Implementation of the risk and harm reduction strategy against unsafe abortion in Uruguay: From a university hospital to the entire country

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**Abstract**

The history of the creation of the risk and harm reduction model applied to unsafe abortion is reviewed, from its initial implementation by a small group of gynecologists at the Pereira Rossell Hospital Center in Uruguay to its spread to the rest of the country. Its ethical rationale, its successful application in the hospital, the decision to disseminate it with the cooperation of the International Federation of Gynecology and Obstetrics (FIGO), and the intervention procedures are explained. It was evaluated from the epidemiological and anthropological viewpoints, from the changes in professionals’ and users’ perception of the care offered and its impact on complications and maternal deaths. A very favorable change was seen in the number and quality of the services, the providers’ attitude, and maternal morbidity and mortality were reduced. It also brought visibility to women with unplanned and unwanted pregnancies and an improved understanding of their problems, which contributed to the legislative changes that were made subsequently.

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1. Introduction

In Uruguay, abortion had been criminalized since 1938 [1]. The law that criminalized abortion also included exculpatory situations, such as the risk to the woman’s health and life, pregnancy caused by rape, financial distress, and personal honor. It was very rare, however, that a woman who met any of these exculpatory conditions was able to terminate her pregnancy in a medical institution.

In this context, low-income women who had an unwanted pregnancy were excluded, marginalized, and abused by the society and the health system. By the early 2000s, this situation had become even more dramatic, owing to the socioeconomic crisis that was severely affecting broad sectors of society. There were no safe places to find information, reflect, and settle doubts before making a responsible, conscious decision. There was still a lot of ignorance about the options and health consequences of a variety of unsafe methods for terminating a pregnancy, from taking toxic substances to inserting plant stalks in the cervix.

As regards the medical relationship, the health professionals faced with this situation applied individual criteria, displaying paternalistic, disciplinary, or condemnatory attitudes toward the women, replicating the deep gender and socioeconomic inequities present in Uruguayan society. Reporting abortion cases in spheres where this was inappropriate violated professional and institutional confidentiality, showing disregard for women’s rights and professionals’ obligations as guarantors of confidentiality. The women’s fear of rejection by the system, the health professional’s disdain, and legal penalties led them to conceal their decision and delay seeking health care, thus remaining outside of the health system [2–4].

All of this helps to explain why, during the five-year period from 1995–1999, unsafe abortion was the leading cause of maternal mortality in Uruguay, accounting for 28% of total maternal deaths. In the five-year period from 1996–2001, at the Pereira Rossell Hospital Center (CHR)—a national reference center for women’s health care in Uruguay—unsafe abortion was the cause of 47% of maternal deaths, with a 2.4-fold higher maternal mortality risk in this hospital compared with the rest of the country [3]. This difference was basically due to the economic and social vulnerability of the population treated at the CHR. While other sectors of the population could undergo safe abortions in clandestine clinics, poorer women continued to resort to high-risk methods. In such a scenario, unsafe abortion and maternal mortality emerge as public health, human rights, and social justice problems.

Classically, the issue was presented as a dichotomy between unsafe illegal abortion and safe legal abortion. This approach took all the transformation effort to the political sphere and sidelined the health teams and the medical system from the change process. Thus, effort was focused on broadening access to abortion to women complying with the legal conditions for terminating pregnancy, such as rape, danger for the mother’s life, etc. In practice, these causes account for a very small percentage and did not impact—and still do not impact—on the major part of the situations that lead to induced abortion in unsafe conditions and cause most of the maternal deaths [5,6].
2. The decision to be “part of the solution” at the CHPR

Until then, health teams’ attitudes and practices were non-committal, unethical, and undermined women’s rights, and, therefore, they were part of the problem. In this context, after the third maternal death caused by an unsafe abortion in 2001, a small group of physicians led by Dr Leonel Briozzo, decided to stop being part of the problem and become part of the solution [7], creating a space where women with an unwanted pregnancy could obtain information and thus make a conscious choice about how to deal with the problem and not take risks that could endanger their health and life.

