International Journal of Gynecology and Obstetrics 118 (2012) S21–S27

Contents lists available at SciVerse ScienceDirect

International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo

URUGUAY

Improving care of women at risk of unsafe abortion: Implementing a risk-reduction model at the Uruguayan-Brazilian border

Verónica Fiol [a,b,*], Leonel Briozzo [b,c], Ana Labandera [a], Víctor Recchi [d], Marta Piñeyro [d]

[a] *Iniciativas Sanitarias, Montevideo, Uruguay*
[b] *Department of Obstetrics and Gynecology, University of the Republic, Montevideo, Uruguay*
[c] *Ministry of Health, Montevideo, Uruguay*
[d] *Iniciativas Sanitarias, Rivera, Uruguay*

ARTICLE INFO

Keywords:
Unwanted pregnancy
Medical profession
Postabortion care
Unsafe abortion

ABSTRACT

Objective: To describe the initial stages of the implementation of a risk-reduction model designed by *Iniciativas Sanitarias* to shield women from unsafe abortion in a traditional community on the Uruguay-Brazil border. *Methods:* This mixed-design study was conducted first between 22 and 26 March 2010, and then between 2 and 7 May 2011, in Rivera, Uruguay, to gather information from women seen at health centers, healthcare providers, and local policy makers before the project started and midway through the project. *Results:* At baseline most women and providers considered abortion justifiable only on narrow grounds, yet favored the implementation of a risk-reduction model that would include preabortion as well as postabortion counseling, the former providing information on different abortion methods and their risks. By the midterm assessment, the counseling service had assisted 87 women with unwanted pregnancies. Of the 52 who came for a postabortion visit, 50 had self-administered misoprostol, with no complications. Women were highly satisfied with the counseling. At baseline, misoprostol seemed to be available from both pharmacists and informal sellers. At midterm, it was still available from informal vendors but pharmacists said they did not provide misoprostol. The risk-reduction initiative heightened public attention to the abortion issue but the controversy it generated did not seriously impede its implementation. *Conclusion:* It is feasible to implement the proposed risk-reduction model in a traditional community such as Rivera, not only in Uruguay but in any country irrespective of its abortion laws.
© 2012 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd. All rights reserved.

1. Introduction

Uruguay, a small country in Latin America with a population of 3.3 million, had an estimated maternal mortality ratio of 2.3 per 10 000 live births for the decade 1992–2001 [1]. This ratio, one of the lowest in Latin America, reflects that women's health care, including prenatal, childbirth, and postpartum care, is of high quality and widely accessible in this country. Nonetheless, evidence indicates that unsafe abortion was the leading cause of maternal mortality during the same period. It accounted for an estimated 29% of maternal deaths countrywide and nearly half (48%) of the maternal deaths that occurred at Pereira Rossell Hospital, the leading women's hospital in Uruguay [1–3]. Worldwide, an estimated 13% of maternal deaths are due to complications of unsafe abortion [4].

As in most countries in the region, abortion is legally restricted in Uruguay. It is legal only when the pregnancy is the result of rape or seriously endangers the woman's life or health, or when fetal malformations are incompatible with life [5,6]. Not coincidentally, most maternal deaths in Uruguay result from unsafe clandestine abortions. In 2001 a new nongovernmental organization, *Iniciativas Sanitarias* (Health Initiatives), designed a risk-reduction model and developed an intervention program to decrease the incidence of unsafe abortion, and thus maternal morbidity and mortality from unsafe abortion [2,3,7]. The model acts on the conviction that even when health professionals are legally restricted from performing abortion, they have a duty to provide women who want to terminate a pregnancy with appropriate counseling and care both before and after a clandestine abortion. The intervention aims at decreasing as much as possible the risks associated with unsafe abortion within the existing legal restrictions. It includes a medical visit to confirm the pregnancy, counsel the woman on her options, and inform her of the risks associated with different means of inducing abortion, including the use of misoprostol. If the woman does terminate her pregnancy, she is offered a postabortion visit to prevent complications and help her obtain contraception. The intervention fosters a change in the healthcare relationship, i.e. the relationship between health professionals and healthcare

* Corresponding author at: Av. Italia 2545/905, Montevideo, Uruguay. Tel.: +598 27099122.
E-mail address: verofiol@hotmail.com (V. Fiol).

0020-7292/$ – see front matter © 2012 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.ijgo.2012.05.006

teams at a particular place and time with a client, the client's family, and the community in which they live as an essential part of the healthcare system. This relationship, and the model itself, are based on bioethical principles and professional values that unequivocally protect client confidentiality and the secrecy of medical records.

