

FIGO SAVING MOTHERS AND NEWBORNS PROJECT IN URUGUAY

To protect the life and health of Uruguayan women by reducing unsafe abortions

Also referred to in some documents as:
Iniciativas Sanitarias Contra el Aborto Producido en Condiciones de Riesgo

or
Health Initiatives Against Unsafe Abortions

Desk-based FINAL EVALUATION
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ACRONYMS

APHA	American Public Health Association
FIGO	International Federation of Obstetrics and Gynecology
HIV	Human Immunodeficiency Virus
IPPF	International Planned Parenthood Federation
IS	<i>Iniciativas Sanitarias</i> , Uruguayan non-governmental organization
MDG	U.N. Millennium Development Goals
M & E	Monitoring and Evaluation
MOH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non-Governmental Organization
OGC	The Society of Obstetricians and Gynaecologists of Canada
PAHO	Pan American Health Organization/ <i>OPS in Spanish</i> , the WHO section in Latin America
SGU	<i>Sociedad Ginecologica de Uruguay</i> /Uruguayan Gynecological Society
SOW	Scope of Work
SMNH	Safe Motherhood and Newborn Health
TOR	Terms of Reference
UN	United Nations
UNFPA	United Nations Agency for Population Activities
VDRL	Venereal Disease Research Laboratory (Syphilis test)
WHO	World Health Organization

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EXECUTIVE SUMMARY

The title of the Uruguay FIGO project is 'To protect the life and health of Uruguayan women by reducing unsafe abortions'. The goal of the project is to reduce maternal and newborn mortality and morbidity. Specifically, the project seeks to: (1) reduce the number of abortions performed under conditions of risk in Uruguay, (2) reduce maternal morbidity and mortality associated with abortion, and (3) implement a sustainable model at the national level within similar legal contexts for reducing the number of abortions performed under conditions of risk in Uruguay.

The project was submitted to the FIGO Safe Motherhood and Newborn Health (SMNH) committee in 2005, accepted in 2006 and the first funds were available in 2007. The project was finalized in August 2010.

BACKGROUND

Despite active lobbying by civil society groups, abortion has remained illegal with very few exceptions since the 1938 Uruguayan Constitution was enacted. Providers who suspected a patient of having undergone an abortion were to report her to the authorities for severe punishment (jail). Even under these circumstances, financially secure women were able to abort unwanted pregnancies safely; it was the poorest, less educated women who resorted to unsafe practices with dire health consequences.

For two decades, Uruguay has had the lowest maternal mortality in Latin America but in 2001, there were 19 deaths, a doubling of this statistic. Nine of the deaths were secondary to unsafe abortion. Based on these data, a group of concerned Ob-Gyn doctors, midwives and academics formed a new NGO, *Iniciativas Sanitarias (IS)* and designed a new strategy for reducing unsafe abortion morbidity and mortality, based on human rights and the 1994 UN Cairo meeting's agreement that women were entitled to have personal privacy and confidential health counseling so they may make appropriate pregnancy-related health choices. . In the new provider-client communication protocol's goal of harm reduction, providers changed their superior and informer status to a patient-centered horizontal relationship: women with unwanted pregnancies of up to 12 week gestation who attended health establishments were given a private, confidential counseling session where those who were seriously considering or had decided to abort their pregnancy received information on unsafe abortion practices to be avoided and safer practices with the self-administration of vaginal medical abortion. Misoprostol is available in pharmacies but can only be obtained in large packages at exorbitant cost, but underground "pharmacies" exist to provide it in 4 pill packs at a lesser cost. The patients were also encouraged to attend a "post" abortion consultation when, after discarding any problem, they received contraceptive information and offered methods to avoid further unwanted pregnancy and abortion.

The IS group, rather than addressing abortion's illegality, had been lobbying for the ethical patient treatment since the 2001 and in 2004, with a changed government, the legislature enacted an "*Ordenanza*" (less than law) which legalized the above described changes in practice.

The IS model was implemented in three seamless phases, from 2004 to 2010:

- It was tested at the largest maternity hospital, the *Pereira Rossell*, where there was a previous average of 4 unsafe abortion deaths/year. Results: no deaths in the 15 months it was used.
- The Uruguayan Gynecological Society submitted a proposal to FIGO's SMNH committee. It was approved in 2006 after FIGO's representative negotiated inclusion of the Midwives' Association as equal partners. But, its then treasurer was delaying making the funds available to IS. Thus the second phase was a pilot project implemented with Ipas bridge funds in 2006 in two first level health centres.
- FIGO's supported project, scaling up to 6 new facilities initiated in 2007 and the Uruguayan congress upgraded the 2004 *Ordenanza* to a legally stronger law in 2008.

RESULTS

It is not always possible to attribute all the changes in health services to IS nor is it possible to attribute them to individual phases of the effort. However, the very efficient and high quality strategy has achieved results way beyond its objectives. Among them:

Services are now in place in six new health centers, in addition to the two pre-existing centres and the Maternity hospital, and are being scaled up by the MOH to all public and private health services in the country. Each center has blood typing and Rhogam available, most have an ultrasound.

- **Providers** and non-professional center staff are trained and with facilitative supervision and are delivering adequate services.
- **Each facility has a coordinator** selected by its staff, trained and assisted by IS and paid by the MOH.
- **Data indicate** reduced hospital admissions for incomplete and infected abortions; increased contraceptive use and decreased deaths secondary to abortions. As a result the MOH, with IS technical assistance is now rolling out the IS Model throughout the country.
- **Women were empowered:** Whether they perceive their action to use information for decision making as empowerment or not, women with an unwanted pregnancy used information to make personal, appropriate choices. There are anecdotal reports that in one of the participating communities, women have been empowered and have made other important decisions to reduce other risks in their lives.
- **International efforts:** IS is now working with IPPF and WHO to replicate the Model in other countries where abortion is illegal.
- **The new service model** is integrated into medical, midwives, nursing and psychology academic curricula.
- **The Uruguayan Gynecological Society** and the Midwives Association have become strategic partners

- **FIGO-IS relations** are firmly cemented and the mentorships/twinning strategy are worth including in future FIGO efforts with some additional criteria.
- **The most important change** has been the newly enacted law to implement this rights-based, woman-centered style in the entire country, thus ensuring the **sustainability** of the project's approaches beyond the period of FIGO support. It appears that IS staff and its 10 years' efforts are in great part responsible for this change. It is hoped that similar changes in other countries where abortions are illegal will be implemented with a concomitant reduction of thousands of maternal deaths and many more maternal injuries.

The project has exceeded its overall goals and proposed outputs; however, the project has not been without challenges which provided valuable lessons for future similar projects. Other challenges remain on the table for agencies to find solutions. We outline these and add some of our recommendations.

