International Journal of Gynecology and Obstetrics xxx (2015) xxx–xxx

Contents lists available at ScienceDirect

International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo

www.figo.org

CLINICAL ARTICLE

Delays and barriers to care in Colombia among women obtaining legal first- and second-trimester abortion

Sarah Baum [a,*], Teresa DePiñeres [b], Daniel Grossman [a,c]

[a] Ibis Reproductive Health, Oakland, CA, USA
[b] Fundación Oriéntame, Bogotá, Colombia
[c] Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology and Reproductive Services, University of California, San Francisco, San Francisco, CA, USA

ARTICLE INFO

Article history:
Received 23 December 2014
Received in revised form 2 June 2015
Accepted 27 August 2015

Keywords:
Abortion
Colombia
Delay to care
Second trimester

ABSTRACT

Objective: To evaluate delays before first- or second-trimester legal abortion and barriers to care in Colombia. *Methods:* A secondary analysis was undertaken of data from a prospective cohort study of women undergoing first-trimester (<12 weeks) and second-trimester (12–15 weeks) abortion between February and July 2012. Participants (aged ≥18 years with access to a telephone) reported key dates in their abortion process and barriers to care. Univariate and multivariate analyses were performed. *Results:* Overall, 100 women in the first trimester and 200 in the second trimester were included. Second-trimester clients experienced longer delays in each step of the abortion process than did first-trimester clients ($P < 0.001$ for all three intervals examined), with the largest delay being time to suspicion of pregnancy (37 days vs 17 days). Difficulty accessing care was associated with the second trimester (odds ratio 5.1, 95% CI 2.9–9.1) and low socioeconomic status (odds ratio 2.3, 95% CI 1.2–4.3). Financial barriers were the most common (30 [30.0%] first-trimester clients; 86 [43.0%] second-trimester clients). *Conclusion:* Despite partial decriminalization of abortion in 2006, Colombian women still face barriers to legal services that probably contribute to late presentation. Interventions promoting early pregnancy recognition and information about how to access legal abortion could reduce the need for second-trimester services.

1. Introduction

Although the overall risk of maternal mortality is lower in Latin America and the Caribbean than in some other regions, the proportion of maternal deaths accounted for by unsafe abortion (10%) is higher than has been reported elsewhere [1]. The risk of mortality increases with length of pregnancy, and therefore most deaths occur in the second trimester [2]. Whereas several jurisdictions in the region, including Uruguay and Mexico City, have expanded legal first-trimester services in Latin America in recent years, few have addressed abortion care later in pregnancy.

In 2006, the Constitutional Court in Colombia lifted the complete ban and decriminalized abortion in three circumstances: rape or incest, endangerment to the woman's life or health, and fetal malformations incompatible with life [3]. This law has made Colombia one of the only countries in Latin America that provides legal abortion without time limits. A recent prospective comparative study at an outpatient clinic in Bogotá, Colombia [4], demonstrated that early second-trimester abortion (at 12–15 weeks) was being provided safely, and that few clients experienced adverse events. Satisfaction was high among both first- and second-trimester clients [4].

Despite decriminalization of abortion, Colombian women continue to face obstacles when attempting to access abortion services. La Mesa por la Vida y la Salud de las Mujeres—a collective advocating for sexual and reproductive rights in Colombia—produced a report in 2014 [5] identifying both institutional and women-centered barriers that could contribute to delays in accessing care. These barriers include lack of training for providers and referral protocols, conscientious objection among individual providers or institutions, stigma, lack of knowledge of where to obtain legal services, and fear of reporting sexual violence [5].

Studies outside of Latin America in the USA [6–8], England and Wales [9], and South Africa [10] have identified lack of knowledge about pregnancy as one of the primary delays to care. All these studies noted that timing of abortion care is often influenced by multiple factors, which can include health-service barriers, lack of information, feelings of fear about the abortion process or judgment from others, and financial and other logistical constraints [6–10]. A study in Mexico City [11] found that abortion clients were more likely to report obstacles accessing care if they were unmarried or had completed at most primary education.

