How much does legal abortion cost in Uruguay?

MYSU MUJER Y SALUD EN URUGUAY

OBSERVATORIO NACIONAL EN GÉNERO Y SALUD SEXUAL Y REPRODUCTIVA EN URUGUAY

November 2024

12 years after the implementation of Law 18.987 on Voluntary Interruption of Pregnancy, this comparative study estimates the cost of legal abortion procedures in the Uruguayan public health system in relation to the cost it would have according to the recommendations from the latest WHO guidelines.

Voluntary termination of pregnancy (VTP) in Uruguay, when performed in a public health service, has a minimum direct cost of US$ 524 per procedure.

We conducted an investigation[1] to estimate the costs of abortion in the country, and the results showed that a standard abortion procedure, without complications and in a public service that has the availability to perform diagnostic tests and the necessary team of professionals, costs 20,963 Uruguayan pesos per legal abortion.

If the procedure were carried out according to the recommendations of the World Health Organization (WHO), the cost would be 14,094 Uruguayan pesos, which represents a 33% reduction. When considering the exchange rate of 40 pesos to the dollar, the cost of the procedure established by law would be US$524, compared to the US$352 it would cost if WHO criteria were applied.

There is a lack of information to adequately evaluate access to this right. The availability of information and cost analysis on abortion and sexual and reproductive health is essential to evaluate these policies. With this study, the information generated is new because, to date, no official calculation of the cost of an abortion procedure had been made, nor were there any previous studies that had done so. The lack of recorded and systematized information, as well as the difficulties in accessing it, is a cause for concern.

The enforcement of Law 18.987 on Voluntary Interruption of Pregnancy constituted a significant advance in sexual and reproductive health rights in Uruguay, enabling abortion at the will of the pregnant woman, within a legal framework of services, during the first 12 weeks of pregnancy. Almost 12 years after its implementation, Mujer y Salud en Uruguay (MYSU), with the support of UNFPA LACRO, carries out a comparative analysis on abortion costs in the public health system in relation to the latest WHO guidelines on abortion. There is evidence of overcost and difficulties in access due to an inefficient regulation that causes obstacles and hinders what is a fundamental right.

The information gathered is novel because to date no official calculation of the cost of an abortion procedure had been made, nor were there any previous studies that had done so.

The current regulations create barriers to ensure universal access to abortion services because they have unnecessary requirements from the point of view of the safety of the practice. These increase the cost of compliance with the law and are not efficient in responding to the requirements of the user population.

Knowing the costs and producing information is essential to provide inputs for those who manage the services, those who decide on public policies and those who carry out citizen oversight. Having this data is important to evaluate the efficiency, quality and access to a service in the health system, to analyze the allocation of spending and to adjust the budget towards achieving better results. Generating and ensuring the availability of a robust information system is a duty of State institutions for transparent governance and management. Sexual and reproductive rights are recognized by law in the country and the Uruguayan state complies with international commitments adopted before the International Human Rights System of the United Nations, as long as it ensures the conditions for their exercise.

1 This research was conducted for MYSU with the support of UNFPA LACRO and was under the responsibility of Santiago Puyol with the collaboration of María Noel Sanguinetti and Lilián Abracinskas.

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Understanding reality in order to change it

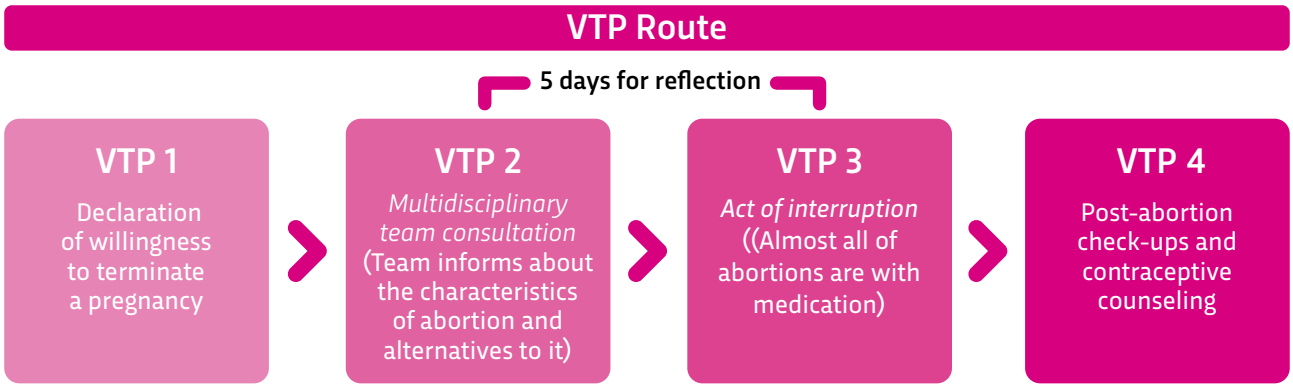
October 22, 2012 marked a turning point in the advancement of sexual and reproductive health rights in Uruguay with the approval of Law 18.987 on "Voluntary Termination of Pregnancy" (VTP). From that moment on, legal abortion services were installed in all institutions of the National Integrated Health System (SNIS, in Spanish), and no penalty is applied for abortions performed up to 12 weeks of gestation, in health institutions accredited by the SNIS, and following the procedure established by law, including mandatory consultations and days of reflection. Almost 12 years after the law was passed, Mujer y Salud in Uruguay (MYSU - Women and Health in Uruguay, in English), with the support of the United Nations Population Fund (UNFPA), identified the relevance of undertaking a cost estimation study on legal abortion services, and comparing them with the latest international recommendations and standards for safe abortion care, specifically the latest made by the World Health Organization (WHO) in 2022.

