From harm reduction to legalization: The Uruguayan model for safe abortion

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Abstract
Advocacy by feminists and healthcare providers was essential in passing the 2012 bill legalizing abortion in Uruguay, which was primarily framed in terms of a public health imperative. Prior to legalization, a group of influential physicians had established a “harm reduction” approach consisting of pre- and postabortion counseling with a focus on safer abortion methods. The existence of a network of providers from this initiative facilitated the implementation of abortion services after legalization. Particularities of the Uruguayan model include a strong focus on medical abortion, and a multidisciplinary approach to patient counseling. The implementation of services was largely successful, and rates of abortion-related morbidity and mortality have decreased. Remaining concerns include high rates of conscientious objection and insufficient human resources to staff interdisciplinary counseling teams. The focus on medical abortion has led to a lack of method choice. Finally, data collection gaps complicate monitoring and identification of barriers to access.

KEYWORDS
Advocacy; Harm reduction; Implementation; Legalization; Medication abortion; Public health; Safe abortion; Uruguay

METHODOLOGY FOR ALL CASE STUDIES

This case study is one of six comprising a comparative examination of varied countries’ approaches to the implementation of national abortion service programs, after changes in laws or policy guidelines that established or expanded access to services. In addition to Uruguay, case studies were conducted in Colombia, Ghana, Ethiopia, Portugal, and South Africa, as they had all either implemented new abortion laws or policies, or changed interpretations of existing laws or policies, within the past 15 years. Each study used the Integrated Promoting Action on Research Implementation in Health Services (i-PARIHS) framework to organize the analyses. i-PARIHS posits successful implementation to be a function of the innovation to be implemented and its intended recipients in their specific context, with facilitation as the “active ingredient” aligning innovation and recipients.¹ For each country case, two types of data sources were used: an in-depth desk review and 8–13 semistructured, in-depth interviews with key stakeholders and experts in each country, selected in collaboration with in-country partners. Respondents provided written informed consent and were guaranteed confidentiality. Several respondents from each country served as in-country coauthors, in doing so giving up their anonymity as participants of the study, although no quotations provided as respondents are directly attributed to them. Respondents included healthcare providers, public health and government officials who had been involved in establishing or expanding the service, academics, and members of nongovernmental organizations (NGOs) and legal and feminist advocacy groups; in some countries interviewees came from the full range listed, in others from a subset (Table 1). Interviews were...
TABLE 1  Professional domains of interviewees in Uruguay.

| Professional domains | Number of interviewees |
|----------------------|------------------------|
| Medical professional | 4                      |
| NGO                  | 3                      |
| Government           | 3                      |
| Other*               | 1                      |

Abbreviation: NGO, nongovernmental organization.
*aOther* comprises academics, or individuals from feminist or legal advocacy groups, or UN agencies.

conducted by a Spanish speaking physician member of the team and a Uruguayan social scientist. Quotes presented are from interviews without attribution as we promised confidentiality. Data analysis comprised a multistep iterative thematic analysis, with coding structured to follow the i-PARIHS framework. The Ethics Committee of the Faculty of Psychology of the Universidad de la República approved the case study conducted in Uruguay. A full discussion of background and methodology can be found in Chavkin et al.²

1 | CONTEXT

Efforts to legalize abortion began after the fall of the military dictatorship in 1985, when feminist organizations mobilized to bring abortion to the forefront as a political concern.³ However, several efforts to bring a bill to Parliament failed, and unsafe abortion remained the major cause of maternal mortality. Although maternal mortality was relatively low,⁴ a rise in maternal mortality due to unsafe abortions had been seen in the early 2000s in the context of an economic crisis.⁵ This led physicians at the nation’s largest academic hospital to form a group called Iniciativas Sanitarias, dedicated to reducing the risks associated with unsafe abortion. Their “harm reduction” strategy comprised offering confidential visits in which women were counseled by a three-person interdisciplinary team (a physician, a social worker, a mental health professional) on how to use misoprostol safely and on warning signs of potential complications.

