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From risk and harm reduction to decriminalizing abortion: The Uruguayan model for women's rights

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ABSTRACT

Objective: To describe public policies, social actions, particularly those of obstetricians/gynecologists, and changes in abortion-related legislation in the different historical periods between 1990 and 2015, and to analyze temporal correlations with a reduction in maternal mortality. *Methods:* The 1990–2015 period was divided into three different stages to permit evaluation of the legislation, health regulations, healthcare system, and professional practices related to the care provided in cases of unsafe abortion: 1990–2001, characterized by illegality and the healthcare system's denial of abortion; 2001–2012, when the model for reducing the risk and harm of unsafe abortions was developed; and 2012–2015, when abortion was finally decriminalized. *Results:* Changes in public policies and expansion of the risk reduction model coincided with changes in the social perception of abortion and a decrease in maternal mortality and abortion rates, probably due to a set of public policies that led to the decriminalization of abortion in 2012. *Conclusion:* Changes in public policies and health actions such as the model for reducing the risk and harm of unsafe abortions coincided with a marked reduction in abortion-related maternal mortality. The challenges still to be faced include managing second trimester abortions, ensuring the creation of multidisciplinary teams, and offering postabortion contraception.

1. Introduction

Historically, maternal mortality rates in Uruguay have been low to moderate. According to a report issued by the Pan American Health Organization and theWorld Health Organization, maternal mortality rates in the 1990s were considered low in Canada and the USA and moderate (20–40 per 100 000 live-born infants) in the Bahamas, Costa Rica, Cuba, Uruguay, and Chile, in that order [1]. In other words, Uruguay started from a privileged position within the region; however, unlike the other countries with similar maternal mortality rates, mortality from unsafe abortion was one of the principal causes of maternal mortality in the country.

On a global level, maternal mortality is greater where the rate of unsafe abortion is higher and where legal restrictions to voluntary termination of pregnancy are greater [2]. Latin America and the Caribbean is the region with the highest rate of unsafe abortion worldwide [2], although abortion-related mortality is lower here than in Sub-Saharan Africa [3]. This occurs within a context of strong social stigma that opposes women's rights, particularly the right to voluntarily terminate a pregnancy, with a strong influence from the Roman Catholic Church and the emergence of an increasingly powerful Protestant Church.

Conservatism regarding sexual and reproductive rights is apparent in all the social and political sectors of the region; hence, it is common to find governments labeled as "progressive," corresponding to the center-left, in absolute opposition to pro rights and the life of the woman and so-called "liberal" or "conservative" governments supporting these rights, at least partially.

The pro-choice versus pro-life debate has monopolized the agenda and despite significant intentions to construct proactive models of dialogue [4], advances have been limited and setbacks in the agenda of rights have been the common denominator. Today there are situations as dramatic as women dying from ectopic pregnancies because they were denied treatment until proof that the embryo was dead, to the imprisonment of women suffering spontaneous abortion because they were unable to prove that they had not induced an abortion (how could they prove it?).

Within a context of high prevalence rates of unsafe abortion and high associated morbidity and mortality rates in an unfavorable legal and social setting, Uruguay chose a different pathway via which to defend women's rights by confronting unsafe abortion and finally decriminalizing abortion. The focus was on the model of risk reduction developed following the health initiatives against unsafe abortion originally drawn up in 2001 [5]. This model obtained the commitment of many health professionals based on confidentiality and professional engagement, thus changing the historical correlation of strengths by placing the health professionals as the social agents of change.

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Application of the model for reducing the risk and harm of unsafe abortions allowed the healthcare teams to take a stance in favor of women's rights, even within an extremely restrictive abortion framework such as that of Uruguay at the end of the last century. The experience showed that implementation of this model led to a dramatic reduction in abortion-related maternal mortality within a setting of public policies in favor of justice and equality [6].

Consolidation of the model for reducing the risk and harm of unsafe abortions contributed to the advancement of sexual and reproductive rights, particularly regarding the prevention of unsafe abortion. This progress was achieved through the actions of three sociopolitical sectors committed to this effort:

- The women's social movement and feminist movement has focused on pro-rights, ensuring the maintenance of this momentum for more than 30 years.
- The political sector, led by the forces of the left and center-left, has also joined in the effort. Former President José Mujica played a decisive role by approving a law decriminalizing abortion in 2012.
- Important and influential sectors of the medical and professional establishment have come together to expand this issue based on the right to health care, creating and implementing the model for reducing the risk and harm of unsafe abortions.