This first group of health professionals developed and implemented a risk and harm reduction strategy with a view to including the care of women with unwanted pregnancies in the health system, even with the restrictive legal framework prevailing at the time. Such women were strong candidates for undergoing a high-risk abortion and the risk reduction strategy consisted of giving them public domain information that would enable them to make a well-informed decision and, if they should decide to go ahead with an abortion, it would at least be a “lower-risk abortion.”

A lower-risk abortion is defined where the user:

- has a counseling visit before reaching a gestational age of 12 weeks and decides to terminate the pregnancy, understanding the information that has been provided to her;
- has access to misoprostol and uses it in accordance with internationally recognized scientific evidence;
- has an uncomplicated complete or incomplete abortion;
- has no immediate complications (within the first month) from the biopsychosocial viewpoint;
- uses a safe, effective contraceptive method that is suitable for her situation and which she herself has chosen.

The theoretical framework for the proposal is based on one of the recommendations of the 1994 International Conference on Population and Development, held in Cairo, which said that “Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling” [8].

This strategy today is known as the “Uruguayan unsafe abortion risk and harm reduction model” (from now on referred to as MODEL). It proposes a change in the medical relationship, which should be grounded on bioethical principles and professional values, upholding confidentiality and medical secrecy from a gender-based perspective. This group decided to give this program the name “Health Initiatives against Abortion in Risky Conditions” (Iniciativas Sanitarias).

In 2002, other members of the interdisciplinary team joined the group (midwives, psychologists, and nurses). Aware that women who were seeking information and care were being left out of the system, they contributed their knowledge from their respective disciplines to provide a complete counseling session, thereby improving the risk reduction process.

At these “counseling visits,” the woman was welcomed, she was given the time she needed to express her problems and the corresponding diagnostic tests were performed, guaranteeing an atmosphere of trust and privacy. She was advised of the options available for an unwanted pregnancy within a restrictive framework: go ahead with the pregnancy and give the baby for adoption; go ahead with the pregnancy after having determined that the causes she has given were not sufficient (from her viewpoint) for terminating the pregnancy; or go ahead with the termination.

After making a decision, at a second visit, she received thorough counseling on the risks she should avoid and how the procedure was carried out in countries where abortion was legal. Women were given an appointment for a third visit for the postabortion evaluation and this occasion was used to provide postevent contraceptive protection. From the beginning and until now, women followed two routes to the service: by direct word-of-mouth recommendation of this service by women who attended the first visits, or by referral from primary care. The referral by health teams happened because Iniciativas Sanitarias deliberately disseminated the information about this service in a planned manner through academic and professional opinion leaders. The MODEL was disseminated in the longer term, through the status of the CHPR as a teaching center, where successive generations of physicians and specialists received training and then adopted the MODEL.

By 2004, there was already a clear decrease in the number of emergency visits to the hospital for abortion complications and in the number of maternal deaths for this reason. This led the Ministry of Health to give to the MODEL official status by Ministerial Decree, Regulation 369, in which the State acknowledges that unsafe abortion is a public health problem and women are entitled to be advised of the risks in the event of an unwanted pregnancy [9]. The Decree facilitated dissemination of the counseling service for women with an unwanted pregnancy.

3. Taking the risk and harm reduction model to the entire country

In 2006, when it was seen that abortion-related maternal mortality had dropped considerably at the CHPR with application of this MODEL, the initial interdisciplinary program was formalized and the Asociación Civil Iniciativas Sanitarias was formed.

At that time, it was already known that, thanks to the CHPR’s leadership in reproductive health practice in the country, the MODEL was being gradually replicated in other settings in Uruguay, but it was a very slow process. It was felt necessary to offer these services to all Uruguayan women, extending the same strategy to the rest of the country. With this goal, the project carried out “Health Initiatives—Protect Uruguayan Women’s Lives and Health by Reducing Unsafe Abortion” was developed to be implemented in the period 2006–2010. The project was sponsored by the International Federation of Gynecology and Obstetrics (FIGO), through the Uruguayan Society of Gynecology, within the context of the FIGO’s worldwide initiative “Saving Mothers and Newborns.”

The project’s goal was to reduce unsafe abortion and the maternal morbidity and mortality associated with this type of abortion, fostering inclusion of women with an unwanted pregnancy in the health system, in the context of a medical relationship that creates favorable conditions for empowering women and communities in the care of their health. As a secondary outcome, it was expected to decrease unwanted pregnancies and the need for women to resort to voluntary abortion.

