Self-care interventions for legal and safe abortions: lessons learned from a woman-centered approach to sexual and reproductive healthcare in Uruguay

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Summary

Problem In the 1990s, almost 40% of maternal deaths in Uruguay were caused by unsafe abortions.

Approach A harm reduction model implemented in Uruguay, which addressed the risks associated with unsafe abortion practices by promoting and supporting the self-management of medical abortions by women in their homes, encouraged women's autonomy.

Local setting Since 2005, an accelerated decrease in maternal mortality has been recorded in Uruguay, coinciding with the implementation of two major actions: a harm reduction approach with active promotion of self-care through self-management of medical abortions; and in 2012, a change in legislation, which made abortion legal within sexual and reproductive health facilities when requested by women up to 12 weeks of pregnancy or later for specific indications.

Relevant changes This example demonstrates that progress in public policies is possible through the combined efforts of civil society, healthcare professionals and policy makers. The initiative expanded the entry points to the healthcare system while strengthening women's autonomy.

Lessons learned Increased access to self-care interventions for SRH contributed to advancing achievement of universal health coverage and the highest, most attainable standards of health.

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Introduction

The World Health Organization's (WHO) first guideline on self-care interventions defines self-care as "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a health-care provider."[1] Self-care may be considered from two complementary perspectives: people-centred and systems-centred. The first perspective focuses on improving an individual's capacity for self-care, and the second focuses on how these practices relate to the healthcare system. The capacity and ability of individuals and communities to use resources and make decisions that benefit their own health is an integral part of the prevention and management of health conditions.

People-centred approaches highlight the need for individual and community capacity-building and resource strengthening as a condition for, as well as a

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product of, the practice of self-care. Complementarily, a system-centred framework highlights "activities that can add value in dealing with specific diseases or health issues that healthcare managers and policy makers consider important."[2] As stated in WHO's conceptual framework for self-care interventions, a supportive and self-enabling environment that includes access to information, products, and interventions linked to health systems is essential for implementation. In such an environment, healthcare systems remain an integral part of providing self-care options, support for self-management and adapting to changes in individual needs and choices taking place over time.[3] Elements from both these approaches can support the introduction, uptake and scaling-up of self-care interventions.

Self-care interventions provided within the framework of a safe and supportive environment, with accountable health systems and enabling policies, in partnership with communities, may address the needs and rights of even the most underserved individuals and communities.[2] This is especially relevant for women and girls affected by cultural, social, religious, political, and legal barriers that limit or impede access to quality sexual and reproductive health services, and who are denied information, choice, autonomy, and agency. Women's empowerment for autonomous decision-making is crucial to achieve gender equality.

Reproductively empowered women must have comprehensive knowledge, health and self-efficacy, social support and appreciation of the political, legal, and policy environment, the health system culture, and of gender and reproductive health norms.[4]

While self-care as a concept is not new, underscoring it serves to highlight, in the context of the international public health community, the intrinsic capacity of individuals to preserve and manage their own health. Uruguay provides an example of the importance of incorporating people-centred and health system approaches into public policies, and of how these policies can subsequently positively affect health outcomes leading to the progressive realization of girls' and women's sexual and reproductive rights and health. In Uruguay, self-management of medical abortion is currently part of a self-care intervention effort that provides women with the necessary tools to have a legal and safe abortion in their own homes. This will increase equity in abortion access through universal coverage and strengthen women's ability to make informed decisions, recognize risk factors, and manage their own health.

From risk reduction to legal abortion in Uruguay

Since 1996, specific sexual and reproductive health policies and programs have been developed and implemented in Uruguay. Before 2012, women who wished to terminate an unwanted or unintended pregnancy were unable to obtain care within the formal health system. They often had to resort to procedures that were performed either by people lacking the necessary skills, or in an environment without minimal medical standards — or both.

Further deterring access to quality care was the fact that abortion was a crime punishable with a prison sentence.[5,6] Maternal mortality was one consequence of such a restrictive legal environment, placing women and young girls in a vulnerable situation.[7,8]

In an effort to address the risks and harms caused by unsafe abortions, in 2001 a civil society organization, *Iniciativas Sanitarias (Sanitary Iniciatives)*, developed a harm reduction approach to abortion care. The organisation was comprised of a group of dedicated healthcare professionals who became agents of social and political change.[8] Protected by the principle of doctor-patient confidentiality, trained health professionals within healthcare facilities offered counselling on safe medical abortion practices without actually prescribing or providing abortion medications (in this case, misoprostol) — which would have been against the law.