Iniciativas Sanitarias first implemented the model at Pereira Rossell Hospital in Montevideo in 2004. In 2006, with funding from FIGO through the FIGO Saving Mothers and Newborns Initiative, the model was further tested at 7 first- and second-level health centers in the Montevideo metropolitan area. The main processes of this second initiative were the following: training professional health teams, implementing a Sexual and Reproductive Health Service (SRHS) unit at each center, and raising the awareness of the community about the services and about safe abortion. Eventually, more than 500 professionals were trained (more than 50 of whom directly in the field of sexual health), and preabortion and postabortion counseling services were successfully integrated in the centers. Multidisciplinary teams committed to sexual and reproductive rights now know and nearly always apply the current law at all these centers, which indicates a positive change in staff attitudes toward women with unwanted pregnancies. Not only did this second initiative bring about a greater commitment to respecting women's decisions among the medical community, but the topics of sexual and reproductive rights have been incorporated in the curriculum of the School of Medicine and Midwifery of Uruguay.

In 2004, the original risk-reduction strategy became a regulation of the Ministry of Health, and in 2008, the strategy was included in the Law of Sexual and Reproductive Health [8]. In December 2011, the House of Representative approved a law to decriminalize abortion. As of this writing, the law has not yet been brought before the Senate.

In 2009, *Iniciativas Sanitarias* received funding from the WHO to implement the risk-reduction model beyond the Montevideo metropolitan area, specifically in Rivera, a Uruguayan town of 64 462 people on the border with Brazil. Compared with Montevideo, the Rivera community is more conservative and traditional, with values deeply rooted in Catholic and Evangelical traditions where women's social identity is chiefly defined by motherhood. Women's subordinate position makes them the target of criticism over their choices on reproductive and other matters, and a woman's decision to terminate a pregnancy is most likely to meet with judgment and condemnation.

This new project involved two main interventions. The first consisted of raising the awareness of, and then training, health professionals and service and other support staff about the need to care for women who may want or who have just had an abortion. The second consisted of implementing, at the provincial level, the program that *Iniciativas Sanitarias* had successfully deployed in Montevideo and providing an assessment of its impact at that level. The project's ultimate goal was to develop and test the risk-reduction model for application to other countries with restrictive abortion legislation.

The project required a qualitative and quantitative assessment before, during, and after the interventions. Its main objectives were: (1) to identify possible changes in perceptions and practices related to sexual and reproductive rights and pregnancy termination among women, health professionals, and support staff in provincial Rivera; (2) to document perceptions regarding a comprehensive SRHS; (3) to identify facilitators and barriers to the implementation of the pregnancy counseling provided at the SRHS; and (4) to gather information about the commerce of misoprostol at the community level.

This report provides interim results for an ongoing project. It presents the findings of a baseline survey that explored the perceptions of local policy makers, healthcare providers, and women seen at healthcare centers (and considered representative of the community) regarding unwanted pregnancy and abortion, and compares them with the results reached midway.

2. Participants and methods

2.1. Implementing the risk-reduction intervention

The interventions were conducted from March 22, 2010, through May 7, 2011, in Rivera, Uruguay. After arrangements with local authorities were made and agreements reached, the intervention unfolded in 4 steps: (1) selecting a health facility and staff for the new SRHS unit; (2) raising the awareness of health professionals and other staff selected to be part of the new unit, and also staff from other centers who may refer pregnant women to the new SRHS unit, and then training all those who were to staff the new unit; (3) launching and steering the new unit; and (4) intervening and disseminating information in the community. The baseline assessment was conducted from March 22 through March 26, 2010, and the midterm assessment from May 2 through May 7, 2011, by 2 interviewers in coordination with a sociologist and an anthropologist.

The José Royol Health Center at Rivera was chosen for the intervention and its new SRHS unit was staffed with employees from the center through peer selection. All staff having contact with women with unwanted pregnancies were trained, from security guards through support, service, and professional staff. The training was carried out in conformity with the risk-reduction model, whose purpose is to promote a supporting environment for women and encourage them to actively participate in their medical care. The aims of the training were to provide specific cognitive, psychoemotional, attitudinal, and practical skills in reproductive health care, and to bring all staff to consider those skills as essential parts of a comprehensive SRHS. Training was also provided to teams from Livramento, a Brazilian city separated from Rivera by only a street.