- FIGO needs to make sure that proposals contain necessary professional alliances, a workable logframe and sufficient funding to allow it to be more involved with implementers on the ground.
- Access to misoprostol is still a work in progress; today, women can buy it underground or by internet but pharmacies should be encouraged to dispense it in the small dose needed.
- Intensive work has been focused on service delivery over a short period of time. The project has contributed to increased empowerment for women accessing these services in terms of their pregnancy choices. Raising the awareness of women in the wider community, however, needs a much longer period of time, as does increasing male involvement and support. The project has not fully achieved community empowerment or male involvement. This is not surprising, considering this was not one of its original objectives. However, the success of the project suggests that this would be an important next step to engage in, and we would encourage strengthening these efforts in the future.
- The MOH needs continued technical assistance from IS for its ambitious plans to progress by integrating IS's experience and lessons learned.
- IS is studying the possibility of establishing itself as the national training center for national and regional health service managers, providers and faculty and university students. We encourage this worthy goal and hope IS is able to obtain the necessary funds and approvals.

ACKNOWLEDGEMENTS

I would like to acknowledge and thank the *Iniciativas Sanitarias* project team for their invaluable help which they provided me despite their very heavy work load; the information they provided and their availability for person-to-person telephone and electronic contacts form the nucleus of my report. In particular the co-director Ana Labandera, representing herself and her co-director Dr. Leonel Briozzo, was most receptive to all my requests and helped me navigate the project and identify key staff as well as fact-checking my draft report and suggesting corrections. In addition, I would like to thank Dr. André Lalonde, FIGO project mentor and Dr. Francisco Coppola, President of the Uruguayan Gynecological Society for replying to my written questions in great detail. I have gained a great deal of knowledge from them and I hope to meet them in the not too distant future.

Finally, I wish to thank Rachel Grellier and Piya Shome of Options Consultancy Services UK, who were always available to support my effort to the maximum extent.

1. INTRODUCTION

This report is a review of the Uruguayan project titled *Iniciativas Sanitarias Contra el Aborto Producido en Condiciones de Riesgo* (Health Initiatives Against Unsafe Abortions), one of ten funded by the International Federation of Gynaecology and Obstetrics (FIGO) as part of the Saving Mothers and Newborns Initiative. Other countries participating in the initiative are Haiti, Kenya, Kosovo, Moldova, Nigeria, Pakistan, Peru, Ukraine and Uganda.

The title of the Uruguay FIGO project is 'To protect the life and health of Uruguayan women by reducing unsafe abortions'. The goal of the project is to reduce maternal and newborn mortality and morbidity. Specifically, the project seeks to: (1) reduce the number of abortions performed under conditions of risk in Uruguay, (2) reduce maternal morbidity and mortality associated with abortion, and (3) implement a sustainable model at the national level within similar legal contexts for reducing the number of abortions performed under conditions of risk in Uruguay.

The Uruguay FIGO Project was proposed in 2005, funded in 2006 and implemented by the Uruguayan non-profit making initiative *Iniciativas Sanitarias/Health Initiatives (IS)* from 2007 to August 2010.

BACKGROUND

1.1 Legal Aspects of Abortion in Uruguay

Abortion has been illegal under most circumstances in Uruguay since the nation's constitution in 1938. Attempts by feminist and provider activists to repeal the law and decriminalize abortion have been unsuccessful. In the constitution health providers who suspect a woman of intending or having had an abortion are legally directed to report the woman to the authorities for punishment (jail).

As is common where abortions are severely restricted, financially secure women in Uruguay have access to and can afford safely conducted abortions with trained professionals in clean surroundings. It is the poorest, least educated women who rely on clandestine abortions provided by untrained traditional agents, placing themselves at grave risk to their health and life. The number of clandestine abortions/year in Uruguay is estimated at 33,000*.

Since the late nineties, Uruguay has had the lowest maternal mortality rates in Latin America (between 2 and 1.7/10,000).** However, in 2001 this statistic jumped to 3.7/10,000 with 19 deaths. Nine of the deaths (47.3%) were due to unsafe abortion***. The largest Uruguayan maternity and children's hospital, *Hospital Pereira Rossell* in Montevideo, cares for women and children of low-socio-economic families: it attends one quarter of the country's 49,000 deliveries and is the main reference hospital for severe obstetric complications. In 2001, they had an unprecedented 7 maternal deaths, of which 5 were secondary to unsafe abortions.

* C.Bradford, 2008, Baseline Review submitted to FIGO/OPTIONS quotes a 2004 submission CEDAW attributed to Sanseviero (no other information available)

** PAHO 2010

*** Uruguayan Ministry of health Statistics

A group of concerned University Medical Faculty and Ob-Gyn providers, professional associations and health worker unions as well as some civil society women's groups, alarmed by these deaths, formed the NGO *Iniciativas Sanitarias* to lobby for a risk reduction initiative. This was modeled on the needle exchange strategy for prevention of HIV transmission by illegal intravenous drug use. This lobbying, combined with a newly elected socialist government, led to Uruguay adopting *Ordenanza*, (less than law but legally binding) in 2004 which was subsequently reaffirmed in 2008 by the passage of Law 18-426 titled *Los Derechos Sexuales y Reproductivos*. The new model sanctioned by law does not change the fact that abortion continues to be illegal under most circumstances. The new Ministry of Health Policies and Norms, however, state that women with an unwanted pregnancy of up to 12 weeks gestation and thinking of abortion must be attended to when they seek advice at a health facility. They should receive a "pre-abortion" counseling session with a provider team (doctor, midwife, psychologist) and, in addition, women who have an abortion are urged to return for a "post-abortion" session which includes assessment of physical and psychological health and counseling for future pregnancy prevention by the use of contraception.

Today, the 1938 Constitution continues to be in effect but there is no verifiable information that it is causing providers to report women to the police ("this practice does not exist", IS informant).

Many civil society groups, mostly feminist, have not desisted from lobbying for decriminalization of the practice of abortion.

1.2 History of the IS Model 2004-2010

The rights based ordinance passed by the Uruguayan congress in 2004 was the needed legal support for IS to test its service model in the *Hospital de la Mujer del Centro Hospitalario Pereira Rossell* with the objective of reducing unsafe abortion and its severe health consequences rather than trying to change its legal status in 2004. The IS Model implies a paradigm shift in providers' attitudes and practices from one where they were responsible for reporting women suspected of carrying out illegal abortions to focusing on clients' needs for confidentiality in their interpersonal communication and the need for a relationship of trust and mutual comfort between the client and the health professional. IS based its intervention on women's rights to receive confidential information on sexual and reproductive health matters and autonomy in decisions related to health as found in the report from the 1994 Cairo UN Population and Development Congress.

