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Changing relationships in the health care
context: the Uruguayan model for reducing
the risk and harm of unsafe abortions

best practices
in gender, ethnicity and health



**Pan American
Health
Organization**

Regional Office of the
World Health Organization



Changing relationships in the health care context: the Uruguayan model for reducing the risk and harm of unsafe abortions

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Introduction

As part of Women's International Day celebrations, the Office of Gender, Diversity and Human Rights and the Safe Motherhood Initiative of PAHO organized the V Best Practices Contest that incorporates the perspective of gender equality in health. The contest aims to identify the experiences that best address the different needs and opportunities for men and women to enjoy optimal health. Ninety-three initiatives from 19 countries in Latin America and the Caribbean took part in the contest.

"Changing relationships in the health care context: the Uruguayan model for reducing the risk and harm of unsafe abortions," by Iniciativas Sanitarias, a non-profit organization from Uruguay, won for designing a model for reducing the risk and harm of illegal and dangerous abortions, which has been empirically applied in eight health centers, covering 62% of Uruguayan women. The model has been carefully evaluated and is considered acceptable in countries where abortion is illegal.

The Office of Gender, Diversity and Human Rights is proud to present this publication containing lessons that may be replicated and adapted to other contexts.

Isabel Noguera, MD
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Summary

Since 2001, Iniciativas Sanitarias has implemented and monitored a risk and harm reduction model for unsafe abortions. The strategy consists of an articulated intervention in three components of the health context—health professionals and teams, users of the health system and institutions that provide health services—with the purpose of implementing sustainable sexual and reproductive health services. It seeks to include, with the involvement of men, wide and comprehensive sexual and reproductive health care for women facing unwanted pregnancies.

The Uruguayan reality in terms of its health system, community and institutions result in it being a favorable scenario to be used as a “social lab” in which the strategy may be evaluated and monitored from an epidemiological and social perspective. This systematic evaluation has resulted in what we currently know as “the Uruguayan model for reducing the risk and harm of unsafe abortions.” The model has proven to be effective in reducing maternal mortality and contributed to Uruguay’s meeting the fifth objective of the Millennium Development Goals, effecting social, legal and political changes that ensure its sustainability.

We believe that this model can be replicated and adapted to other countries where there are legal limitations for abortion, and it provides an immediate solution for women facing the harsh reality of an unwanted pregnancy. To that end, the model requires an ethical-legal framework that ensures confidentiality in the doctor-patient relationship as well as the commitment of the relevant professional institutions.

Why did we do it?

In Uruguay, abortion is illegal and has been punishable by law since 1938. There are exemptions; that is to say, situations under which the judge may choose not to penalize a woman who has an abortion or a physician who performs the procedure. These include: risk to the women's health and life, the pregnancy is a result of rape, women who live in extreme poverty and personal honor. However, users under these exemptions seldom turned to the institutional interruption of pregnancy.

Within this context, and in spite of Uruguay having signed multiple international human rights conventions that guarantee the rights of women, those facing unwanted pregnancies were excluded, marginalized and harassed by the community and the health system. In the early 2000s, this situation became more dramatic, given the socioeconomic crisis, and there was no safe place to seek information, reflect on and clarify doubts in order to make a responsible decision. Instead, people ignored the options available and the consequences of such unsafe methods for the interruption of pregnancies as taking drugs or placing vegetable stems in the cervix.

As to relationships in the health care context, when health professionals faced this situation they adopted personal, patronizing, punitive or censorious stances towards women, reinforcing the gender inequalities in Uruguayan society.

Reporting abortions that were not covered by the legal exemptions constituted a violation of professional secrecy, which demonstrated the lack of information about their rights and obligations. Women lived in constant fear of being rejected by the system, of being scorned by health professionals and of being punished by law. As a result, they would hide their decision to abort or avoid any contact with the health system—or, when they did so, it was too late. This situation violated women's right to access health care.

From 1995 to 1999, unsafe abortions were the primary cause of maternal mortality, representing 28% of deaths.¹ From 1996 to 2001, they accounted for 47% of maternal deaths at the Pereira Rossell Hospital Center (CHPR)², the national hospital for all aspects of women's health, where maternal mortality risk was 2.4 times higher than in the other hospitals in the country. This difference was primarily due to the social and economic vulnerability of the population

attended to at the CHPR. While other sectors of the population could seek abortions in clandestine clinics, the poorest women continued to use unsafe methods, like the ones mentioned above. Within this context, we declared that unsafe abortion and maternal mortality were public health, human rights and social justice issues.

At the international level, health organizations had been addressing this problem for many years. They had put forth the classic dichotomy of illegal unsafe abortions and legal safe ones. This de facto situation displaced all attempts to effect change in the political arena and left health care teams and support systems on the margins. Thus, the strategy to interrupt pregnancies focused on arguing the medical indications that make it possible, such as sexual assault or when the life of the mother is at risk. However, in practice these causes were very few and they had little impact on most of the risk situations that lead to the majority of maternal deaths.

The theoretical framework of our model is based on one of the recommendations from the International Conference on Population and Development, held in Cairo in 1994, which reads: "Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling."³

The model is based on the following five conceptual pillars:

1. Harm and risk reduction policies that have already been successfully applied to other complex social problems, such as unwanted pregnancies.
2. The need to defend and promote human rights.
3. Actions by health professionals that are based on the values of "medical professionalism."
4. Professional work based on bioethics.
5. Legal basis for the proposal.

From this perspective, a new category emerges—"safer abortions"—as a viable objective within the framework of the illegality of abortion. The model for intervention is based on changes to the doctor-patient relationships through action. That is to say, before the potential abortion takes place, counseling is provided and, once it has been done, comprehensive postabortion care is given.

Services Administration CHPR-ASSE.

3. International Conference on Population and Development, Chapter VII, paragraph C, 8.25.

1. Source: Ministry of Public Health of Uruguay, Department of Statistics, Mortality System; classification of deaths by cause, sex and age of the deceased in the country (except infant deaths). Uruguay 2001.

2. Pereira Rossell Hospital Center (CHPR), national referral center in women's health, where 1 out of 5 Uruguay Integrated Health System in 2008, CHPR now reports to the National Health

“Safer abortions” are those in which the woman:

- Attends a counseling consultation before 12 weeks of gestational age and decides to interrupt her pregnancy in accordance with the information that she has received.
- Has access to misoprostol and uses it as indicated and in accordance with internationally recognized scientific standards.
- Has a complete or incomplete abortion without complications.
- Shows no immediate complications (within the first month) from the bio-psycho and social points of view.
- Uses a safe and quality contraceptive method that is appropriate to her reality and that was chosen by her.

Within this context, in 2001 a group of health professionals, who would found Iniciativas Sanitarias in 2006, designed and implemented a strategy that sought to include care for women facing unwanted pregnancies in the health system, in spite of there being a restrictive legal framework.

