Progress and barriers in accessing legal abortion services in Argentina

PAPER IN PROGRESS

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Abstract

In 2021, Argentina passed an abortion law that grants the right to abortion on-request up to 14 weeks' gestation, and continue to allow abortion after 14 weeks on specific grounds. Based on a survey of 223 public health facilities in three provinces conducted in July 2022 to January 2023, the aim of this e paper is to assess the progress and identify the barriers in the first two years of the implementation of the law. We collected information on abortion services, resources, personnel, training, and obstacles to provision. Results show that facilities adhered to protocols, had adequate supplies and equipment, and kept comprehensive records. The majority of abortions were conducted with misoprostol, and 10% with MVA. The greatest barrier to service provision was insufficient personnel to meet demand, due to high levels of conscientious objection, as well as lack of training in methods other than misoprostol, particularly at primary level. The paper discusses advance, as well as the recent new challenges faced with the new government that took office in December 2013 that has openly expressed opposition to abortion and has already begun to implement substantial budget cuts in public programs, including those that support reproductive health care.

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INTRODUCTION

In December 2020, Argentina's Congress passed the Law on Voluntary Interruption of Pregnancy (IVE, by its acronym in Spanish) giving the right to women and people of other gender identities with gestational capacity to freely access abortion up to 14 weeks' gestation without giving a reason, at the primary and secondary care levels. This landmark decision made Argentina the third, and most populous, country in Latin America to legalize abortion on request in the first trimester of pregnancy. Additionally, the law provides for Legal Interruption of Pregnancy beyond 14 weeks (ILE, by its acronym in Spanish) under specific circumstances such as rape or health risks, guaranteed by secondary-care providers (hospitals).[1] Prior to the new law, early abortion was available under the restricted circumstances of rape or health risks, but was very difficult to access in practice, with anti-abortion groups often interfering with its implementation. This led women to resort to clandestine (often unsafe) abortions, with their associated health and social consequences.[2–7] While estimates of abortion incidence are scarce and based on indirect measures,[8] official statistics indicate that 53000 women were hospitalized due to abortion in 2013, 15% of them adolescents.[9]

The new law heralds significant progress in women's health, reproductive rights and autonomy. It guarantees the right to receive free care, access the procedure within 10 days, respectful treatment, privacy and confidentiality, accurate and accessible information, and free contraceptive methods. The Ministry of Health protocol for abortion care outlines medical and surgical techniques for performing abortions following safety and quality standards, including misoprostol alone or with mifepristone, and surgical procedures like manual vacuum aspiration (MVA) and dilation and evacuation (D&E).[1]

Government provision of abortion care through the public sector is critical for increasing abortion access, particularly for those who cannot afford private sector services: one third of the total population and two thirds of the more disadvantaged population groups rely solely on the public system for healthcare[a]. Despite additional challenges brought on by the Covid-19 pandemic for a

[a] Authors' calculations based on the Permanent Household Survey, 4th trimester 2022.[11]

public health sector with already limited capacity and resources to operate,[10] government agencies worked to ensure effective and widespread implementation of the law, putting in place service delivery protocols, training providers for quality care, coordinating the operational aspects of integrating the service into public facilities, and educating the public about the rights and responsibilities established by the law. And public-sector abortion provision has been growing, from 73,487 abortions provided in 2021 to 96,664 in 2022.[12,13]

The early years after law reform provide a unique opportunity to assess progress, identify implementation barriers and work towards solutions. These assessments can both inform government efforts to ensure that access to quality safe abortion is available for all those in need, as well as guide other countries undergoing abortion law reform in anticipating potential challenges. Studies monitoring the implementation of the 2018 law liberalizing abortion in Ireland have been critical in informing further policy-making and programming to improve access.[14–16] Efforts to monitor the implementation of new abortion regulations are similarly being undertaken in Uruguay[17] and Colombia[18] following law reform. In Argentina, the *proyecto mirar* ("Looking forward") is an initiative to monitor implementation of the abortion law across four dimensions (enabling environment, supply, demand, and quality), based primarily on official data.[19] This initiative, however, does not include facility-based data on resources, personnel, training, and other aspects that are crucial to identify advances and obstacles in the provision of quality abortion services. The present study fills this gap.