The hypothesis was that nationwide deployment of the model would not only reduce the morbidity and mortality caused by unsafe abortions but would also lead to changes in the societal perception of abortion as a health and human rights issue.

The project was supported by a strong alliance with the Uruguayan Medical Union (SMU) and the School of Medicine, and was co-managed with the Uruguayan Midwives Association (which represents professional midwives in Uruguay).

The initial ambition to encompass the entire country was limited by practical reasons. Consequently, the project proposed evaluating the impact of implementing the MODEL in eight health centers in four departments which had almost two-thirds (62%) of the Uruguayan female population.

The centers were selected on the basis of the prevalence of unsafe abortions, local conditions that favored the development of counseling services, presence of sympathetic local coordinators, and the possibility of performing social and epidemiological monitoring activities in a specific geographical area.

The intervention consisted of:

1. Generating awareness/training of the medical professionals and administrative personnel working in the centers addressed...
Changing the provider/user relationship, with workshops aimed at building commitment among all of the centers’ personnel.

2. Courses targeting the professionals who are directly responsible for attending to women with an unwanted pregnancy, based on the constructivist learning model as a generator of “cognitive conflict.” When the subject’s preconceptions are not sufficient to account for or solve new situations or problems, a conflict is created between old knowledge and new needs, which causes the individual to start a new learning process. Priority was given to interdisciplinary teamwork.

3. Informative-educational actions targeting direct users, and also the community, while disseminating the risk and harm reduction strategy in academic and political spheres.

4. Implementation of sexual and reproductive health services monitored by a training supervisor [10], which provides follow-up for practical implementation of the services and gives added empowerment to the local coordinators. A quality monitoring tool was adapted and applied [11].

The project was evaluated by independent institutions from an epidemiological and socioanthropological viewpoint.

Mortality was evaluated by means of a systematic review of all deaths of women of reproductive age in the entire country and a medical record audit that sought to identify the causes. Severe morbidity was evaluated by reviewing admissions to the intensive care units (ICUs) in all the medical institutions in the participating departments and their referral centers, identifying cases of morbidity due to unsafe abortion and auditing medical records, and recording all uterine evacuations performed in these institutions.

All the visits for unwanted pregnancy and postabortion follow-up in the services implemented were also recorded and analyzed. Given that a large number of women did not return for follow-up after the counseling visit, a convenient sample of these women was interviewed by telephone, to determine which decision they had taken. The sample comprised all women who had received counseling at the CHPR during one month who did not return within 30 days.

The socioanthropological monitoring was performed by the Institute of Higher Studies (Instituto de Altos Estudios, IAE), coordinated by a sociologist and an anthropologist. They performed a qualitative analysis of discourses and practices with respect to sexual and reproductive health and abortion, in three groups: users, medical personnel, and administrative personnel. The pre/post intervention evaluation was carried out in 2007 and repeated in 2009, in six intervention centers and three comparable control centers.

Confidentiality of the data was guaranteed during collection, systematization, and analysis, and participation was agreed with all agents.

4. Results of implementation of the project

Within the context of the project, 1240 professionals were trained in applying the MODEL and the socioanthropological evaluation showed an increase from 50% of the medical and technical personnel who knew and applied the model in 2007 to 80% in 2009. At the same time, in 2009 the professionals were more likely to create favorable conditions to help the women decide independently whether or not to terminate their pregnancy than in 2007.

All the centers selected implemented the MODEL and developed the sexual and reproductive health (SRH) care process to provide comprehensive services in existing healthcare facilities and within a broader spectrum of SRH services that included contraception counseling, detection of sexually transmitted infections, prenatal education, and detection and guidance for women exposed to domestic violence, among others.

As regards the quality of the services, the monitoring tool showed a positive impact in institutional aspects such as infrastructure, privacy, confidentiality, human resources, application of standards and protocols, and access to services.

The users’ care has been provided by cross-functional multidisciplinary teams. The joint visits and work meetings generate self-criticism, experience, and confidence, and build truly interdisciplinary professional teams.

During the period May 2007 to July 2009, 2717 users were seen for an unintended/unaccepted pregnancy. The users’ average age was 28 years. Sixty percent had used contraceptive methods that failed.

