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The role of medical abortion in the implementation of the law on voluntary termination of pregnancy in Uruguay

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ABSTRACT

Objective: To evaluate the implementation of the law that liberalizes voluntary abortion in Uruguay and enables health services to offer these services to the population. *Methods:* The legal and regulatory provisions are described and the national data—provided by the Ministry of Public Health's National Information System (SINADI)—on the number of voluntary terminations of pregnancy, the abortion method (medical or surgical), and whether it was performed as an outpatient or inpatient are analyzed. To determine complications, the number of maternal deaths and admissions to intensive care units for pregnant women was used. The study period ran from December 1, 2012, to December 31, 2014. *Results:* A total of 15 996 abortions were performed during the study period; only 1.2% were surgical and 98.8% were medical. Of the latter, only 3.4% required hospitalization. Less than half of the pregnancies were terminated up to 9 weeks of gestation and 54% were at 10 to 12 weeks in a sample from the Pereira Rossell Hospital. *Conclusion:* The rapid nationwide rollout of voluntary termination of pregnancy services to all women was possible to a large degree thanks to the availability and broad acceptance of medical abortion, facilitated by the prior experience in applying the risk and harm reduction strategy.

1. Introduction

Abortion was decriminalized in Uruguay in November 2012. It may be carried out during the first 12 weeks of pregnancy if that is the woman's wish [1] and during the first 14 weeks if the pregnancy is the outcome of an officially reported rape.

To enable implementation of the voluntary termination of pregnancy (VTP) law, the Ministry of Public Health drafted a decree regulating it and published a procedures manual and technical guide for VTP in December 2012.

One of the crucial points was defining which procedure would be preferred for pregnancy termination. In the decision-making process, the following aspects were particularly important:

(1) Solid scientific evidence that substantiates the higher risk of dilatation and curettage as an abortion method [2].
(2) Lack of training and resources for performing manual vacuum aspiration (MVA) and/or electrical aspiration in Uruguay.
(3) Clear scientific evidence regarding the safety and efficacy of medical termination of pregnancy up to the ninth week of pregnancy [2,3].
(4) Experience in the medical management of abortion as part of the risk and harm reduction strategy that has been implemented in Uruguay in recent years. This strategy, which was started by the nongovernmental organization Iniciativas Sanitarias in 2001, had been deployed in all of the country's sexual and reproductive health services, with excellent results and a well-advanced learning curve [4–6].
(5) National experience in the medical management of incomplete abortion following the recommendations of the International Federation of Gynecology and Obstetrics (FIGO).
(6) It was thought that there would be a higher prevalence of conscientious objection to voluntary termination by aspiration or curettage. Self-administered, outpatient medical VTP was not only a safe and effective method but was also more acceptable for both users and health teams.

This led to medical abortion (mifepristone and misoprostol) becoming established by the Ministry of Public Health as the procedure of choice for performing VTP within the framework of the law. WHO's

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recommendations [2] were adapted and it was established that it would be the health team who, after the user had followed a counseling and guidance process and together with her, would define the time and dose to be used.

The law that decriminalizes abortion came into force without any major incidents in December 2012. The prior existence of sexual and reproductive health services, the experience obtained from the risk and harm reduction strategy, and the possibility of performing the abortion as an outpatient procedure with medicines as an effective, safe, and acceptable technique were key factors in the process.

The present article describes the features of the VTP process in Uruguay, as established in Law 18.987, and the role of medical abortion in its deployment.

2. Materials and methods

The Voluntary Termination of Pregnancy Law (Law 18.987) was approved by the Uruguayan Parliament on October 22, 2012, and was regulated one month later. On the basis of these regulations, the following procedure was established for terminating a pregnancy [7].

(1) First visit to the doctor (VTP 1), the woman indicates her decision. Compliance with the law's requirements is confirmed, an ultrasound scan is requested to confirm pregnancy and establish the gestational age, and a blood test is performed for ABO-Rh classification. The patient is referred for the second visit, within the following 24 hours.
(2) Second mandatory visit to the interdisciplinary team (VTP 2): counseling. Three professionals (a gynecologist, a professional from the social area, and a professional from the mental health area) advise the patient on the options available for an unwanted pregnancy and inform her of the reflection period proposed by the law, which should not be less than 5 days consecutively.
(3) Third visit to the gynecologist (VTP 3): final expression of the patient's wish. At this visit, the VTP procedure defined in the Ministry of Health's technical guide is started.
(4) The technical guides add a fourth post-VTP follow-up visit at which it is verified that the process is progressing satisfactorily, contraceptive guidance is given, and the user receives the method she has chosen.