The study was conducted in three provinces of Argentina (Buenos Aires, Chaco, and La Rioja) with diverse socioeconomic profiles, sexual and reproductive health indicators, sociocultural norms, and backgrounds providing abortion prior to law reform. Buenos Aires is the most populous and economically developed province, with historically better access to legal abortion. In contrast, Chaco and La Rioja have more pronounced economic barriers, and cultural and religious traditions resistant to abortion. While these diverse jurisdictions are not nationally representative, they provide a useful snapshot of how law implementation and barriers encountered may differ across the country.

METHODOLOGY

Data collection

We conducted a survey of public health facilities from July 2022 to January 2023. The Health Facility Survey (HFS) gathered information from administrators or doctors in charge of abortion provision, to understand progress and obstacles in delivering quality services in compliance with the law. The HFS was administered in 223 public-sector health facilities in three provinces: Buenos Aires, Chaco, and La

Rioja. Sampling was stratified by province and facility type, selecting 30% of hospitals and 25% of health centers from each province through systematic random sampling, based on Ministry of Health lists of abortion-providing facilities in the Province of Buenos Aires, and of all facilities in Chaco and La Rioja (where facilities' abortion provision status was unknown) (Table 1). Given the large size and diversity of the Province of Buenos Aires, we divided the sample into two jurisdictions: Greater Buenos Aires (GBA) excluding the City of Buenos Aires (a separate jurisdiction of less interest to this study because it has the most resources for implementation and most advanced monitoring), and the rest of the province (RPBA). The HFS questionnaire covered basic facility characteristics, abortion provision, number and characteristics of procedures, staff training, provider attitudes and beliefs, obstacles during the COVID-19 pandemic, and women's knowledge about the law and abortion methods.

Table 1. Sampling frame and sample for the health facilities survey

	Hospitals		**Health Centers**		**Total**	
Jurisdiction	Sampling Frame	Sample N	Sampling Frame	Sample N	Sampling Frame	Sample N
GBA	68	23	184	44	252	67
Rest of PBA	78	29	142	35	220	64
Chaco	52	21	96	24	148	45
La Rioja	33	19	54	28	87	47
Total	**231**	**92**	**476**	**131**	**707**	**223**

Data analysis

Data from the HFS were analysed using descriptive statistics and cross-tabulations to compute the distributions and characteristics of abortion services by province and facility type. As the study was not nationally representative, we do not present overall estimates of all 4 jurisdictions combined. Instead, we present estimates by province (weighted to be representative at the province level) and by facility type, to provide a snapshot of abortion service provision in diverse geographical/cultural contexts and facility levels. Estimates among abortion-providing facilities are presented for 3 jurisdictions: GBA, RPBA, and La Rioja, because Chaco included only 5 facilities that provided abortion. As our aim was not to evaluate the significance of differences between provinces or facility types, we do not present any significance tests.

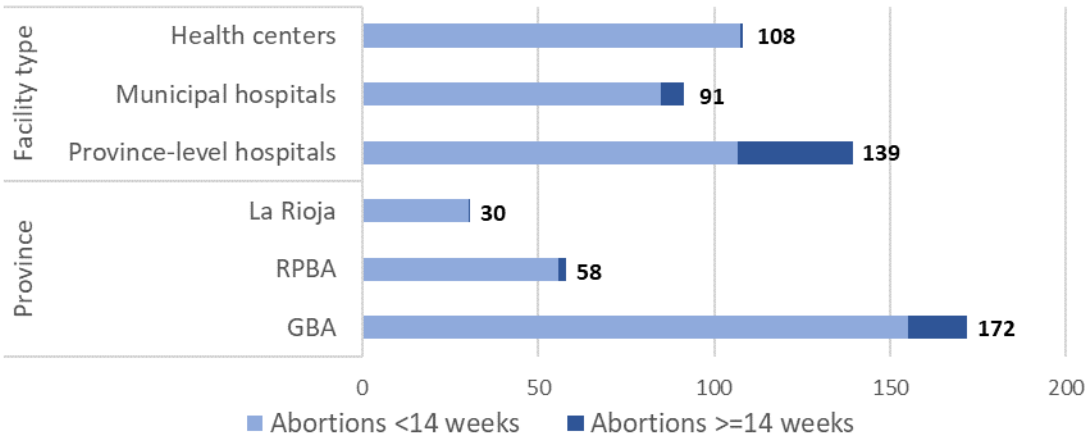
RESULTS (in progress)

Abortion provision landscape

In the government list of facilities registered as providing abortion in Buenos Aires province used to draw the sample, just over half (55% in GBA, 52% in RPBA) provided only IVE (up to 14 weeks), while 33% and 36% provided both IVE and ILE (beyond 14 weeks). As the facility sampling frame for Chaco and La Rioja included all facilities regardless of their official abortion provision status, it is to be expected that a smaller proportion were providing abortion: in La Rioja, 30% provided only IVE, and 10% provided both IVE and ILE. In Chaco, 4% provided IVE alone, and 5% provided both types.