The hospital asked regional health centers to refer women who had an unwanted pregnancy for counseling on their options for addressing their problem. During this counseling session each woman was informed of unsafe/dangerous and safer abortion methods. She was urged not to seek an abortion from untrained traditional provider using poisonous preparations or inserting objects into her cervix or uterus in an unclean manner; rather, if she chose to abort her pregnancy, she was verbally informed about the use of misoprostol as a safer method, including dosage, venue of administration and expected outcomes and potential complications. In the 15 months during which the new Model was pilot tested, 675 women were seen and no deaths secondary to abortion were reported at the hospital*. With this positive evidence documented

* Briozzo et al., A risk reduction strategy to prevent maternal deaths associated with unsafe abortion, Int. J. of Gyn. And Obs. 2006;95: 221-226

during the pilot testing IS decided to scale-up the model. In 2005, the Uruguayan Gynecological Society (SGU) submitted a proposal to FIGO's SMNH Committee to replicate and scale-up the IS Model to a total of 8 health facilities: an initial stage in a maternity hospital and two primary centers followed by scale-up to 6 further centers with a combined target population of 70% of the Uruguayan population and a large proportion of low socioeconomic status families.

The project was titled 'To protect the life and health of Uruguayan Women reducing unsafe abortions' aims to reduce maternal mortality and morbidity (MDG #5). Specifically, the project's objectives were:

1. Diminish maternal mortality by preventing unsafe abortion
2. Diminish maternal morbidity and complications secondary to unsafe abortion
3. Diminish unwanted pregnancies and thus reduce further abortions

The project was accepted and launched in September 2006 with the presence of Dr. Andre Lalonde, Executive Vice-President of the Society of Obstetricians and Gynaecologists of Canada, after FIGO had negotiated the inclusion of the Uruguayan Midwives' Association as a partner. Funds, however, were not available until 2007. By then, IS had initiated its activities in two primary health centers in 2006 with Ipas interim assistance and funding. In addition, IS was awarded UNFPA funds to publish Dr. Briozzo's book describing the Model in detail. FIGO funds were disbursed in 2007, after the SGU accepted FIGO advice to change their treasurer. Funds were to scale-up to the remaining six new sites (four hospitals and two primary health centers) and continue work in the two original centers. The initiative in the total 8 health establishments plus the *Hospital Pereira Rossell* reaches 70% of the Uruguayan population comprising its lowest socioeconomic level in or near Montevideo and on the coast.

Responding to a request from IS managers who were having difficulty monitoring activities and documenting outcomes with the existing project Log Frame, Options at the direction of FIGO, provided a consultant to assist by revising the original log frame. The basic elements of the revised log frame are in Appendix #4 and are the basis for this report's results. The FIGO funded project ended in August 2010.

As a result of IS evidence, Uruguay's Ministry of Health has started scaling up The IS model to all health centers in the country.

2. EVALUATION METHODOLOGY

This review, managed by Options Consultancy Services, London, UK, was conducted by Emma Ottolenghi MD, Independent Consultant in Sexual and Reproductive Health (SRH).

The review included:

- A critical review of written material (narrative reports etc) and other evidence provided by Options, FIGO and the *Iniciativas Sanitarias* team.
 - The key document provided by IS was a draft of their Final Project Report, Sept 2010.
 - Dr. Andre Lalonde, Executive Vice-President of the Society of Obstetricians and Gynaecologists of Canada (SOGC), kindly consented to the use of his written response to the final evaluation questions, and it is quoted extensively in this report. The rationale for this is that he has been intimately involved with the Uruguay project and team since its initiation.
- A series of phone interviews with key IS staff and other stakeholders (Appendix # 2)
- Questionnaires sent by e-mail to other key players, both IS staff and other stakeholders (President of the Uruguayan Gynecological Society and Canadian FIGO twinning mentor)

Caveats: Desk-based reviewers must, by nature, depend on what people report and do not have the opportunity to verify received information and data with exhaustive open interviews and viewing actual records. They also depend on receiving timely responses to requests for interviews and/or e-mailed questionnaires. In this review's case, several key persons did not respond to repeated requests for either verbal/telephone conversations or written responses to questionnaires sent two weeks or more in advance, or after requests by the Project Associate Director. In addition, unfortunately it was not possible to have a telephone interview with the project director, Dr. Briozzo, due to his ill health.

3. FINDINGS

It is a well known fact that many women with unwanted pregnancies seek to abort whether safely or not and whether legal or not. In countries where abortions are illegal, women with more education and income are more likely to have safe abortions by trained providers in sanitary conditions. It is the poorer women who can only afford to see traditional providers using unsafe practices and it is these women who are at risk of subsequent serious health problems and death.

The Uruguay project, implemented in a national climate where abortions are almost always illegal and punished severely, has achieved changes in the Uruguayan health system beyond what was originally proposed. By addressing the harm caused by dangerous abortions as a human rights and health problem rather than addressing the illegality of abortions, it has changed providers' paternalistic, punitive attitudes and behaviour towards the women who access services. In the process of implementing this unique strategy, women who seek abortions are empowered to self-induce abortions with misoprostol, probably the safest method available today. In addition, as a result of evidence obtained by this service model, Uruguayan policy has been changed with the introduction of a law that directs providers to give clients holistic integrated reproductive health services rather than act as informants to the police

Before: Providers in public health services were offering services based on the 1938 constitution in which abortion was described as a crime and women who were suspected of having had one were punished by jail-terms; the providers' role was to report these women/clients to the police.

Now: protected by the 2004 Ordinance and affirmed by the 2008 Law, providers in all project-supported health centers are practicing under protocols of the *Iniciativas Sanitarias* (IS) service model (a maternity hospital, two primary health centers of the Ipas funded pilot project and six centers proposed to FIGO). Women with either planned or induced abortion for their unwanted pregnancy are offered "pre" and "post" comprehensive counseling sessions in a safe, private and confidential setting. In addition to an examination and blood tests, the pre-counseling session includes provision of information on the dangers of seeking an abortion from an untrained provider and/or unclean site and on the alternative safer abortion practice with self-administered misoprostol. The post-abortion counseling offered to women who have undergone an abortion (unsafe or safe) includes a psychological and physical evaluation and information on prevention of future unwanted pregnancies by the use of contraception.

This change in practice has shown very positive results (a reduction of maternal deaths secondary to abortion at the *Pereira Rossell Hospital* from an average 4/yr up to 2004 to zero/yr since 2007). In addition, there have been no deaths secondary to abortion in the entire country in the last 2 years. Maternal deaths did show an increase to 16 in 2009; half of which were due to complications of the H1N1 flu. No deaths were attributed to abortion complications.

The changes cannot be attributed entirely to the FIGO project because it was constructed on the foundation of several years' efforts by its principal actors to test, pilot and document results of the IS Model, first in a large maternity hospital and then in two primary health centers, followed by an additional six health establishments, covering over 70% of the Uruguayan population with a majority of women living in low socio-economic conditions. In addition this project was working in a more enabling political environment; however the project strengthened implementation of the policy changes that took place, causing the congress to upgrade the 2004

ordinance to the more binding 2008 law. Anecdotal information provided stated that providers throughout Uruguay no longer feel bound to report women to the penal authorities. This practice has essentially disappeared in the country since the 2004 legal statute.

The appointment of Dr. Leonel Briozzo by the Ministry of Health to establish a strong sexual and reproductive health policy represents both changing attitudes at national level towards strengthening women's reproductive health rights, but also demonstrates another major achievement: that of institutionalizing the IS model within the government's national sexual and reproductive health strategy.