After the training phase, a comprehensive SRHS unit with gynecologists, psychologists, nurses, and midwives was created at the José Royol Center. The service included provision of contraceptive products, routine screening for domestic violence, and counseling in cases of unwanted pregnancy. To spread knowledge about the new SRHS unit and promote the exercise of sexual and reproductive rights, its team applied a strategy called Community Resonance, by which health professionals meet with members of the community in the field (that is, outside the healthcare setting) to discuss the program and answer questions.

2.2. Baseline and midterm assessments

The main objectives of the assessments reported here were to build an initial diagnosis of the conditions in the Rivera community that were relevant to the project, and, midway through the project, identify possible changes in perceptions and practices among different types of actors. These actors were local policy makers, local health professionals, administrative and support staff of selected health centers, persons engaged in the sale of misoprostol, and women attending the Royol SRHS unit or 4 other centers that may refer women to the Royol SRHS unit (these other centers were the public hospital in Rivera, a first-level health center in Rivera, Federico Díaz Center; and 2 first-level health centers in the nearby towns of Tranqueras and Vichadero). The issues of interest were knowledge of the current Sexual and Reproductive Health Law and what this law implied; perceptions regarding unwanted pregnancy and abortion; knowledge and perceptions of the Royol SRHS unit within the community; and the commerce of misoprostol.

The views and knowledge of local policy makers as well as health professionals, support staff, and women seeking care at 5 Rivera health centers were assessed by a combination of qualitative and quantitative methods before the project started and midway through the project.

For the baseline survey, 30 local policy makers from the political, judicial, and health areas were selected after mapping and discussions with local authorities and community leaders. These policy makers

Table 1
Number of respondents, by type of study and type of respondent.

Respondent	Baseline study		Midterm study	
	Qualitative assessment	Structured questionnaire	Qualitative assessment	Structured forms [a]
Health professionals	7	25	14	0
Administrative and support staff	0	12	3	0
Local policy makers	30	0	16	0
Persons engaged in misoprostol sale	10	0	14	0
Women using a selected health center	14	86	15	87
Total	61	123	62	87

[a] These predesigned forms were completed by healthcare professionals, rather than by the interviewed woman, during the before- and after-abortion visits.

participated in group and individual interviews. Views on and knowledge of induced abortion and related topics were also assessed during face-to-face interviews with 10 persons selling misoprostol (7 pharmacists and 3 informal sellers) as well as 14 women and 7 health professionals from the selected centers. In addition, a structured questionnaire with close-ended questions was administered to 25 health professionals from the José Royol and other Rivera health centers that may refer women to the Royol SRHS unit, 86 women using health services at the 5 selected centers, and 12 administrative and support staff from these same centers (Table 1).

For the midterm survey, the views and knowledge of 16 local policy makers, 14 persons engaged in the sale of misoprostol (3 informal sellers and 11 pharmacists), 15 women receiving health services at the 5 selected centers and 14 health professionals from the same centers were again assessed qualitatively by means of semistructured and in-depth interviews and by direct observation. In addition, the records of 87 women were reviewed (Fig. 1). These were women with unwanted pregnancies who were assisted under the risk-reduction model at the Royol SRHS unit. After obtaining informed consent, the professionals whom the women consulted transcribed all relevant information on 2-part forms designed for the project: one part was for data recorded during the preabortion and the other was for data recorded during the postabortion visit (Table 1).

3. Results

3.1. Justifiability of abortion and perceptions about unwanted pregnancy

At baseline, women attending the selected health facilities (and considered to be representative of the female population of their community), health professionals, and support staff were asked whether they thought abortion was justified in different situations (Table 2). Most in all 3 groups thought that abortion was justifiable when pregnancy resulted from rape or seriously jeopardized the health of the woman, and in cases of fetal malformations. Less than one-fifth of the women attending the health facilities, but around half the health professionals, considered abortion to be justifiable "when the woman does not want to be a mother at this time in her life" and "when the woman has serious economic problems." A substantial majority in these 2 groups did not consider that having too many children, being a teenager, or being abandoned by one's partner were sound justifications for abortion. However, health professionals were more likely than the women to consider abortion justifiable for these reasons. The attitudes of the administrative and support staff were closer to those of the women than to those of the health professionals.

The qualitative interviews showed that abortion was a taboo subject among local policy makers. It was identified both as an issue that many did not want to discuss and as a highly controversial topic:

> "This is not an issue that is much talked about and therefore many people do not want to get into that topic to avoid getting into murky waters." (Local government representative 1)

The woman who gets an abortion is usually condemned. Although abortion was seen as justified in specific cases, which were precisely those legally justified, the survey participants believed that even in such cases women faced barriers that kept them from getting a lawful abortion. Rivera is located in a very conservative Uruguayan department where "there are very conservative actors with whom we will have to battle in case [abortion] is legalized" (Local government representative 2).