Reflecting official guidelines, ILE was mainly provided by hospitals (around half of surveyed hospitals offered ILE, against 14% of health centers). Among health centers, 48% provided IVE only, while 38% did not provide any abortions. The lower proportion of health facilities providing abortion is explained by the establishment of referral circuits to centralize abortion provision across districts. Key informants described how health centers that do not provide abortions refer to (generally) province-level hospitals. Consequently, these hospitals perform the highest volume of abortions (on average 139 procedures over the past six months) (Figure 1). While this means that some women will have to travel further to access abortion, the majority of providers reported that most service users live within 10 km of the facility. However, it is difficult to know how many would-be users did *not* access a facility because of distance.

Figure 1. Average number of abortions per facility in last six months among abortion-providing facilities



In all three provinces, more than 90% of the abortions performed were less than 14 weeks gestation. Almost all abortions were under 14 weeks in health centers (99%) and municipal hospitals (94%), while in province-level hospitals a higher proportion of abortions (24%) were at gestations of 14 weeks or more (Figure 1).

Implementation successes

Despite the additional challenges created by the COVID-19 pandemic in terms of service access restrictions, disrupted supply chains and decreased personnel, the public sector offered services free of charge with minimal method stock-out problems. Several successes in these first two years of implementation are worth highlighting.

Comprehensive data records

Results highlighted the need for timely reporting of facility-level abortion statistics, in order to restock medication such as misoprostol. Over 90% of facilities used the medical history form, and under 20% (also) used the Perinatal Computer System (SIP). Most facilities collected basic data on abortion method (90-100%), weeks' gestation (79-93%) and clients' age (79-91%). While the Voluntary and Legal Termination of Pregnancy Information System (SILVE) will facilitate complete information and enable comparisons of abortion characteristics across the country, at the time of the survey it was used by less than 5% of facilities (mostly hospitals), and only in GBA and RPBA.