What were we looking for?

The purpose of our work is to protect the life and health of women with unwanted pregnancies, reduce the risks and harms associated with unsafe abortions, prevent unsafe abortions and diminish maternal mortality through adoption of gender and human rights in health perspectives.

Our general objective is to include women facing unwanted pregnancies in the health care system. It is also to create a health care relationship that guarantees women’s empowerment and that of communities in taking care of their health.

Our specific objectives are:

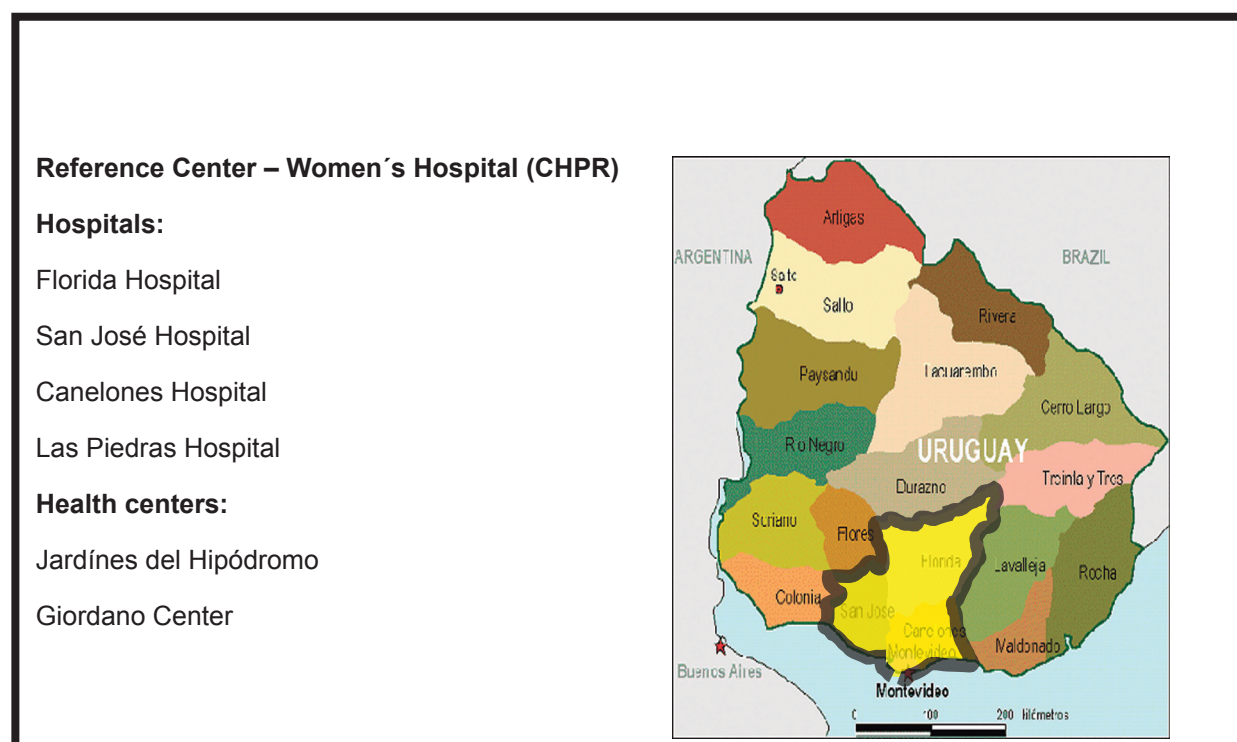
- To reduce maternal morbi-mortality associated with unsafe abortions
- To reduce the number of unsafe abortions
- To reduce the number of unwanted pregnancies
- To reduce the need for women to turn to voluntary abortions

The intervention we are presenting was carried out from 2006 to 2010, within the framework of the project called “Iniciativas Sanitarias: protecting the life and health of Uruguayan women by reducing unsafe abortions.” The project was sponsored by the International Federation of Gynecology and Obstetrics as part of a FIGO global initiative known as “Saving Mothers and Newborns.”

The project sought to evaluate the impact of the implementation of the Model in eight health care centers located in four departments where 62% of the Uruguayan women live. The centers were chosen based on the prevalence of the problem in specific places; local conditions that enabled

the implementation of counseling services; the existence of trained local coordinators with local management and decision-making powers; the presence of members of Iniciativas Sanitarias; and the chance to conduct social and epidemiological monitoring in a specific geographical area (Figure 1).

Figure 1. Sexual and Reproductive Health Services Project FIGO / Iniciativas Sanitarias against Unsafe Abortion.



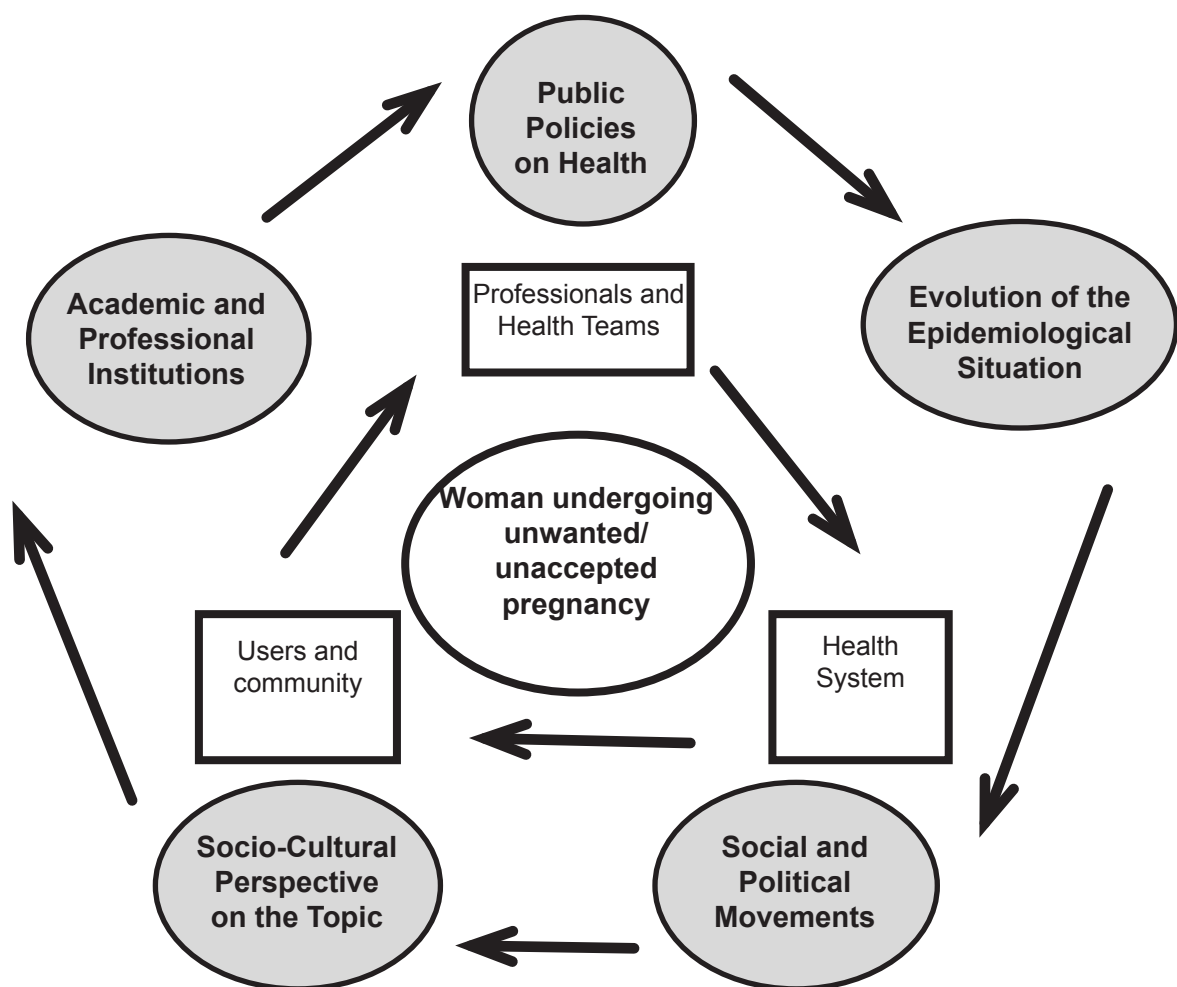
How did we do it?

