Women's Satisfaction with Decriminalized Abortion Services

at Uruguay's National Women's Hospital Pereira Rossell

ABSTRACT

Objectives: Uruguay decriminalized first trimester abortions in October 2012. No published survey studies have examined client satisfaction with abortion services in the Uruguayan healthcare setting since. This study aimed to evaluate abortion clients' satisfaction at the national hospital for women's health Pereira Rossell Hospital Center (CHPR) in Montevideo, Uruguay's largest provider of abortion services.

Methods: The PI conducted this study in collaboration with the organization Iniciativas Sanitarias (IS) as an internal quality assessment of the sexual and reproductive health services at CHPR. IS provided an intensive one-week training course on Uruguay's abortion law and its implementation. The PI observed 20 abortion consultations and conducted a self-administered satisfaction survey with abortion clients using a convenience sample. Satisfaction scores and clients' comments were analyzed for total of 81 responses.

Results: Overall client satisfaction and perceived support of healthcare professionals were very high. Dissatisfaction was most often due to the legally mandated 5-day waiting period and scheduling delays.

Conclusions: 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 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.

Introduction

Access to safe abortion services prevents mortality and morbidity among women, as evidenced by statistics from countries with access to legal, safe abortion or effective harm reduction models within restrictive legal contexts (1). However, 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 (2).

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), an estimated 95% of which are unsafe. As a result, abortion-related mortality accounts for 12% of all maternal deaths (1, 3, 4). According to the World Health Organization (WHO), an unsafe abortion is one performed either by persons lacking the necessary skills, one which takes place in a sub-standard medical environment or both (5). Abortion on request is only available in three of the 20 countries in Latin America: Cuba (since 1965), Guyana (since 1995) and Uruguay (since 2012) (6). Mexico City decriminalized abortions up to 12 weeks in 2007, while the procedure remains highly restricted in the rest of Mexico (7). Many women in legally restrictive environments turn to medical, self-induced abortions with the medication misoprostol, a common practice in Latin America (8).

Prior to decriminalization of the procedure, Uruguayan law only allowed abortions in cases of danger to a women's life, health or honor, as well as for 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 deaths nationwide and for 47% at the national women's hospital Pereira Rossell (CHPR) (9). In 2001, a group of health

professionals that would become the organization Iniciativas Sanitarias ("Health Initiatives", IS) developed a model for reducing the risk and harm of unsafe abortions.

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" (10). 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 (11). In the case of abortion, the harm reduction process consists of providing evidence-based information and counseling around self-induced medication abortions as well as providing post-abortion care where possible. 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 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 legality 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, healthcare 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 to rule out possible complications. Family planning services and counseling were also offered during the follow-up visit. In 2008, 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 public and private healthcare facilities offering sexual and reproductive health services (12). Despite the fact that abortion remained illegal, by 2011 no maternal deaths from abortions had been reported in three years (13).

Since 2012, Uruguay has provided abortion services through a system largely based on an extension of the 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 (14). Women are required to undergo 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 medical abortions in all cases except where surgical methods are medically necessary. A post-abortion check-up is recommended, but not legally required. Conscientious objection allows gynecologists 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 or from referring women to another provider in a timely manner. About one third of gynecologists making use this legal right, limiting the availability of abortion services (15).

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 consultations and the timeline as established by the law, which in practice may vary according to the availability of the healthcare professionals, potentially

resulting in delays. The law has drawn much criticism from women's rights groups and abortion supporters because of the mandatory five-day waiting period and the required consultation with the multidisciplinary team, often referred to as a 'panel' in the media. Many consider these steps to be barriers to access (16, 17).

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. Patient satisfaction in healthcare has been documented as an important indicator of quality of care in general (18) and of women's healthcare in particular (19) . However, with regards to abortion services, the literature has largely focused on medical aspects and procedural safety, with few published studies examining client experiences and satisfaction. One US study found very high satisfaction among abortion clients, who ranked accuracy of information received, privacy and treatment by staff as very important (20). Another study from the US shows very high overall satisfaction, with clinic environment, treatment by clinical staff and managed pain levels as the most important determinants (21). In Mexico City, a study performed three years after decriminalization, also found high overall satisfaction as well as opportunities for improvement, particularly in the areas of psychosocial support and post-abortion contraception (22). Women in a 2007 study in Vietnam gave providers high satisfaction scores in a survey, but reported poor interaction with providers in in-depth interviews, while researchers in Belgium found very high satisfaction with pre-abortion counseling (23). A qualitative study of women's experience with abortion services in three Uruguayan provinces (including services at CHPR in Montevideo), shows similar results, with women generally perceiving staff as non-judgmental, polite and respectful and the information provided as clear and easy to understand (24).