Little research in Latin America has explored the key intervals between suspecting pregnancy and obtaining care, or the main factors

* Corresponding author at: Ibis Reproductive Health, 1330 Broadway Street #1100, Oakland, CA 94612, USA. Tel.: +1 510 986 8953; fax: +1 510 986 8960.
E-mail address: sbaum@ibisreproductivehealth.org (S. Baum).

http://dx.doi.org/10.1016/j.ijgo.2015.06.036
0020-7292/

associated with presenting for abortion care later in pregnancy. The aim of the present study was to evaluate differences in the key intervals among women obtaining legal abortion care in their first and second trimester in Bogotá, Colombia, and to assess obstacles experienced by both groups.

2. Materials and methods

A secondary analysis was performed of data from a prospective comparative study of women undergoing surgical first-trimester abortion (11 weeks and 6 days or less since the last menstrual period [LMP]) and second-trimester abortion (12–15 weeks since LMP). The methods of the prospective comparative study have been reported previously [4]. Briefly, between February 1 and July 31, 2012, women were recruited from one of the Fundación Oriéntame clinics in Bogotá, Colombia. Women who were aged 18 years or older, were undergoing first- or second-trimester abortion, were able to give consent, and had access to a telephone for follow-up were eligible to participate and were recruited at the time of their first abortion visit by a clinic staff member. The study was approved by Allendale Investigational Review Board (Old Lyme, CT, USA) and the Ethics Committee of Fundación Oriéntame.

Before the procedure, trained study interviewers asked women whether they had difficulty accessing services at the clinic after their decision to terminate and, if so, to identify the most substantial barrier. Participant response to the question about the most substantial barrier was open-ended, and the interviewer documented the answer in pre-identified categories or provided further detail in the category "Other." Women were asked about three key dates in their abortion process [7]: date on which pregnancy was suspected, date on which pregnancy was confirmed, and date on which the decision to terminate was made. A fourth relevant date—that of the procedure—was also recorded by the interviewer.

Additionally, the interviewer reviewed clinical charts to collect information on participants' demographics and reproductive history. Socioeconomic stratum in Colombia is measured primarily by neighborhood of residence; each neighborhood has a different stratum (1–5) which is determined by the city. Women who reported strata one or two were categorized as having a low socioeconomic status; strata three and four were classified as middle, and strata five or six as high. Women were given a store voucher worth the equivalent of approximately US$10 as compensation for their time.

On the basis of the dates provided by participants, the number of days was calculated for three intervals leading up to the abortion: 1) conception to suspicion of pregnancy, 2) suspicion of pregnancy to decision to terminate, and 3) decision to terminate to procedure. Date of conception was calculated on the basis of gestational age (determined by ultrasonography at the time of the procedure). Pregnancy confirmation was excluded from the timeline because it occurred at different times in the process for different women. Most women reported confirming their pregnancy on the same day they decided to terminate (54%), whereas for other women it occurred before their decision to terminate (31%) or after they decided to terminate (15%). In addition to the key dates, the proportion of women who were in the second trimester (12–15 weeks since LMP) at the end of each time interval was assessed.

Reported barriers to accessing care were categorized into five main factors: logistical, financial, interpersonal, emotional, and delayed pregnancy recognition. Logistical barriers included not knowing where to go, the distance to a clinic, and difficulty getting time off work, childcare, or a driver to the appointment. Financial factors included not having enough money to pay for services and fear of not having enough money. Interpersonal factors include unsupportive partner or family. Emotional factors included ambivalence, fear of complications, fear or experience of abortion-related stigma, or religious conflict.

