12 weeks in 2007, while the procedure remains highly restricted in the rest of the country (Guttmacher Institute, 2013).

Although mainly illegal, abortion is widely practiced in Latin America. The region has the world's highest abortion rate (32 per 1000 women aged 15-44), nearly all of which are unsafe (Guttmacher Institute, 2012). According to the World Health Organization, an unsafe abortion is one performed either by persons lacking the necessary skills or in a sub-standard medical environment or both (WHO, 2014). Methods of unsafe, self-induced abortion include drinking toxic fluids, insertion of foreign objects or inappropriate medication into the vagina and external injury, such as trauma to the abdomen. In addition, inappropriate care by unskilled providers or in unhygienic settings can cause infections and injuries to internal organs (Haddad & Nour,

2009). Many women in legally restrictive environments turn to medical, self-induced abortions with misoprostol, a common practice in Latin America (IPAS, 2010). Used correctly, misoprostol can significantly reduce the dangers of unsafe abortion, even without the supervision of a skilled healthcare provider (Hyman, Blanchard, Coeytaux, Grossman, & Teixeira, 2013). Despite the legal restrictions on abortion in Latin America, most of its countries have approved misoprostol for the treatment of gastric ulcers or for the treatment of miscarriages. A 2009 study identified 39 medications containing misoprostol that were available in the region (Fernandez, Coeytaux, de Leon, & Harrison, 2009).

Information about where and how to obtain misoprostol is usually spread by word of mouth among women or their partners. The medication is frequently obtained illegally through pharmacies, medical providers or the Internet. However, on the black market misoprostol is often very expensive and lack of information can make its use risky. Latin America has the highest regional prices for misoprostol and women do not usually receive adequate counseling on the proper administration of the drug, including warning signs and information on when to seek help for complications. In addition, women cannot be sure that they are purchasing the right medication or the correct quantities, making a safe procedure potentially harmful (IPAS, 2010).

Harm Reduction Models for Safer Abortions

Several factors make the Latin American context suitable for harm reduction models using self-induced medication abortion. The legal context is highly restrictive and substantial legal reforms are unlikely to happen in the foreseeable future. Any progress towards legalization of the procedure remains slow, leaving many women dead or disabled in the process and inflicting

enormous costs on society. Abortion-related maternal mortality is unacceptably high and misoprostol is widely available. Strong historical, cultural and religious opposition exists, but the goal of reducing maternal mortality has been increasingly prioritized by many Latin American national governments (Center for Reproductive Rights, 2014; WHO, 2013).

The concept of harm reduction, often used in the context of drug abuse, refers to the implementation of "strategies to reduce harm and preserve health in situations where policies and practices prohibit, stigmatize and drive common human behavior underground" (Hyman et al., 2013). The use of harm reduction models is based on the principles of neutrality towards the activity in question, the prioritization of human health needs over moral judgment and a pragmatic approach to reducing the harm caused by behaviors that cannot be easily changed (Erdman, 2011). In the case of abortion, the harm reduction process consists of providing evidence-based information and counseling around self-induced abortions with medications as well as post-abortion care to women with unwanted pregnancies. Harm reduction strategies have enormous potential to dramatically decrease, even eliminate, abortion deaths in Latin American countries and pave the way to legalization, as the Uruguayan experience effectively demonstrates.

The Uruguayan Model for Reducing the Risk and Harm of Unsafe Abortions

Prior to 2012, Uruguayan law criminalized abortion, allowing exceptions only in cases of danger to a women's life, health or honor, rape or extreme poverty, although the practical applications of these exceptions were minimal. In the late 1990s, abortion was the leading cause of maternal mortality, accounting for 28% of maternal mortality nationwide and for 47% at the national

women's hospital Pereira Rossell (PAHO, 2012). Here, a group of health professionals started developing a model for reducing the risk and harm of unsafe abortions, a project that would lead to the establishment of the organization Iniciativas Sanitarias ("Health Initiatives", IS) in 2006 (PAHO, 2012). This harm reduction model aimed at including women with unwanted pregnancies within the healthcare system instead of alienating them. Women were provided with information on the following: the legal situation of abortion in Uruguay, unsafe abortion practices to be avoided, the proper administration of misoprostol, warning signs and what to do in cases of emergency. In adherence with the law, health care staff provided no information on where and how to obtain the medication. Women were encouraged to return for post-abortion care to confirm that the pregnancy termination was complete and that no complications had occurred. Family planning services and counseling were also offered during the follow-up visit. In 2008, the law 18.426 ("Defense of the Right to Sexual and Reproductive Health") officially recognized women's right to confidential care within the Uruguayan healthcare system and scaled up the harm reduction model developed by IS to all healthcare facilities in the country, both public and private, by making comprehensive counseling for women with unwanted pregnancies mandatory (Iniciativas Sanitarias & IPPF/WHR, 2011). According to the Uruguayan Ministry of Public Health, by 2011 this measure had made Uruguay the only country in Latin America that had not registered any maternal deaths from unsafe abortion in three years (UNFPA, 2011).

Decriminalization of Abortion in Uruguay

In October 2012, Uruguay passed Latin America's most liberal abortion law, which is heavily based on the preceding harm reduction model. The "Law of Voluntary Interruption of Pregnancy" (Interrupción Voluntaria del Embarazo, "IVE" in Spanish) decriminalized abortion up to 12 weeks of gestation, extending the gestational age limit to 14 weeks for rape victims and allowing later-term procedures for women facing health risks and fetal abnormalities incompatible with life (Law 18.987, 2012). Eligible women must be at least 18 years of age, Uruguayan citizens or legal residents of at least one year. In cases of adolescents under the age of 18, the gynecologist will determine the emotional maturity of the individual. Consent from a parents or responsible adult is required in cases where the health care provider deems the adolescent incompetent to make the decision.

Women are required to undergo a total of three consultations with different healthcare professionals, including a multidisciplinary team consisting of a gynecologist, a mental health professional and a social worker, in order to obtain the procedure. They must be informed about health risks and alternatives to abortion as well as comply with a five-day reflection period. Gynecologists provide prescriptions for self-induced medical abortions in all cases except where surgical methods are medically necessary. A post-abortion check-up is recommended, but not legally required. About one third of gynecologists refuse to provide prescriptions for the procedure, making use of their legal right of conscientious objection, which impacts the availability of abortion services (Presidencia de la República del Uruguay, 2013). Conscientious objection allows gynecologist to refuse providing the third consultation, during which the medication is prescribed, but does not exempt them from their obligation to participate in the

multidisciplinary team consultation (the client's second visit) or to refer women to another provider in a timely manner.

The four consultations (termed IVE 1, IVE 2, IVE 3 and IVE 4) take place within Uruguay's National Health System, which encompasses both the public and the private sector. Figure 1 provides an overview of the four visits and the timeline as established by the law. In practice, the timeline may vary according to the availability of the healthcare professionals, potentially resulting in delays.