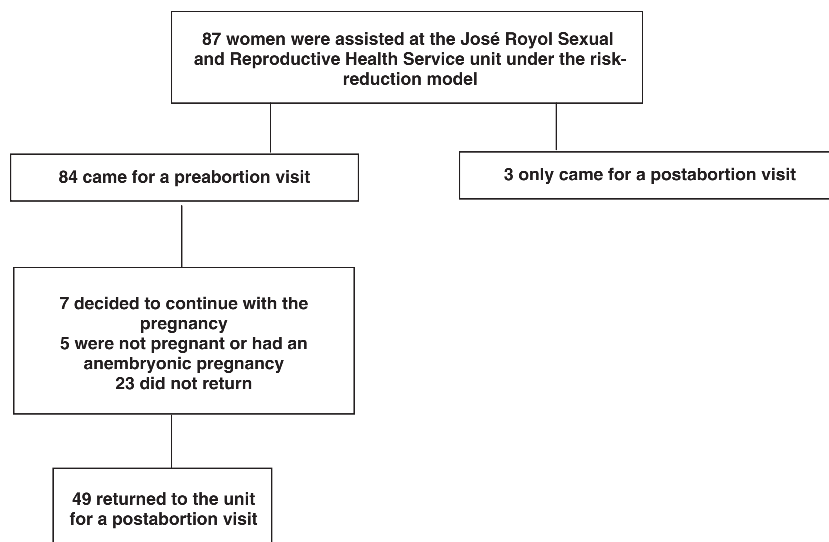

Fig. 1. Flowchart for the 87 women with an unwanted pregnancy who were assisted at the José Royol SRHS unit under the risk-reduction model.

Table 2
Numbers and percentages of respondents considering abortion to be justified under various conditions by type of respondents from the José Royol SRHS unit and other selected centers: baseline survey.[a]

Condition	Health professionals No. (%) (n = 25)	Administrative and support staff No. (%) (n = 12)	Women receiving care No. (%) (n = 86)
When pregnancy is the product of rape	24 (96)	11 (92)	65 (76)
When pregnancy seriously jeopardizes the health of the woman	21 (84)	10 (82)	59 (69)
In cases of fetal malformations	17 (68)	9 (75)	56 (65)
When the woman has serious economic problems	12 (48)	3 (25)	15 (17)
When she does not want to be a mother at this time in her life	12 (48)	2 (17)	12 (14)
When the couple has too many children	8 (32)	1 (8)	11 (13)
When the woman is a teenager	7 (28)	1 (8)	7 (8)
When she has been abandoned by her partner	7 (28)	0	8 (9)

Abbreviation: SRHS, sexual and reproductive health service.
[a] Each respondent could choose more than 1 option.

Some local policy makers stated their religious and moral objections to abortion:

> "I am also against abortion…and…God allowed life… That's how I think, although sometimes there are cases like the rape of a 10- or 15-year-old girl who becomes pregnant, in which case there could be a doubt whether the girl would accept or not." (Local representative of the Human Rights commission)

> "I believe, I think the question is already answered, it's about the abortion law. What we think about abortion, the point is that we are against it and what is needed is education." (Local representative of the Human Rights commission)

3.2. Perceptions regarding a SRHS in Rivera

At baseline, health professionals, support staff, and women were asked their opinions about the implementation of a professional counseling service based on a risk-reduction model for women with unwanted pregnancies (Table 3). Even before the intervention, 92% of the health professionals and 82% of the support staff indicated that they would favor the implementation of a risk-reduction model requiring an on-site counseling service dealing with gynecological care and the question of unwanted pregnancy. In face-to-face interviews, the health professionals mentioned the importance of training in the area of sexual and reproductive rights, and said that a lack of training was a major obstacle to the implementation of an SRHS. Most of the women also supported the implementation of an advisory service for women with unwanted pregnancies. Two-thirds said the service would be very useful and 86% thought it should focus on providing clear and timely information.

Nonetheless, some health professionals were against the implementation of the risk-reduction model and there were contradictions regarding what medical and support staff understood as counseling for women with unwanted pregnancies:

> "It is good to note that women who have consulted with that service, most decided to continue their pregnancy, this is interesting." (Local health policy maker).