Implementation process and design of the Model.

We used a conceptual diagram of concentric circles whose components interact constantly and dynamically in order to provide a comprehensive explanation of the process followed for the construction of the Model (Figure 2).

In the inner circle, we find the women facing unwanted pregnancies. The circle beyond that represents the health care relationship, which occurs within a social and health care system whose key actors in regard to abortion are found in the outer-most circle.

Figure 2. Changes in the health care relationship, components and actions.



The intervention is focused on prioritizing health care relationships (second circle) in order to have a positive influence on the specific situations of women facing unwanted pregnancies (first circle) and to effect change in the third circle and its components (Figure 2).

1. Including women with unwanted pregnancies in the health care system.

In the clinical practice, the Model provides for health care services for women facing unwanted pregnancies at two moments: professional counseling prior to the final decision and comprehensive postabortion health care, providing qualified and ethical information for each woman to make her decision about the continuation or interruption of the pregnancy in a free, responsible and safe way.

This way of working allows for progress to be made on the right to health care services as a human right that must be guaranteed, regardless of the illegality of abortion. At the same time, it promotes gender equality by facilitating women's access to the health care system, enabling their autonomy in making an informed decision. Likewise, the strategy includes men who accompany these women, creating spaces for dialogue and support for both.

2. Professionals and health teams.

A training strategy is applied to encourage the involvement of all professionals in the selected health care centers in order to alter the health care relationships by organizing workshops for all staff that directly assist the women with unwanted pregnancies.

The Model is based on the constructivist theory of learning to encourage "cognitive conflict." This means that, for whatever reason, when an individual's prior conceptions fail to explain or solve new situations or problems, there is conflict between old knowledge and new requirements. This results in individuals concentrating on a new learning process, since almost no meaningful learning occurs if there is no cognitive conflict.

This change in the professionals' attitude, especially medical professionals, allows them to question the hegemonic model (patronizing and masculine) that regarded inequalities as something natural.

3. Women and empowered communities.

The communications strategy includes information and educational actions to influence direct users and that are useful to the community as a whole. In other words, it seeks to have an impact on the community, civil society and on the professional, institutional and political actors. This relationship network requires moving from communication to action and to be part of the change process.

The educational actions that are implemented involve the preparation and dissemination of evidence for the

strategy in different spheres:

- **Community:** It aims to increase knowledge about the existence of sexual and reproductive health services and the exercise of those rights. Each health team designed the means of dissemination to be used in their community and in the appropriate language and modality. The "Community Resonance" strategy was applied for interaction between professionals and communities, which meant working face-to-face with the population in the field.
- **National dissemination:** Multiple channels were used: websites, resources guides, forums, mass media, press conferences, institutional newsletters,
- **Academic context:** Dissemination of the strategy and its results, encouraging collective reflection and seeking institutional commitment.
- **Political context:** Friendly audiences and sympathetic congressmen were identified, to whom data and results were presented and who were invited to learn about sexual and reproductive rights, looking for common ground and reaching agreements.

4. Implementation of sexual and reproductive health services.

The training supervision strategy is implemented with the purpose of strengthening the local coordinators and to provide follow-up to the practical implementation of sexual and reproductive rights. A quality monitoring tool is also designed and implemented to evaluate the perception of the women, the practices of the health teams and the logistical aspects of these services. Based on this evaluation, actions are planned for the continuous improvement of the quality of health care.

5. Monitoring and evaluation.

They were conducted by independent institutions that carried out epidemiological and socio-anthropological follow-up.

5.1 Epidemiological monitoring.

- It was run by the Montevideo Clinical and Epidemiological Research Unit (UNICEM), a group of clinical epidemiologists. It sought to measure several impact indicators such as maternal mortality and morbidity (before, during and after the intervention), apart from analyzing the data recorded in the forms used in the counseling and post-abortion consultations.
- Maternal mortality indicators were measured in the entire country; screening of all deaths of women of reproductive age was done in an effort to find out the cause of death through a review of the clinical history of the patient.
- Severe mortality indicators were measured: screening for ICU admissions in all health institutions of the participating departments and their primary centers was done, identifying cases of unsafe abortion-related morbidity and auditing medical histories. Hysterectomy screening and

curettages in those institutions were also carried out.

- All consultations for unwanted pregnancies and post-abortion visits at the services implemented were recorded and analyzed.

5.2 Social-anthropological monitoring.

It was conducted by the Institute of Higher Studies (IAE) and coordinated by a sociologist and an anthropologist.

Qualitative analysis of concepts, attitudes and practices in connection with sexual and reproductive health, and abortion in three groups: users, professional staff and administrative staff. Qualitative and quantitative methodology was used through self-administered questionnaires as well as in-depth group and individual interviews.

Application of tools in 2007 and 2009, pre- and postintervention studies (baseline/endline) comparing six centers that provide treatment and three comparable control centers.

Main topics for analysis: justifiability of abortion, use of misoprostol and response to the unwanted pregnancies situations by the health system. Confidentiality is guaranteed for data during the collection, systematization and analysis of the accepted participation of all actors. Data are brought together and analyzed by management and health teams of the selected centers, and by multidisciplinary teams of researchers from UNICEM and IAE. Results are shared with health and academic authorities, community organizations and professional collectives.