A pregnant woman's visit to any physician or midwife in the country can initiate the process. During this first visit, the client's eligibility is verified and she receives information about the legal context and the steps required to obtain an abortion. Women are referred for IVE 2, as well as for an ultrasound to verify pregnancy and gestational age and for a blood test to determine blood group and Rh status. Clients with Rh-negative status will be given an anti-D immunoglobulin injection during IVE 3 to prevent adverse effects on subsequent pregnancies. The law establishes that IVE 2, the consultation with the multidisciplinary team, takes place the same or the next day, but in practice this will depend on the availability of the health professionals. In some healthcare facilities the team may only be available once or twice a week, particularly in more rural areas. IVE 2 takes place with a gynecologist, a mental health professional (psychologist or psychiatrist) and a social worker, each serving a different role. The gynecologist informs the client about the medical and legal aspects of the termination of pregnancy and associated risks, based on the gestational age. If the client is past the legal gestational age limit, she is counseled under the harm reduction model. The mental health professional evaluates and addresses factors that may impact the psychological well-being of the woman, such as the process of decision-making and existing support systems. The social worker

explains alternative options available to the client (as required by law), like adoption and support if the pregnancy was to be continued, and addresses social support and financial issues, such as child support for existing children if needed. This consultation initiates the legally mandated five-day waiting period, after which the client can return for IVE 3, which takes place with a gynecologist. Here, the woman states her final decision and receives the prescription for the medication, along with information about proper administration, potential risks, warning signs and what to do in case of emergency. The phone number for a 24-hour emergency hotline is provided and the anti-D immunoglobulin injection is given if applicable. Women are instructed to return for their post-abortion check-up, IVE 4, at least 10 days after the abortion is completed. At that time, they are evaluated for physical or psychosocial complications and referred or treated accordingly and family planning services are provided as desired.

Client Satisfaction as an Indicator of Quality of Abortion Services

Patient satisfaction in healthcare has been documented as an important indicator of quality of care in general (Bleich, Ozaltin, & Murray, 2009) and of women's healthcare in particular (Scholle et al., 2000) . However, with regards to abortion services, the literature has largely focused on the medical aspects and procedural safety, with few published studies examining client experiences and satisfaction. One US study from 1999 found very high general levels of satisfaction among abortion clients, who ranked accuracy of information received, privacy and treatment by staff as very important to their satisfaction (The Picker Institute, 1999). Another 2013 study from the US found very high overall satisfaction, with clinic environment, treatment by clinical staff and managed pain levels as the most important determinants of client satisfaction

(Taylor et al., 2013). One study examined client satisfaction in Mexico City three years after decriminalization and found overall high levels of satisfaction as well as opportunities for improvement, particularly in the areas of psychosocial support and post-abortion contraception (Olavarrieta et al., 2012). Women in a 2007 study in Vietnam gave providers high satisfaction score in a survey, but reported poor interaction with providers in in-depth interviews (Nguyễn, Gammeltoft, & Rasch, 2007). One study in Flanders found very high satisfaction with pre-abortion counseling (Vandamme, Wyverkens, Buysse, Vrancken, & Brondeel, 2013). A qualitative study of women's experience with abortion services in three different provinces in Uruguay (including services at CHPR in Montevideo), shows similar results, with women generally perceiving sexual and reproductive health services staff as non-judgmental, polite and respectful and the information provided as clear and easy to understand (Médecins du Monde, 2014).

To monitor abortion services at CHPR, IS adapted a quality assessment tool created by IPPF/WHR. This tool assesses the quality of service provision from three different perspectives: healthcare institutions, healthcare professionals and healthcare clients. An external observation is carried out to evaluate the interaction between clients and healthcare professionals and aspects of the healthcare environment such as infrastructure and equipment, educational materials, privacy and confidentiality, and the adherence to norms and protocols. Healthcare professionals complete a self-assessment to identify strengths and weaknesses in their service provision. To assess the satisfaction of abortion clients, women complete a self-administered survey (provided by the healthcare professionals and completed anonymously and in private), rating their satisfaction of aspects of the services provided, including how they felt treated by the providers, quality and usefulness of the information provided, privacy and confidentiality and access issues (such as

obtaining a timely appointment and wait times). The last assessment before this study took place in 2010, before the decriminalization of abortion services, to assess services provided within the harm reduction model (consisting of one counseling and one post-abortion care visit). The responses indicated overall high levels of satisfaction. The treatment by healthcare staff was rated as “friendly” or “very friendly” in most responses (75% for administrative staff, 84% for nursing staff and 97% for providers). With regards to the information provided, satisfaction was highest with the information about the reason for the consultation, the use of the medication and the follow-up examinations, and slightly lower for signs of emergency and what to do in case in emergency. With regards to overall satisfaction with the services, satisfaction was highest with the support received and privacy provided, and slightly lower for delays and the hospital facilities.

Chapter 3: Project Content

Methods

Study Design & Data Collection

The study took place between June 12 to July 31, 2014 at the public Pereira Rossell hospital (CHPR), Uruguay's largest women's hospital and national referral center. The principal investigator (PI) conducted this study in collaboration with Iniciativas Sanitarias (IS), whose central office is located within the Pereira Rossell hospital, and the hospital's sexual and reproductive health (SRH) services. IS provided an intensive one-week training course on Uruguay's abortion law, its historical and legal context as well as aspects of service implementation and monitoring. The PI then observed 20 consultations at CHPR's SHR services, including all four types of visits, with women obtaining pre-abortion counseling, medication prescriptions and post-abortion care, and recorded observations as field notes.

The PI used an adapted version of a component of the IS quality assessment tool, the clients' satisfaction survey. The questions on satisfaction remained the same, but questions about background information (consultation type, age, partner status, education and whether or not the woman was accompanied during the consultation) were added. A convenience sample of participants was recruited by asking providers to invite clients who attended any type of IVE consultation during the study period to complete the survey after the consultation. There were no exclusion criteria. A total of 105 IVE clients completed the confidential survey alone in an area separate from the consultation room and placed it in a locked box.

As this study consisted of an internal quality assessment on request of the organization Iniciativas Sanitarias, it was not considered human subject research by the Emory Institutional Review Board and no review was required.

Data Analysis

The PI conducted the data analysis in SPSS. Questionnaires with fewer than 80% of completed questions were eliminated from the sample, resulting in a final sample size of 81. Since the questionnaires were completed anonymously and clients come in for up to four consultations, the sample may contain more than one questionnaire completed by the same individual during different consultations. Based on a comparative analysis of background characteristics, identifying respondents with identical attributes of year of age, race, education and partner status, this possibility could not be excluded for 21 of the 81 questionnaires. In our analysis, we refer to the remaining 60 respondents as unique individuals.

A total satisfaction score was calculated for each questionnaire by adding up scores for individual survey items, and dichotomized into “excellent” (defined as a total satisfaction score of 95% or above), and “less than excellent” (less than 95% overall satisfaction). Using a chi-square test, the PI examined the responses for differences in total client satisfaction by background characteristics and consultation type for the 60 respondents that could be identified as unique participants.

For satisfaction by survey item, frequency distributions were examined for all 81 visits by survey was dichotomizing satisfaction into “excellent” (defined as a score of 5) and “less than excellent” (scores of 1-4).