While abortions remained illegal and could not be obtained within the health system, this approach gave some legitimacy to women’s decision to terminate a pregnancy.⁷ It also brought women facing unplanned pregnancies closer to the health system, and reduced abortion-related morbidity and mortality.⁸ In 2004, this model was adopted as an official policy of the Ministry of Health, allowing it to be scaled up to other hospitals throughout the country.⁹ Meanwhile, civil society advocacy during the country’s first left-wing coalition government led to Parliamentary approval in 2008 of a bill on sexual and reproductive health, including the decriminalization of abortion. Despite broad political and public support, the President vetoed the chapters of the bill related to the decriminalization of abortion (although the harm reduction model did retain its legal status).⁹,¹⁰ In 2012, renewed advocacy efforts framing abortion as a public health issue brought another bill decriminalizing abortion under specific circumstances to a vote, which was approved.¹¹

The harm reduction strategy to reduce morbidity from unsafe abortions was an important background to the implementation of the new law as it created a favorable context for the provision of abortion services. The strategy had been successfully implemented in several cities around the country, even in smaller cities with high levels of stigma.¹² This provided a strong foundation for the implementation of abortion services after legalization. As one interviewee explained:

When the legalization occurred, we had already done arduous work on this topic, so the implementation itself wasn’t extremely challenging.

According to one respondent who was involved in designing the harm reduction initiative:

I would say [it helps] to approach the problem from a maternal mortality angle, begin to change the culture, create acceptance [...] all of this before implementing the changes in the law.

In addition to reducing stigma, Iniciativas Sanitarias had built an infrastructure that facilitated the provision of abortion services, as providers already knew how to counsel patients and interdisciplinary teams had been established for the pre- and postabortion visits. This allowed the initial implementation steps to run smoothly:

There was this history of working together before the law anyway [...] there were people that had been working this way for 10 years, they were part of the critical mass, which is why from 1 day to another you can implement the law [...].

Another contextual element that allowed abortion services to be quickly established after 2012 was the existence of a strong national health system. After 2004, with the leftist coalition in power, a series of reforms was implemented within the health system.¹³ These included creating an Integrated National Health System (INHS) financed through health insurance contributions paid by workers and government budget transfers for the unemployed and poor. This system organizes and manages the public–private healthcare delivery network, prioritizes primary health care, and has universal health coverage as a main objective.¹⁴ The Ministry of Health regulation of the 2012 law limits abortion services to public and private health facilities within the INHS. As an interviewee explained:

We made the decision that the solution needed to be provided at the state level [because] we want to provide care, not just for [abortion], but all care using the integrated health model.

The concern that private clinics could turn abortion into a profit-making procedure was a strong incentive to limit services to the INHS. The Ministry of Health deliberately avoided isolating abortion from other health services, and opted to incorporate it into sexual and
reproductive services. The existence of an integrated system with a strong primary care network allowed for relatively easy addition of abortion to the services rendered. Abortion is provided at the primary care level because implementers felt this was the best way to guarantee access across the national territory. As one respondent explained:

We always looked toward accessibility and guaranteeing their rights [...] and we knew that this was something we could do within the first level of care.

This strategy was largely successful in guaranteeing broad access to services.

2 | INNOVATION

Uruguay’s 2012 law authorizes abortion upon a woman’s request up to 12 weeks of pregnancy, up to 14 weeks in the case of rape, and without limitations if a woman’s health is at risk or in case of fetal malformations incompatible with life. Compared to the bill originally proposed, the final law does not emphasize women’s rights and imposes several restrictions on women seeking abortions. It requires women seeking an abortion on request or for social or economic reasons to have three consultations: the first with a health professional, in which she expresses her intention to terminate the pregnancy (IVE 1); the second, with a three-person interdisciplinary team (a physician, a social worker, a mental health professional), for a preabortion counseling session (IVE 2); this is followed by a mandatory 5-day reflection period that is to precede the actual procedure. The third consultation must be with a gynecologist who will perform the surgical procedure or write the prescription for medical abortion (IVE 3). The Ministry of Health regulation adds a fourth, postabortion consultation for follow-up and contraceptive counseling (IVE 4). Abortions must be provided within the INHS, where they are free of charge. Interview respondents explained that the law, a result of political compromise, was disappointing for many abortion advocates. Despite its restrictions, implementers were motivated to quickly provide access to services.

A key implementation decision made by the Ministry of Health was to focus on providing medical rather than surgical abortions. As one interviewee put it, “it hasn’t been the goal to include surgical abortions in voluntary terminations; the goal was always medication for abortions.” This was a practical, logistical, and political decision. First, implementers felt that training and resources for performing manual vacuum aspiration (MVA) in Uruguay were lacking. Second, the availability of misoprostol in the country (and of mifepristone following law reform) made medical abortion easier to implement logistically. Third, the pre-existing harm reduction model meant that a large number of providers were comfortable counseling women about how to use misoprostol at home, and about potential complications of medical abortion. One respondent explained:

The teams that kicked off the efforts post legalization were the same teams that were part of the process to legalize.