With whom did we do it?

We recognize an interdependent pairing in the learning process toward possible changes, which has already been in place for 10 years: health professionals and women facing unwanted pregnancies. The initiative and engine for this action stems from a multi-disciplinary team of health professionals from the Faculty of Medicine who work at the CHPR-ASSE (National Health Services Administration), who are committed to the reality around them and with the idea that social change can be achieved through management of health issues.

Without a doubt, women, particularly the most vulnerable ones and those who come from underprivileged circumstances, have been the motivating force for the team to take the initiative to operate through an innovative strategy that allows them no longer to be part of the problem, but part of the solution.

In establishing this process, we recognize the

valuable and essential contribution of people from different fields:

- Health professionals and administrative personnel at the health institutions as well as training sessions where the sexual and reproductive health services were implemented.
- Communities and their primary health centers with whom we engaged, allowing us to learn about communication and to identify other community needs and our own deficiencies.
- Non-governmental organizations and national institutions, (MySU, RUDA, Cotidiano Mujer), which contributed their expertise in different fields for the dissemination of the model in the community, working in collaboration with organized women's networks; "El Abrojo", an organization that developed strategies in the field of community resonance and monitoring of stigma levels; DODECA, an Uruguayan cinema school that worked in the preparation of audiovisual material; and UNICEM and IAE, the institutes that designed and carried out the epidemiological and socio-anthropological monitoring, respectively.
- The Ministry of Public Health (MSP), acting in its capacity of public policy authority, and the ASSE have been the places for the implementation of the Model. They have cooperated with qualified personnel who work at the selected centers, making possible their development and the ultimate adoption of the practice as a sustainable public health policy, first at the CHPR and, since 2004, through a regulation of the MSP (Regulation 369/04), at the ASSE primary care centers.
- It is worth pointing out the role of our alliances with the Uruguayan Obstetric Association, the Uruguayan Society of Gynecology (SGU), the Uruguayan Medical Association and the School of Medicine with the purpose of protecting our Model.
- We were also supported by international organizations and agencies: FIGO contributed to the promotion of the core project presented; UNFPA collaborated in the dissemination of the experiences; IPAS was involved in the dissemination and implementation of services and community work, the same as Medicus Mundis International and the WHO. The Safe Abortion Action Fund (SAAF) collaborated in the area of institutional strengthening; Latin American Consortium against Unsafe Abortion (CLACAI) and the International Planned Parenthood Federation – Western Hemisphere Region (IPPF/RHO) supported us in the expansion and regional adaptation of the Model in such countries as: Argentina, Bolivia, Brazil, Ecuador, Guatemala, Mexico, Nicaragua, Peru, Suriname, Venezuela.
- In 2008 Iniciativas Sanitarias received the National Medicine Award from the National Academy of Medicine for the Model and its impact on maternal health.

What did we achieve?

In order to show the achievements made, we present a retrospective analysis of quantitative variables to define morbimortality in the 2001-2010 period. The intervention covering 2006-2010 includes a prospective analysis of quantitative and qualitative variables by means of interviews with users, community and staff in the health institutions. We will analyze the three circles mentioned in Figure 2.

- **3rd Circle: epidemiological, social and legal changes.**

Epidemiological results: Significant and continuous reduction of maternal mortality in general, and maternal mortality associated with unsafe abortions in Uruguay and at Pereira Rossel Hospital Center (Figures 3 and 4).⁴

Figure 3. Evolution of maternal mortality for all causes in Uruguay and at the Pereira Rossel Hospital Center in the 2001-2010 period.

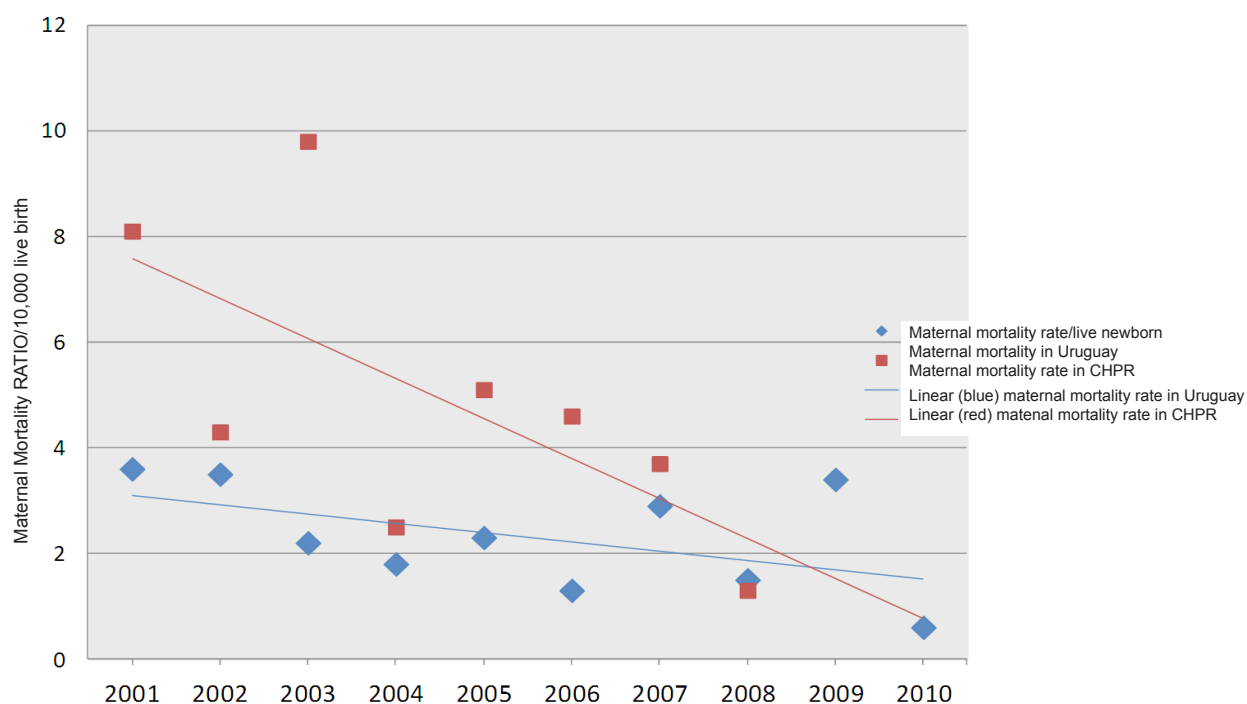
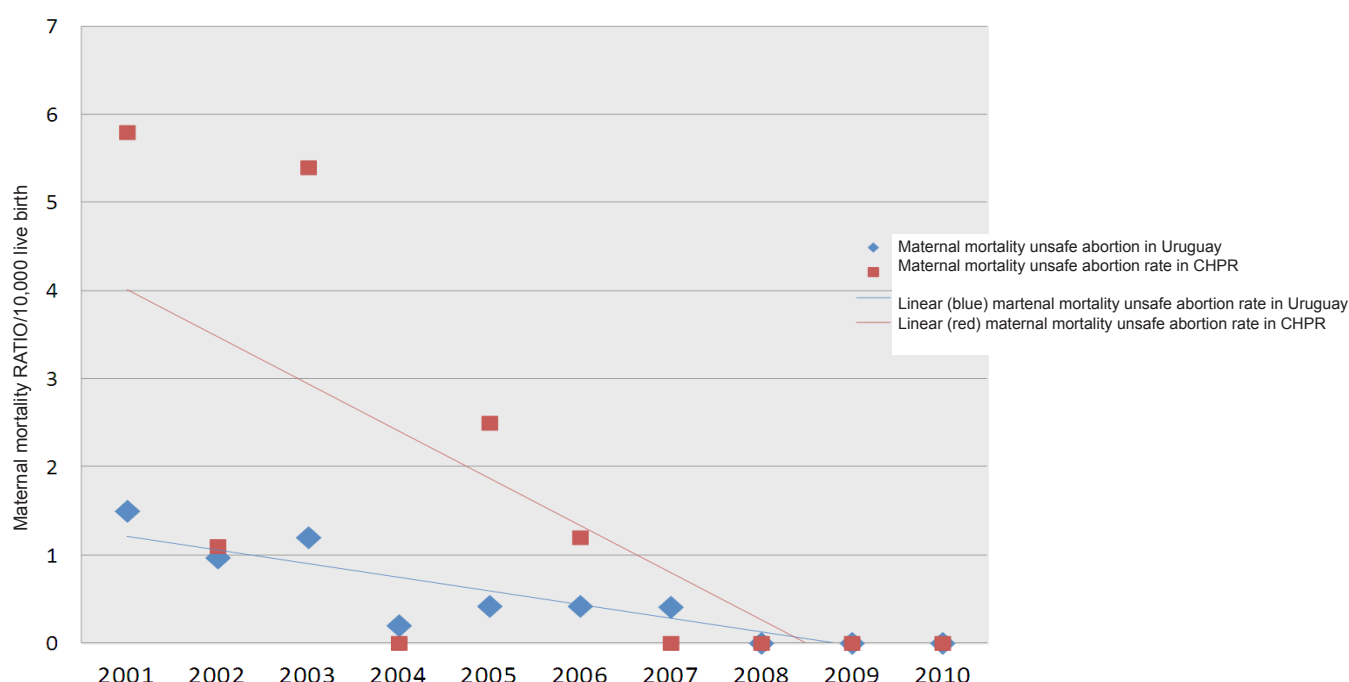