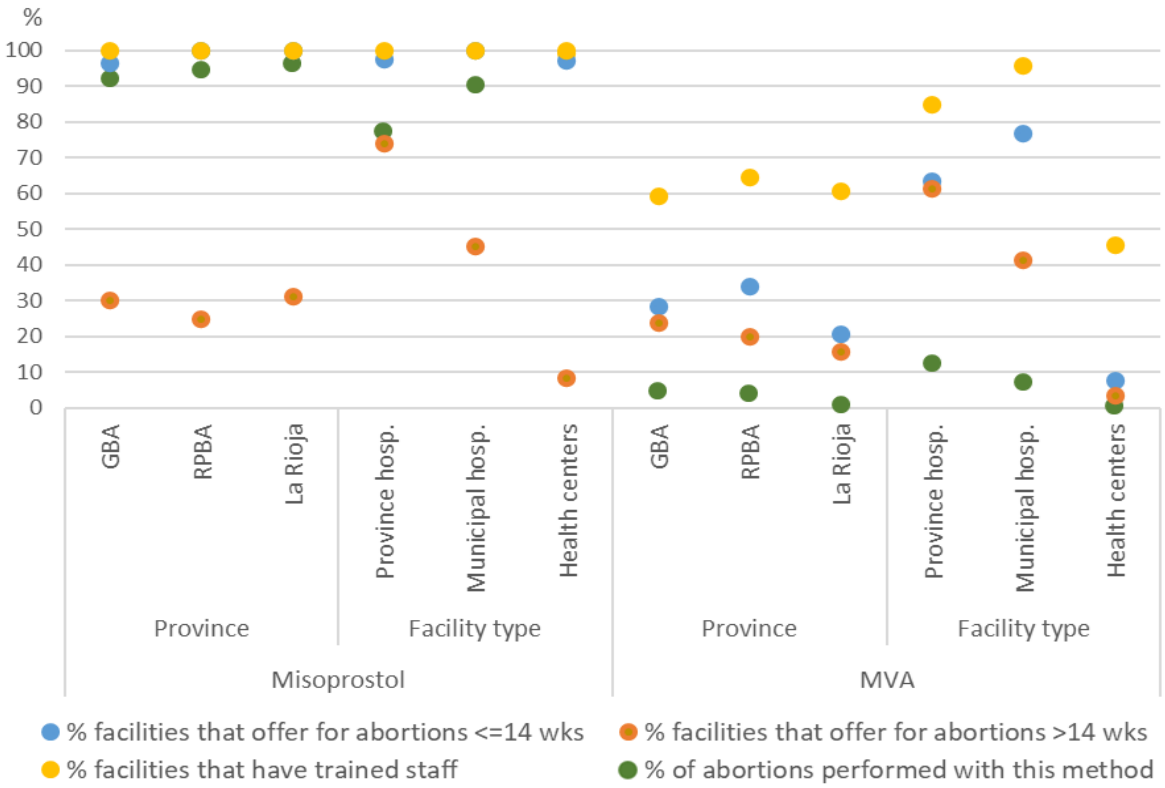
Stock of methods and equipment

Nearly all abortion-providing facilities offered misoprostol for abortions up to 14 weeks (Figure 2). Misoprostol for later abortions was mainly offered by province-level hospitals (74%), with only 8% of health centers offering it. In the six months preceding the survey, misoprostol was used for 98% of abortions in health centers, 90% in municipal hospitals, and 75% in province-level hospitals (which tend to receive later abortions more likely to require a surgical procedure). Mifepristone was only officially registered for commercial use in Argentina in March 2023, so at the time of the survey the combination of mifepristone and misoprostol was still not widely offered. Most health facilities obtained misoprostol supplies from the provincial government, and respondents reported that the quantity supplied was generally sufficient.

While one or more surgical methods were available in up to 77% of hospitals (depending on the method), and an even higher proportion of facilities had personnel trained in these methods, in

practice only a small proportion of abortions were performed with surgical methods, mostly MVA (Figure 2), and very few with non-recommended D&C (<1%). While most hospitals were satisfied with the number of MVA kits supplied, satisfaction dropped to 64% for health centers (99% of whom received no kits; data not shown).

Figure 2. Availability, trained personnel, and proportion of abortions performed with misoprostol and MVA, by province and facility type



All abortion-providing facilities reported offering postabortion contraceptive counseling, and over 90% provided pills, injectables, implants, condoms, and intrauterine devices free of charge. Tubal ligation was offered free of charge in 60-77% of hospitals, but only 16% of health centers. While the majority of facilities reported that "most clients" adopted a contraceptive method post-abortion, around a quarter of municipal hospitals and health centers reported that "over half" of users did not. Some key informants suggested incorporating counseling on long-acting contraception from the beginning of the abortion process, rather than waiting till the post-abortion follow-up appointment (which many health center clients reportedly did not return for).

Remaining implementation challenges and potential solutions

Abortion provider capacity

On average, each abortion providing facility had 2.6 physicians, with the largest number in province-level hospitals (5.6), followed by municipal hospitals (2.9) and health centers (1.7). While the majority of facilities reported having an adequate number of physicians to meet demand, 15% of municipal hospitals and 32% of province-level hospitals and health centers reported insufficient numbers, particularly in GBA (38% of facilities). As official guidelines require a doctor to provide or sign off on all abortions (whether MA or surgical), this restricts lower-level providers from filling the capacity gap.

Abortion provider training

During 2022, 83% of province-level hospitals, 70% of municipal hospitals and 68% of health centers reported that their staff received training on abortion-related topics. While the training was considered sufficient by the majority of facilities, several gaps were identified. First, respondents highlighted an urgent need to extend training to health personnel beyond medical staff (mentioned by 23-32% of facilities). The second most cited training gap in health centers was the use of mifepristone combined with misoprostol (25%). Although all facilities had one or more physicians trained in the use of misoprostol, a non-negligible proportion did not have any professionals trained in the mifepristone-misoprostol combination, particularly in health centers (26%). In hospitals, the second most cited training gap was second-trimester abortion techniques (19-23%). MVA training was requested by 13% of municipal hospitals, and 19% of health centers.