Results

Background characteristics and type of visit

The distribution of respondent characteristics is displayed in Table 1. Respondents' age ranged from 16 to 39 years. Among unique individuals, mean age was 26.7 and most (85%) self-identified as white. Nearly a third (30%) indicated they had completed primary education, over half (62%) completed secondary education, and 8% completed post-secondary education. About half (51%) of respondents were in a stable relationship at the time of the consultation and nearly half of all visits (43%) were unaccompanied.

The distribution of satisfaction ratings across all survey items is shown in Table 4 (dichotomized "excellent"/"less than excellent") and Table 5 (frequency distribution) for all consultation types. Tables 6-9 show satisfaction ratings across all survey items by consultation type.

Overall satisfaction

Overall satisfaction scores were high across the sample, with scores ranging from 65-100%. Nearly 80% of visits were rated as "excellent" (95% or higher), with 44% rated as 100% satisfactory (see Table 2). As shown in Table 3, no statistically significant association was observed between satisfaction scores and any background characteristics or type of consultation among the 60 unique participants. For all 81 visits, results of a chi-square test showed a statistically significant association between education and overall satisfaction, (χ^2=10.45; df=2; p<.01), with higher education associated with lower satisfaction. No statistically significant association was observed between satisfaction scores and other background characteristics or

type of consultation. The distribution of overall satisfaction for all visits by consultation type is shown in Table 10.

Perceptions of treatment by staff

As shown in Table 3, satisfaction with treatment by staff was high across the sample. For nearly all visits (99%) treatment received by the professionals during the consultations was rated as "excellent" and for the majority of visits the treatment by nurses (90%) and scheduling staff (84%) was rated as "excellent".

Perceptions of clarity of information

Clarity of information given during the consultations was rated as "excellent" by close to 90% of visits across all categories. Clarity of information about the reason for the visit was most commonly rated as "excellent" (96%), with clarity of information about warning signs and what to do in case of emergency rated slightly less often as "excellent" (87%).

General perceptions about the service

In over 90% of visits, support by staff and privacy were rated as "excellent". The lowest rates of "excellent" ratings were given to the time needed to obtain an appointment (75%) and the time spent in the waiting room (69%). The comfort and cleanliness of the facilities were also rated as "excellent" less frequently than other aspects of the visit (80% and 77% respectively).

Participant comments

Of the 81 questionnaires, 35 included client comments. Three quarters of these comments expressed great satisfaction with the services and the staff. Most commonly, the attention received was referred to as "excellent" or "very good". Eight responses articulated that women had felt "comfortable" or "well treated" by the staff, and six responses expressed gratitude. About one third of the comments expressed criticism and concerns about delays, referring to the legally mandated five-day waiting period as well as to delays in obtaining appointments, with just one women saying that the process had been "quick and efficient". One response expressed concern about getting pregnant again before obtaining a family planning appointment and another one communicated anxiety about getting too close to the gestational limit due to scheduling delays. One response recommended referral to a psychologist after the procedure. Figure 2 shows examples of clients' comments.

Observations

The PI observed 20 consultations, including all four types of visits. According to those observations and the filed notes taken, treatment by healthcare providers was respectful and non-judgmental and the information provided seemed clear.

Chapter 4: Discussion and Conclusion

Discussion

In the case of the decriminalized abortion services offered at CHPR, the single most important finding of this study was very high overall satisfaction among abortion clients, particularly with the treatment received by healthcare professionals. Demographic characteristics, partner status and consultation type had no impact on reported satisfaction among unique individuals.

The decriminalization of abortion in Uruguay received great media attention, which sometimes portrayed the multidisciplinary team as an intimidating 'panel' of experts, potentially discouraging women from continuing the abortion process (Cavallo, 2014; La Nacion, 2013). This study suggests that in this setting the SRH services staff, including the multidisciplinary team, were generally perceived as respectful and supportive rather than as a barrier. In the abortion clients' comments in this sample, positive interaction with the healthcare professionals was the most frequently mentioned aspect of their experience. This is consistent with satisfaction surveys carried out by Iniciativas Sanitarias for the harm reduction services before the decriminalization of the procedure (Briozzo et al., 2010), the qualitative study by Doctors of the World (Médecins du Monde, 2014) as well as with the observations of the PI.

According to one of the psychologists at CHPR, the purpose of the multidisciplinary team is to "improve the physical, psychological and social health of a woman" and to not only consider the client as a "body that walks in", but as a person with psychological and social needs, which need to be taken into consideration during an emotionally complex process. The SRH services team at CHPR, however, has been at a champion of safe abortion for years and their attitudes may differ from other SRH services around the country. The high rate of conscientious objection in other

provinces (Presidencia de la República del Uruguay, 2013) can be seen as an indicator of prevalent ambivalence about the procedure among healthcare providers elsewhere. Given that the law requires healthcare professionals to provide abortion services, only making an exception for gynecologists and only for the third consultation (during which the medication is dispensed), supportive attitudes may vary in different settings. In the Doctors of the World study, three women (none of whom received services at CHPR), reported that they felt that providers had not been impartial towards their decision to terminate their pregnancies (Médecins du Monde, 2014). While women in this study felt treated well by SRH services staff at CHPR, satisfaction rates were lower with the scheduling staff, which is centralized for the entire hospital and may not be sensitized or supportive of abortion provision.

Disrespectful treatment by healthcare staff has been linked to under-utilization of reproductive health services despite increased health risks, particularly in the realm of childbirth (Bowser & Hill, 2010), but also in abortion services. D'Oliveira, Diniz and Schraiber state that disrespectful treatment by healthcare staff "affects health-services access, compliance, quality and effectiveness" in obstetric and abortion care (2002). Other have established positive interactions with healthcare professionals as an important factor of women's satisfaction with abortion services (Wu et al., 2015; Zapka, Lemon, Peterson, Palmer, & Goldman, 2001).

A secondary finding in this study was dissatisfaction among respondents due to delays in completing the procedure, caused by the five-day legally mandated waiting period as well as delays in obtaining an appointment. According to women's comments these concerns encompass the challenge of prolonging an emotionally complex situation as well as fears about reaching the gestational limit. Although the Uruguayan Ministry of Health establishes that the process should be "completed in the shortest time possible" (Ministerio de Salud Pública, 2012), given the

multi-step nature of the process and the mandatory waiting period, terminating a pregnancy can be lengthy and complex, therefore timely referrals and effective scheduling of consultations are needed. In Uruguay, satisfaction with abortion services may be particularly important. Women who wish to avoid following the lengthy legal abortion procedures may feel tempted to use the well-established black market for misoprostol, which continues to be used by women who are past the legal gestational limit, to self-induce unsupervised.

Delays in completing the abortion process have been established as barriers to access to care and as factors that negatively influence the patient experience (Guttmacher Institute, 2009; Zapka et al., 2001). A qualitative study by Grossman et al. found that concerns about the length of the abortion process in clinical settings was a motivation for self-induced abortions (2010). Bartlett et al. found gestational age to be the greatest risk factor for abortion-related mortality in the United States. For each additional week of pregnancy, the risk of dying increased exponentially by 38% (Bartlett et al., 2004), suggesting that potential barriers for women to access timely quality abortion care that satisfies their needs should be closely monitored to avoid risks. Shortening delays offers a chance to increase satisfaction and to decrease the gestational age at which women obtain an abortion. Internal quality improvement of CHPR cannot address the five-day waiting period, but decreased wait times in the waiting room as well as improved cleanliness of the facilities might improve satisfaction among abortion clients.