Although the VTP law marks an important change in terms of comprehensive sexual and reproductive health care, it is essential to improve the tools for its implementation and follow-up, as well as the in-depth analysis and review of its application to promote and defend sexual and reproductive rights as human rights. The challenge of putting into practice the VTP services has today more than a decade of results and there are relevant aspects that need to be addressed and problematized in order to improve the quality, access and efficiency of the services. This remains a fundamental aspect in advancing towards a full realization of the right to bodily autonomy and the power to decide whether or not to have children, how many and with what spacing. This has been more than problematized and analyzed from different perspectives, all of them complementary, ranging from the criminalization of abortion to the operationalization of the procedure, as Schenck (2003) points out.

The voluntary termination of pregnancy (VTP) is a core aspect in the development of human rights and is necessary to build a comprehensive approach to sexual and reproductive health. For this reason, the reality of services, their costs, accessibility and optimal conditions and guarantees for citizens are fundamental elements in ensuring the necessary conditions and resources so that people can make free and autonomous decisions, without discrimination or exclusion.

Different studies conducted by MYSU (2014, 2017, 2023) have identified difficulties in the implementation of abortion due to failures in the regulation of conscientious objection, the lack of professional resources to meet the requirements of the procedure, the time constrains for those abortions on grounds of sexual abuse and rape, the limited possibilities to terminate a pregnancy based on risk of health, the restriction of access for migrants and other persons with gestational capacity. The complexity of the procedure, the lack of dissemination of information about the VTP services, the weakness in respecting the confidentiality of the consultation, the bias in professional interventions and the lack of adequate supervision by the health authorities in the face of non-compliance with guidelines and protocols on the part of teams and institutions providing health care, make up the list of the problems detected.

There is evidence of difficulties due to the requirements in terms of the institutional framework, the availability of professionals required and the limited timeframes for accessing a legal abortion. Based on current regulations, it is clear that in order for a person to have access to abortion services, she/they must undergo at least four consultations, which are detailed below: initial consultation (VTP 1), consultation with the multidisciplinary team (VTP 2), after the mandatory 5 days of reflection, the confirmatory consultation (VTP 3) and a post-abortion consultation (VTP 4).



Source: ***SERVICIOS LEGALES DE ABORTO EN URUGUAY - Logros y desafíos de su funcionamiento***, MYSU, 2017.

In order to comply with the specified requirements, it is necessary to have sufficient financial resources to support the work teams, laboratory time and resources, without considering any delays. Not all services throughout the Uruguayan health system and the territory have equal conditions and resources to provide care in the same way to all women or pregnant people who require it (MYSU, 2017). The requirements established in the VTP law are more demanding than what is recommended in the last update of the WHO Guidelines and the data on the incidence of legal abortion show that the legislator's assumptions that defined the characteristics and obligations of the procedure cannot be supported based on the evidence from more than a decade in operation. In addition to the organizational and functional aspects that are impossible to comply with in order to increase the territorial availability of the teams due to the deficit of professionals required, it is important to know the dimension of the impact in economic terms since it was not calculated. Hence the challenge of estimating the cost of an average legal abortion procedure in order to assess its efficiency based on the quality standards accepted by the international community and on the requirements of the user population.

Data from MYSU's Sexual and Reproductive Health Observatory (2021), from the report *"Aborto en Cifras. Datos de Uruguay al 2021"*[2] record that, as a consequence of the COVID-19 health emergency and in the context of the economic and social crisis derived from it, more than 100,000 people changed their health affiliation from the mutual system to the public services provided by ASSE. However, the percentage of public abortions remained stable, with a predominant trend towards private services. This observation prompted the question of whether care is *"reaching all women who require legal abortion services, since the services may not be serving or even expelling many of the women in abortion situations and, in particular, those who are more socioeconomically vulnerable"*. The question that also motivated this study was to estimate the economic cost required to provide legal abortion care in the public health system in order to analyze possible scenarios that would improve access to the user population that requires it.