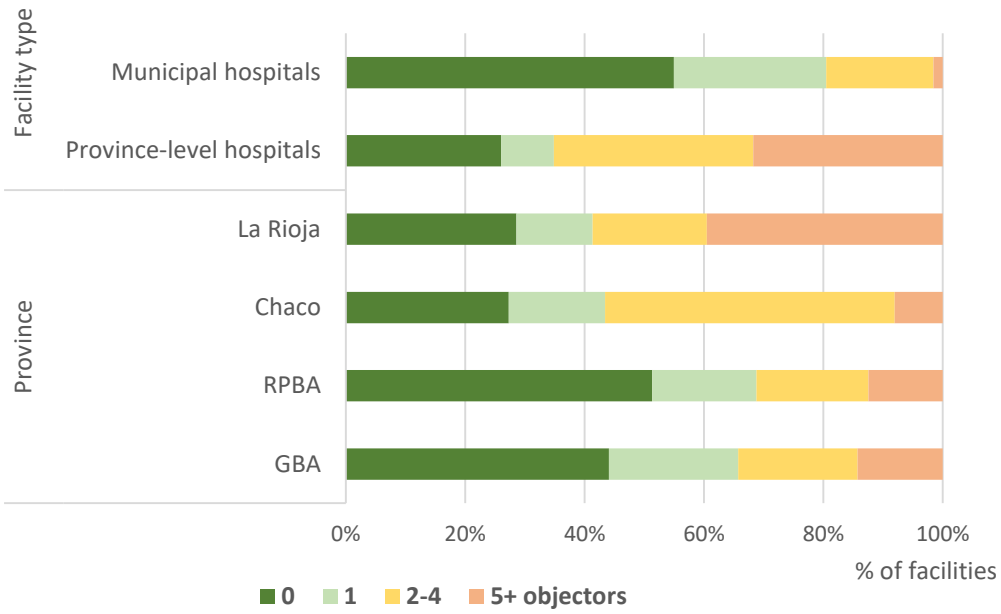
Conscientious objection

The right to conscientious objection (CO) established in article 10 of Law 27,610 can only be exercised by individual professionals who directly participate in the termination process, and should not imply the denial or obstruction of the practice, which should be guaranteed according to the referral protocol. Among abortion providing facilities, conscientious objectors were found among professionals involved in abortion care in 71-74% of hospitals and 45% of health centers, particularly in La Rioja (Figure 3). Nearly half (47%) of province-level hospitals and 33% of municipal hospitals registered five or more objecting physicians. In addition, 55-65% of hospitals and 18% of health centers reported objecting staff other than physicians – mainly nurses, but also administrators, psychologists, social workers, health agents, anesthetists, laboratory technicians, surgical technicians and

sonographers. This can present a significant barrier to accessing abortion in facilities with otherwise willing physicians.

To minimize the effect of CO on service provision, providers chose to form interdisciplinary teams with those who did not object, thus guaranteeing abortions. Guidelines for performing safe abortions emphasize the importance of having interdisciplinary teams spanning medicine, social work and psychology to provide comprehensive, people-centered care,[20] and 77-83% of facilities had an interdisciplinary team in place, despite the high prevalence of CO.

Figure 3. Percentage of facilities reporting conscientious objection among physicians, according to number of objecting physicians, by province and facility type



User obstacles

Health providers' reported that a significant proportion of users do not know any abortion method (though most users have heard of misoprostol), and many do not know they can request a termination under 14 weeks without giving a reason, suggestig the need for more sustained public information campaigns, so that people know their rights and where and how to access services.

DISCUSSION

While a large proportion of countries worldwide still have restrictive abortion laws, in recent years several countries have liberalized abortion access. Newly reformed countries would benefit from having better information on likely barriers and facilitators of implementation, yet studies documenting the implementation of law change soon after it has occurred are rare. This study examined the first two years of implementation of the 2021 abortion law reform in Argentinian public health facilities in three provinces, offering valuable insights to inform public policies aimed at improving access to abortion services. The promising progress documented in the study is the result of a committed collaborative effort between national and provincial governments, service providers and civil society organizations following a long history of social mobilization around abortion law reform.[21–25] In particular, it was facilitated by the large-scale societal support fostered by the Green Wave movement that later spread to other countries in the region,[26] resulting in abortion liberalization in two more influential nations since 2021: Mexico and Colombia.[27] Given Argentina's position as a leader fueling demands for law reform in the region,[28] newly reformed Latin American countries and others considering abortion liberalization are likely to turn to Argentina as a model, taking stock on successful implementation strategies based on their experience. It is therefore crucial to carefully document successes and challenges so others can learn from them. Below, we highlight key findings and their implications around four themes.