They had the experience around medication and less so with the instrumentation. It was the easiest way to continue doing what had already been done.

Fourth, leaders anticipated that the limited provider role in medical abortion would result in less conscientious objection. As one key respondent explained:

We decided to go this route because we felt that was the best way for the law to be successful. There is a lot less conscientious objection to prescribing a termination than there is for performing a termination with instrumentation [...] it was a political decision [...] made in anticipation of possible conscientious objectors, so they would not be able to delay the implementation of the law [...] there are a lot less gynecologists who object if the procedure is administered with medicine.

Another particularity of the Uruguayan abortion model is the interdisciplinary approach to counseling. This innovation also started during the time of Iniciativas Sanitarias, as that model included multidisciplinary teams of psychologists, midwives, and nurses counseling women about their options, each bringing expertise from their discipline. As one health professional explained, this approach allows for some task sharing among different professions:

[we are] part of a complete team, because the midwives will do the first and fourth appointments [...] speaking with the women, speaking about alternatives, doing the diagnosis, sending the ultrasound, and preparing for the second appointment [...] and in the fourth appointment, the midwife is the one that receives them, making sure everything’s all right, advising them on the contraception of their choice.

A majority of interview respondents felt that the interdisciplinary approach was, overall, a positive feature of the Uruguayan model, and recommended it for other countries. Framing abortion as a multifaceted issue that is more than just medical, allowed the services to be more “friendly” and open toward women’s needs. As one respondent explained,

There is that influence of the doctor in our society. But the response to this was trying to implement a service that was the most multidisciplinary, the most integrated that it could be [...] there was a systematic effort to try and demedicalize some of these issues.

3 | RECIPIENTS

As “recipients” of the new law, the teams who had been involved in the pre-existing harm reduction initiative were well positioned to quickly
start providing services. Because many providers had been trained as part of this initiative, and because the emphasis was placed on medical rather than surgical abortion, few additional training efforts were required. Obstetricians/gynecologists were key to the implementation of the law, which requires that they be the ones to prescribe mifepristone and misoprostol or perform surgical abortions. For these reasons, implementers sought the support of the Gynecological Society of Uruguay. As one interviewee explained, gynecologists had differing opinions on the law:

The law relied on gynecologists, so I tried to get the Gynecological Society of Uruguay involved from the very beginning, even though it was quite a challenge because there was a lot of resistance from within the group. So, I created a work group comprised of healthcare professionals including gynecologists, whom I believe had the technical competence to be able to develop the regulation and implement the law.

Including gynecologists in the group of implementers was key to obtaining buy-in from within the profession.

Because not all providers welcomed the law, however, conscientious objection quickly emerged as a barrier to accessing abortion services. Estimates of the prevalence of conscientious objection vary from 30% nationwide, to 50% in some suburban areas, and up to 100% in one department.14 Even in the capital region, one study found that more than 50% of gynecologists in the primary healthcare network are objectors. This means some centers only provide the first and/or second abortion consultation but must refer to other centers where a gynecologist is available for the third consultation to receive a prescription for medical abortion or receive surgical care.16 In some regions with high numbers of objectors, respondents explained that women are required “to travel 200 or even 300 km just to get a prescription” for medical abortion. In one department where 100% of gynecologists were objectors, a gynecologist from the capital city was sent to provide abortions, but this kind of human resource mobilization in response to conscientious objection was a rare exception. Respondents also believe that some providers refuse to participate in abortion care because there are no economic incentives, or because they fear being stigmatized as abortion providers, particularly in small, conservative towns, rather than because of genuine conscientious objection. Because the country is small and health facilities are required to refer if they do not provide services, most demands for abortions can be met, albeit with travel and delays. Yet most interviewees agreed that conscientious objection remains a significant barrier, and that current limits to conscientious objection are insufficient. As one explained:

Conscientious objection will need to be discussed clearly in Parliament: either they establish [stricter] limits for it or they allow professionals [other than gynecologists] to prescribe misoprostol.