Contributing to the study of the costs of sexual and reproductive health services represents for MYSU a new stage in the different works, research and tools that it has been developing and strengthening since the creation of the National Observatory on Gender and SRH in 2007. It implies a challenge to improve the knowledge and assessment of public policies in order to further the exercise of rights and the process of citizen demandability in the defense of them.

The objective of this work is to provide a first cost estimate to generate a summary indicator that can be monitored and evaluated over time. At the same time, it analyzes and presents recommendations on possible modifications to be implemented in order to make a more efficient use of resources, in line with international quality standards. This will make it possible to improve abortion care, universalize access and meet the specific needs of certain sectors of the population.

This work is considered a significant development in knowledge about the implementation of abortion services in Uruguay. Implementing cost studies addresses a relevant gap in the monitoring and analysis of this sexual and reproductive rights. It thus establishes a turning point to continue researching, generating tools and improving the various benefits and knowledge on sexual and reproductive health in our country, within the broader framework of Population and Development policies.

Justification and methodology

The recognition of the right to sexual and reproductive health is fundamental to the well-being and the full exercise of human rights, and its provision includes access to contraceptives, pregnancy and childbirth care, safe abortion, prevention of sexual violence, among other needs. Assessing the costs of these services is essential to improve their quality and accessibility, allowing for an efficient allocation of financial, material and human resources. Well-designed policies around these services, such as promoting access to contraceptive methods and safe pregnancy termination, can prevent complications and reduce costs associated with unsafe abortions, thus improving health systems.

The cost studies that can be carried out are multiple and the approaches are complementary and can address different dimensions, all of which are relevant. In our country, unlike other realities such as Mexico (Levin *et. al*, 2009)[3], Colombia (Prada *et. al*, 2014) or Argentina (Monteverde and Tarragona, 2020; Manzuelli, 2022), there is no precedent of a cost study of abortion. Thus, a first advance is made with this

2 Abortion in Figures. Data from Uruguay up to 2021, in English.

3 It should also include the study "Cost of unsafe abortion in Mexico. Results at the national level", research conducted by Dr. Reyes Manzano, in a consultancy convened by UNFPA Mexico.

research to determine the cost of legal abortion care according to the regulations in force in our country at the public level (in charge of ASSE, the Administration of State Health Services, in English) and the cost that would be incurred if the latest WHO guidelines with recommendations on safe abortion were applied.

The analysis of costs, both direct and indirect, allows governments and health systems to anticipate financial needs and design appropriate financing strategies. This ensures the sustainability and accessibility of services, especially for vulnerable populations. In low-income countries, unsafe abortions represent a significant burden on health budgets. In summary, proper cost management and evaluation not only improves the efficiency of the health system, but also promotes social justice and economic well-being.

We developed a model for calculating the cost of a procedure for the Voluntary Interruption of Pregnancy (VTP) in Uruguay. The study evaluated a basic procedure for a woman, without complications, in a public service with the minimum necessary resources and complying with the requirements established by current regulations[4]. The minimum cost of an abortion under these conditions (standard cost) was estimated and compared with the estimated cost if WHO guidelines (2022b) were followed. Scenarios involving additional consultations, other diagnostic studies and transfers were not included, due to limitations of time, resources and access to information.

The model was developed in consultation with ASSE's sexual and reproductive health professionals and gynecologists involved in the management of abortion. Several data sources were used to gather the necessary information for the definition of a typical VTP cost. Each stage, input, consultation, study or medication was surveyed, estimating the associated costs. Current regulations, specialized bibliography, and official data such as salary councils for professional fees were some of the sources consulted. In addition, a request for access to public information was filed to obtain data from ASSE and MSP, in accordance with Law 18.381. When the information was not available, detailed estimates were made based on market costs.

4 Including Law 18,987, its regulatory decree (375/012), the Procedural Manual for the Sanitary Management of the Voluntary Interruption of Pregnancy (MSP, 2016) and the Technical Guide for the Voluntary Interruption of Pregnancy of the Ministry of Public Health (MSP, 2016b).

VTP type cost model

A cost model was constructed considering a "typical" VTP at the level of a public service. For this purpose, a study of the VTP regulations and all the steps involved in the procedure was carried out, each of the direct costs of the procedure were detailed according to the existing regulations in Uruguay and the cost was estimated if the latest WHO recommendations regarding safe abortion were applied.

