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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.

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 (CHPR)—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 CHPR. 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].

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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 called "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