Integration of abortion services into the public healthcare system

Less than two years after law reform, a large number of public facilities were successfully offering abortion services. According to the National Department of Sexual and Reproductive Health (DNSSR), the number of abortion-providing facilities increased from 907 in 2020 to over 1,900 in 2023.[19] The speed of implementation is all the more notable given the context of the COVID-19 pandemic and the numerous challenges it engendered.[10] According to one study, this quick expansion of service provision was facilitated by providers' experience performing abortions under the specific indications of the previous law, as well as strong political will and commitment from health authorities and growing destigmatization of abortion.[21] Statistical records have also been greatly improved, with the majority of surveyed facilities collecting data on abortion services, although the SILVE, introduced in 2021 to enable more efficient tracking across the country, is still not widely used. Robust monitoring systems are key to ensuring implementation barriers can be swiftly addressed. Ongoing monitoring

initiatives based on official statistics, such as *proyecto mirar*, are crucial;[19,29,30] in addition, regularly conducted facility-based surveys such as ours can assess service provision quality on the ground. In Ireland, the 2018 abortion law reform included reporting requirements to review implementation after three years.[31] Introducing similar requirements for Argentina may help accelerate and institutionalize reporting.

Full roll-out of abortion services is likely to take some time: many facilities that would be expected to provide abortion did not do so, and relatively few non-providing facilities planned to offer abortion in the future. Abortion-providing facilities were particularly scarce in the more remote provinces of Chaco and La Rioja. Too few providers in rural areas was also reported in recent reviews of implementation.[21,24,29] While this is partly due to a lack of trained providers, particularly for second trimester abortions,[21] we found that a major reason for the patchy coverage is the organization of referral circuits that concentrate abortion provision in a few district or province-level hospitals. While this may be an efficient way to organize provision, key informants noted challenges with the system, and it is unclear whether it effectively meets demand in areas far from the closest referral hospital.

Accessibility of abortion services

Before law reform, service users regularly had to overcome several obstacles to accessing abortion, including the requirement for police reports in rape cases and unnecessary delays in procedures.[32] We found that less than two years in, protocols were correctly applied, with timely provision of the service and respect for privacy and confidentiality. Users were not required to present an Argentinian ID, reside within a specific area, or show a police report in cases of rape. While all facilities offered post-abortion contraceptive counseling, including a wide range of free methods, contraceptive uptake still needs to be improved, especially in lower-level facilities.

A key mechanism for improving service access is making potential service users aware of the service and their rights. *Proyecto mirar* similarly found a lack of public information disseminated by the government.[21] While information is made available via targeted channels, including hotlines[13,33] and civil society initiatives[21], there is little communication to the general public.

Availability of supplies, equipment and training

Implementation progress is also seen in the provision of misoprostol by trained professionals in all abortion-providing facilities, with minimal stock-out issues. The DNSSR increased its distribution of

misoprostol treatments from 18,500 in 2020 to around 70,000 per year following law reform.[19] The survey of health facilities found that a minority of abortions were done using the combined medication abortion (MA) method (misoprostol and mifepristone): this was made possible by a special waiver allowing mifepristone distribution despite it not being registered in the country at the time.[21] With mifepristone's official approval in March 2023,[34] use of the combined MA method is expected to increase. However, training is currently lacking, particularly in health centers. Similarly, only half of health centers had personnel trained in MVA, despite many expressing an interest in providing this service. Integrating a wide range of techniques into training protocols will ensure clients have a choice of methods, as recommended by the WHO abortion care guideline.[35]