The main recipients of the new law are Uruguayan women. Uruguay is a very small country with a relatively homogenous population that has good access to information. Because of persistent advocacy from women’s rights groups, abortion had garnered media attention before legal change. After legal change, two key feminist organizations took an active role in providing practical information to help women access abortions. As one feminist leader explained:

We were responsible for putting together pamphlets that outlined which centers were providing the services […] we did a lot of our work through social media, we advertised which centers provided the service in social media […] during the initial phases, this was something that was discussed daily on talk shows, the news and all of the print. That had a big repercussion on the information that was distributed to the public.

Feminists defined their role post legalization as one of monitoring implementation of the law, and of creating demand for services. One interviewee explained:

Civil society participation was fundamental in demanding the services, making sure that things were as the law saw them […] there was a role of this being implemented and the role of the monitoring to make sure that this was something that was really happening, which fell on civil society.

4 | FACILITATION

The key elements that facilitated the implementation of abortion services in Uruguay are the catalytic role played by the harm reduction initiative and the Ministry of Health’s commitment to quickly define the conditions for implementation of the law. The Uruguayan example is unique in that the physicians’ leadership role went beyond advocacy and included a component of implementation prior to legal change. The development of a harm reduction model was a creative approach that successfully built capacity to respond to a crisis of unsafe abortions. This model has already been replicated with some success in the neighboring country of Argentina.19 The strategic alliance between the Ministry of Health and healthcare providers was key as it allowed for strong political will to be translated into action. As one interviewee explained:

The political will of the teams that are part of this is very important. Of course, on one side, you have the activists, who help achieve a lot of things but if the healthcare professionals don’t want to implement, then it doesn’t get implemented, and access is awful.

Through effective collaboration with government, health professionals played a key facilitative role in the implementation of abortion services. As described above, feminist groups were also important in creating the demand for services and monitoring the implementation of the law thus ensuring that recipients’ needs would be met.
5 | REMAINING CONCERNS

Respondents cited several barriers to accessing abortion in Uruguay. As described above, the high prevalence of conscientious objection among gynecologists is a key remaining challenge, and is further complicated because the law specified gynecologists as those who can perform abortions or prescribe medications. Another concern is the third party authorization required in the form of a three-person team. While the integrated, holistic, multistep approach has the advantages described above, making it a legal requirement as stated in Uruguayan law rather than an option removes autonomy from the woman, who is made to justify her choice and explain her circumstances to multiple providers over several appointments. This process slows down and often impedes access to safe abortion, especially where human resources are scarce and assembling multidisciplinary committees is a challenge. As one respondent explained:

One of the major challenges was that interdisciplinary teams only really work in the [main] cities. They don’t exist in smaller cities and you have some of the smaller cities that are 100% objectors. This translates to women having to travel. [...] What is lacking is the human capital to be able to put together teams the way they should be [...] it’s not an issue of will, it really is a logistics challenge, a resource challenge.

In many instances, the multidisciplinary team requirement thus becomes a barrier to accessing services in a timely and convenient fashion. Further, while many respondents thought that the multidisciplinary team addressed women’s needs, they recognized that women were not asked about their preferences and that this may in fact not be an ideal model in the eyes of women seeking an abortion.

Human resource constraints had been considered in the strategic decision to focus on medical rather than surgical abortion. However, focusing exclusively on medical abortion was not enough to prevent high rates of conscientious objection, and also created other disadvantages. Currently, surgical procedures are almost never performed. Some exceptions include cases in which medical abortion has failed multiple times, and cases in which the gestational age is close to the legal limit and there is no time for a medical abortion. When surgical procedures are required, women are referred to tertiary care centers, as the capacity to provide surgical abortion is limited elsewhere. Indeed, training for surgical abortion was not initially planned, and subsequent trainings rarely included manual or electric vacuum aspiration. Some respondents felt that this was not necessary as most providers were familiar with the technique from their experience with incomplete abortions; others felt that more training is needed but that resistance among gynecologists remains high. Some respondents expressed concern about the lack of availability of surgical abortion because they felt women should be able to choose their preferred method, and also because the excessive reliance on medical abortion sometimes leads to medical complications. As one explained:

We believe there should be a basket with all of the necessary methods for the woman to be able to choose the method that best suits her [...] But [surgical abortion] is not even offered. The only method available is medication, and there are cases where the medication doesn’t work the first time, so it is prescribed once more, then again and again [...] we’ve identified cases in the interior when the medication doesn’t work, they will repeat the dosages up to five different times [...] there is huge resistance from the medical teams to do a surgical procedure.

Another added that since “it is a vicious cycle: [surgical abortion] is offered so rarely, few are practicing it on a regular basis, few are trained, and it becomes something that just isn’t offered to the patient.”