It is important to note that the IS Model application has had three phases which were almost seamless from one to the other. It was initiated in 2004 in the maternity hospital (*Pereira Rossell*) in Uruguay and scaled up with Ipas funds in two pilot first level centers in 2006 before the FIGO supported phase, 2007-2010, adding six health establishments. It has not always been possible to disaggregate results and report only on FIGO/IS project.

4. ACHIEVEMENTS

4.1 Services: Services are now in place in six new health centers in addition to the two pre existing centers and the Maternity hospital and are being scaled up by the MOH to all public and private health services in the country.

4.1.1 Providers and non-professional center staff are trained and supervised

- Four hundred and forty one (441) professional and non-professional workers in health centers participated in workshops designed to clarify their values and modify their attitudes from paternalistic and prejudiced against women who had unwanted pregnancies and abortions to one of professional mutual trust and confidentiality.
- Two hundred and five (205) professionals (doctors, midwives, psychologists and social workers) were trained in recently established norms to give women the space to learn and understand their rights to quality, comprehensive Sexual and Reproductive Health services and empower them with the knowledge of abortion methods to be avoided because of their high risk and the alternative less risky method, vaginal self-administration of misoprostol (Cytotech). Providers and staff who joined the centres after the initial basic training were also trained, and all are continuously re-trained during twice-yearly facilitative supervisions.
- One coordinator for each clinic, selected by the participating centers on the basis of jointly established criteria, were trained by IS and assumed the responsibility of maintaining the quality of services offered. IS staff and local MOH coordinators met every 6 months to discuss positive experiences and address needed improvements and plan how to achieve them. These leaders are not only MOH staff but feel part of IS in their professional image and are members of this NGO.

4.1.2 Adequate Clinic Infrastructure

- Each clinic was visited before service introduction and very modest changes were implemented, mostly to provide complete privacy to clients, and the new Norms and educational materials were distributed.
- All the clinics have blood typing capacity and supply of antibodies (Rhogam); however, it should be noted that some of the desirable equipment has not yet been provided to all centers (ultrasound, HIV and VDRL test kits).

4.1.3 Clients feel comfortable coming to health centers for attention when faced with an unwanted pregnancy and thinking of abortion

- Two thousand seven hundred and seventeen women (2,717) received services with FIGO support between 2007 and 2009 in the 6 new (FIGO) and in the original maternity hospital and two primary (Ipas) establishments. The numbers increased significantly during the first year and have now stabilized.*
- Anecdotally, most clients who returned for a second visit, both those who decided to abort and those who decided to continue the pregnancy, were very satisfied with the service provided on the first visit and thanked the providers and the clinic for the attention they received. There were also some unusual outcomes: a woman who reported being 7 weeks late for her period when she received a pre-counseling

* Anecdotal information: women are not only being referred by their primary health centre but also are informed of the new services by previous clients

session, reported the clinic as having performed an illegal abortion on her and showed a 16 week fetus as its product. This fetus was later shown to be her sister's spontaneously aborted fetus; as a result the case was dropped and the midwife who attended the client was back to work the next day.

Of the 2,717 clients:

- 1988 (73.2%) received only the pre-abortion counseling, 552 (20.3%) received pre- and post-abortion counseling and 177 (6.5%) received only post-abortion counseling. 65% of the women coming for the pre-abortion service were less than 9 weeks pregnant and another 19.9% had gestational ages of 9-12 weeks.
- 60% of the pre-abortion clients stated that they were using a contraceptive method, principally condoms and oral contraceptives, when they became pregnant but, due to lack of information, use of these contraceptive methods had not been consistent or correct.

The project conducted a telephone interview, with prior informed consent, with a non-representative sample of 94 of the women who did not return for the post abortion visit. The reason given for not returning was that they chose to go for their post-check at their primary health center which had referred them to one of IS intervention centers for the pre-service. The interviews showed that:

- 53% had self aborted with the use of misoprostol and 95% of them had received a post-abortion check-up at their primary health service.
- 21% had made an informed choice to continue their pregnancy after receiving IS's counseling. This fact affirms that the provided counseling is not directive.
- 4.3% had a spontaneous abortion without any problem and 5.3% had not been pregnant.
- 13 did not wish to be interviewed.

4.1.4 Service Quality is adequate in most participating centers

- Service quality was evaluated and showed that at the time of writing this report, 80% were deemed to be either very adequate or acceptable. All participating centers will continue to be upgraded, more intensively in those that had not reached an acceptable qualification. In the 20% which were of low quality the providers will attend new trainings on all aspects of the model.
- Client-determined quality was assessed in the 8 participating centers by 20 exit interviews. At least 17 of these, clients reported satisfaction with services, respectful, confidential attention received in all service stops. They reported leaving the center having received clear and complete information on the use of misoprostol and happy with the involvement of a multidisciplinary team of service providers.

4.1.5 Scale-up has taken place and today the MOH is gradually implementing the IS Model in the entire country

- The results indicate a reduction in unsafe abortions and hospital admissions for incomplete and infected abortions; increased contraceptive use to prevent further unwanted pregnancies and an apparent reduction of deaths secondary to abortions. As a result the MOH is implementing the IS Model throughout the country. To date they have trained teams of trainers who are in turn training center staff. They

forecast that the new services will be established throughout Uruguay by next year (2011). Postscript: the Minister of Health affirmed the plan to cover the entire country with the IS model services during the Closing Presentation of the FIGO project in October 2010, at which Uruguay's president was present.

4.2 Women who received services were empowered

- The term 'empowerment' in this report refers to women gaining greater power not only over decision-making in terms of their individual reproductive health, but also within the broader socio-political environment. From this perspective it is possible to say that the project achieved a number of these aims. These can be summarized as: providing women with information to enable them to make appropriate choices and, if necessary, the appropriate actions regarding their pregnancy; and engaging in discussions with health professionals who recognize each woman's right to make their own informed decisions. This is an important step towards greater changes in the current gender imbalances in power, particularly when coupled with the new national Sexual and Reproductive Health Policy.

Whether women perceive their action to use information for decision making as empowerment or not, women with an unwanted pregnancy who were counseled about their options used the information to make personally appropriate choices. The majority decided to abort their pregnancy, which is what they intended to do when they came to the health facility. To accomplish this they further understood that misoprostol is a safer means of inducing a self abortion and were able to obtain the drug and use it according to the protocol discussed in the clinic. Over 20% of them on the other hand decided to continue and accept the pregnancy and planned to have a baby. It would be interesting to know if these women can act to empower others and further, to pressure community leaders to seek sexual and reproductive education for women, men and youth delivered in the community by provider teams. To date there is no verifiable data to show this is occurring but there is anecdotal information that women who have been to the centers and received counseling are referring other women to the clinic.