A 2010 satisfaction survey carried out by IS at CHPR in Montevideo assessed services provided within the Uruguayan harm reduction model (consisting of one counseling and one post-abortion care visit). The responses indicated overall high levels of satisfaction. Treatment by healthcare staff was rated as "friendly" or "very friendly" in a majority of 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 warning signs and what to do in case in emergency. With regards to overall satisfaction with the services, satisfaction was highest for perceived support received and privacy, and slightly lower for delays and the hospital facilities (25).

Methods

Study Design and Procedures

The study took place from June 12 to July 31, 2014 at the public Pereira Rossell Hospital Center (CHPR) in Montevideo, Uruguay's largest women's hospital and the country's largest provider of abortion services. The principal investigator (PI) conducted this study in collaboration with the organization Iniciativas Sanitarias (IS), located within CHPR, and the hospital's sexual and reproductive health (SRH) services. Prior to the study, 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 also observed 20 consultations at CHPR's SHR services, including all four types of consultations, with women obtaining pre-abortion

counseling, medication prescriptions and post-abortion care, and recorded observations as field notes.

Providers of the SRH services recruited a convenience sample of participants by inviting IVE clients during the study period to complete the satisfaction survey after the consultation. There were no exclusion criteria. A total of 105 IVE clients completed the anonymous survey alone in an area separate from the consultation room and placed it in a locked box.

The survey was adapted from the satisfaction survey tool used by IS in 2010 to evaluate abortion counseling services under the harm reduction model. The questionnaire was created by the International Planned Parenthood Federation/Western Hemisphere Region and then modified by IS and the PI. Satisfaction was rated on a scale from 1 (lowest) to 5 (highest). The measures are summarized below.

Background information. Information on type of consultation, age, race/ethnicity, partner status, education and whether or not the client was accompanied during the consultation.

Treatment by healthcare staff. Clients rated treatment by appointment staff, nurses and medical professionals.

Clarity of information provided: Clients rated the clarity of information on following: reason for the consultation, how to use the mentioned treatments, how to make an appointment for the next consultation, how to obtain required examinations, warning signs and what to do in case of an emergency.

General aspects of the service: Clients rated perceived support, privacy, delays in obtaining an appointment, delays in the waiting room, comfort and cleanliness of the facilities.

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

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.

The data analysis was conducted in SPSS. 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" (94% or below). 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 unique individuals.

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

Results

Background characteristics

The distribution of respondents' background 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 (43%) were unaccompanied during the visit.

Satisfaction scores

Overall satisfaction: Overall satisfaction scores were high across the sample, with scores ranging from 65-100%. The vast majority of visits (79%) were rated as "excellent" (95% or higher), with 44% rated as 100% satisfactory. No statistically significant association was observed between satisfaction scores and any background characteristics or type of consultation among unique individuals.

Satisfaction by survey item: The distribution of satisfaction ratings for individual survey items is shown in Table 2.

Perceptions of treatment by staff: Satisfaction with treatment by staff was high across the sample. Nearly all participants (99%) rated the treatment received by medical professionals as "excellent" and the majority also rated the treatment by nurses (90%) and scheduling staff (84%) as "excellent".

Perceptions of clarity of information: Clarity of information given during the consultations was rated as "excellent" by close to 90% of participants across all categories. Clarity of information about the reason for the visit was most commonly rated as "excellent" (96%), followed by information on when and how to use the mentioned treatments (93%), make a new appointment for another consultation (93%) or get the required examinations (91%). Clarity of information about warning signs and what to do in case of emergency were rated slightly less often as "excellent" (both 87%).

General perceptions about the service: In over 90% of visits, support by staff and privacy were both rated as "excellent". Comfort and cleanliness of the facilities were rated as "excellent" in 80% and 77% of the visits respectively. 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 time to obtain an appointment was rated highest for IVE 2 consultations (95% rated as "excellent") and lowest for IVE 3 consultations, which occurs after the mandated 5-day waiting period (60% rated as "excellent").

Participant comments

Of the 81 surveys, 35 (43%) included client comments (examples shown in Box 1). Three quarters of 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.