> "[It matters] whether it is objective advice or whether you have a subjective bias according to moral, ethical, or personal standards… Advice varies somewhat according to who gives it." (HIV program director)

By the time of the midterm assessment, the topic had received much publicity and had generated controversy, as different positions were now clearly voiced about abortion and the Sexual and Reproductive Health Law. Some thought that there was a growing recognition of women's right to make choices and regarded this as an "evolution." Awareness and tolerance at the local level was linked to a greater possibility for women to be open about their decision to terminate a pregnancy:

> "I think that there is greater openness in this regard, with less guilt. It is handled like an option…to also terminate the pregnancy. Even though, I think an important component of guilt is still in play." (National Institute of Child and Adolescent authority)

> "I think that society has evolved and does not judge that much women who decide to interrupt their pregnancy because they do not feel able, because it is not the right time in their life, or whatever. I as a member of society see it this way…especially on the

Table 3
Perceptions regarding the implementation of an advisory service by type of respondents from the José Royol SRHS unit and other selected centers: baseline survey.[a]

Perception	Health professionals No. (%) (n = 25)	Administrative and support staff No. (%) (n = 11)	Women receiving care No. (%) (n = 86)
Should focus on providing clear and timely information to users	24 (96)	11 (100)	74 (86)
The service would be very useful and necessary	23 (92)	9 (82)	58 (67)
Should provide care in case of complications resulting from unsafe abortions	22 (88)	9 (82)	74 (86)
Should focus on providing emotional support to clients	23 (92)	8 (73)	71 (83)
Should be provided by doctors, psychologists, and social workers	20 (80)	11 (100)	70 (81)
It should be located at the same health facilities	21 (84)	8 (73)	68 (79)
It should work as part of general gynecological services	20 (80)	9 (82)	62 (72)
Legal advice should be incorporated	19 (76)	10 (91)	68 (79)
A complementary service telephone counseling and support would be useful	15 (60)	9 (82)	71 (83)

Abbreviation: SRHS, sexual and reproductive health service.
[a] Each respondent could choose more than 1 option.

issue of misoprostol. This is a method that is not invasive, where women do not risk their lives, and that has been a [great] solution to those [in need] who decided to have an abortion." (Local health authority)

Conversely, those who denied women abortion as an option stressed the difficulties of implementing an SRHS. Some viewed the advisory service as promoting abortion, even as forcing women to abort pregnancies. They presented the issue in terms of considering the rights of one person over those of another:

"The information handled is risky because on the one hand I am promoting health but on the other hand I am encouraging the use of paths that are not legal." (Staff specializing in domestic violence)

"I think with this law public health authorities have a tool, through the public and private health systems, to interfere with the policies of birth control in the country…to reduce the number of poor." (Legislative decision maker)

The health professionals who were interviewed for the midterm assessment recognized the importance of the training carried out by *Iniciativas Sanitarias* and the impact of learning the risk-reduction strategy. They especially mentioned how to properly refer pregnant women to the Royol SRHS and how the women were being cared for at the unit: "Sure, we first refer women to the gynecologist, and then he/she makes other references as needed" and "By the way, we know that there in the Service, first they confirm the pregnancy, before doing anything else." The importance of confidentiality was also stressed: "It is something confidential, information does not go out from here, and we do not write it down in our daily report, just that we referred the woman."

Many providers who were not members of the SRHS considered its existence very useful even though they were personally opposed to abortion:

"Me, while I have my religion, I think that it is a decision of the individual; I think that I am neither against nor in favor, it is each person's problem. If the woman is an adolescent she is always accompanied by her father or mother and they are also very well advised, but as everywhere we know that there are people who are in favor and people who are not." (Support staff)

3.3. Availability of misoprostol

At baseline, health professionals and support staff were asked their opinions about the women's knowledge on how to get misoprostol to induce abortion. Forty-four percent of professionals and 50% of the support staff surveyed thought women had good or very good knowledge, and most of the rest thought they had fair to poor knowledge (some said they did not know). When asked if they thought that the SRHS unit should provide misoprostol to users, the opinions of health professionals differed from those of support staff. Whereas 52% of the health professionals thought the SRHS should prescribe misoprostol and 44% said it should provide it free of charge, less than 20% of the administrative and other support staff thought that the service should do those things. Of the 86 women surveyed, 50 said they did not think that providers should directly deliver misoprostol.

Informal sellers and pharmacists were interviewed regarding the sale of misoprostol in the community. Informal sellers were easy to find at "the line," the street border between Rivera, Uruguay, and Livramento, Brazil. They mentioned the price before anything else and knew the trade name of the product, Cytotec (Pfizer, New York, USA). They also clearly and repeatedly stated that abortion was forbidden. When asked, they said that many women bought the drug anyway and had good results: "Yes, lots of them, here everyone knows that they can get it, it is very common, and very easy." They also provided information on how to use it, and they recommended different doses depending on pregnancy duration. They did not recommend consultation with physicians: in their opinion, doctors were not the most appropriate persons to give advice on these issues because they insisted on pregnancy continuation.