4.3 New, international efforts to replicate the IS Model are underway

- IS has signed an MOU with the Western Hemisphere IPPF and has conducted meetings, provided materials and technical support to its member Agencies in Nicaragua, Panama, Mexico, Guatemala, Venezuela, Peru and Ecuador. IPPF is considering the possibility of replication in Africa and Asia where most maternal mortality secondary to unsafe abortion is recorded.
- With funding from WHO, IS working in one of its health centers near the frontier with Brazil with clients from both countries.

4.4 Curricular changes to include the IS model are in place in the National Medical, Midwives', Nursing and Psychology Schools

- The IS model components: privacy and confidentiality, risk reduction, information provision and client's autonomy right to make personal decisions is now in place in the curricula for health professionals. The IS Model counseling components for women with unwanted pregnancy is expected to be added in the next couple of years.

4.5 Policy changes derived from the IS/FIGO data are in place (see detailed description in Background section 2.1: Legal aspects of abortion in Uruguay)

- Most informants assert that it will be almost impossible for these changes to be rescinded by a more conservative future government because communities are empowered and are fully aware of their reproductive rights to allow back-tracking.

4.6 The Uruguayan Gynecological Society and the Midwives Association are now strategic partners

Background: The project proposal was written and submitted to FIGO by the Uruguayan Gynaecological Society (SGU). In this, the midwives were relegated to a secondary role due to historical poor working relations and competition for territorial power between the two professions. Both gynaecologists and midwives were passionate regarding women's rights to ethical treatment, regardless of whether abortion was legal or not, but had not worked together as partners on this objective. Changes to this situation were negotiated by FIGO's representative, Dr. Lalonde, and midwives' inclusion as equal partners was a condition of the proposal's approval.

- Today: professional relationships between gynaecologists and midwives are both equitable and respectful. The IS/FIGO project has Co-Directors representing the two professional groups: a Gynaecologist as Administrative Director (Dr. Leonel Briozzo) and a Midwife Associate Director (Ana Labandera). They work as a team and collaborate to strengthen all IS project corporate and management aspects
- The two societies have made significant efforts to achieve a completely horizontal relationship based on collaboration and division of responsibilities. They have regular joint meetings during the project to review achievements and discuss and solve challenges and these will continue into the foreseeable future. To avoid perceived, or real, conflict of interest, the Associate Director who was the president of the midwives' association when the project started took a leave from this organization's dealings with IS/FIGO (two other midwives have been charged with this relationship). For the same reason, the Dr. Leonel Briozzo who has recently been named Director of the MOH Strategic Initiatives' Program, has taken leave-of absence from his administrative responsibilities within IS/FIGO. Today, he is a member/adviser of the board.

4.7 Sustainability

- To quote Dr. Lalonde: *"I believe that the project has achieved its goal and is completely sustainable. It is now incorporated into the country's ministry of health action plan. They also created a new department called the strategic management of health programs. This was to put together all of the promotion programs and health prevention care across the country. The head of this new department is Lionel Briozzo, director and co-chair of our project"*.
- The evidence gathered during this final evaluation also indicates that the IS strategy is now protected by law. The involvement of the MOH in ensuring national coverage and implementation indicates that the project has achieved long-term sustainability. This does not mean that IS is now relieved of all its commitments: it needs to continue giving technical assistance to the MOH, the academic institutions and others.

4.8 FIGO-IS relations are firmly cemented

- The strengthening of FIGO-IS relations is largely due to the fact that Dr. Lalonde is Chair of FIGO's Safe Motherhood and Newborn Health Committee, he has provided assistance in an enabling manner and has gained the IS staff's confidence. He has been: *"very involved with FIGO and with this project. Since the beginning, I have been monitoring this project, talking with the team, and participating at meetings in their country and outside of Uruguay"*. He expects that personally, he and FIGO will continue this collegial relationship. In addition, the co-directors of the IS/FIGO project are convinced that FIGO will continue to provide advice and support. The President of the Uruguayan FIGO member (SGU) asserted it will continue to be intimately involved with IS and with the MOH in the extension of the project.

4.9 Summary of key changes resulting from the project:

<p>National changes to professional education</p> <p>The National Medical, Midwives', Nursing and Psychology Schools are changing their curricula to include IS model components.</p>	<p>Changing professional attitudes</p> <p>646 professionals (doctors, midwives, psychologists and social workers) and health center staff provided with training on:</p> <ul style="list-style-type: none"> • A rights based approach to care • The need for mutual trust and confidentiality between staff and client (moving away from the previous paternalist and punitive approach towards women seeing abortion. • Recently established norms which make explicit women's rights to non-judgemental care; quality, comprehensive sexual and reproductive health services; information regarding the risk of unsafe abortion; and information and access to safe abortion methods.
<p>Strengthening service delivery</p> <ul style="list-style-type: none"> • Health facility layout changed to provide complete privacy to clients • Literature on new Norms and educational materials distributed to health facilities. • All the clinics have blood typing capacity and supply of antibodies (Rhogam). • Service delivery changes are being scaled up by the MOH to all public and private health services in the country. 	<p>Improving women's experience of care</p> <ul style="list-style-type: none"> • Women received non-judgemental pre- and post-abortion counseling. • Women were able to make an informed decision about whether to continue or terminate their pregnancy. • Women wishing to do so were enabled to safely induce abortions. • Anecdotal evidence that women who have accessed services provided by the project are referring other women to health facilities.

5. CHALLENGES

The project has exceeded its overall goals and proposed outputs; however, the project has not been without challenges. Most of these have been overcome, providing valuable lessons learned for future similar projects and for FIGO.

Some challenges have been described in their pertinent Achievement section, however additional challenges are described below:

5.1 Proposal development

- It was felt that FIGO did not make it explicitly clear that one of its intentions in supporting new innovative projects to improve maternal and neonatal health was equal status and collaboration between provider categories. In the Uruguay case, the original proposal was written and appropriated by the SGU, giving only subordinate status to the Midwives Association. After FIGO's position was clarified, the project proposal was modified to include both at the same administrative level and value.

5.2 Original project funding and Board directors

- Once the project was funded and launched in 2006, there were initial internal challenges in obtaining timely release of funds. This challenge was overcome by a change in Treasurer. This change in personnel was seen as resulting in *“an excellent collaboration with the new treasurer and with the finance committee. The holder of funds worked outside of the association as an independent monitor”* (Dr. Lalonde).
- As the Midwives were not involved in proposal writing, there was no budget-line item for the twinning mentors to visit the site. This resulted in the lack of significant inputs throughout the life of the project.

5.3 Buy-in from proposal organization (SGU)

- The SGU membership was sharply divided into, mostly older, members who believed that the project intended to provide abortions and those that did understand that the project objective was to reduce unsafe abortions and their consequences. With intensive meetings some, but not all, of the former group changed their stance. Key informants for this final evaluation, including the new (younger) president of the professional organization, believe that as older members retire and are replaced by a younger cohort, the problem will cease to exist.

The SGU's president reported that: “The greatest challenge for the IS project was breaking the status quo of Gynaecologists' negative opinion towards abortion and acceptance of the professional secrecy and confidentiality required on their relation to patients and their concern that they would result in confrontation with the judicial system. The project, however, achieved an important ethical shift in the professionals' attitudes which has resulted in a drastic reduction of maternal deaths due to unsafe abortion”.