Figure 4. Evolution of maternal mortality associated with unsafe abortion in Uruguay and at the Pereira Rossell Hospital Center in the 2001-2010 period.



4. Data source: 2001-2006: Population Information Department of the National Health Services Administration – Ministry of Public Health 2007-2010: National Committee for the Monitoring and Reduction of Women’s Deaths Associated with Pregnancy, Delivery, C-Section Puerperium and Abortion. Maternal mortality rates are given for 10,000 births since the number of births in the country is under 10,000; it ranges from 45,000-50,000 per year.

In the years leading up to 2010, there were no deaths associated with unsafe abortions in the entire country; at the CHPR, there have been no similar deaths since 2007. Likewise, we noticed a reduction in morbidity associated with unsafe abortions as well as a lower number of admissions to the intensive care unit and hysterectomies due to them.

Legal, social and public policies outcomes It should be emphasized that, since 2008, the IS Model has been included in Law 18.426 (“Defense of the Right to Sexual and Reproductive Health”).

Although the new law does not legalize abortion, it ensures women’s right to decent, confidential and ethical health care within the health care system when they are facing unwanted pregnancies, based on the fact that they are citizens.

This regulation underscores the need for these services to be part of sexual and reproductive health services in the Uruguayan health care system. Since

2011, the MSP has enforced the law and this coincided with the change in the national government, which contributed to the training of designated centers designated by the health institutions for of sexual and reproductive health services. The IS team was responsible for training the health staff, followed by the implementation of the sexual and reproductive health services.

Public discussion about unsafe abortion has had an impact, linking it to health care, which has resulted in it being more openly discussed, overcoming socio-cultural barriers such as fear and stigma. This has undoubtedly meant significant progress toward the achievement of gender equality and the effective exercise of human rights, since public policies embrace a woman’s own needs in regard to her access to health services. Public discourse has noticeably evidenced a shift: there have been social and legislative openings, favoring changes to the restrictive laws on abortion.

2nd Circle: Changes in relationships in the health care context.

Professionals

IS has trained 1240 professionals in the application of the Model. Gender inequality, long supported by professional associations—which reproduce the

male hegemonic model in their practices—comes into question in light of the need for a change in perspective of the health care relationship that enables an approach to the problem centered on ethics, professional values and support for women's rights.

Table 1. Social-anthropological monitoring. Physicians and health professionals.

33.3% nurses, 28.6% gynecologists and 19.8% midwives 60% are between 30 and 49 years old, 22% between 50 and 60			
Variables and verified changes		2007 n= 91	2009 n= 87
Justifiability of abortion according to cause (Averages, 1 = Never justifiable and 10 = Always justifiable)	When pregnancy results from rape	9.3	9.7
	Woman lives under extreme poverty and has economic problems to support her family	5.9	7.5
	When the woman was abandoned by her partner	4.0	5.5
	To avoid the birth of children with malformations	8.3	9.2
	When the pregnancy seriously risks the woman's health	9.0	9.5
	When the woman has too many children	4.5	6.0
	When the woman is an adolescent	3.9	5.5
	When the woman does not want to be a mother at that moment	5.0	7.2
Knows about the existence of misoprostol and the Model	He/she knows the regulation about counseling	50.0	80.0
	Application of the Model	46.3	78.0
Procedure to be followed when a user states she wants to have an abortion (% of professionals)	She is reminded about the fact that abortion is illegal in Uruguay	45.2	53.5
	She is referred to another health professional in the health center	14.3	59.2
	She is referred somewhere outside the health center	50.0	5.6
	An attempt is made to persuade her not to have an abortion	28.6	5.6
	She receives the information and counseling needed to carry out their decision	61.9	71.8
	She is reported for surveillance	14.3	1.4

As shown in Table 1, the socio-anthropological monitoring reveals conceptual and attitudinal changes:

- More physicians and health staff use the Model, with an increase of 50% in 2007 and 80% in 2009.
- When compared to 2007, in 2009 professionals are more likely to create an environment in which women can independently decide whether or not to interrupt their pregnancy (respect for their decision, non-reporting of them, resolving cases in the center and internal referral)
- An increase in the reasons that justify an abortion, since disaggregating data by gender reveals a

comparatively greater change in the perception of female physicians and specialists in comparison to male staff in both periods of time studied.