This study has some limitations. The survey was self-administered and it could not be determined exactly how many unique individuals provided the responses, since questionnaires were filled out for each of the four consultation types without unique identifiers for respondents (the possibility of a participant having completed more than one survey exists for 21 out of 81 questionnaires). Moreover, we do not know what proportion of women coming for any particular

visit did not return for subsequent visits. Our findings are not generalizable beyond the SRH services of CHPR. Respondents may have been subject to selection bias and social desirability bias. Despite these limitations, this study suggests high level of satisfaction with abortion services and some minor areas of improvement.

Conclusion

In a region with harsh legal restrictions on abortions, Uruguay is unique in its approach to reduce maternal mortality and morbidity from unsafe abortion. The nation has accomplished this first through its innovative harm reduction model and later through decriminalizing first trimester abortion and integrating abortion services into the National Health System. Their experience, and the potential for expansion of their model, is being closely watched by supporters for broader access to abortion in Latin America and elsewhere. The experience of the women in this study shows that high levels of satisfaction with the newly decriminalized abortion services are possible, although areas of improvement remain, especially with regards to the reduction of delays.

Figures and Tables

Figure 1: The four consultations for voluntary termination of pregnancy (Interrupción Voluntaria del Embarazo, IVE) in the Uruguayan healthcare system including the timeline established by the law 18.987 that decriminalized abortion in 2012.

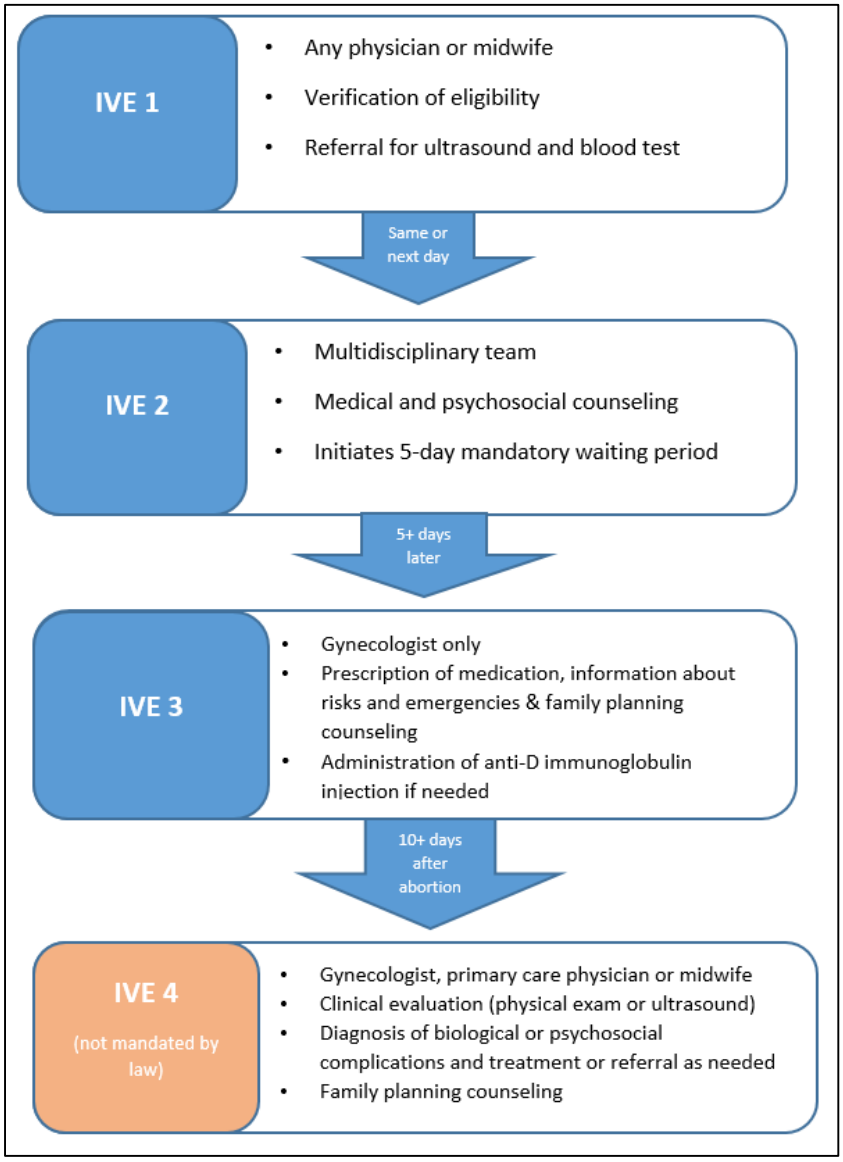

Figure 2. Examples of abortion clients' comments, from the qualitative part of the 2014 satisfaction survey among abortion clients at the Women's Hospital Pereira Rossell, Montevideo Uruguay

Positive comments

- "Excellent team, I felt very comfortable".
- "I think it is good that we can make the decision about having or not having a child, that we are not being judged and that the means are made accessible to us, that we can be guided and counseled. I thank you for it, this has not been an easy decision".
- "Great service, the professionals are very helpful, I felt comfortable. Keep it that way! Thank you".
- "This is the first time I came. I was treated beautifully. […] I have no complaints. The treatment at the Pereira Rossell is very good."

Concerns about delays

- "(…) In this situation of vulnerability the service needs to be faster, since it's nearly a month between the first and the last consultation. One is consumed by nervousness, anguish and uneasiness".
- "I feel that there should be appointments reserved for women closer to the 12 weeks of gestation, for peace of mind".
- "The five-day waiting period is torture. The decision is made from the moment you find out and it's difficult, dragging it out is not good."
- "Some more help for the professionals [is needed]. There are moments when they cannot attend to so many people".

Table 1. Demographic characteristics of study participants and consultation type. Satisfaction survey among abortion clients at the Women's Hospital Pereira Rossell, Montevideo Uruguay, 2014

Characteristic	n (%) per category n=60 (identified as unique respondents)	n (%) per category n=81 (all visits)
Age*		
16-19	6 (11)	10 (12)
20-24	20 (38)	25 (31)
25-29	9 (17)	12 (15)
30-34	10 (19)	14 (17)
35-39	8 (15)	9 (11)
Mean age	26.7	26.3
Race/Ethnicity*		
Black	2 (3)	2 (3)
Indigenous	1 (2)	1 (1)
White	51 (85)	68 (84)
Does not know	5 (8)	5 (6)
Other	1 (2)	3 (4)
Highest level of education*		
No formal education	0 (0)	0 (0)
Primary education	18 (30)	23 (28)
Secondary education	37 (62)	47 (58)
Post-secondary education	5 (8)	10 (12)
Relationship status*		
Not in a stable relationship	29 (48)	39 (48)
In a stable relationship (not living together)	5 (8)	13 (16)
In a stable relationship (living together)	26 (43)	28 (35)
Type of visit		
IVE 1	27 (45)	32 (40)
IVE 2	13 (22)	19 (24)
IVE 3	12 (20)	20 (25)
IVE 4	8 (13)	10 (12)
Accompanied during visit		
Yes, by partner	11 (18)	15 (16)
Yes, by friend or family member	15 (25)	22 (27)
No	34 (57)	43 (53)