We started from a medical outpatient abortion scenario, performed during the first 12 weeks of gestation as it corresponds to the absolute majority of procedures performed in the country (Fiol *et. al*, 2016; MYSU, 2023).

In the medical costing literature, the standard cost is the one detailed in the regulations and according to existing protocols, medical and legal procedure guides (Charlita Hidalgo, 2009; Santamaría Benhumea *et. al*, 2015).

The various elements related to a procedure were considered in general terms, excluding complications or additional difficulties. The corresponding concepts, units and quantities were identified, as well as the costs associated with each of them.

Once the model was defined and assembled, physical volumes and unit costs were associated with it. For this purpose, the estimated time of a medical consultation with a gynecologist or general practitioner in the cases that were considered, the type of ultrasound, the medication alternatives and the different stages of the procedure were taken as references for the agreements, for example. The work was carried out for the procedure as established in the regulations in force in our country and a comparative in relation to the estimated cost following the WHO recommendations. Its last update is from 2022, when it published new guidelines on abortion care, whose purpose is to protect the health of women, girls and adolescents, helping to prevent the more than 25 million unsafe abortions that currently occur each year globally (WHO, 2022).

For the present study, the direct costs associated with the procedure and its execution were considered, including the confirmatory analysis of pregnancy and gestation time, consultations and time of assigned professionals and medication, among others.

Direct costs refer to all costs associated with the provision of the service that are directly identifiable and can be associated with the provision of the service (Charlita Hidalgo, 2009; Santamaría Benhumea *et. al*., 2015).

Indirect costs are those that are difficult to identify and cannot be assigned with precision, such as administrative costs, waiting times, hospitalization costs in cases where they were required to complete the procedure or due to complications, among others. In general, they are difficult to quantify because a set of estimates and a prorating is required to assign the share associated with what is to be quantified, which was not possible with the conditions, time and scope of this study (Charlita Hidalgo, 2009; Santamaría Benhumea *et. al*, 2015).

The costs of medical services and benefits, human resources, supplies, equipment, basic services, administrative services, general services, medical studies and analyses, and medication are identified.

The unit cost was consulted at the ASSE services level with a request for access to public information as detailed, as well as in different interviews, in particular an interview with the administrative management where a detail of the requested information was made.

Relevance, contents, pertinence and scope of the WHO guidelines for safe abortion.

The World Health Organization (WHO) constantly updates its guidelines on abortion care, with the goal of protecting the health of women and girls and preventing the 25 million unsafe abortions that occur annually worldwide (WHO, 2022). WHO stresses the importance of sexual and reproductive health services that include access to safe abortion and family planning. Regulations that facilitate this access are crucial to reduce deaths and complications from unsafe procedures.

WHO recommendations cover clinical, service delivery and policy intervention aspects. These standards seek to guarantee that abortion services are safe and people-centered, ensuring the protection of the rights of those who seek them (WHO, 2022b). Countries' compliance with these recommendations requires not only adequate regulations, but also effective access to procedures that minimize the risks of complications and provide quality care.

A highlight of the new recommendations is the introduction of telemedicine as a tool that can facilitate access to abortion services in contexts where geographic or social barriers are significant. It is also recommended that unnecessary regulatory barriers such as mandatory waiting times, third-party approval and/or restricted timelines be removed. These requirements not only delay access to safe abortion, but also expose individuals to increased health risks and other consequences in their personal, work, and educational lives (WHO, 2022b).

It has been proven that restricting access to abortion does not reduce the number of abortions, but leads to more unsafe procedures. In countries where abortion is more restricted, only 1 in 4 abortions is safe, in contrast to 9 in 10 in those with broad legal access (WHO, 2022). To prevent unsafe abortions, it is necessary to guarantee a comprehensive set of services that includes sex education, promotion and access to contraceptives, dissemination of rights and guarantees for their exercise. Ensuring quality care based on WHO standards is key to protecting the health and rights of women and girls.

Comparison of VTP Uruguay and WHO guidelines

There are 50 public health services where abortion is performed in Uruguay, and the process of legal abortion can be initiated directly in one of the services specialized in sexual and reproductive health or by referral after a consultation with a general practitioner, midwife or gynecologist.

Table 1 shows the different instances comparing the Uruguayan legal procedure with that stipulated in the WHO guidelines. There is a clear difference that overloads the cost in the Uruguayan model due to instances that imply a greater number of consultations, time of assigned professionals, ultrasound scans and indication of analyses that are not necessary according to the guidelines for the procedure to be safe unless. Thus, the cost is higher and the requirements imply difficulties that have an impact on the universality of access, furthering inequality of conditions and costs depending on the place in the country. In departments[5] where there is a lack of professionals or where ultrasound scanners are not available, the service is affected. Following WHO recommendations and promoting telemedicine could help to overcome these barriers and weaknesses of the services.