The technical guide for VTP [8] was drafted by the Ministry of Health to provide clinical recommendations regarding VTP procedures. It is based on the WHO recommendations [2], with certain modifications made to adapt it to local conditions. This guidance establishes the use of medicines as the method of choice for abortion, and preferable to surgery. It stresses that the woman must be informed that the preference for medication is based on scientific evidence, the experience acquired at national level, and the country's healthcare conditions. The use of clinical recommendations should be adapted to each woman and stress should be put on her clinical condition and the specific abortion method that will be used. The treatment regime specified in this technical guide consists of giving 200 mg mifepristone orally, followed 36–48 hours later by 800 μg misoprostol (by the oral or vaginal route). In those cases with a gestational age greater than 9 weeks, a second dose of 800 μg misoprostol will be given 4 hours after the first dose. During December 2012, only misoprostol was used because mifepristone was not yet available in the country. From January 2013 onward, the general rule was a combined treatment with mifepristone–misoprostol.

If the medical treatment fails or if the woman does not want to use the drugs, a surgical procedure is performed that consists of MVA or electrical aspiration.

After receiving guidance, the woman can use the medication (mifepristone and misoprostol) at her home. The gynecologist will identify those cases for which it is recommended that the procedure is carried out at a hospital: unaccompanied women, extreme emotional lability, limited access to health services where she lives, pregnancies at 12 weeks, users with risk factors for VTP (multiple uterine scars, blood dyscrasias, etc), or if the woman requests admission.

The data presented in the present article were obtained from an observational retrospective analysis of the national data provided by the Ministry of Public Health's National Information System (SINADI). The data concerning the number of VTPs and the type of procedure were taken from the monthly compulsory report that all health providers must submit to the Ministry of Health [9]. The study period ran from December 1, 2012, to December 31, 2014. The SINADI database includes the total number of VTPs performed during the study period and the abortion method chosen (medical or surgical). In the case of medical abortions, whether the procedure was outpatient or inpatient is also stated.

The complications report is derived from the report issued by the National Committee for Reducing Obstetric Morbidity and Mortality, which was created in 2011 to implement mechanisms for monitoring maternal mortality: mandatory reporting, verbal autopsy, and improved quality of records. Thus, the number of maternal deaths and admissions to the intensive care unit for pregnant women (near misses) must be reported monthly by all health providers to the Ministry of Health. It is also mandatory to report zero maternal deaths, which minimizes the possibility of under-recording.

As national data are limited, for example missing basic data such as gestational age at the time of performing the VTP, it was decided that a subanalysis from the Pereira Rossell Hospital's Sexual and Reproductive Health Service should be included. An analysis was performed of the number of VTPs by gestational age and the method used from August 2014 to December 2014. The data were obtained by filling in a pre-designed form that did not contain any identifying data.

The project was approved by the Department of Sexual and Reproductive Health of the Ministry of Public Health, and by the Pereira Rossell Hospital Center, School of Medicine, University of the Republic, Uruguay.

3. Results

During the first two years after implementation of the law, 15 996 VTPs were performed within the health system in the country as a whole: 7447 in the period from December 1, 2012, to December 31, 2013; and 8549 in the period from January 1 to December 31, 2014 (Table 1).

In almost 99% of cases, the abortions were medical (Table 1), using the medication schedule described in the WHO technical guidance.

Considering only the medical abortions, approximately 96% of the women in each period used the medication as outpatients (Table 2).

Considering all procedure types, slightly more than 3% of the women had to be admitted to hospital during the VTP process (Table 2).

As regards complications, zero maternal deaths for abortions carried out within the framework of the VTP law were reported during the period 2012–2013. One maternal death was reported for an illegal unsafe abortion (in the country's capital, Montevideo, public health sector). Two serious complications were reported: one post-VTP hysterectomy and one admission to the intensive care unit for an illegal unsafe

Table 1
Total voluntary terminations of pregnancy and method used.

Method	Study period					
	2012–2013		2014		Total	
	No.	(%)	No.	(%)	No.	(%)
Medical	7318	(98.3)	8483	(99.2)	15 801	(98.8)
Surgical	129	(1.7)	66	(0.8)	195	(1.2)
Total VTPs	7447		8549		15 996	

Abbreviation: VTP, voluntary termination of pregnancy.