Note: Percentages may not add up to 100% due to rounding

- *Nonresponses for n=81 for age (11), race/ethnicity (2), education (1) and relationship status (1)*
  Nonresponse for n=61 for age (9), race/ethnicity (2), education (2) and relationship status (2)

Table 2. Distribution of total satisfaction scores – all visits. Satisfaction survey among abortion clients at the Women's Hospital Pereira Rossell, Montevideo Uruguay, 2014 (n=81)

Total Satisfaction	***n (%)***
100%	36 (44)
95-99%	28 (35)
80-94%	13 (16)
65-79%	4 (5)
Mean	95.81
Median	98.67
Excellent (95-100%)	17 (79)
Less than excellent (65-94%)	62 (22)

Note: Percentages may not add up to 100% due to rounding

Table 3. Factors associated with satisfaction among abortion clients at the Women's Hospital Pereira Rossell, Montevideo Uruguay, 2014

Total Satisfaction	***Unique Individuals (n=60)***	***All Visits (n=81)***
Consultation type	.206 (not significant)	.410 (not significant)
Age (5-year intervals)	.444 (not significant)	.488 (not significant)
Race/Ethnicity	.637 (not significant)	.514 (not significant)
Education	.703 (not significant)	.040
Partner status	.674 (not significant)	.341 (not significant)
Accompanied visit	.740 (not significant)	.503 (not significant)

Table 4. Satisfaction by survey item (dichotomized "excellent"/"less than excellent") - all visits. Satisfaction survey among abortion clients at the Women's Hospital Pereira Rossell, Montevideo Uruguay, 2014 (n= 81)

How were you treated in the hospital?			
Question	***n (%) responses***	***Excellent n (%)***	***Less than excellent n (%)***
By the staff who made your appointment	81 (100)	68 (84)	13 (16)
By the nurses in the SRH service	79 (98)	71 (90)	8 (10)
By the providers during the consultation	80 (99)	79 (99)	1 (1)
With regards to the clarity of information that you were given during the consultation:			
Question	**N (%) Responses**	***Excellent n (%)***	***Less than excellent n (%)***
Information about the reason for this consultation	81 (100)	78 (96)	3 (4)
About when and how to use the mentioned treatments	81 (100)	75 (93)	6 (7)
About when and how to get the required examinations	81 (100)	74 (91)	7 (9)
About the warning signs for which you should seek professional advice	79 (98)	70 (87)	9 (11)
About where to go in case of emergency	79 (98)	70 (87)	9 (11)
About when and how make a new appointment for another consultation	80 (99)	74 (93)	6 (8)
Your general opinion about the service you have received at the hospital:			
Question	**N (%) Responses**	***Excellent n (%)***	***Less than excellent n (%)***
I received the support and attention that I needed	79 (98)	73 (93)	6 (8)
Privacy	76 (94)	68 (90)	8 (11)
The time it took me to obtain an appointment for the consultation	79 (98)	59 (75)	20 (25)
The time I waited in the waiting room when I came in for the consultation	81 (100)	56 (69)	25 (31)
Comfort of the hospital facilities	80 (99)	64 (80)	16 (20)
Cleanliness of the hospital	79 (98)	61 (77)	18 (23)

Note: Percentages may not add up to 100% due to rounding.

Table 5. Frequency distribution of responses by question – all visits. Satisfaction survey among abortion clients at the Women's Hospital Pereira Rossell, Montevideo Uruguay, 2014 (n= 81)

How were you treated in the hospital?						
Question	***N (%) Responses***	***5 Very good***	***4***	***3***	***2***	***1 Very bad***
By the staff who made your appointment	*81 (100)*	*68 (84)*	*8 (10)*	*3 (4)*	*2 (2)*	*0*
By the nurses in the SRH service	*79 (98)*	*71 (90)*	*3 (4)*	*2 (3)*	*3 (4)*	*0*
By the providers during the consultation	*80 (99)*	*79 (98)*	*0*	*0*	*1 (1)*	*0*
With regards to the clarity of information that you were given during the consultation:						
Question	***N (%) Responses***	***5 Very clear***	***4***	***3***	***2***	***1 Very confusing***
Information about the reason for this consultation	*81 (100)*	*78 (96)*	*3 (4)*	*0*	*0*	*0*
About when and how to use the mentioned treatments	*81 (100)*	*75 (93)*	*5 (6)*	*0*	*1 (1)*	*0*
About when and how to get the required examinations	*81 (100)*	*74 (91)*	*6 (7)*	*0*	*1 (1)*	*0*
About the warning signs for which you should seek professional advice	*79 (98)*	*70 (89)*	*6 (8)*	*1 (1)*	*1 (1)*	*1 (1)*
About where to go in case of emergency	*79 (98)*	*70 (89)*	*6 (8)*	*1 (1)*	*1 (1)*	*1 (1)*
About when and how make a new appointment for another consultation	*80 (99)*	*74 (93)*	*3 (4)*	*1 (1)*	*1 (1)*	*1 (1)*
Your general opinion about the service you have received at the hospital:						
Question	***N (%) Responses***	***5 Very satisfactory***	***4***	***3***	***2***	***1 Not at all satisfactory***
I received the support and attention that I needed	*79 (98)*	*73 (93)*	*4 (5)*	*2 (3)*	*0*	*0*
Privacy	*76 (94)*	*68 (90)*	*4 (5)*	*3 (4)*	*0*	*1 (1)*
The time it took me to obtain an appointment for the consultation	*79 (98)*	*59 (75)*	*12 (15)*	*3 (4)*	*1 (1)*	*4 (5)*
The time I waited in the waiting room when I came in for the consultation	*81 (100)*	*56 (69)*	*15 (19)*	*7 (9)*	*0*	*3 (4)*
Comfort of the hospital facilities	*80 (99)*	*64 (80)*	*12 (15)*	*3 (4)*	*1 (1)*	*0*
Cleanliness of the hospital	*79 (98)*	*61 (77)*	*14 (18)*	*1 (1)*	*1 (1)*	*2 (3)*

Note: Percentages may not add up to 100% due to rounding

Table 6. Frequency distribution of responses by question – IVE 1. Satisfaction survey among abortion clients at the Women's Hospital Pereira Rossell, Montevideo Uruguay, 2014 (n= 32)