Women who were able to obtain misoprostol were equipped with knowledge of the abortion regimen, including dosages; warning signs; and what to look for to assess completion. These women were able to complete their abortions at home and report to the health system for post abortion care and to receive additional counselling and post abortion contraception, if desired.[9] The use of this unique harm reduction approach by health professionals in Uruguay entailed going beyond advocacy to include a component of implementation prior to legal change,[10] eventually gaining political commitment from the Ministry of Health, and ultimately leading to a reduction of unsafe abortions nationally.[9,11]

In 2012, Uruguay passed the Voluntary Termination of Pregnancy Law [*Ley de Interrupción Voluntaria del Embarazo*, or *IVE* in Spanish],[12] which expanded access beyond specific legal indications to include abortion on request for women up to 12 weeks of pregnancy. In addition, abortion was legalized not only for Uruguayan women but also for those legally residing in the country for more than a year, with coverage incorporated into the Integrated National Healthcare System [*Sistema Nacional Integrado de Salud* or *SNIS* in Spanish].

Transition to a more holistic self-care model for legal and safe abortion

When creating the harm reduction model, *Iniciativas Sanitarias* demonstrated a strong commitment to women, while acknowledging the responsibility of the healthcare system to adequately respond to women's healthcare needs, protecting and promoting their health. The doctors and midwives involved were committed to

being both healthcare providers and social agents of change, advocating for safer reproductive health practices while offering direct clinical care. In support of the government's public policies, the organization provided evidence-based guidance, quality standards of care to build competencies, knowledge, skills, and all the necessary training. This dual commitment—both as advocates for policy reform and as clinicians offering direct care—was central to the model's success in meeting women's needs and advancing reproductive rights.

The changes in abortion policy and laws were quickly accompanied by shifts in societal attitudes towards abortion. For instance, after abortion was legalized, conservative lawmakers attempted to impose restrictions on access. However, it is essential to note that this restrictive stance enjoyed support from only a minority, representing less than one-tenth of the population.[13]

Since 2005, maternal mortality in Uruguay has decreased steadily, coinciding with the implementation of a series of social and health actions to protect women. Even before the change in legislation in 2012, the harm reduction approach was scaled up nationally in the years following the initial efforts led by *Iniciativas Sanitarias*. Policies related to sex education and universal coverage of sexual and reproductive health services further contributed to a rapid decline in maternal mortality (Fig. 1), as they continued to support self-care interventions, but with greater integration to the health system.[14]

Unsafe abortion and resulting maternal mortality, which was responsible for almost 40% of the deaths at the beginning of this century, has dramatically reduced over the last 25 years.

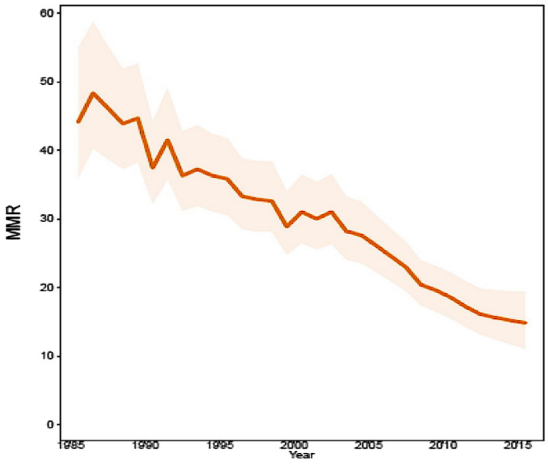

Fig. 1: Maternal mortality rates over 25 years in Uruguay, with their respective 95% confidence intervals. Source: Maternal mortality rates in Uruguay.[14]

This significant reduction is directly associated with the implementation of harm reduction policies and the legalization of abortion, as documented by Briozzo et al. (2016). These actions have been critical in transforming reproductive health outcomes in Uruguay, contributing to the sharp decline in abortion-related maternal mortality.[14]

The increased use of self-care interventions linked to self-management of abortions has greatly contributed to this decrease. Specifically, the focus on access to information has meant that women are better equipped to manage their abortion process. The current model ensures that women can access information and quality medication at any healthcare centre, which goes beyond the original harm reduction approach.[13] The current law guarantees the provision of free mifepristone and misoprostol, following WHO standards.[15,16] At the same time, stronger links have been established with the formal health system to ensure accountability of the health sector; individuals are financially protected, which promotes health equity; thus, women are enabled to safely have their abortion at home, should they desire this course.

Finally, the law requires healthcare facilities to offer counselling services; psychological support is provided to women by an interdisciplinary team to address the multidimensional biological, psychological, and social aspects of women's health.[17] While this requirement may be viewed as a potential barrier to the access to safe abortion that limits women's autonomy, for some individuals it ensures access to a range of healthcare providers and support for decision-making and for use of self-care interventions. In addition to providing information, emotional support and reassurance to women choosing an abortion, this approach facilitates a safe space for dialogue and expression of feelings, values, and personal motivations — offered to women from a place of respect, agency and empowerment, essential to making informed decisions responsibly, freely and consciously, without discrimination, stigma, and coercion.[16,17] Unfortunately, there is evidence that this approach is not always implemented as intended, as not all health professionals feel comfortable providing abortion counselling, and some women are still judged and stigmatized by others and themselves.[18–20] Sustained efforts are needed to mitigate the unwanted impacts of this legal requirement, with sensitization and comprehensive training on sexual and reproductive health to ensure that healthcare is viewed as a human right.