5 Uruguay is politically divided in 19 departments (departamentos, in Spanish). Each department has its own government and legislative body, but general health policies (such as SRH in general) are defined on a national level and mandatory in all of the territory.

Table 1. Summary of the legal abortion route according to national regulations and WHO guidelines.

SERVICES	URU	WHO
Pre-abortion services		
First counseling on the VTP law during the initial consultation (VTP 1)	X	X
Confirmatory ultrasound of pregnancy	X	
Beta-hCG analysis	X	
Second consultation of the process with the multidisciplinary team (VTP 2)	X	
Reflection time (5 days)	X	
Consultation with gynecologist to ratify decision and start procedure (VTP 3)	X	
Abortion care		
Pain treatment is recommended with NSAID (Ibuprofen 400 mg every 4 to 6 hours from the beginning of the procedure until the pain passes).	X	X
Medical abortion		
In Rh-negative women with irregular (Coombs) negative antibodies, immunoprophylaxis with anti-D gamma globulin will be provided prior to the procedure.	X	X
Self-administered		
Mifepristone 200 mg orally	X	X
Misoprostol 800 mg oral	X	X
Misoprostol 800 mg vaginal	X	X
Internment		
Days of hospitalization	X	
Misoprostol 800 mg oral	X	
Misoprostol 800 mg vaginal	X	
Repeat for non-expulsion of Misoprostol (400 mg vaginally or sublingually, every 3 hours until expulsion is achieved, with a maximum of 4 additional doses or 800 if Misoprostol alone has been used).	X	X
Consultation during procedure	X	
Complications due to hemorrhage		
Evacuative curettage	X	
Surgical abortion		
Rh negative, with negative irregular antibodies (Coombs), anti-D gamma globulin is administered.	X	
Cervical preparation		
400 µg of Misoprostol sublingually or vaginally, 3 hours before the procedure.	X	X
200 mg oral Mifepristone (24 to 48 hours before)	X	X
Antibiotics	X	X
Post-abortion care services		
Post-abortion follow-up visit (VTP 4)	X	X
Uterine Evacuation	X	
Misoprostol (single dose of 400 µg sublingually or 600 µg orally)	X	
Contraceptive counseling	X	X
Control ultrasound	X	

Main results

The cost of a voluntary termination of pregnancy (VTP) procedure in a public service, without complications, is $U 20,963 (Uruguayan pesos). Following WHO recommendations, this cost would be reduced to $U 14,094, which is 33% less than the current cost. In U.S. dollars, at an exchange rate of 40 pesos to the dollar, the cost per law of a legal abortion procedure is US$ 524, compared to US$ 352 if WHO criteria are applied.

The results of the revised model for all the items of the procedure can be seen in the following table for each of the alternatives under evaluation in this work.

It should be noted that this is the minimum cost of the procedure without considering other expenses for additional studies, hospitalization, transfers, consultation, among others, and without including indirect costs.

VTP type cost

According to the Uruguayan system
$U 20.963
Following WHO Guidelines
$U 14.094
33% higher

Table 2 shows a comparative table of costs for the VTP procedure according to the regulations currently in force in Uruguay and if the WHO guidelines were followed, by major items (professional consultations, medical studies, medications). The costs of procedures such as curettage or aspiration were omitted since they aren't included in a standard abortion procedure.

The difference in cost between one procedure and the other is noticeable and mostly due to the unnecessary use of studies, consultations and professionals involved. This additional cost does not contribute to the safety of the procedure, since both models coincide in terms of dosage and abortion method. Therefore, the Uruguayan procedure is just as safe, but it costs more for reasons that do not contribute to ensure the best service but, on the contrary, negatively affect the universality of access. It is more costly but neither more efficient nor safer.

The difference between the models is important and overcoming it would allow optimizing resources and readjusting them to better meet people's requirements. Addressing these issues should be the basis for legislative change, rising above assumptions made when the VTP law was approved and that have proven to be unsubstantiated, hinder implementation, cost more and limit universal access.

THaving to go through unnecessary steps during the process of a pregnancy that has not been planned and is to be terminated makes the process more difficult, and the barriers to access and response from the Health Care System become points of expulsion towards unsafe practices that could lead to risks and complications for the individual. However, in the face of possible complications, the health system must also respond in an attempt to avoid health risks and life-threatening consequences for the individual. This also results in higher economic costs for the system. Furthermore, interdisciplinary consultation (VTP 2) is not a necessary condition in terms of abortion safety, which makes it more expensive and prevents the possibility of expanding the number of abortion teams in the country. Nor does it necessarily respond to the

Table 2 . Summary of the legal abortion pathway according to national regulations and WHO guidelines, by cost of major items.[6]

VTP cost items	URU			WHO		
	pesos	*USD*	*%*	*pesos*	*USD*	*%*
Professional consultation	1627	41	7%	431	11	3%
Medical study	4612	115	22%	0	0	0%
Medications	14724	368	71%	13663	341	97%
Total	20963	524	100%	14094	352	100%

6 The complete table can be reviewed in the annexes.

need for psychological or psychosocial care according to the needs of the person undergoing the procedure.