How were you treated in the hospital?						
Question	***N (%) Responses***	***5 Very good***	***4***	***3***	***2***	***1 Very bad***
By the staff who made your appointment	*32 (100)*	*28 (86)*	*2 (6)*	*1 (3)*	*1 (3)*	*0*
By the nurses in the SRH service	*31 (97)*	*26 (84)*	*3 (10)*	*1 (3)*	*1 (3)*	*0*
By the providers during the consultation	*32 (100)*	*32 (100)*	*0*	*0*	*0*	*0*
With regards to the clarity of information that you were given during the consultation:						
Question	***N (%) Responses***	***5 Very clear***	***4***	***3***	***2***	***1 Very confusing***
Information about the reason for this consultation	*32 (100)*	*32 (100)*	*0*	*0*	*0*	*0*
About when and how to use the mentioned treatments	*32 (100)*	*28 (88)*	*3 (10)*	*0*	*1 (3)*	*0*
About when and how to get the required examinations	*32 (100)*	*31 (97)*	*1 (3)*	*0*	*0*	*0*
About the warning signs for which you should seek professional advice	*30 (94)*	*27 (90)*	*2 (7)*	*0*	*0*	*1 (3)*
About where to go in case of emergency	*31 (97)*	*26 (84)*	*3 (10)*	*1 (3)*	*0*	*1 (3)*
About when and how make a new appointment for another consultation	*31 (97)*	*30 (97)*	*0*	*0*	*0*	*1 (3)*
Your general opinion about the service you have received at the hospital:						
Question	***N (%) Responses***	***5 Very satisfactory***	***4***	***3***	***2***	***1 Not at all satisfactory***
I received the support and attention that I needed	*32 (100)*	*30 (100)*	*0*	*0*	*0*	*0*
Privacy	*31 (97)*	*29 (91)*	*2 (6)*	*0*	*0*	*0*
The time it took me to obtain an appointment for the consultation	*31 (97)*	*22 (71)*	*6 (19)*	*0*	*0*	*3 (10)*
The time I waited in the waiting room when I came in for the consultation	*32 (100)*	*21 (66)*	*8 (25)*	*1 (3)*	*0*	*2 (6)*
Comfort of the hospital facilities	*31 (100)*	*23 (74)*	*6 (19)*	*1 (3)*	*1 (3)*	*0*
Cleanliness of the hospital	*32 (100)*	*24 (75)*	*7 (22)*	*0*	*0*	*1 (3)*

Note: Percentages may not add up to 100% due to rounding.

Table 7. Frequency distribution of responses by question – IVE 2. Satisfaction survey among abortion clients at the Women's Hospital Pereira Rossell, Montevideo Uruguay, 2014 (n= 19)

How were you treated in the hospital?						
Question	***N (%) Responses***	***5 Very good***	***4***	***3***	***2***	***1 Very bad***
By the staff who made your appointment	*19 (100)*	*19 (100)*	*0*	*0*	*0*	*0*
By the nurses in the SRH service	*19 (100)*	*17 (90)*	*0*	*1 (5)*	*1 (5)*	*0*
By the providers during the consultation	*19 (100)*	*18 (95)*	*0*	*0*	*1 (5)*	*0*
With regards to the clarity of information that you were given during the consultation:						
Question	***N (%) Responses***	***5 Very clear***	***4***	***3***	***2***	***1 Very confusing***
Information about the reason for this consultation	*19 (100)*	*18 (95)*	*1 (5)*	*0*	*0*	*0*
About when and how to use the mentioned treatments	*19 (100)*	*18 (95)*	*1 (5)*	*0*	*0*	*0*
About when and how to get the required examinations	*19 (100)*	*16 (84)*	*2 (11)*	*1 (5)*	*0*	*0*
About the warning signs for which you should seek professional advice	*19 (100)*	*17 (90)*	*1 (5)*	*1 (5)*	*0*	*1 (5)*
About where to go in case of emergency	*18 (95)*	*16 (89)*	*1 (6)*	*0*	*1 (6)*	*0*
About when and how make a new appointment for another consultation	*19 (100)*	*17 (90)*	*1 (5)*	*0*	*1 (5)*	*0*
Your general opinion about the service you have received at the hospital:						
Question	***N (%) Responses***	***5 Very satisfactory***	***4***	***3***	***2***	***1 Not at all satisfactory***
I received the support and attention that I needed	*19 (100)*	*16 (84)*	*2 (11)*	*1 (5)*	*0*	*0*
Privacy	*18 (95)*	*16 (89)*	*0*	*2 (11)*	*0*	*0*
The time it took me to obtain an appointment for the consultation	*18 (95)*	*17 (95)*	*1 (5)*	*0*	*0*	*0*
The time I waited in the waiting room when I came in for the consultation	*19 (100)*	*16 (84)*	*1 (5)*	*2 (11)*	*0*	*0*
Comfort of the hospital facilities	*19 (100)*	*18 (95)*	*1 (5)*	*0*	*0*	*0*
Cleanliness of the hospital	*18 (95)*	*16 (89)*	*2 (11)*	*0*	*0*	*0*

Note: Percentages may not add up to 100% due to rounding.

Table 8. Frequency distribution of responses by question – IVE 3. Satisfaction survey among abortion clients at the Women's Hospital Pereira Rossell, Montevideo Uruguay, 2014 (n= 20)

How were you treated in the hospital?						
Question	***N (%) Responses***	***5 Very Good***	***4***	***3***	***2***	***1 Very bad***
By the staff who made your appointment	*20 (100)*	*16 (80)*	*3 (15)*	*1 (5)*	*0*	*0*
By the nurses in the SRH service	*19 (95)*	*18 (95)*	*0*	*0*	*1 (5)*	*0*
By the providers during the consultation	*19 (95)*	*19 (100)*	*0*	*0*	*0*	*0*
With regards to the clarity of information that you were given during the consultation:						
Question	***N (%) Responses***	***5 Very Clear***	***4***	***3***	***2***	***1 Very confusing***
Information about the reason for this consultation	*20 (100)*	*18 (90)*	*2 (10)*	*0*	*0*	*0*
About when and how to use the mentioned treatments	*20 (100)*	*19 (95)*	*1 (5)*	*0*	*0*	*0*
About when and how to get the required examinations	*20 (100)*	*12 (90)*	*2 (10)*	*0*	*0*	*0*
About the warning signs for which you should seek professional advice	*20 (100)*	*17 (85)*	*2 (10)*	*1 (5)*	*0*	*0*
About where to go in case of emergency	*20 (100)*	*18 (90)*	*2 (10)*	*0*	*0*	*0*
About when and how make a new appointment for another consultation	*20 (100)*	*18 (90)*	*2 (10)*	*0*	*0*	*0*
Your general opinion about the service you have received at the hospital:						
Question	***N (%) Responses***	***5 Very satisfactory***	***4***	***3***	***2***	***1 Not at all satisfactory***
I received the support and attention that I needed	*20 (100)*	*18 (90)*	*2 (10)*	*0*	*0*	*0*
Privacy	*20 (100)*	*14 (82)*	*1 (6)*	*1 (6)*	*1 (6)*	*1 (6)*
The time it took me to obtain an appointment for the consultation	*20 (100)*	*12 (60)*	*4 (20)*	*2 (10)*	*1 (5)*	*1 (5)*
The time I waited in the waiting room when I came in for the consultation	*20 (100)*	*12 (60)*	*5 (25)*	*2 (10)*	*0*	*1 (5)*
Comfort of the hospital facilities	*20 (100)*	*16 (80)*	*2 (10)*	*2 (10)*	*0*	*0*
Cleanliness of the hospital	*19 (95)*	*14 (74)*	*3 (16)*	*0*	*1 (5)*	*1 (5)*

Note: Percentages may not add up to 100% due to rounding.