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 medical 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, sometimes portraying the multidisciplinary team as an intimidating 'panel' of experts that potentially discouraged women from continuing the abortion process (16, 26). 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 IS’s 2010 satisfaction survey (25) and the qualitative study by Doctors of the World (24).

According to a psychologist 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 (15) 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 (24). 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 (27), 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 (28). Other have established positive interactions with healthcare professionals as an important factor of women's satisfaction with abortion services (29, 30).

A secondary finding in this study was dissatisfaction among respondents due to delays in completing the procedure, caused by the mandatory five-day 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" (31), 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 necessary. 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 a barrier to access to care and as factors that negatively influence the patient experience (30, 32). 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 (33). 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% (34), suggesting that potential barriers for women to access timely quality abortion care 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 consultations. 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.

Tables & Figures

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.

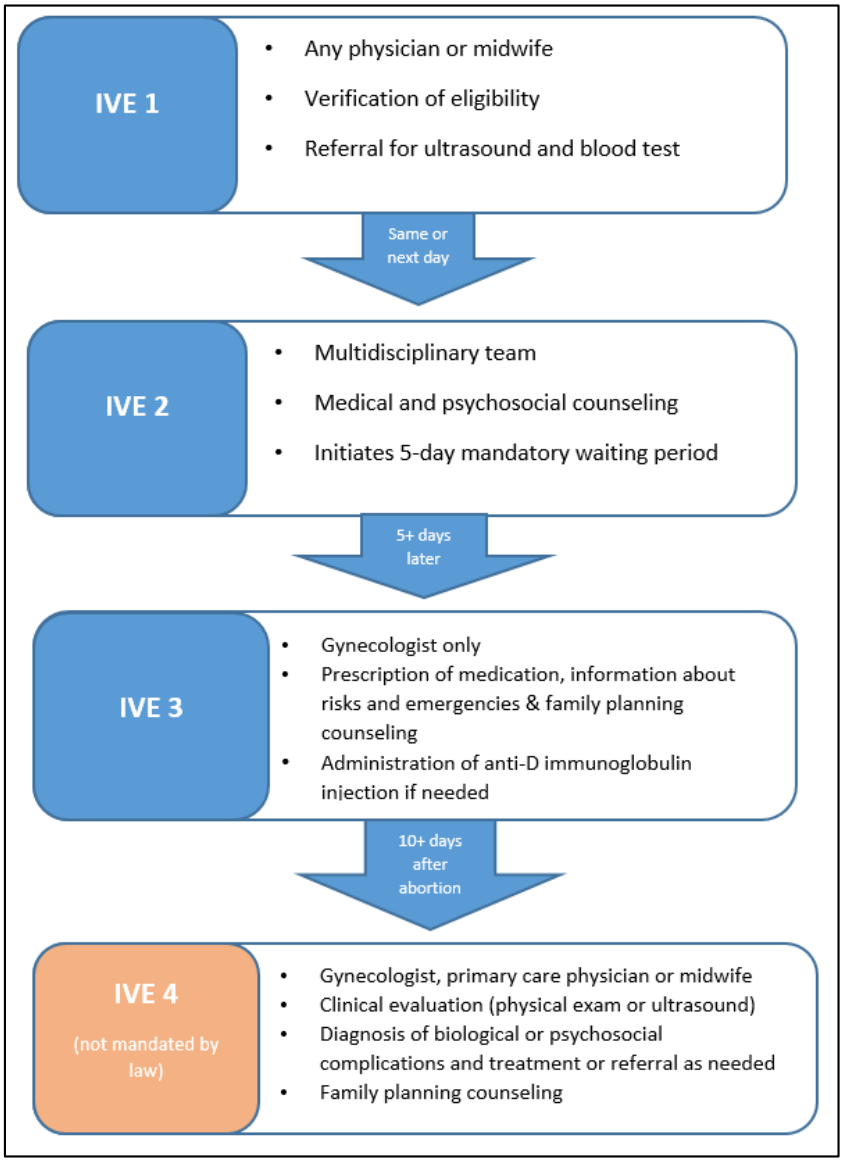

Table 1. Demographic characteristics of study participants – unique participants. Satisfaction survey among abortion clients at the Women's Hospital Pereira Rossell, Montevideo Uruguay, 2014

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

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

**Nonresponse 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)***

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.

Box 1. Examples of client comments

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 [hospital] 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".

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