The VTP 4 post-abortion control stage, which includes contraceptive counseling to prevent future unintended pregnancies, is not registered in the official VTP information system. Therefore, the legal procedure, which requires a series of consultations to access abortion medication, costs in professional fees but does not ensure, for those who require it, psychosocial support if the person is in a precarious socio-economic situation or psychological care after the abortion if the person needs it. If the legislator's intention was to reduce the practice of abortion in the country, he should reconsider the conditions imposed because they had no effect in discouraging the practice, they make the care more expensive and put barriers that if they were lowered would improve service quality.

One relevant element corroborated in the different interviews conducted to compare the information received with the requests for access, is there is no official data on the costs of abortion care or other SRH components. Information on prices of supplies, organization of the service, professional team fees, cost of delay in response, complications, transfers, hospitalizations, among others, is weak and scattered. The availability of data on cases, typology, user profiles and service costs is essential for assessing and monitoring care, and for improving resource efficiency and use in order to optimize the scope and ensure a high-quality response for everyone who requires it, on time and in a safe manner.

The annexes at the end of the article include the information surveyed, the available documentation, the list of interviews with referents and the requests for information submitted to ASSE and the MSP. Their review shows the weakness of the available information and studies on these aspects of SRH policy that should be reviewed for improvement.

If quality abortion care is to be effective, it must be accessible and safe for those who demand it. Efforts should focus on training health personnel, allocating resources and supplies and disseminating adequate and timely information that respects the needs and rights of women and girls in particular, although it should also include all persons with the capacity to get pregnant. Uruguay does, essentially, comply with an important part of the international standard, but it does so in a way that is unnecessarily more costly and does not address all the aspects that users of the services might require. These weaknesses are at different levels, for example, efforts to sustain ongoing staff training, conduct information and service dissemination campaigns, and strengthen systems for prevention and promotion of good SRH. There were trainings at the beginning of the implementation of the services, but they have been discontinued or there is no oversight to ensure compliance (MYSU, 2017). The information and data recording system has shortcomings, it is not easily accessible, there are delays when replying to official data requests, and those are incomplete. Shortcomings in service provision have an impact on women's, trans, and GNC-rights and generate unnecessary costs. The procedure should also be reviewed on the basis of the new international guidelines that improve the safety of the service. It is also a field of healthcare where the use of telemedicine could improve access and solve difficulties that currently affect the response to situations that become unnecessarily problematic.

The procedure is costly and difficult to comply with for most ASSE services due to the lack of professionals required by law to intervene in the process. Therefore, a revision of the law would be advisable in order to modify conditions and adapt services to provide better care, complement the comprehensive approach with other services, guarantee access, avoid complications and contribute to a more effective and efficient system. These are conditions that must be taken into account if the system is to be improved.

This study was able to build a first model for calculating the associated cost and deepen the analysis of the need for resources and revision to improve the response. The study, while identifying weaknesses, makes a significant contribution and provides an indicator that can be considered as a reference to review the procedure, the associated resources, as well as to identify the monetary effort required and analyze the possibilities of making it more efficient and effective by improving the scope and accessibility of VTP services throughout the territory.

Alternative scenarios

Although it was not part of the purpose of this study to consider scenarios, it was possible to make some estimates and analyses based on the survey that can contribute to the development of alternatives. These are varied and can be classified into different types, from those that refer to including the cost of the process due to pregnancy complications to those that should address the various socio/educational and economic determinants linked to SRH requirements. The costs of

omission, of insufficient or inadequate responses or of the impact of the limitations imposed by the law could also be calculated. This study opens up opportunities to delve deeper into these dimensions that have not been addressed so far.

More in-depth studies could identify other costs related to abortion that are not included in the cost of the basic process. From the interviews with authorities and professionals who provide care, several situations appeared in which more consultations are required, more medication to complete the abortion process, additional studies, lack of a professional in the service or of an ultrasound scanner that implies transfers to other services or locations in the country, hospitalization, need for curettage, consultations with a multidisciplinary team in multiple stages, among others.

Discussions pending or to be installed

Cost analysis has important potential when it comes to providing relevant information and gives us an important indicator for monitoring services, but at the same time it allows us to analyze other aspects ranging from implementation, accessibility, information accuracy, efficiency and scope.