Table 9. Frequency distribution of responses by question – IVE 4. Satisfaction survey among abortion clients at the Women's Hospital Pereira Rossell, Montevideo Uruguay, 2014 (n= 10)

How were you treated in the hospital?						
Question	***N (%) Responses***	***5 Very Good***	***4***	***3***	***2***	***1 Very bad***
By the staff who made your appointment	*10 (100)*	*5 (50)*	*3 (30)*	*1 (10)*	*1 (10)*	*0*
By the nurses in the SRH service	*10 (100)*	*10 (100)*	*0*	*0*	*0*	*0*
By the providers during the consultation	*10 (100)*	*10 (100)*	*0*	*0*	*0*	*0*
With regards to the clarity of information that you were given during the consultation:						
Question	***N (%) Responses***	***5 Very Clear***	***4***	***3***	***2***	***1 Very confusing***
Information about the reason for this consultation	*10 (100)*	*10 (100)*	*0*	*0*	*0*	*0*
About when and how to use the mentioned treatments	*10 (100)*	*10 (100)*	*0*	*0*	*0*	*0*
About when and how to get the required examinations	*10 (100)*	*9 (90)*	*1 (10)*	*0*	*0*	*0*
About the warning signs for which you should seek professional advice	*10 (100)*	*9 (90)*	*1 (10)*	*0*	*0*	*0*
About where to go in case of emergency	*10 (100)*	*10 (100)*	*0*	*0*	*0*	*0*
About when and how make a new appointment for another consultation	*10 (100)*	*9 (90)*	*0*	*0*	*0*	*0*
Your general opinion about the service you have received at the hospital:						
Question	***N (%) Responses***	***5 Very satisfactory***	***4***	***3***	***2***	***1 Not at all satisfactory***
I received the support and attention that I needed	*10 (100)*	*9 (10)*	*1 (10)*	*0*	*0*	*0*
Privacy	*10 (100)*	*9 (10)*	*1 (10)*	*0*	*0*	*0*
The time it took me to obtain an appointment for the consultation	*10 (100)*	*8 (80)*	*1 (10)*	*1 (10)*	*0*	*0*
The time I waited in the waiting room when I came in for the consultation	*10 (100)*	*7 (70)*	*1 (10)*	*2 (20)*	*0*	*0*
Comfort of the hospital facilities	*10 (100)*	*7 (70)*	*3 (30)*	*0*	*0*	*0*
Cleanliness of the hospital	*10 (100)*	*7 (70)*	*2 (20)*	*1 (10)*	*0*	*0*

Note: Percentages may not add up to 100% due to rounding.

Table 10. Distribution of total satisfaction scores – by consultation type, all visits. Satisfaction survey among abortion clients at the Women's Hospital Pereira Rossell, Montevideo Uruguay, 2014 (n=81)

Type of Consultation	***Total Satisfaction n (%)***	
	Excellent (95-100%)	Less than excellent (65-94%)
IVE 1 (n=32)	26 (81)	6 (19)
IVE 2 (n=19)	16 (84)	3 (16)
IVE 3 (n=20)	15 (75)	5 (25)
IVE 4 (n=10)	7 (70)	3 (30)

Note: Percentages may not add up to 100% due to rounding.

References

Bartlett, L. A., Berg, C. J., Shulman, H. B., Zane, S. B., Green, C. A., Whitehead, S., & Atrash, H. K. (2004). Risk factors for legal induced abortion-related mortality in the United States. *Obstet Gynecol, 103*(4), 729-737. doi: 10.1097/01.aog.0000116260.81570.60

Bleich, S. N., Ozaltin, E., & Murray, C. K. (2009). How does satisfaction with the health-care system relate to patient experience? *Bull World Health Organ, 87*(4), 271-278.

Bowser, D., & Hill, K. (2010). Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth. Report of a Landscape Analysis.

Briozzo, L., Stapff, C., Fiol, V., Leus, I., Labandera, A., & Pereira, M. (2010). Procesamiento Encuesta de Evaluación de la Satisfacción de las Usuarias. Julio-Agosto 2010. In M. Gorgoroso (Ed.), *Ser Parte de la Solución...* (pp. 119-122). Montevideo, Uruguay: Tradinco S.A.

Cavallo, S. (2014). After Victory in Uruguay: Addressing Gaps Between the Right to Abortion and Access to Services. *International Women's Health Coalition*.

Center for Reproductive Rights. (2014). World Abortion Laws.

Committee on Quality of Health Care in America. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: : National Academies Press.

d'Oliveira, A. F. P. L., Diniz, S. G., & Schraiber, L. B. (2002). Violence against women in health-care institutions: an emerging problem. *The Lancet, 359*(9318), 1681-1685. doi: http://dx.doi.org/10.1016/S0140-6736(02)08592-6

Erdman, J. N. (2011). Access to Information on Safe Abortion: A Harm Reduction and Human Rights Approach *Harvard Journal of Law & Gender, Vol. 34, pp. 413-462, 2011*.

Fernandez, M. M., Coeytaux, F., de Leon, R. G., & Harrison, D. L. (2009). Assessing the global availability of misoprostol. *Int J Gynaecol Obstet, 105*(2), 180-186. doi: 10.1016/j.ijgo.2008.12.016

Grossman, D., Holt, K., Peña, M., Lara, D., Veatch, M., Córdova, D., . . . Blanchard, K. (2010). Self-induction of abortion among women in the United States. *Reproductive Health Matters, 18*(36), 136-146. doi: http://dx.doi.org/10.1016/S0968-8080(10)36534-7

Guttmacher Institute. (2009). The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review. from https://www.guttmacher.org/pubs/MandatoryCounseling.pdf

Guttmacher Institute. (2012). Facts on Abortion in Latin America and the Carribbean.

Guttmacher Institute. (2013). Unintended Pregnancy and Induced Abortion in Mexico: Causes and Consequences.

Haddad, L. B., & Nour, N. M. (2009). Unsafe abortion: unnecessary maternal mortality. *Rev Obstet Gynecol, 2*(2), 122-126.

Hyman, A., Blanchard, K., Coeytaux, F., Grossman, D., & Teixeira, A. (2013). Misoprostol in women's hands: a harm reduction strategy for unsafe abortion. *Contraception, 87*(2), 128-130. doi: 10.1016/j.contraception.2012.10.020

Iniciativas Sanitarias & IPPF/WHR. (2011). Guia para Difundir y Promover el Modelo de Reduccion de Riesgos y Danos frente al Aborto Provocado bajo Condiciones de Riesgo Retrieved October 29, 2014, from https://www.ippfwhr.org/sites/default/files/guia%2520IPPF%2520final.pdf

IPAS. (2010) Misoprostol and medical abortion in Latin America and the Caribbean.

La Nacion. (2013). Uruguay mantiene la ley pro aborto tras una fallida consulta popular.