More than two-thirds of the users were seen with a gestational age of 9 weeks or less and in over 20% the gestational age was between 10 and 12 weeks. Just over 10% were at more than 12 weeks at the time of the first visit (Table 1).

A total of 729 (26.8%) users were seen for a postabortion check. Of the 1988 women who did not return for the postabortion visit, 94 were contacted by telephone (Table 2).

Excluding the 13 women who did not give any information, 62% had terminated the pregnancy which, when added to the 2% who had decided to terminate the pregnancy but had not yet done it, gave 64%. Evaluation of this sample shows that 11% of the women who were lost to follow-up were either not pregnant or had had a spontaneous abortion and that 25% continued with their pregnancy (Table 2).

Considering that about 75% of the women counseled in a first visit do not return, it can be estimated that close to 20% (25% of 75%), or one in every five women attending the counseling, took the informed decision of continuing with their pregnancies. All of the women interviewed who continued with their pregnancy were attending prenatal care.

Over the course of the project, the percentage of women who returned for the postabortion visit remained at about 27% of the women who attended the first visit. This would be equivalent to about 40% of those who ended up aborting, if the general population of these women behaves like the study sample.

Of the 729 users who returned for the postabortion visit, 672 (92.2%) used self-administered misoprostol. Of these, 93.7% suffered no complications and the others (6.3%) only had bleeding or infectious complications that were classified as mild that did not require hospital admission (data not shown in the tables).

Family planning counseling was given to 77.6% of the cases and 97.3% of these users started to use a modern contraceptive method (75.5% of those who had this visit).

The socioeconomic monitoring showed that after the intervention, users acknowledged a greater respect for their confidentiality, their fear of being reported diminished, as did the lack of information and the feeling of a lack of support by the health team. This boosted the women’s feelings of empowerment and lessened the social stigma.

Almost all (95%) of the users felt respected during the visit, none felt judged and 5% gave other answers (understood, listened to). Eighty-five percent of the users reported that they had received the support and attention they needed during their care at the hospital/health center. The remaining 15% reported that they had not received the attention they expected. In most of these cases, the unmet expectation was because they were not given the medication used to abort (misoprostol).

Observation of the interaction between users and professionals showed that the care is ethical and proficient in the conceptual and attitudinal aspects.

With reference to epidemiological, social, and legal changes, a marked, sustained decrease was observed in maternal mortality in general and in unsafe abortion-related maternal mortality in particular.

Table 1

<table>
<thead>
<tr>
<th>Gestational age, wk</th>
<th>No.</th>
<th>(%)</th>
</tr>
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<tbody>
<tr>
<td>&lt;10</td>
<td>1777</td>
<td>(68.7)</td>
</tr>
<tr>
<td>10–12</td>
<td>541</td>
<td>(20.9)</td>
</tr>
<tr>
<td>13–20</td>
<td>247</td>
<td>(9.5)</td>
</tr>
<tr>
<td>&gt;20</td>
<td>22</td>
<td>(0.9)</td>
</tr>
<tr>
<td>Total</td>
<td>2587</td>
<td>(100)</td>
</tr>
</tbody>
</table>

*Information about gestational age is missing in 130 cases.*
The health system. In other words, the MODEL does not foster abortion, of a decision-making process during which women were empowered by more, the fact that close to 20% of the users seen for an unwanted start using a modern contraceptive method after the abortion. Further-
of the MODEL show that women seek professional help at an early lives was shown to be unjusti
ned. The inequities that are traditionally present in the health system. The inequities that are traditionally present in
country, although some differences were maintained. The reduction in maternal mortality is described in detail in another article included in this Supplement [12].

The differences between the intervention area and the rest of the country were not great because the CHPR is the reference center for human resources training in gynecology and obstetrics, so it has the potential of permeating its practices to the rest of the country. Accordingly, even though the intervention was initially circumscribed to eight public centers in the area in which the FIGO project was developed, women could access counseling at the CHPR from anywhere in the country, which in turn is made easier by the country’s small size. It was even found that about 25% of the users came from the private sector but were seen in public services because this service was not provided in their private health institutions.