Among pharmacists, reports varied. A few said they did not sell misoprostol because it was used for abortion: "I do not sell it…with or without prescription. It would be cynical of me to say that I am opposed to abortion and still sell the product." Some pharmacists who did not approve of abortion nonetheless sold it, however, noting that "there is a legal problem to implement the proper sale of misoprostol": "Yes, but misoprostol is not contraindicated. When someone asks for it and has a prescription, [then] I have no doubt about the doctor's indication."

The midterm interviews confirmed that access to informal sellers was easy. These sellers repeatedly said that their products were guaranteed, that they brought them from Paraguay. They also mentioned knowing of the SRHS unit and the name of its attending gynecologist. The pharmacists interviewed at midterm were mostly the same ones as those interviewed at baseline, and most now said that they refused to sell it. Indeed, their major concern was to make perfectly clear that pharmacies did not sell misoprostol. The evident decrease in the pharmacists' willingness to provide misoprostol between the baseline and midterm interviews suggests that "social controls" on pharmacists were reinforced as a result of the increased public attention to the issue.

As for the health professionals from the SRHS unit, they made it clear that they did not prescribe the drug: "They ask us but it is information we cannot give. We say that we are working under the rules, the law requires us to give advice but we cannot prescribe the drug. What they do with the information is up to them." They advised women about using misoprostol and told them not to buy any other pills for abortion. They never heard of anyone who could not obtain the drug:

"In fact we cannot say where to buy it, or who sells it, we cannot do that because the model does not allow it… What we tell them is the name of the drug, to check the expiration date, not to buy if they give them pills loose in a bag… In reality women who consult and receive advice return to the postabortion visit having used it. I do not believe that access is so difficult."

3.4. Women and unwanted pregnancy

In the baseline face-to-face interviews, women appreciated that there could be a service to "help women when they feel lost." They believed the service would be important:

"Women have abortions by their own means, and they could get some help there. For example in the case of an adolescent, parents do not want her in the house, then she goes and has an abortion. And if she is assisted by the psychologist she'll be safer, she may not even abort."

In the view of the women and others who were interviewed at baseline, women who terminated their pregnancies did so because they felt they were without support: "Women mainly abort when they feel alone." In face-to-face interviews, misoprostol was discussed as one abortion method among others. While it seemed easily accessible, the women interviewed did not mention knowing how to obtain it.

At midterm, 87 women with an unwanted pregnancy had been assisted under the risk-reduction model at the Royol SRHS unit. Their characteristics are shown in Table 4, and whether they sought preabortion and postabortion visits is shown in Fig. 1. The main

Table 4
Demographic characteristics of 87 women with an unwanted pregnancy who were assisted at the José Royol SRHS unit under the risk-reduction model.[a]

Characteristics	No. (%)
Civil status	
Without partner	28 (32)
With partner	49 (56)
Unknown	10 (12)
Previous pregnancies	
0	32 (37)
1–3	22 (25)
>3	32 (37)
Unknown	1 (1)
Had previous induced abortions	12 (14)
Race	
White	81 (93)
African American	4 (5)
Unknown	2 (2)

Abbreviation: SRHS, sexual and reproductive health service.
[a] The mean age of the women was 26 years.

reasons the women did not want the pregnancy were interference with their life plans (68%), economic problems (27%), and the absence of a stable partner (27%) (some women reported more than 1 reason). Most came for the preabortion visit with a gestation duration less than 12 weeks (Table 5). After counseling, 7 decided to continue with the pregnancy, a few were found not to be pregnant, and the remaining women decided to abort the pregnancy. Of the 52 who came for a postabortion visit, 50 had self-administered misoprostol at home to induce abortion. None incurred complications.

When interviewed face-to-face, the women assisted under the risk-reduction model reported that they had been assisted very well, that they had been listened to and supported by health professionals, and that they would recommend the service: “I agree with the service because sometimes we do things wrong, in a moment of desperation and things happen to us. You may die without knowing what to do” said one, and “I would recommend the service to all women, I would do it to give them information to care for their health and not put it at risk, so they do not have to go through this experience alone” said another. Some expressed regret that the service could not perform abortion: “It's very useful, but the doctor cannot do it because it is not allowed yet, they cannot touch you.”