The present paper provides a systematic analysis of the different historical periods from 1990 to 2015 in relation to the changes that have occurred regarding the human issue of unsafe abortion and its association with the reduction in maternal mortality and the prevalence of abortion in Uruguay.

2. Historical changes in public policies and social actions regarding abortion

For the purpose of this analysis, three separate periods have been defined with respect to the public policies implemented to combat maternal death due to unsafe abortion.

The prevalence and severity of unsafe abortion as a cause of maternal morbidity and mortality depends basically on three elements: the legal and health-related aspects of unintended/unwanted pregnancy, women's access to contraception, and the education policies developed by the government [7]. Based on those concepts, the 1990–2015 period was divided into three stages to permit an appropriate analysis of the legislation and health regulations, the functioning of the healthcare and education systems, and professional practices regarding the care provided in cases of unsafe abortion. These three historical stages are as follows:

(1) 1990–2001, the period preceding implementation of the model for reducing the risk and harm of unsafe abortions;
(2) 2001–2012, the period during which the risk reduction model was gradually implemented, and;
(3) From the end of 2012, when legislation decriminalizing abortion was implemented nationwide, until the end of 2015.

The principal characteristics of each one of these stages are as follows:

1990–2001

During this period, abortion was illegal. The relevant legislation in force at that time was law 9763 dating back to 1938, which cites three grounds for exemption, none of which were being complied with [8] (when the husband's honor was at stake, when there was risk to the woman's life, and extreme poverty). The response of the healthcare system at that time was to close its doors to women confronted with an unintended/unwanted pregnancy. The unethical behavior of denouncing women seeking help for an incomplete abortion was common and prevented such women from seeking help. Either they were obliged to die alone or, if they finally sought help at healthcare services, it was at very late stages for very severe complications [9]. During that time, contraceptive methods were not universally available. In addition, education policies did not systematically include subjects related to sexual and reproductive health and rights.

2001–2012

This period is marked by the development and progressive implementation of the model for reducing the risk and harm of unsafe abortions, denominated "Health initiatives against unsafe abortions" (ISCAPCR) [10,11]. The model was successfully put into practice with the support of the International Federation of Gynecology and Obstetrics (FIGO) as well as other national and international partners [12]. The success of its implementation, evaluated according to its impact on the reduction in maternal mortality rates and in promoting reproductive rights and gender equality, was recognized by PAHO–WHO, together with three other initiatives from the region, in an award given in commemoration of International Women's Day [13].

The "low-risk abortion" model was developed with the full and committed collaboration of the healthcare professionals, thus altering the relationship between the healthcare worker and the user of the service [11,14]. This change in professional behavior was based on ethical and professional commitment (medical professionalism) [6], the basis and foundation of the Conscientious Commitment to Women's Health [15] that later led to implementation of the law decriminalizing abortion in 2012.

2012–2015

This period is characterized by the implementation of the law decriminalizing abortion established in October 2012. This extremely complex legislation was the result of intense political negotiation at parliamentary level. Its principal characteristics are as follows:

- Voluntary termination of pregnancy (VTP) is a non-punishable offense under the following conditions: if the woman is a Uruguayan citizen and gestational age is no more than 12 full weeks or 14 full weeks in cases of rape.
- The institutions belonging to the Uruguayan National Health Service (SNIS) are responsible for implementing pregnancy termination services. Private, for-profit practice is not permitted in cases of VTP.
- A multidisciplinary consultancy team was established to analyze the patient, the situation and the perspectives, including monitoring the entire VTP process.
- An obligatory reflection time of five days was established between consultation with the healthcare team and the pregnancy termination.
- The clinical guide for implementation of the legislation established that the first option in all cases (other than exceptional cases) should be the use of medication, i.e. the mifepristone–misoprostol kit should be used.
- The law recognizes the right to conscientious objection—although the concept is unclear—and introduced the concept of ideological objection to abortion by institutions linked in their statutes to the Roman Catholic and other religions.

The aim of this legislation was three-fold: to reduce maternal mortality, to reduce abortion-related complications, and to reduce the practice of abortion [16].

Table 1 lists the principal characteristics of the three time periods.

3. The situation of unsafe abortion and maternal mortality in each period

A dramatic reduction in maternal mortality has occurred in Uruguay over the past 25 years. According to PAHO–WHO, the country now has the second lowest maternal mortality ratio in the region (14 per 100 000 live births), after Canada (11 per 100 000). A detailed discussion of the rapid decline in maternal mortality is the subject of another article in this Supplement [17].