The sample size was based on satisfaction, one of study's primary outcomes. Using satisfaction rates reported in a questionnaire in a previous study [12], it was hypothesized that 90% of first-trimester clients and 76% of second-trimester clients would be very satisfied with their care. The necessary sample size was calculated as 300. Twice as many second-trimester participants were enrolled because this was the population of interest and because of study staff time constraints.

Analysis was conducted using StataIC version 12.0 (StataCorp, College Station, TX, USA). Univariate and bivariate analyses were performed to compare the timelines and barriers between the first- and second-trimester groups; other key subgroups were compared using χ^2 tests and t tests. $P < 0.05$ was considered statistically significant. Multivariate logistic regression was used to examine demographic factors associated with reporting difficulty in accessing care. The model included dichotomized covariates that were associated with difficulty in accessing care in the bivariate analysis at a level of $P \leq 0.2$. Age was also included in the model because younger women were significantly more likely to present in their second trimester in our sample, and younger women have been previously shown to have a significantly harder time accessing care [6,7].

3. Results

A total of 300 women (100 in the first trimester and 200 in the second trimester) provided information about delays and barriers to care and were included in the analysis. The mean age was 25.5 years (range 18–42), and most were single (78.0%), in the middle socioeconomic strata (51.3%), and had at least one prior pregnancy (57.7%) (Table 1). Demographics were similar for first- and second-trimester clients, except women in the second trimester were younger than were those in the first trimester ($P = 0.001$) (Table 1).

The mean number of days between conception and the procedure was 41.4 days (median 35 days; range 14–69) for women presenting in their first trimester and 80.8 days (median 77 days; range 70–95) for women in their second trimester (Fig. 1). For each of the three

Table 1
Characteristics of participants undergoing first- and second-trimester abortion.[a,b]

	Study population (n = 300)	First Trimester (n = 100)	Second Trimester (n = 200)	*P* value
Age, y	25.5	26.9	24.8	0.001
18–25	182 (60.7)	50 (50.0)	132 (66.0)	
26–35	98 (32.7)	38 (38.0)	60 (30.0)	
>35	20 (6.7)	12 (12.0)	8 (4.0)	
Number of years of education completed				0.886
≤5	16 (5.3)	6 (6.0)	10 (5.0)	
6–11	140 (46.7)	45 (45.0)	95 (47.5)	
≥12	142 (47.3)	48 (48.0)	94 (47.0)	
Relationship status				0.272
Single	234 (78.0)	73 (73.0)	161 (80.5)	
Married	46 (15.3)	19 (19.0)	27 (13.5)	
Separated/divorced	19 (6.3)	7 (7.0)	12 (6.0)	
Socioeconomic strata				0.830
Low	137 (45.7)	46 (46.0)	91 (45.5)	
Middle	154 (51.3)	49 (49.0)	105 (52.5)	
High	2 (0.6)	1 (1.0)	1 (0.5)	
Paid for work	148 (49.3)	53 (53.0)	95 (47.5)	0.326
Currently in school	71 (23.7)	21 (21)	50 (25)	0.442
Prior pregnancy				0.682
0	92 (30.7)	32 (32.0)	60 (30.0)	
≥1	207 (69.0)	67 (67.0)	140 (70.0)	
Prior induced abortion	98 (32.7)	34 (34.0)	64 (32.0)	0.685
Length of pregnancy on date of procedure	11.5	7.7	13.4	
<10 wk	77 (25.7)	77 (25.7)	–	<0.001
10 wk to 11 wk, 6 d	23 (7.7)	23 (7.7)	–	
12 wk to 13 wk, 6 d	119 (39.7)	–	119 (59.5)	
14–16 wk	81 (27.0)	–	81 (40.5)	

[a] Values are given as mean or number (percentage), unless indicated otherwise.
[b] Column numbers do not always sum to total because of missing data.

Please cite this article as: Baum S, et al, Delays and barriers to care in Colombia among women obtaining legal first- and second-trimester abortion, Int J Gynecol Obstet (2015), http://dx.doi.org/10.1016/j.ijgo.2015.06.036