Trusted persons, especially friends, were very important when it came to searching out misoprostol: “I got it easily because my friend already knew, she had already done it, it was very easy to get it.” However, the women did not always receive the best information from these sources: “It was expensive. For my situation it was very expensive. I spent almost a month's wages and it did nothing for me.”

4. Discussion

The program developed in Uruguay complies with the recommendation of the International Conference on Population and Development that “women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling” [9]. The model is grounded in professional values, a bioethics approach, the legal context of the country, and respect for human rights [10]. An essential component of the model requires attitudinal changes on the part of health professionals and support staff, which can be achieved through awareness raising and a training based on a gender-and-rights perspective. Principally, the program makes illegal abortion safer, even in a country such as Uruguay with a restrictive abortion law. Moreover, by discussing the alternatives to abortion along with different abortion methods and their risks, and by providing advice about using contraception once the pregnancy ends, the program may reduce the incidence of abortion.

The baseline survey revealed that a high percentage of participants in all groups thought that abortion was justified in the 3 circumstances in which current legislation allows it. Abortions for other, legally impermissible reasons were generally regarded as unjustifiable. Thus, opinions on these matters mostly aligned with the law. The reasons for which abortion was generally viewed as the least justifiable were clearly rooted in social and cultural values that encourage motherhood and define the central role and responsibility of women as the upbringing of children.

At the same time the interviews revealed that even though abortion was concealed and condemned, it was frequent in all socioeconomic and age groups and its condemnation varied in degree of severity according to the circumstance. In fact, at midterm, the main reason the women using the advisory service gave for wanting an abortion was the pregnancy's interference with their life plans—a reason that was not considered a valid justification for abortion by a large majority of the women surveyed at baseline.

There was broad (though not universal) support at baseline for establishing an SRHS advisory service to counsel women about unwanted pregnancy and abortion. However, most women did not think the service should prescribe or deliver misoprostol. This is consistent with the prevailing views that abortion is unjustified except under the restrictive conditions allowed by the current law. Among the groups surveyed, only health professionals were divided regarding whether the Royol SRHS unit should prescribe misoprostol that women would self-administer.

Even though health services do not provide misoprostol in Uruguay, women in the Rivera area have access to it. The midterm survey revealed that those who chose to abort a pregnancy after attending the new advisory service successfully used misoprostol to achieve a complete medical abortion without complications. Clinical studies have reported few complications and very low morbidity following misoprostol administration to induce abortion [11–16]. The first results analyzed in this report coincide with those findings, for women who self-administered misoprostol at home.

The health professionals interviewed at the midterm assessment, after the SRHS had begun operating, recognized the importance of the training carried out by *Iniciativas Sanitarias* and the effects of learning the risk-reduction strategy. They understood and appreciated the procedures that had been established for identifying and referring potential users of the service, and for the proper reception of these users.

At the same time, by the midterm assessment, it had also become apparent that there were limits to the effects of the awareness-raising and training efforts. Some health professionals manifested opposition. There seemed to be a hard core of resistance at the health center of which the SRHS is a unit. Going forward, the members of the health center in favor of the service will need to take responsibility for it in a way that reduces internal conflict and ensures its continued support.

In summary, by the time of the midterm assessment, the advisory service at the José Royol Health Center had been established and women used it and recommended it to others. A key factor for its success was the high level of user satisfaction with the care provided.

These findings show that, despite some local resistance, it is possible to establish an advisory service for women with unwanted pregnancies in a small, traditional, socially and economically vulnerable community such as Rivera. In Uruguay, with its restrictive abortion

Table 5
Gestation duration at the preabortion visit.

Duration, wk	No. (%)
≤9	54 (64)
10–12	10 (12)
13–20	19 (23)
Unknown	1 (1)
Total	84 (100)

laws, the service makes illegal abortion safer by offering sound, objective preabortion counseling. Such a service is inexpensive and may be implemented in any country irrespective of its legislation regarding abortion. It is a question of political will on the part of those responsible for public policies [17].

Acknowledgments

The study was financially and technically supported by the Special Programme in Human Reproduction of the World Health Organization.

Conflict of interest

The authors declare no conflicts of interest.