- No changes were observed in connection to facilitating access to misoprostol.

The training of future health care professionals has evidenced important changes. Such is the case of the degree in medicine, in which the course traditionally called Maternal and Child Health was renamed in 2007 to "Course in women's health, pregnancy, infancy and adolescence." This signified both a conceptual and programmatic change.

The Faculties of Nursing and Psychology, as well as the School of Obstetrics-Gynecology, currently include topics such as unwanted pregnancy, abortion and risk and harm reduction models in their curricula.

The women

Throughout the project, the percentage of women who received counseling for unwanted pregnancy who returned for the post-abortion consultation remained around 20%. For this reason, it was decided that a telephone follow-up was needed for women who failed to attend the post-abortion visit a month after the initial counseling consultation. The study showed that 55.4% of the women had decided to interrupt their pregnancy; out of these, 95% had been

carried at the location where they had received the initial consultation or in other centers (primary health care centers, private medical institution, etc.) and had presented no complications. The remaining 5% of the women who had interrupted their pregnancy did not seek a post-abortion visit and did not present immediate complications.

Upon evaluation of a 94-case sample, the results of which are summarized in Table 2, it was found that 21% of women had decided to continue with their pregnancy, were satisfied with their decision and began their pregnancy control visits. In 5.3% of cases, women were found not to be pregnant.

Table 2. Users' decision after the initial counseling consultation at the Sexual and Reproductive Health Service of the Pereira Rossell Hospital

Resolution	Number of users	Percentage (n=94)
Already interrupted pregnancy	50	53.2%
Decided to interrupt, but still not done	2	2.1%
Continued with pregnancy	20	21.3%
Spontaneous abortion	4	4.3%
User was not pregnant	5	5.3%
Unknown resolution	13	13.8%
Total	94	100%

The 13.8% of women whose final decision is unknown corresponds to those who did not return to the sexual and reproductive health service center and whom we were unable to contact over the telephone (due to lack of response or because the protection of confidentiality was at risk).

In terms of the women's perception:

- Ninety-five percent of them felt they were respected during the consultation; no one felt

judged; and 5% gave other replies (she was understood, she was listened to).

- Eighty-five percent of women stated having received support and the care needed during their stay in the hospital/health care center. The other 15% stated that they had not received the expected health care services. In most cases, the dissatisfaction corresponded to the administration of the abortion method (misoprostol).

Table 3. Social-anthropological monitoring.

Users PROFILE: 90.6% were Caucasian and 10.4% were African American Average age 32.2 years old. Educational Background: 54.9% secondary school not completed, 20.9% secondary school completed. 60.8% does not work, 39.2% works, 46.4% housewife, 20% head of household.			
Variables and verified changes		2007 n= 153	2009 n= 144
Main difficulties found by a woman who decides to have an abortion	Fear of being reported	57.8%	40.4%
	Lack of information	49.0%	38.3%
	Lack of support and emotional support by health professionals and staff	25.2%	22.7%
	Lack of family support	60.5%	56.0%
	Discrimination	31.3%	23.4%
	Guilt and internal conflicts	57.1%	48.2%

The data in Table 3 reveal that, after the intervention, women's fear of being reported decreases, as well as the lack of information and their feeling of not being supported by the health team. All of this has a positive impact on women since it strengthens their autonomy and diminishes social stigma.

No meaningful changes were observed in terms of abortion justifiability and the use of misoprostol in the women's group.

Women's testimony.

Giordano Health Care Center: *"During the consultation with the doctor...I felt supported because I didn't have a solution myself....."*

And I wasn't sure whether to do it or not, you know? You see, there are many who say "yes, but then you bleed," and if I go to the Pereira Rossell Hospital... and you end up in jail...and all..... but the truth is this doctor helped me a lot."

Florida Hospital: *"What they are doing is really good. Sometimes methods don't work and women often don't know where to turn."*

Health System

All the selected centers implement sexual and reproductive health services by applying the Model and they offer comprehensive care.

They include comprehensive services in already existing health care centers and they are provided within a wider range of sexual and reproductive health services, providing counseling on contraception, detection of sexually-transmitted

infections, birth preparation, identification of and counseling for women who are victims of domestic violence, etc.

Women are seen by many multi-disciplinary teams that are committed to sexual and reproductive rights, and who know and enforce existing regulations. Consultations with more than one professional at the same time and work meetings are essential since they result in opportunities for self-analysis and they build experience, self-confidence and professional bonds that are truly inter-disciplinary.

The quality of services are summarized with the results of the monitoring tool, which show a positive impact in institutional aspects such as infrastructure, privacy, confidentiality, human resources, application of norms and protocols, and access to services.

By observing the interaction between women and professionals, we find that health care is ethical and qualified, both in terms of concepts and attitudes.

• 1st Circle: Women facing unwanted pregnancies.

From May 2007 to July 2009, 2,717 women sought consultations for unwanted pregnancies. Sixty percent of them used some form of contraceptive method that failed to work (Figure 5). Among the causes for these failures are the following: women had difficulty negotiating with their partner about the systematic use of a condom; women had difficulty gaining sustained access to hormonal methods; and

counseling on the effectiveness of contraceptive methods was incomplete or inadequate, such as oral contraceptives while breastfeeding, the decrease in effectiveness when suffering from food intolerance or concurrently taking other drugs. Of the women, 65.4% consult before week nine of pregnancy and 19.9% between weeks 10 and 12 (Figure 6).

Figure 5. Causes of unwanted pregnancies.