Lastly, this program also had a legal, social, and public policy impact. After 2008, the Iniciativas Sanitarias MODEL was included in Law 18 426 concerning “Protection of the Right to Sexual and Reproductive Health.” This law acknowledges and guarantees the right of women with an unwanted pregnancy, as citizens, to be treated with dignity, confidentially, and ethically within the health system.

There has been a strong social impact on the public discourse on unsafe abortion, relating it to health care. This creates empowerment to talk about the subject, overcoming social and cultural barriers such as fear and stigma. There has been a significant change in the public discourse about abortion and broad-based social and legislative majorities have been formed in favor of changing the law.

In the light of the results achieved, in 2012 the Pan American Health Organization distinguished the MODEL with the Best Practices Award for reducing maternal mortality, with a gender, race, and health-centered perspective [13].

5. Discussion

The key to the success of Iniciativas Sanitarias was that it showed that it was possible to transform the health professional/user relationship, enabling the inclusion of women with an unwanted pregnancy in the health system. The inequities that are traditionally present in this relationship (class, knowledge, gender, among others) can be reversed, creating spaces for reflection in which health professionals dignify their vocation and commitment allowing users to take ownership of their rights.

The skepticism as to whether women from lower social classes would be able to make conscious decisions about their health and lives was shown to be unjustified. The results of the implementation of the MODEL show that women seek professional help at an early stage, inform themselves, use misoprostol safely and many of them start using a modern contraceptive method after the abortion. Furthermore, the fact that close to 20% of the users seen for an unwanted pregnancy decided to continue with their pregnancy proves the existence of a decision-making process during which women were empowered by the health system. In other words, the MODEL does not foster abortion, but helps women make a well-informed conscious decision.

Table 2

<table>
<thead>
<tr>
<th>No. (%)</th>
<th>% valid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination done</td>
<td>50 (53.2)</td>
</tr>
<tr>
<td>Termination decided on but not done yet done</td>
<td>2 (2.1)</td>
</tr>
<tr>
<td>Continuation of pregnancy</td>
<td>20 (21.3)</td>
</tr>
<tr>
<td>Spontaneous abortion</td>
<td>4 (4.3)</td>
</tr>
<tr>
<td>The user was not pregnant</td>
<td>5 (5.3)</td>
</tr>
<tr>
<td>Total</td>
<td>81 (86.2)</td>
</tr>
<tr>
<td>Unknown resolution</td>
<td>13 (13.8)</td>
</tr>
<tr>
<td>Total</td>
<td>94 (100)</td>
</tr>
</tbody>
</table>

This experience suggests that converting a high-risk abortion into a “lower-risk abortion” is feasible even in restrictive legal contexts and that the MODEL is adaptable and reproducible in countries with restrictive legislation on abortion. It is able to give an immediate, effective, and tested response to women who find themselves in the difficult situation of an unwanted pregnancy. The development and application of the MODEL generates conditions for transforming public policies.

The commitment shown in applying the model by traditionally male-dominated and socially respected professionals and institutions, repositioning themselves in favor of women’s sexual and reproductive rights, and who consciously accepted the challenge of changing their practices, is one of the keys to the strategy’s success [14].

We believe that this experience has contributed significantly to the change in the public discourse with respect to unsafe abortion. The vis-

ibility of unwanted pregnancy as a health problem has clearly facilitated its inclusion in the new legislation, by giving visibility to women with an unintended/unaccepted pregnancy as citizens with rights that the State must uphold.

This requires an ethical–legal framework that guarantees confidentiality in the doctor–patient, health team–user relationship and has the active support of the leading professional institutions in this field.

We hope that recounting this experience of creating, applying, and disseminating the risk and harm reduction strategy encourages colleagues in other countries to also accept the challenge to cease being part of the problem and become part of the solution. The example of the Province of Buenos Ares in Argentina, described in another article in this Supplement indicates that the replication of the MODEL in other countries is feasible [15].

Replication of the MODEL requires that professionals and health teams review their paternalism, and acknowledge their professional undertaking and their obligation to guarantee medical secrecy and confidentiality. The satisfaction of seeing how the complications of unsafe abortion and maternal deaths disappear is the type of reward that all health professionals pursue from the time they decide to devote themselves to this profession.

Conflict of interest

The authors have no conflict of interest.

References