References

[1] Briozzo L, Vidiella G, Vidarte B, Ferreiro G, Cuadro JC, Pons JE. El aborto provocado en condiciones de riesgo: emergente sanitario en la mortalidad materna en Uruguay: situación actual e iniciativas médicas de protección materna (Induced abortion in unsafe conditions: emerging health issue on maternal mortality in Uruguay: current situation and medical initiatives for maternal protection). Rev Med Urug 2002;18:4–14.
[2] Briozzo L, Vidiella G, Rodríguez F, Gorgoroso M, Faúndes A, Pons JE. A risk reduction strategy to prevent maternal death associated with unsafe abortion. Int J Obstet Gynecol 2006;95(2):221–6.
[3] Briozzo L, editor. Iniciativas Sanitarias contra el Aborto Provocado en Condiciones de Riesgo. (Health Initiatives against induced abortion under unsafe conditions) Montevideo, Uruguay: ARENA; Feb 2007. p. 21–44.
[4] World Health Organization. Unsafe abortion: Global and regional estimates of incidence and mortality due to unsafe abortion. Geneva, Switzerland: WHO; 2008. http://whqlibdoc.who.int/publications/2011/9789241501118_eng.pdf. Accessed April 27, 2012.
[5] Cairoli Martínez M. El Aborto. Curso de Derecho Penal Uruguayo (Abortion. In: Uruguayan Criminal Law Course. Vol. III), Tomo III. Montevideo, Uruguay: Fundación de Cultura Universitaria; 1989. p. 119–39.
[6] Borges F, de Pena M, Mercant M, Gallino G. Aborto. In: Mesa G, editor. Medicina legal. (Abortion. In: Mesa G, ed. Legal Medicine. 2nd ed)2ª ed. Montevideo, Uruguay: Oficina del Libro AEM; 1995. p. 317–32.
[7] Briozzo L. coord. Iniciativas sanitarias contra el aborto provocado en condiciones de riesgo: Aspectos clínicos, epidemiológicos, médico-legales, bioéticos y jurídicos [Briozzo L, ed. Health Initiatives Against Induced Abortion in Unsafe Conditions: Clinical, Epidemiological, Medical, Legal and Bioethical Issues]. Montevideo, Uruguay: Sindicato Médico del Uruguay; 2002.
[8] Gobierno del Uruguay. Ministerio de Salud Pública. Iniciativas Sanitarias contra el aborto provocado en condiciones de riesgo. Normativa de atención sanitaria y Guías de práctica clínica de la ordenanza 369/04 del MSP «Asesoramiento para una maternidad segura medidas de protección materna frente al aborto provocado en condiciones de riesgo» (Government of Uruguay, Ministry of Public Health. Health Initiatives Against Induced Abortion in Unsafe Conditions: Health Care Regulation and Clinical Practice Guidelines in Ministry of Public Health Ordinance 369/04, "Advice for Safe Motherhood: Medical Initiatives for Maternal Protection Against Induced Abortion in Unsafe Conditions"). Montevideo, Uruguay: MSP; 2004.
[9] United Nations. Report on the International Conference on Population and Development, Cairo, 5–13 September 1994. Programme of Action. http://www.un.org/popin/icpd/conference/offeng/poa.html. Accessed April 22, 2012.
[10] Briozzo L, Faúndes A. The medical profession and the defense and promotion of sexual and reproductive rights. Int J Gynecol Obstet 2008;100(3):291–4.
[11] Faúndes A, Fiala C, Tang OS, Velasco A. Misoprostol for the termination of pregnancy up to 12 completed weeks of pregnancy. Int J Gynecol Obstet 2007;99(Suppl. 2): S172–7.
[12] Ngai SW, Tang OS, Chan YM, Ho PC. Vaginal misoprostol alone for medical abortion up to 9 weeks of gestation: efficacy and acceptability. Hum Reprod 2000;15:1159–62.
[13] Salakos N, Kountouris A, Botsis D, Rizos D, Gregoriou O, Detsis G, et al. First-trimester pregnancy termination with 800 mcg of vaginal misoprostol every 12 h. Eur J Contracept Reprod Health Care 2005;10(4):249–54.
[14] Carbonell JL, Rodriguez J, Velazco A, Tanda R, Sanchez C, Barambio S, et al. Oral and vaginal misoprostol 800 mcg every 8 h for early abortion. Contraception 2003;67(6):457–62.
[15] Carbonell Esteve L, Varela L, Velazco A, Tanda R, Sanchez C. Vaginal misoprostol for abortion at 10–13 weeks gestation. Eur J Contracept Reprod Health Care 1999;4(1):35–40.
[16] Faúndes A, Santos LC, Carvalho M, Gras C. Post abortion complications after interruption of pregnancy with misoprostol. Adv Contracept 1996;12(1):1–9.
[17] Faúndes A, Tao K, Briozzo L. Right to protection from unsafe abortion and postabortion care. Int J Gynecol Obstet 2009;105(2):164–7.