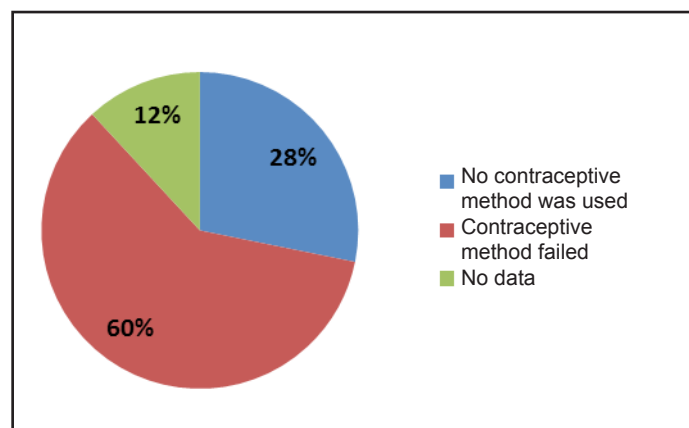
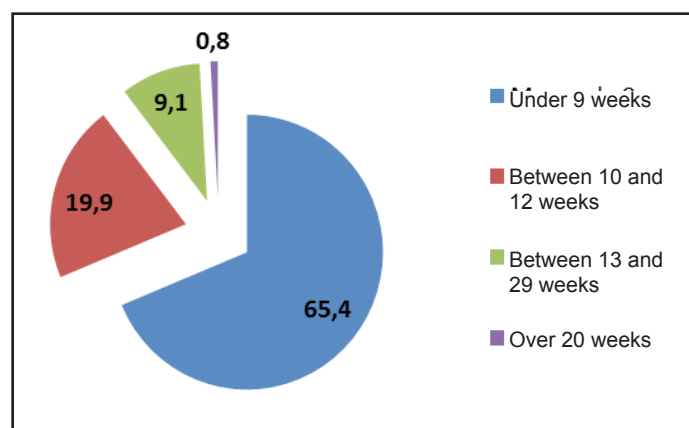


Figure 6. Gestational age at the time of the counseling consultation.



If we consider the same period of time, 729 were seen for their post-abortion control, 92.2% used self-managed misoprostol and 93.7% had no complications.

In 77.6% of the cases, women received counseling on contraceptive methods. (The remaining percentage accounts for women who failed to complete the care services process at the time of the study.) Ninety-seven percent of these users adopted a safe contraceptive method.

How do we sustain it?

Conceptual sustainability of the Model.

In order for the Model to be sustainable, conceptual changes are necessary, since they will in turn enable changes in health care practices. As for the health teams, they have changed—or are in the process of doing so—the way in which they interact with and relate to women by adopting an ethical commitment to sexual and reproductive health. Now health care professionals critically analyze their old practices and see the inequalities upon which they were built, while a counter-hegemonic attitude has been developed within their primary health institutions (professional and academic). The health teams play an active role in the social and health changes.

The capacity to oversee these changes and the professional team's leadership is grounded on this commitment, rather than on the hegemonic and paternalistic "medical power" that is being deconstructed in practice. From this perspective, health professionals do not need to "be in favor" of abortion in order to provide counseling to a woman. Instead, they need to be aware of their role and take on the responsibility of solving the ethical conflicts that emerge from their daily practice. Perhaps, and maybe precisely for this reason, we have seen very few professionals who show conscientious objection to applying the Model once they become familiar with it.

Simultaneously, working in communities contributes to the sustainability of the Model as it disseminates and promotes the defense and demand of rights by users of the National Integrated Health System (SNIS).

Team sustainability.

Multiple circumstances affected the natural evolution in the collective actions of Iniciativas Sanitarias and in the individual health care services that it provided. In order to overcome being worn down by such a controversial issue as unsafe abortions, action and reflection mechanisms need to be applied constantly throughout and be based on professional values and commitment to women's health. In addition, a multidisciplinary vision that brings together the expertise and competence of each one of the members of the health team contributes to comprehensive health coverage.

The possibility of sharing experiences within the team,

identifying weaknesses and looking for solutions together are some of the tasks that contribute to strengthening the health team. The team supports professionals, which creates a feeling of belonging by lending importance to the practice and reflection on it. This is made possible by means of regular meetings to discuss cases and by organizing academic presentations to share results.

Social and public sustainability.

Key components of public discourse to defend the strategy:

- To be in favor of life.
- To promote human rights as the basis of our work: women's autonomy and the true exercise of their rights.
- Health professionals have a responsibility to act.
- The model of reducing the risk and harm of unsafe abortions is an innovative and proven intervention in public health that can save lives.
- Implementing the Model supports the processes geared to social change.

Today, abortion is discussed as a public health issue among the Executive Branch, Congress, the University of the Republic, trade unions and a wide range of professional and social organizations in Uruguay. This has modified the way in which Uruguayan society sees, discusses and manages unwanted pregnancies, which contributes to the decriminalization of abortion. Abortion appears in news about health, national politics and education, and is no longer restricted to news about crime.

Political sustainability.

The inclusion of the Model in Uruguayan legislation since 2008 (Act 18.426), together with the implementation of sexual and reproductive rights that it implements in a comprehensive way, has resulted in its enforceability by users of the institutions that are part of the SNIS.

The more professionals learn about and implement the Model, the greater the evidence in favor of its effectiveness. Thus, academic and professional institutions support and include it in their health care services, resulting in a change where the letter of the law becomes public policy.

Politically, we have chosen the path of least resistance, seeking the greatest agreement possible to implement

the changes and avoiding the polarization of opinions that usually result in being obstacles.

In other words, the progress made in the field of public policies we have described above results from an advocacy strategy carried out by committed professionals who fight for the defense of rights on the basis of consolidated scientific evidence.

Economic sustainability.

Throughout its history, Iniciativas Sanitarias has received financial support for the design and implementation of the Model. Since 2001, the MSP, through various departments, and the faculty of the University of the Republic have contributed human resources beyond their professional roles. When Iniciativas Sanitarias became a non-profit organization, the CHPR and the MSP provided a physical location to be used as the institutional headquarters and as a training center, and to have the first sexual and reproductive health service apply the Model, which is now the national referral care service. This is where the professionals at the national and international levels are trained in clinical practice.

In 2005, UNFPA's financial aid contributed to the publication of primary results. Since then, Ipas supported the application of the model in two health care centers, within the framework of a pilot project geared to working with a network of organized women; and, later on, it also supported the Community Resonance project.

In 2006, the project went even further with the collaboration of FIGO, the local contribution of the SGU and the CHPR-ASSEE, as well as the participation of gynecologists and professional midwives who work in the selected centers. Since 2007, Iniciativas Sanitarias has received the support of the SAAF and IPPF in London, toward institutional strengthening, improvement of its premises and service implementation. Also, since 2007, IPPF/RHO has provided funding to Iniciativas Sanitarias for, among other things, the dissemination and expansion of the model in countries in Latin America, for a virtual course for the training of professionals and for the preparation of material for a distance-learning course organized in collaboration with DODECA. Since 2009, the WHO and, since 2011, MMI have supported the service implementation in the border areas of Uruguay: Rivera, Cerro Largo, Paysandú and Artigas.