Availability of personnel

Over a third of province-level hospitals and health centers reported that they did not have sufficient staff to meet demand. Lack of trained staff was the second most cited reason for not offering abortion at all, and was identified as the greatest obstacle to implementation. While lack of trained staff is partly due to inadequate training of *available* staff, it is also due to insufficient numbers of doctors, compounded by the high number of conscientious objectors, particularly in hospitals. A recent study also found high levels of conscientious objection (CO), particularly among tertiary level providers and those working in more remote provinces.[36] Although CO is permitted only for doctors, other staff frequently invoke it. While CO did not usually lead to denial of procedures by abortion-providing facilities, it reduces the number of available staff and increases the workload of providing doctors. CO appears to be even more problematic in non-providing facilities, and was frequently cited as a reason for not providing abortions in La Rioja and RPBA. A 2020 study predating law reform found that CO was often used by hospital authorities as an ideological tool to impose conservative political agendas, while individual staff tended to use CO not for moral reasons, but as a protective mechanism for fear of stigma or legal repercussions should they perform abortions.[37] Indeed, abortion providers in Argentina have historically been seen as less legitimate than conscientious objectors, and subjected to harassment and discrimination.[5]

Yet, there is also evidence that abortion law reform has helped to de-stigmatize the procedure, in particular among medical providers.[21] Additional research on staff motivations for CO *post-law reform* could help devise better guidelines to minimize CO and resulting disruptions. For example, another reason for CO cited in the 2020 study was avoidance of heavy workloads; if this is still the case, offering better incentives to prospective doctors and other staff to perform abortions may increase the pool

of providers. In parallel, task-shifting to authorize and train midwives to perform first trimester abortions would help fill the capacity gap, and a bill to this effect is currently making its way through Congress.[21] Finally, the recent review by *proyecto mirar* found that the general lack of oversight of CO enables professionals to claim it without following official regulations, such as prompt referral to consenting providers.[21] In another recent study, providers – and particularly conscientious objectors – erroneously believed more requirements needed to be fulfilled for on-request abortions, such as judicial authorization for minors, dissuasive counseling and HIV tests, which can unnecessarily delay or obstruct clients' timely access to abortion.[36] Extending training to non-medical staff on legal requirements for abortion, CO and the scope of the law, coupled with more strict enforcement of regulations, could help reduce the growing number of objectors.[14,37]

Study limitations

This study is not representative at the national level. The research was carried out in three provinces selected with an eye to diversity, and as such provides a snapshot of different situations in the country. However, the small number of abortion-providing facilities in Chaco limited our ability to generate estimates for this province. Second, given that this study was focused on the supply side of abortion provision, we did not examine the perspectives and experiences of service users themselves: all information presented on clients is based on health providers' perceptions. Further research on clients' experiences accessing abortion, and more generally on people's needs in relation to abortion services, could help identify demand-side barriers to obtaining abortions, and strategies to address them. A few studies have described people's experiences and preferences seeking abortions prior to 2021,[6,38,39] but evidence is lacking on service users' experiences and needs following law reform.

CONCLUSION

The first two years following abortion law reform in Argentina have seen significant progress in increasing access to abortion services, especially given the pandemic and limited resources. The biggest remaining challenge is around availability of trained personnel, including the regulation of conscientious objection. We suggest the following recommendations to improve abortion provision in the next stage of implementation.

1) Increase the number of providers to meet demand: Encourage more doctors to provide abortion by offering incentives such as free training and improved working conditions, and counteracting

stigma; authorize and train midlevel staff such as midwives and nurses to provide early abortions without needing a doctor to sign off; organize compulsory training on the limits of CO for all staff (including non-medical) involved in abortion provision; and more strictly enforce CO regulations.

2) Improve the quality of abortion services: Increase training on safe abortion methods such as the misoprostol-mifepristone combination and MVA; integrate contraceptive counseling early in the abortion process rather than waiting till the post-abortion follow-up appointment; and monitor the effectiveness of referral circuits in meeting demand in more remote provinces.