5.4 Coordination between professional societies

Please see section 4.5, p.17

5.5 Mentorships/twinning strategy

The mentoring process which is inherent in project activities has been challenging to implement successfully. The reasons for this were:

- The original mentor was strongly opposed to abortion on religious and personal grounds. As a result collaboration was not possible, nor would it have been beneficial to the project. This mentor was replaced by Dr. Lalonde who has actively participated and engaged with the project teleconferences and attended two meetings in Uruguay.
- Lack of project funds prevented the midwife twinning mentor from visiting the project. As a result her engagement with the project was limited to a brief meeting in Chile where she and Ms. Labandera were attending another meeting. This was unfortunate as Ms Labandera stated that having a midwife mentor would have been very valuable since it would have brought a different perspective to the project.
- In both Dr. Lalonde's and IS Co-Director, midwife Ana Labandera's opinions, the current twinning/mentorship strategy is valuable for the present and future FIGO projects like this one. It represents important status to the implementer as well as advice and backup for decisions made.

5.6 Understanding a logframe

- The logframe presented in the original proposal focused on the policies of unsafe pregnancy and the indicators did not facilitate monitoring, evaluation and reporting of results. With assistance from a consultant provided by Options at the request from FIGO, the logframe was modified in 2008, was successfully implemented and found very useful by the staff and FIGO mentor.

5.7 Access to misoprostol

- Misoprostol is widely available in pharmacies with a prescription. However, the cost is prohibitive. Women have been able to find underground providers who have existed from years ago and who provide the misoprostol dose at an affordable price. Also, some women have found that it can be ordered via internet from other countries and inform other women on how to do it from internet cafés. It is difficult to imagine that this can change by providing women with the drug in the clinic because this would, in essence, be a punishable action according to the prevailing 1938 constitution.

5.8 Empowering communities

- In 2008, a new initiative to bring the services to the attention of communities was implemented among the population accessing the first two participating health centers. This activity was based on the assumption that women who received this information in groups in the community would choose to access services if faced with an unwanted pregnancy.
 - The strategy, funded by Ipas used multidisciplinary teams from the clinics to educate and provide information on sexual and reproductive health (reproductive anatomy and physiology, fertility, contraception, unsafe abortion); in addition to discussion of the management of unwanted abortion.

- The workshops were designed for a large variety of potential participants including incarcerated women, adolescents, mothers of young children and babies in nurseries, school teachers and parents among others.
- Unfortunately, the workshops did not attract a large enough number of attendees and did not result in increased demand for clinic services. Patients continued to access services because they had been referred by a provider in a neighboring clinic, a private practice or by a single woman who had received services.
- Barriers to accessing services included: more time needed, lack of information; incorrect information and myths found in the community; and community leader apathy. However, this baseline information provides important information which could be of use if similar community approaches to empower women are attempted by other projects.

6. DISSEMINATION

These are some of the notable dissemination activities conducted since 2004 by IS staff:

Presentations in National and International Congresses including the FIGO Latin America Congress held in Uruguay and in South Africa in 2008. In 2010, IS health services coordination presented at the Fifth Latin American Congress on Health and Sexual and reproductive rights held in Guatemala. A presentation has also been accepted for the November 2010 APHA meeting in Washington.

Publications: Multiple articles have been published in national and international peer-reviewed journals describing the problem of health risks of unwanted pregnancy with unsafe abortion.

Press: IS staff facilitated health centre physicians to give many interviews to print, radio and television journalists at both national and district level. These have resulted in frequent dissemination of the changes in policies regarding providers' obligations to patients; and on advances and results of the implementation of the FIGO/IS project Model.

The participating health facilities have produced locality-appropriate **pamphlets and posters** which are widely distributed. No patient dedicated pamphlets have been produced to date.

The IS **website** www.iniciativas.org.uy has been functional for several years and has been well maintained. The website has an average of 500 visits/month from Uruguayans.

One of the participating centers recently produced a **blog** that is being used for discussions by clinic providers from project and non project clinics.

The single most important dissemination activity took place at the October 2010 end-of-project meeting in Montevideo, with the presence of Uruguay's President and Minister of Health, the FIGO representative/mentor and most national decision makers. Links to media coverage of the project are given below:

<http://www.larepublica.com.uy/comunidad/427085-experto-alabo-plan-uruguayo-de-consejeria-sobre-aborto>

<http://www.larepublica.com.uy/politica/427168-aborto-a-favor-de-consulta-popular>

http://www.180.com.uy/articulo/14321_Mujica-llamo-a-mirar-el-aborto-de-frente

<http://www.observa.com.uy/Actualidad/nota.aspx?id=103153>

http://www.teledoce.com/noticia/13633_%5C%20Lo-mas-importante-es-proteger-la-vida-y-la-salud-de-las-mujeres%5C-dijo-Mujica/

http://www.montevideo.com.uy/notnoticias_121881_1.html

7. LESSONS LEARNED

For FIGO:

- Requests for Proposals and Scope of Work documents should be very clear about special criteria for acceptance and should assist writers of worthy proposals to include a useful logframe which will enable results to be documented.
- When twinning strategies are involved, FIGO should include funds for mentors to have 2 or three visits during the project implementation: launch, midterm and results presentations. Ideally central funding should include a budget for the coordinator/mentor to visit the project on an annual basis; and for project participants to meet colleagues in other countries to facilitate shared learning around key issues such as unsafe abortion.
- There is a need to establish criteria for the selection of Mentors and, particularly in the case of projects addressing sensitive issues, to confirm that Mentors will not face conflict of interests for personal or religious reasons before formalizing their relationship with the project.
- It would be beneficial to project teams, mentors and twinning societies if a clear definition of the role of mentors and twinning societies, and expected levels of involvement were set out by FIGO at the beginning of the project, and reviewed on an annual basis.

For the IS project

- Significant positions within the project should only be held by people who agree with the proposal and its strategy.
- Ownership of the project by clinics and decentralizing service oversight can be achieved by allowing the clinics to select a coordinator based on IS criteria.
- Quantitative data collection and reporting is only worthwhile if the sample size is sufficient and representative of the wider population (See client satisfaction).

8. CONCLUSION

It is not difficult to conclude that this project is exemplary for the implementing country, Uruguay. The project strategy should serve as a model to be replicated and/or adapted in many settings where abortion is illegal through its emphasis on not addressing the illegality of abortion, but rather taking both rights based and harm reduction approaches.

9. RECOMMENDATIONS

Community outreach and empowerment

- Community participation has been accepted worldwide as essential for many development activities. It is recommended that IS seek the resources to test new strategies in this regard.

Continued technical support to the MOH

- During the MOH national replication stage of the new service model, IS's continued accompaniment and technical support will be very important to assure the quality of training, community outreach, materials' development, etc.