Another challenge brought by the focus on medical abortion is that immediate postabortion contraception (particularly with long-acting reversible methods) is more difficult to implement. Because many women do not come for the fourth, postabortion consultation, uptake of postabortion contraception has been limited. Overall, some interviewees agreed that there should be additional training in MVA, but others felt that there is no need for this because the public health problem has been solved by medical abortion, as abortion-related morbidity and mortality are extremely low, and because women almost never request surgical abortions. In their opinion, medical abortion has successfully alleviated tensions among healthcare providers and has met a great majority of users’ demands: “we have a 99% success rate with medical abortion [...] At the end of the day, the use of medicine is a much better adaptation for the current Uruguayan healthcare system.”

Some interviewees explained that the logistical and other barriers to access have led to the persistence of illegal, unsafe abortion in Uruguay. One explained:

Some women that don’t fall into the categories of the law, such as immigrant women who have been in the country for less than a year, women that are past the 12 week and 6 day mark, they’re all finding a resolution in a clandestine network [...] women are still choosing to go to the clandestine network instead of accessing the legal services [...] You don’t have to look very far, here we have a main bus terminal and it’s become the hub for the illegal sale of misoprostol.

It is worth noting that the gestational age limit can be a significant barrier for women seeking abortions following prenatal diagnosis, as results are often not available before 12 completed weeks, or even 14 weeks (the limit for abortions in case of malformations that are incompatible with life). While limited data are available on abortions that continue to be performed outside the healthcare system, respondents expressed deep concern about the problem, and stated that there is an urgent need to improve estimates of illegal (and potentially unsafe) abortion and further reduce barriers to accessing safe, legal abortion.

While data collection had always been a priority, some respondents explained that the monitoring system designed by the Ministry of Health has important gaps. One physician explained: “I would like to be able to
see the number of women that were able to successfully navigate the care route from start to finish." Women who come in for the first consultation but do not come for the second or third may indeed be women who change their mind about having an abortion, or they may face a barrier that leads them to obtaining an abortion outside the INHS. Abortion records are not linked with other medical records: "like any procedure that provides care, it [should be] captured in the patient’s history, but it is not [...] so you can’t cross reference." While this helps protect patient confidentiality, it leads to incomplete demographic and historical information about women who seek abortions, and about women who may have incomplete abortions or other complications. Respondents felt that linking records could be done carefully to obtain information without compromising confidentiality. Several interviewees also wished a measure of patient satisfaction and a more detailed record of postabortion contraception had been included in monitoring and evaluation efforts.

6 | LESSONS LEARNED

In addition to physicians, other influential healthcare providers and feminist groups in Uruguay played significant roles in advocating for legal change and in establishing abortion services. Strategic alliances with government officials were key to ensuring the translation of political will into action. Focusing on the public health argument was successful in this society where the political system’s resistance to the decriminalization of abortion was widespread.

Integrating abortion into the National Health System addressed equity in access to services. Focusing on medical rather than surgical abortion reduced training and infrastructural requirements and was more acceptable to healthcare providers. However, this was not enough to prevent high rates of conscientious objection, and excluding the option of surgical abortion may lead to medical complications and user dissatisfaction.

Counseling by an interdisciplinary team and incorporation of abortion into other sexual and reproductive health services created opportunities for task sharing among professionals. However, the three-person counseling team requirement is an important barrier to access, especially where fewer professionals are available. The requirement for gynecologists to provide abortions is also limiting, particularly outside the capital city, where rates of conscientious objection are highest.

Overall, the implementation of abortion services in Uruguay was quick, strategically planned, well documented, and resulted in a significant reduction in maternal morbidity and mortality. Remaining challenges include collecting more data to monitor user satisfaction and to track users lost to follow-up who may be seeking abortions outside the National Health System.

AUTHOR CONTRIBUTIONS

BMS: Contributed toward initial proposal, interview instrument, conducted Uruguay interviews, wrote first draft of paper, and collated edits and reviews. MC: Conducted four interviews, provided information and details while writing, and reviewed, corrected, and edited the manuscript at multiple points. ALG: Advised on interview instrument, interviewee, served as in-country point person, provided information and details while writing, and reviewed, corrected, and edited the manuscript at multiple points.

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CONFLICTS OF INTEREST

ALG functioned as key informant, was interviewed and served as coauthor. MC served as an interviewer and coauthor. The authors have no conflicts of interest to declare.

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