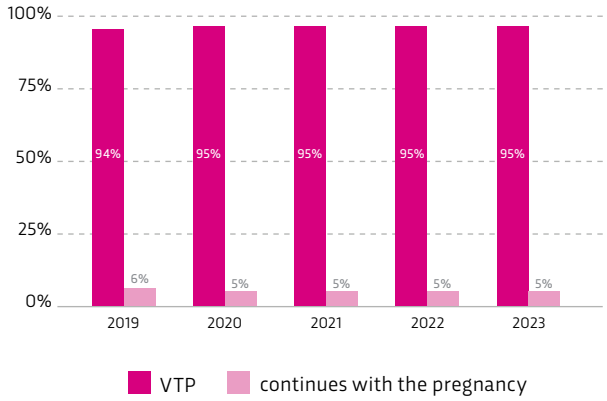
A paper published by the Guttmacher Institute called *"Adding It Up: Investing in Sexual and Reproductive Health"* (Sully *et al*, 2020) highlights that women need these services from adolescence through the end of their reproductive years whether or not they have children. And those who do have children require essential services to protect their health and ensure that their newborns survive. There is evidence that increased resources for SRH have a significant impact on reducing the number of maternal and newborn deaths.

Reductions in maternal and newborn deaths in developing countries over the past decade indicate that globally, increased efforts and resources devoted to safe motherhood and child survival are yielding better results.

It is clear that the situation varies across regions and territories. Accessing an abortion service in Montevideo, with services such as the Pereira Rossell Hospital and the ASSE primary care network, is not the same as what happens in departmental capitals or in smaller cities that do not always have the professionals or the supplies required for analysis and studies. Not all localities have a gynecologist, an ultrasound scanner or a multidisciplinary team that can act simultaneously as stipulated.

The findings support those suggestions pointing out that the VTP law has become outdated relative to the progress that has been made in the decade since it was passed. It contains unnecessary conditions that do not fulfill the purposes for which they were established, such as discouraging the practice by making the legal process for abortion cumbersome. As official figures corroborate, more than 95% of those who initiate the VTP route complete it, and the remaining 5% are not known (see *Graph* 1).

Graph 1. Percentage of women who ratify their decision to terminate or continue their pregnancy[7]. Period 2019-2023.



More resources are allocated than necessary to ensure safe abortion and many of the conditions hinder a more universal implementation that facilitates access to the service, particularly in a large part of the country's localities. It seems clear that making the procedure simpler facilitates the organization of services, favors the safe resolution of unintended pregnancies and reduces the cost of these services or makes it possible to reallocate it to improve the response to SRH requirements.

It is clear that unnecessary requirements hinder access and cause additional costs, which in turn limit the provision of voluntary termination of pregnancy and other sexual and reproductive health promotion and prevention needs.

7 It is officially assumed that those who chose not to continue with the abortion process in the stipulated way have chosen to carry on with their pregnancies, but this assumption should be put under scrutiny considering the many complications related to the legal abortion services that have been mentioned before.

Unnecessary requirements of the VTP law hinder access and cause additional costs.

Concluding remarks

The enactment of laws recognizing people's sexual and reproductive rights, including legal abortion care in the case of unintended pregnancies, represents undeniable progress for Uruguay. Once the services have been installed and the practice has been incorporated into the SNIS, its operation should be reviewed to ensure that the guarantees, that the State must provide, are the most appropriate and meet the needs of the people who require them.

Although access and provision of the services showed that approximately half of the legal abortions are performed in the public health subsystem, the costs involved were not calculated. The available data did not cover studies on the costs of providing abortion care or other SRH services. However, cost studies are fundamental inputs when evaluating public policies, the relevance and impact of investments in Sexual and Reproductive Health and the costs of inefficiencies or failures in services.

Even though it is not the purpose of this paper to quantify the resources allocated to abortion in Uruguay in a public service today, nor to evaluate whether they are too many or too few in relation to health spending or in relation to other types of services, it does show that the resources allocated today are not efficient, since there are stages that are not necessary, that any type of complication would be attended to if necessary, and that these regulatory requirements not only cause inefficiencies, but also major difficulties in ensuring access to rights.

In any case, based on the estimated calculation of US$ 524 per procedure if all legal abortions were performed under equal conditions[8], in the average of 5,000 that ASSE attends per year, the amount allocated would be approximately US$ 2,620,000 per year. As a reference point for this expenditure, according to the Ministry of Public Health (MSP) of Uruguay, total expenditure on health is around 9% of GDP, a total of approximately US$ 3.6 billion. According to the Budget Law, about 30% of the total expenditure is allocated to public health services (approx. US$ 1.08 billion).