Despite the limitations of the Uruguayan Voluntary Termination of Pregnancy Law, women have generally reported positive experiences related to receiving information, including the ability to recognize expected symptoms[10] and identify whether additional help is needed. In addition to improved mortality, morbidity has also improved with the enactment of the law. Few women present to the emergency room and 90% of

abortions are self-managing performed in an outpatient setting; women seeking hospital care do so for mild symptoms.[21] Existing evidence also indicates that women prefer to manage their abortions at home,[20] accompanied by the people they choose, at a time and place that suits them best. Health and care workers further support women during this process by strengthening referral to the health system where needed or desired.[13]

According to the WHO, making health for all a reality depends on individuals and communities having access to information and quality health services to ensure their own health as well as the health of their families. This requires access to skilled, competent healthcare workers providing respectful, people-centred care as well as policy makers committed to investing in universal health coverage.[22] In keeping with the WHO's conceptual framework for self-care interventions,[2,3] the ability of women to self-manage their abortions empowers them to make decisions about their own sexual and reproductive health, while still maintaining a strong link to quality sexual and reproductive health services.

Conclusion

A series of actions — harm reduction followed by legalization of abortion and access to information, quality medications, appropriately trained health workers, and evidence-based national guidance — has led to improved health outcomes for women requiring an abortion in Uruguay. Women can self-manage their abortions in the first 12 weeks of pregnancy without suffering financial hardship, thereby reducing health inequities. Progress has been made in Uruguay through the combined efforts of civil society, healthcare professionals, and policy makers; through the provision of evidence-based self-care interventions that improve access and coverage nationally; and through the empowerment of women as active health decision makers.

The success of the Uruguayan model in reducing maternal deaths and morbidity can be attributed to two crucial elements: a strong connection with the healthcare system and accountability within the health sector. Furthermore, both of these pillars — supporting services within the health system and at home — have played significant roles in achieving these positive outcomes. However, limitations in the current regulatory framework still exist, particularly around mandatory psychological counselling requirements and healthcare provider reluctance to fully support abortion services, which may impact women's autonomy. Future policy changes could address these barriers, ensuring that all women can exercise full control over their reproductive health decisions.

While there is still room for improvement, including review of the present legal framework, the Uruguayan model (from the harm reduction approach to the legalization of safe abortion) has produced positive insights (Panel 1). The provision of abortion as a self-care intervention, with links to the healthcare system, and placing women's rights at the centre, ensures that healthcare is responsive to individual needs. This example of self-care intervention favours the advancement of universal health coverage by expanding the entry points to the healthcaresystem, strengthening women's autonomy and empowerment in health decision-making towards the highest attainable standards of health.

Future research could explore the scalability and sustainability of the Uruguayan model in different cultural and legal contexts, as well as the long-term impact of self-care interventions on reproductive health outcomes. Key questions include: How can the self-care approach be further integrated into the healthcare system? What legal and policy changes would enhance women's autonomy in managing their sexual and reproductive health? Addressing these questions will be crucial for adapting and refining self-care interventions globally to meet the needs of women seeking safe and legal abortion services.

***Panel 1*: Lessons learned.**

- Self-care interventions contribute to advancing universal health coverage by improving choice and access.
- The example of reduction in maternal mortality by prevention of unsafe abortions in Uruguay demonstrates that public policies can be advanced through the combined effort of civil society, healthcare professionals, and policy makers.
- In compliance with legal requirements, the Uruguayan model demonstrates that a closer link between the healthcare system and its users, with acknowledgement of the situated needs of people, may facilitate self-care options that are in addition to facility-based care and significantly improve health outcomes.

Contributors

MN, RGPL, CS and LGG conceived this study. LB provided critical information of the historical perspective of abortion in Uruguay. CS and LGG collaborated to draft the manuscript, collect and integrate feedback from all authors, and submit the final version of the manuscript. AL and MN provided technical revision from a self-care perspective. AL, MN, LB and RGPL reviewed and verified the underlying data reported in the manuscript.

The authors contributed equally to this work and approved the final version of this paper.

Declaration of interests

Dr Gomez Ponce de Leon is a staff member of the Pan American Health Organization. The author alone is responsible for the views expressed in this publication, and they do not necessarily represent the decisions or policies of the Pan American Health Organization. Dr Antonella Lavelanet and Dr Manjulaa Narasimhan are staff members of the World Health Organization. The authors alone are responsible for the views

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Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.lana.2024.100981.

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