***Iniciativas Sanitarias* is ideally poised to develop a training center devoted to its model strategy which could serve not only Uruguay but also become an international resource for public and private providers.**

- This idea has been studied by the project staff and is one of the recommendations of the 2 participating professional associations.
- The IS staff and the professional Societies involved in the FIGO project are:
 Ana Labandera, Midwife (*obstetra*), representing herself and Dr. Leonel Briozzo, project Co-Directors
 Dr. Verónica Fiol, M & E and Training Co-Ordinator
 Dr Mónica Gorgoroso, Health Service Implementation Co-Ordinator
 Psychologist Cecilia Stapff, Dissemination and Advocacy co-ordinator
 Psychologist Ivana Leus, Training and support to make counseling more holistic
 Midwife Beatriz Gimenez, recently elected president of the Uruguayan Obstetric Midwives Association
 Dr. Francisco Coppola, President of the Uruguayan Gynecological Society
 Dr. André Lalonde, Executive Vice-President, the Society of Obstetricians and Gynaecologists of Canada and Chair of FIGO/Safe Motherhood and Newborn Health Committee. Twinning mentor to the Uruguay project.

APPENDICES

Appendix #1 Terms of Reference

FIGO Saving Mothers and Newborns (SMN) Project Final Evaluation

Background:

The goal of this 4 year project has been to reduce maternal and newborn morbidity and mortality and contribute to the achievement of MDG goals 4 and 5 in a series of low income countries. Secondary objectives of the project include:

1. Strengthening the capacity of national professional societies to engage in maternal-newborn health through the design and implementation of projects in the field;
2. Strengthening cooperation between FIGO and national societies, and also between societies in regions or of different economic levels;
3. Strengthening cooperation between national societies and national stakeholders involved in safe motherhood and newborn health;
4. Increasing the credibility of national societies locally to provide technical support to Ministries of Health and national professional councils.

The project has been implemented in a number of countries wherever possible through twinning mechanisms between ob/gyn societies of developed countries with those in the implementing countries (north-south partnerships). In turn, the ob/gyn societies in the low income countries were expected to partner with national midwifery societies, Ministries of Health, civil society organizations and other relevant stakeholders to ensure harmonization of the project with the health policies and practices in the countries and the proper implementation and sustainability of the tenets of the project

The key innovation of this initiative has been to increase women's access to new, cost-effective and evidence-based technology for the reduction of maternal and newborn mortality in the countries concerned. Thus, the individual projects should have included staff training and re-training using modules such as the ALARM International program, maternal mortality audits, improvement of antenatal and delivery services, improvement of emergency obstetrics care (EOC) in selected districts, the development and dissemination of obstetric management protocols and algorithms, introduction and dissemination of partogram monitoring of labor and consolidation of the use of essential drugs like misoprostol and uninject for the prevention and treatment of post-partum hemorrhage. Projects were also intended to work with local communities to increase awareness on issues related to safe motherhood, and to promote increased utilization of interventions to reduce maternal and newborn morbidity and mortality.

Scope of work (general):

FIGO has engaged Options to undertake a final evaluation, in the form of a critical review, of each project and to provide individual country reports and an overall evaluation report to submit to the funder (SIDA). These reports will summarise and state to what extent the objectives of the project have been achieved.

Individual projects have been sited in ten countries and individual reviews are required for each project. Five reviews will take place in-country (Peru, Uganda, Pakistan, Haiti and Nigeria) and

five will be desk-based (Kosovo, Kenya, Moldova, Uruguay and Ukraine). The reviews will take place between April 2010 and July 2011. Concise individual reports will be submitted to FIGO after each review. A summary report will also be prepared when all reviews are completed.

FIGO recognizes that measuring the maternal health impact of this project is not feasible. However there may be areas/examples where this has occurred. In this case, vignettes could be provided in the report to illustrate this. This final evaluation needs to take into consideration and highlight in the report the fact that the project has had limited funding.

Objectives of each review:

- To evaluate the acquired capacity of the ob/gyn and midwifery society to conduct projects relevant to the promotion of safe motherhood and the improvement of maternal health
- To report on and evaluate any of the following indicators that were listed in the initial project proposal:
 - Improvements in access to essential obstetrical care services and new technologies
 - Improvements in access to skilled birth attendants
 - Improved health facilities
 - Lowering of maternal case fatality rate
 - The level of community mobilization and participation
 - Improvements in access to health facilities with basic equipment, supplies and medication for basic obstetrical care services and new technologies such as tamponade and uniject
 - How social and cultural barriers to maternal care have been identified and addressed
 - Improvements in collaboration and the engagement of health providers, governments, community organizations and civil society to understand why women and newborns are dying and how to prevent it
- To describe what the project has meant to each country project and professional society as well as FIGO as an organization
- To list the lessons learnt for FIGO
- To present the successes, challenges and shortcomings of the project, together with a discussion of possible recommendations for the future direction for each country's project (if the project is continuing beyond the period of FIGO funding)

Scope of work (Uruguay):

Desk review to include:

- A series of phone interviews with key individuals within the project including the partners etc. (A full list of interviewees will be provided in advance of the review).
- A critical review of any written material (narrative reports etc), and other evidence individuals in the project can cite to support the endline review.
- Interviews with mentors, FIGO staff and SMNH Committee members as necessary.

A draft interview schedule will be provided before the evaluation, together with a draft report structure. However, the consultant will need to use his/her professional judgement in deciding if there are other issues that also need to be explored and/or which key issues need to be investigated in greater depth than the draft interview schedule provides. Both qualitative and quantitative evidence should be presented in the report to support the consultant's findings.

A brief summary of the project is provided at the end of this document.

Deliverables:

Report of the individual country evaluation. (Individual country reports will be approximately 10 pages long, although this will be confirmed prior to the evaluation).

It is intended that the project will have submitted final documentation which will be made available to the consultant, as will other key documents such as the report of an earlier baseline review, annual narrative reports etc.

The assignment will take place between 2nd and 17th September¹. The total assignment should take no more than 5 days. The breakdown of days is:

1 day	Preparation
2.5 days	Review
1.5 days	Report writing

The evaluation should be submitted to Options by Monday 28th September. Options will provide comments on the draft written outputs within 2 weeks of submission. The consultant will finalise written outputs, responding to comments received, and submit final versions.

Languages:

It is envisaged that the majority (or all) the telephone interviews will be in Spanish. Documents are likely to be in either Spanish or English.

Summary of the Uruguay project:

“The title of the project is ‘To protect the life and health of Uruguayan women and to reduce abortion under conditions of risk’. The goal of the project is to reduce maternal and newborn mortality and morbidity. Specifically, the project seeks to: (1) reduce the number of abortions performed under conditions of risk in Uruguay, (2) reduce maternal morbidity and mortality associated with abortion, and (3) implement a sustainable model at the national level that is transmissible within similar legal contexts for reducing the number of abortions performed under conditions of risk in Uruguay”.

¹ Some flexibility has been allowed regarding the allocation of the 5 contracted days. This is to enable the consultant to arrange telephone interviews over a total period of two working weeks.