The existence of cost studies is a fundamental step in the improvement of services, in the guarantee of access and in the adequate use of resources. Today, Uruguay has standards and procedures with unnecessary levels of complexity that generate expenses that do not contribute to guaranteeing safe practice. These are superfluous expenses. Revising the procedure and adapting it to WHO recommendations seems very reasonable both to ensure universal access and to encourage the development of studies and strengthen an information system that will allow a better assessment of the scope, investment and health outcomes for the population. In particular, with regard to SRH.

Regulations that result in a procedure with unnecessary instances already evaluated by agencies such as the WHO are not only a clear indication of the willingness to continue hindering and stigmatizing access to a fundamental right in SRH, but also a source of inefficiency in the use of resources that could be better directed to address abortion and other relevant services, not only in SRH but also in health in general. Among some examples, we can highlight prevention, such as contraception processes, post-abortion psychological care, among others. We can also point out that these potentially reoriented resources would be an opportunity to make relevant investments required at a system level and that could make a difference in care, as is the case of telemedicine (Wiebe, 2013; Endler *et. al*, 2019; Berer, 2020), applicable both in SRH and in other areas, and which would enhance access to appointments throughout the territory.

The study opens up possibilities for further work on the economic dimension that would be needed to improve the response and conditions for the exercise of SRR. There are inequality gaps that must be overcome and costs that must be addressed so that unnecessary expenditures can be redirected and used in the best way to redress inequities. When there is inefficiency, there are difficulties and these have consequences that tend to have a disproportionate impact on those whose rights are most violated.

Our research opens up possibilities for further work on the economic dimension that would be needed to improve the provision and conditions for the exercise of SRR. There are inequality gaps that must be overcome and costs that must be addressed so that unnecessary expenditures can be redirected and used in the best way to rectify inequities. Inefficiency leads to difficulties, and these have consequences that tend to

8 No complications, additional transfers or consultations, or repeat medication, for example.

have a disproportionate impact on those most vulnerable to the violation of their rights.

The data obtained in this study reinforces the positions that advocate the promotion of informed public policies based on record-keeping systems that make it possible to assess them in all of their scope. No information was available on the economic cost of providing legal abortion care, although it is estimated that the overall cost for the SRH field in Uruguay represents between 5% and 7% of total health expenditure[9] (approx. 180 - 250 million USD per year[10]). We believe that the findings represent a step forward and we hope that they can be expanded with further research, as well as contributing to improve care in Uruguay in addition to being useful for other countries in the region.

Sexual and reproductive health is critical[11], it requires services and conditions that ensure health, legal, cultural and economic dimensions for its adequate exercise and enjoyment, and all available information shows that not attending to it represents higher costs for the country and people of all kinds.

We are grateful to the institutions and individuals who were willing to respond to our requests and consultations; to the United Nations Population Fund for supporting us in this study and it is our hope these findings will contribute to improving the conditions for the exercise of rights, without discrimination.

9 According to figures from the Ministry of Public Health. ***https://www.gub.uy/ministerio-salud-publica/tematica/salud-sexual-salud-reproductiva***.

10 For reference, international spending on SRH is estimated at about US$14 billion per year, according to WHO figures available on its website: ***https://www.who.int/es***. This spending includes family planning services (including contraception and abortion, where available), prenatal care, delivery care and sexual health. The Global Initiative on Sexual and Reproductive Health highlights that a 3-5% increase in annual public spending is required to achieve the Sustainable Development Goals on sexual and reproductive health.

11 As MYSU has monitored, as part of the regional initiative Reproductive Health is Vital, the most dramatic costs of not meeting sexual and reproductive health needs and requirements are paid by women and people in the most vulnerable situations, in many cases with complications, health risks and even their lives. More information here: ***https://saludreproductivavital.info/***.

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Glossary of acronyms

NSAID	Nonsteroidal Anti-inflammatory Drug
ASSE	Administración de Servicios de Salud del Estado (Administration of State Health Services)
NGO	Non-governmental organization
MSP	Ministerio de Salud Pública (Ministry of Public Health)
MYSU	Mujer y Salud en Uruguay (Women and Health in Uruguay)
Rh	Rhesus (blood group)
SNIS	Sistema Nacional Integrado de Salud (National Integrated Health System)
SRH	Sexual and Reproductive Health
SRR	Sexual and Reproductive Rights
UNFPA	United Nations Population Fund
VTP	Voluntary Interruption of Pregnancy
WHO	World Health Organization

This research was conducted for MYSU with the support of UNFPA LACRO and was under the responsibility of Santiago Puyol with the collaboration of María Noel Sanguinetti and Lilián Abracinskas.

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