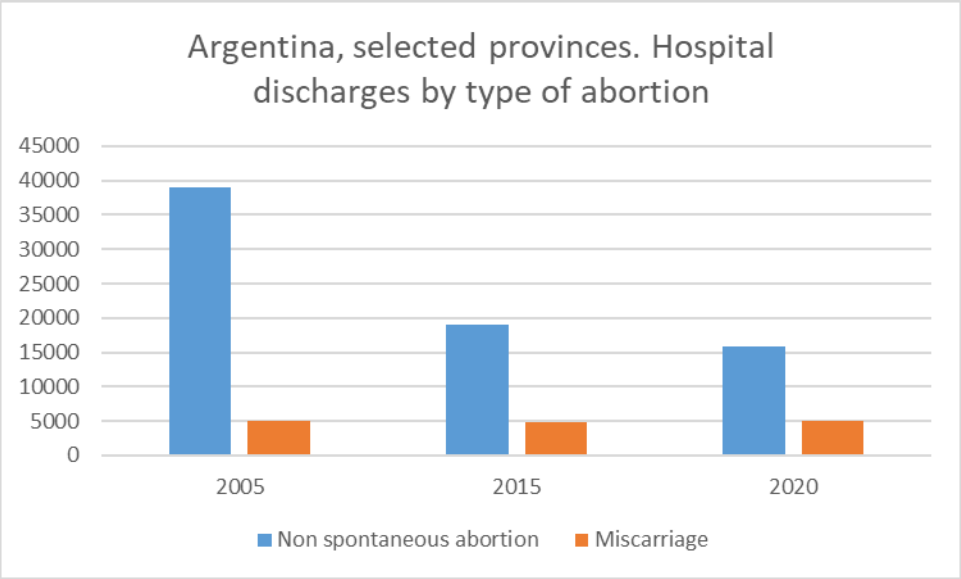
3) Carry out public information campaigns to reach all those who might need an abortion, covering the right to abortion, how to access the service and available methods.

Investing in these strategies, along with more research on service users' needs and on how to address CO, and ongoing monitoring of implementation progress in facilities, can help improve abortion provision and inform guideline updates, to ensure that comprehensive services are available to all those who need them. Argentina's experience implementing abortion law reform offers useful guidance to stakeholders in other countries that have or are seeking to liberalize their abortion laws.

Three years into the implementation of the abortion the country is facing new challenges with the new government that took office, that openly expressed their opposition to abortion, and any gender perspective oriented policy. The new government immediately has implemented substantial budget cuts into public programs, including those that support reproductive health care. (As this paper is being written there was not any new provision of misoprostol by the new government to provincial health ministries) These has implied again that provinces will face different opportunities according to the provincial government to keep supporting access, as well as making civil society organization to become again key actors in supporting and providing women in need to terminate a pregnancy.

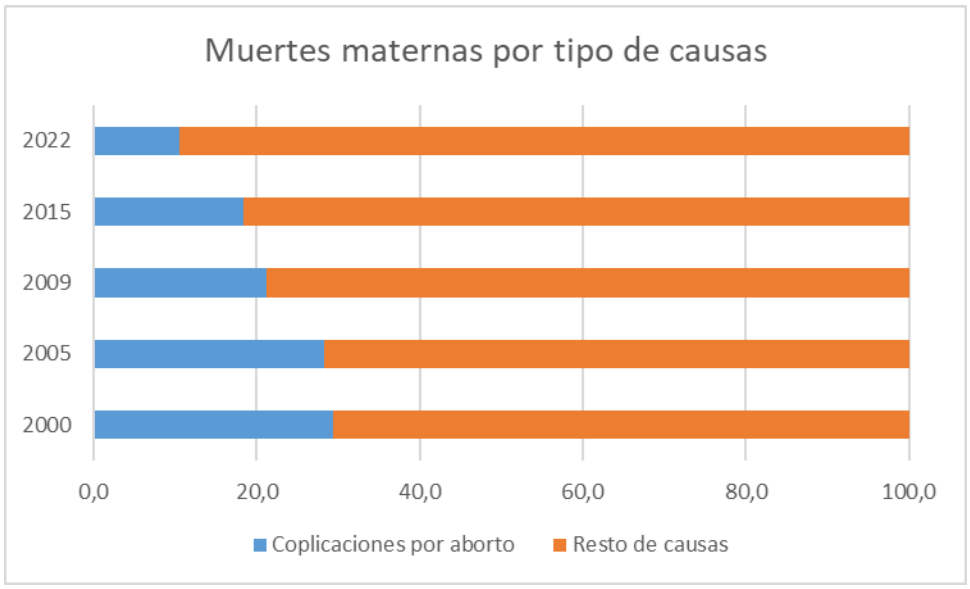
WORK IN PROGRESS . ADDITIONAL TABLES TO BE INCLUDED, RELATED TO ABORTION BEFORE THE LAW

Graphic. Argentina, hospital discharges by type of abortion.



Source: own elaboration based on Data from Direccion de Estadisticas I informacion de la salud.

Graphic. Argentina, Maternal death by cause.



Source: own elaboration based on Data from Direccion de Estadisticas Iinformacion de la salud.

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