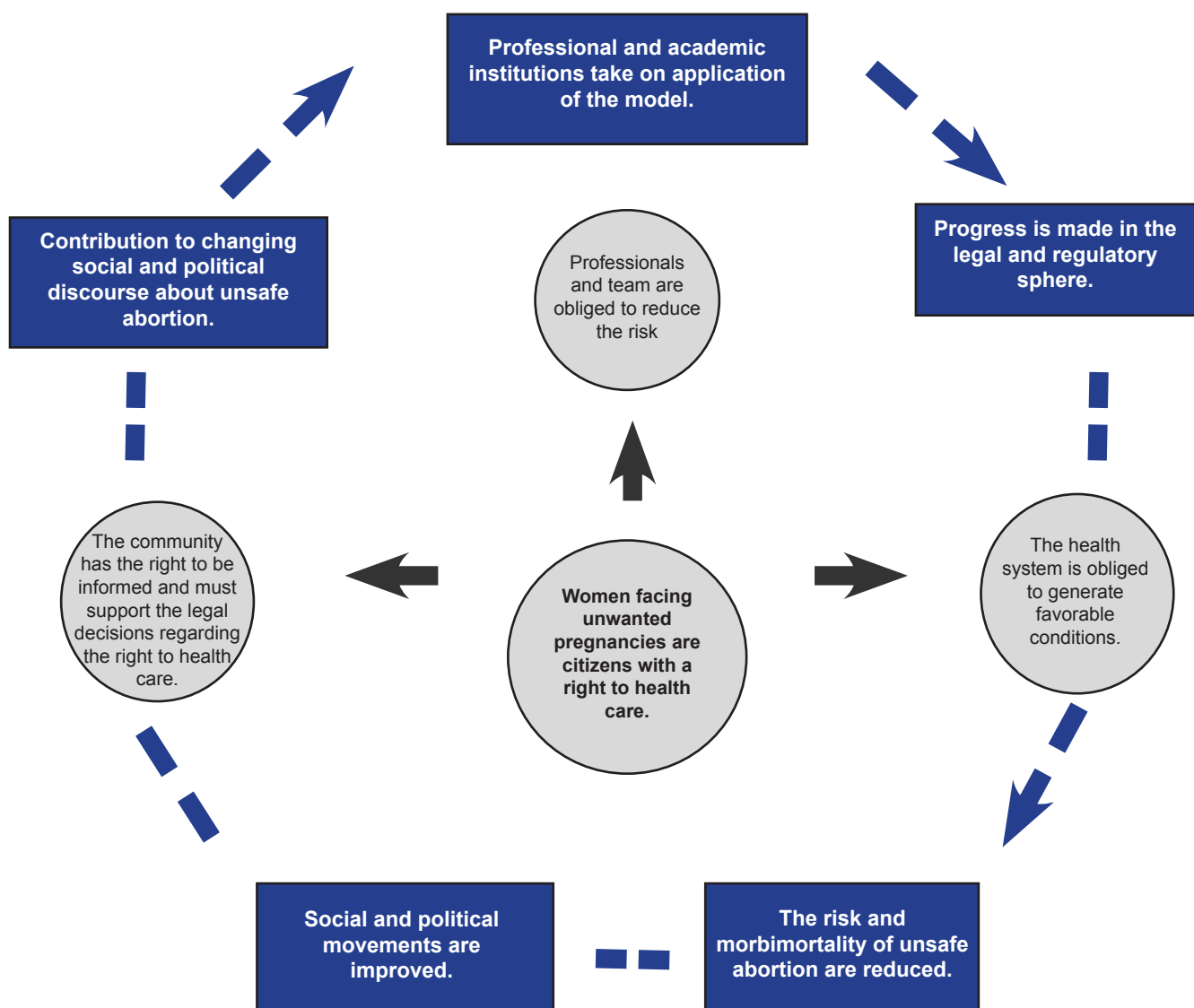
Funding agencies have respectfully supported Iniciativas Sanitarias in a variety of manners without their influencing the design, implementation,

interpretation and publication of reports, since Iniciativas Sanitarias has always been autonomous, from the preparation of the Model to the publication of its works. External audits have been conducted: FIGO with OPTION for the general project, UNICEM for the epidemiological audit and IAE for the social

and anthropological monitoring.

Figure 7 presents the conceptual map of the intervention and the pillars for the sustainability of the Model.

Figure 7. Conceptual map of the intervention.



What did we learn?

Changing relationships in the health care context is possible.

The hypothesis considered is valid. We can transform relationships in the health care context by including women facing unwanted pregnancies in the health care system, and this change resulted in a reduction of maternal mortality because of unsafe abortions.

The Model contributes to decision-making.

The fact that 21% of users who sought a consultation for unwanted pregnancies decided to continue with their pregnancies signifies acknowledgement of a process of empowerment for women in decisionmaking that was initiated by the health care system. The Model does not encourage abortion, but rather contributes to having women make responsible decisions.

The Model is adaptable and replicable.

In terms of its being replicated, the socio-health and institutional characteristics of Uruguay and its health system make it a favorable scenario to act as a “social laboratory.” This made it possible to monitor the strategy with the possibility of replicating it in other countries. The Model originally developed in Uruguay by Iniciativas Sanitarias is one that may be adapted to other countries with restrictive legislation on abortion. It allows for an immediate, effective and proven response for women facing the difficult situation of an unwanted pregnancy. Moreover, its development and application contribute to the transformation of public policies.

In order to achieve this change, an ethical and legal framework is needed that ensures doctor-patient confidentiality and that has the commitment of the professional referral institutions. Thanks to an agreement with IPPF/RHO for the dissemination of the Model, it has been replicated in Argentina, Bolivia Honduras, Mexico, Nicaragua, Peru Suriname, Uganda, Venezuela.

Barriers to implementation.

The obstacles or primary barriers that arose in the implementation of the Model were the following:

- In the health care system: lack of adequate legislation during the initial stage. Following ministerial regulations and Law 18.426, the scope of action was widened.
- Among professionals and health teams: the hegemonic and paternalistic structure, ignorance of professional commitment and the assurance of professional secrecy and confidentiality, not to mention stigmatization of women facing unwanted pregnancies.
- Among the women: mistrust in the health system and ignorance of their rights.
- Among society as a whole: the sociocultural guidelines that imply gender inequalities and stigmatization of abortion.

We, the committed professionals, can contribute to social change.

When analyzing the Model’s transformative potential, we see the involvement of traditionally-male and socially-legitimized professions and institutions, which now defend sexual and reproductive health rights and consciously embark on the challenge of changing their practices, constitutes one of the key successes of the strategy.

We feel that we made significant contributions to changing public discourse regarding unsafe abortions. The visibility of unwanted pregnancies as a health problem has clearly favored its inclusion in the legislation and regulations in force, acknowledging women facing them.

Abbreviations

ASSE	National Health Services Administration
CHPR	Pereira Rossell Hospital Center
FIGO	International Federation of Gynecology and Obstetrics
IAE	Institute of Higher Studies
IPPF/RHO	International Planned Parenthood Federation - Western Hemisphere Region
MSP	Ministry of Public Health
SAAF	Safe Abortion Action Fund
SGU	Uruguayan Society of Gynecology
SNIS	National Integrated Health System
UNICEM	Montevideo Clinical and Epidemiological Research Unit

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