Law 18.987. (2012). Despenalización del aborto. Retrieved October 29, 2014, from http://www.impo.com.uy/bancodatos/18987.htm

Médecins du Monde. (2014). Lo que cuentan las mujeres., from http://www.clacaidigital.info:8080/xmlui/handle/123456789/536

Ministerio de Salud Pública. (2012). Manual de Procedimientos para el Manejo Sanitario de la Interrupción del Embarazo (IVE). Retrieved February 2015, 2015, from http://www.mysu.org.uy/IMG/pdf/manual_de_procedimientos_ive_2012.pdf

Nguyễn, M. H., Gammeltoft, T., & Rasch, V. (2007). Situation Analysis of Quality of Abortion Care in the Main Maternity Hospital in Hải Phòng, Viet Nam. *Reproductive Health Matters, 15*(29), 172-182. doi: http://dx.doi.org/10.1016/S0968-8080(07)29283-3

Olavarrieta, C. D., Garcia, S. G., Arangure, A., Cravioto, V., Villalobos, A., AbiSamra, R., . . . Becker, D. (2012). Women's experiences of and perspectives on abortion at public facilities in Mexico City three years following decriminalization. *International Journal of Gynecology & Obstetrics, 118*, S15-S20. doi: 10.1016/j.ijgo.2012.05.005

PAHO. (2012). Changing relationships in the healthcare context: the Uruguayan model for reducing the risk and harm from unsafe abortions.

Presidencia de la República del Uruguay. (2013). Briozzo destacó que el 70% de médicos trabaja a favor del derecho de las mujeres Retrieved from http://portal.gub.uy/wps/wcm/connect/presidencia/portalpresidencia/comunicacion/comunicacionnoticias/briozzo-salud-publica-interrupcion-voluntaria-embarazo-objecion-conciencia

Scholle, S. H., Weisman, C. S., Anderson, R., Weitz, T., Freund, K. M., & Binko, J. (2000). Women's satisfaction with primary care: a new measurement effort from the PHS national centers of excellence in women's health. *Women's Health Issues, 10*(1), 1-9. doi: http://dx.doi.org/10.1016/S1049-3867(99)00031-6

Sedgh, G., Singh, S., Shah, I. H., Åhman, E., Henshaw, S. K., & Bankole, A. Induced abortion: incidence and trends worldwide from 1995 to 2008. *The Lancet, 379*(9816), 625-632. doi: http://dx.doi.org/10.1016/S0140-6736(11)61786-8

Taylor, D., Postlethwaite, D., Desai, S., James, E. A., Calhoun, A. W., Sheehan, K., & Weitz, T. A. (2013). Multiple determinants of the abortion care experience: from the patient's perspective. *Am J Med Qual, 28*(6), 510-518. doi: 10.1177/1062860613484295

The Picker Institute. (1999). From the Patient's Perspective:Quality of Abortion Care. . Menlo Park, CA: Kaiser Family Foundation;.

UNFPA. (2011). Eliminating Maternal Deaths from Unsafe Abortion in Uruguay.

United Nations. (2011). Right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

United Nations. (2013). World Abortion Policies 2013.

Vandamme, J., Wyverkens, E., Buysse, A., Vrancken, C., & Brondeel, R. (2013). Pre-abortion counselling from women's point of view. *Eur J Contracept Reprod Health Care, 18*(4), 309-318. doi: 10.3109/13625187.2013.796586

WHO. (2011). Unsafe Abortion: Global and Regional estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003. (5 ed.).

WHO. (2013). A promise renewed for the Americas: Reducing inequities in reproductive, maternal, and child health.

WHO. (2014). Sexual and Reproductive Health: Preventing Unsafe Abortion.

Wu, J. P., Godfrey, E. M., Prine, L., Andersen, K. L., MacNaughton, H., & Gold, M. (2015). Women's Satisfaction With Abortion Care in Academic Family Medicine Centers. *Fam Med, 47*(2), 98-106.

Zapka, J. G., Lemon, S., Peterson, L. E., Palmer, H., & Goldman, M. B. (2001). The silent consumer: women's reports and ratings of abortion services. *Med Care, 39*(1), 50-60.

Appendix A

Survey Tool

ASSE CHPR	FORMULARIO	FO 05	V2
	ENCUESTA DE EVALUACION DE LA SATISFACCION DE USUARIAS	Página 1 de 2	
Servicio Salud Sexual y Reproductiva		SERVICIO SALUD SEXUAL Y REPRODUCTIVA	

¡TU OPINION NOS AYUDA A MEJORAR NUESTRO SERVICIO. TU PARTICIPACION ES VOLUNTARIA Y ANONIMA

Queremos brindarte una excelente atención. Para ello necesitamos tu opinión y te agradecemos que llenes este formulario.

Información General. *Marca con una cruz según tu situación.*

Consulta:	Edad:	Etnia / Raza:	Mayor nivel de estudios:	Situación de Pareja:	¿Viniste acompañada?
❑ IVE 1 ❑ IVE 2 ❑ IVE 3 ❑ IVE 4 ❑ MAC	__ __ años	❑ Afro o negra ❑ Blanca ❑ Indígena ❑ Amarilla ❑ Otra ❑ No sabe	❑ Sin educación formal ❑ Primaria (escuela) ❑ Secundaria (liceo/UTU) ❑ Nivel Terciario (universidad o similar)	❑ Sin pareja estable ❑ Pareja estable (no viven juntos) ❑ Pareja estable (viven juntos)	❑ No ❑ Sí, por mi pareja ❑ Sí, por un/a amigo/a o familiar

¿Cómo te trataron en el hospital? *Si 5 es MUY BIEN y 1 MUY MAL marca en cada renglón según tu opinión.*

	5 MUY BIEN	4	3	2	1 MUY MAL
Las **personas que te dieron día y hora**					
Las **enfermeras** que te atendieron en el servicio					
Los **profesionales** que te atendieron en la consulta					

En cuanto a la claridad de la información que te dieron durante la consulta en este servicio:

	5 MUY CLARA	4	3	2	1 MUY CONFUSA
Información sobre tu **motivo** de consulta					
Sobre cuándo y cómo **usar los tratamientos** mencionados					
Sobre cuándo y cómo **realizarte los exámenes** solicitados					
Sobre los **síntomas de alarma o riesgo** por los que debes consultar					
Sobre **dónde consultar** en caso de dudas o emergencia					
Sobre cuándo y cómo **solicitar fecha** para una nueva consulta de control					

En cuanto a tu opinión general sobre la atención que recibiste en el hospital

	5 MUY SATISFACTORIA	4	3	2	1 MUY POCO SATISFACTORIA
Recibí el **apoyo y la atención** que necesitaba					
Privacidad					
El **tiempo** que demoré en **conseguir número para la consulta**					
El tiempo que **esperé en sala de espera** cuando vine a la consulta					
Comodidad de las **instalaciones** del hospital					
Limpieza del hospital					

Por favor, continúa al revés de la página.

	FORMULARIO	FO 05	V2
ASSE CHPR Hospital de la Mujer "Dra Paulina Luisi" Servicio Salud Sexual y Reproductiva	ENCUESTA DE EVALUACION DE LA SATISFACCION DE USUARIAS	Página 2 de 2	
		SERVICIO SALUD SEXUAL Y REPRODUCTIVA	

¿TIENES ALGUN OTRO COMENTARIO O SUGERENCIA?

TU OPINION ES IMPORTANTE. TE AGRADECEMOS TU PARTICIPACION

Appendix B

Women protesting in support of decriminalization of abortion, Montevideo, Uruguay

Source: International Women's Health Coalition

http://iwhc.org/2012/09/uruguayan-house-of-representatives-allows-abortion-up-to-12-weeks-but-imposes-other-barriers/