APPENDIX # 2: Interviewees

Persons interviewed and/or who provided e-mail information for the present report

IS/FIGO project staff:

- Ana Labandera, Midwife (*obstetra*), representing herself and Dr. Leonel Briozzo, project Co-Directors
- Dr. Verónica Fiol, M & E and Training Co-Ordinator
- Dr Mónica Gorgoroso, Health Service Implementation Co-Ordinator
- Psychologist Cecilia Stapff, Dissemination and Advocacy co-ordinator
- Psychologist Ivana Leus, Training and support to make counseling more holistic

Stakeholders

- Midwife Beatriz Gimenez, recently elected president of the Uruguayan Obstetric Midwives Association
- Dr. Francisco Coppola, President of the Uruguayan Gynecological Society
- Dr. André Lalonde, Executive Vice-President, the Society of Obstetricians and Gynaecologists of Canada and Chair of FIGO/Safe Motherhood and Newborn Health Committee. Twinning mentor to the Uruguay project.

APPENDIX # 3: Revised Log Frame

Taken from Carol Bradford's Report – August 2008

FIGO PROJECT: Protecting the Life and Health of Uruguayan Women by Diminishing Induced Abortion under risky Conditions (vf/cb aug08)		INDICATORS	MEANS OF VERIFICATION	RISKS
GOAL – To protect the health of women while pregnant, giving birth, and during the post-partum period in Uruguay		Maternal mortality diseases	Department of Vital Statistics (compiled by UNICEM)	Repeal of Ministerial Regulation
PUPOSE – To demonstrate the impact of the implementation of the <i>Health Initiatives Against Unsafe Abortion</i> model by applying the 2004 ministerial regulation in sex centres (70% of the population) and improving the relationship between the health professionals and the users [NOTE: In 2004, the MOH passed a regulation stating that health centre staff were no longer responsible for reporting women suspecting of having (illegal) abortions].		Maternal mortality from unsafe abortion declines in the study areas Maternal morbidity from unsafe abortion declines in the study areas (complications of abortion)	Department of Vital Statistics (compiled by UNICEM) Admissions to intensive care unit provided by hospitals; number of hysterectomies and D&Cs extracted from hospital records	No provision of death certificates data from the Ministry of Health.
OUTPUTS				
Professionals	1 – COMMITTED PROFESSIONALS To change the relationship between the health professionals and the users to emphasise confidentiality and trust in the six centres	Changes in: ➤ Knowledge ➤ Practice ➤ Attitudes Participation in Sexual and Reproductive Health (SRH) Services	Quantitative Social and anthropological monitoring (done by IAE) Training evaluation Monitoring Tool (Professional chapter)	Professional being prosecuted for adjusting to professional secrecy: disincentive to advise

		Diffusion materials		
	2 – COMMITTED PROFESSIONAL ASSOCIATIONS To reposition professional associations and academic institutions to commit to sustainable sexual and reproductive health	Publications	Report on activities and publications.	Activity of fundamentalists groups
		Scientific activities (E.g. Sexual and Reproductive Congress in Montevideo, April, 2008) Creation of Conduction Committee of FIGO project	Concrete changes in curricula of School of Medicine and School of Midwives.	
Women	3 – EMPOWERED WOMEN AND COMMUNITIES To empower women and communities to understand	Knowledge and understanding of the rights, the services and the new regulation Community Resonance Strategy (Florida and Jardines del Hipodromo)	Quantitative and qualitative Social and anthropological monitoring (done by IAE)	Women prosecuted because of criminal abortion
	4 – WOMEN-CENTRED QUALITY SERVICES To reassure the woman with an unwanted pregnancy that she is welcome in the health system and that her rights will be respected	Use of SRH Services (number of pre-abortion visits) Users Satisfaction questionnaires (Monitoring Tool)	Analysis of pre and post-abortion forms (processed by UNICEM) Social and anthropological monitoring: qualitative investigation (done by IAE) Monitoring Tool (Users	Restricted access to Misoprostol Adulteration on Misoprostol Episodes of violation of confidentiality that may keep users away from the services.

			chapter)	
Health System	5 – QUALITY SERVICES EMBEDDED To embed quality SRH services within the six selected health centres	Support of Health Centre authorities. Existence of SRH Services	Interviews with Health Centres authorities Reports on SRH Services conformation Monitoring Tool (Institutions chapter)	Repeal of Ministerial Regulation
	6 – COMMITTED NATIONAL AND LOCAL AUTHORITIES To make sustainable changes within the Ministry of Health, the Ministry of Education, and the Ministry of Social Development as well as within local governments	Creation and operation of the National Commission for compliance with the Ministerial Regulation. Diffusion of the Regulation by the Ministry of Health (e.g. regulation included within the 2007 Prenatal Care Regulation)	Reports. Interviews with members MOH Publications of the MOH that include the regulation	Government barriers Repeal of Ministerial Regulation Activity of fundamentalist groups
ACTIVITIES				
OUTPUT 1: COMMITTED PROFESIONALS				
1.1 To design training courses (based on past experience with Ipas in two pilot centres) that emphasise the importance of a trusting relationship between professionals and users 1.2 To run sensibilisation days in each of the six health centres of all workers 1.3 To give training courses in all six health centres to all medical and non-medical professionals (four modules of four hours each). 1.4 To have the trained health professionals offer confidential SRH services to women 1.5 To spread the knowledge and understanding of user confidentiality to other health centre professionals who were unable or did not choose to attend the training				
OUTPUT 2: COMMITTED PROFESSIONAL ASSOCIATIONS				
2.1 To involve the professional associations including doctors, psychologists, midwives, and nurses in the spreading of the				

understanding of the regulation.

2.2 To include SRH themes in scientific activities (e.g. the April Congress in 2008)

2.3 To change the curricula of medical training institutions to a) acknowledge women with unwanted pregnancies and b) include midwives, nurses and psychologists as well as doctors

2.4 To form associations that will support this work such as Sociedad Uruguaya de SSYR and Grupo de Jovenes la Confidencialidad.

2.5 To publish results of project in scientific journals

2.6 To publicise pamphlet on Confidentiality to all health professionals

OUTPUT 3: EMPOWERED WOMEN AND COMMUNITIES

3.1 To design and display posters aimed at women who have an unwanted pregnancy which publicise the ability of health professionals to give women confidential services

3.2 To work intensely with the surrounding communities of two of the six health centres (Proyecto de Resonancia Comunitaria)

3.3 To publicise the Confidentiality pamphlet within the communities

3.4 To work with journalists to publicise the confidential services

3.5 To build alliances with other organisations such as women's groups, ethnic minorities and gays/lesbians

OUTPUT 4: WOMEN-CENTRED QUALITY SERVICES

4.1 To deliver women-centred high quality services within the health centres

4.2 To monitor the quality of the services using the Confeccion de la Herramienta instrument looking carefully at the relationship between the professionals, the users, and the health system

4.3 To pay special attention to the opinions of women on the quality of the services

OUTPUT 5: QUALITY SRH SERVICES EMBEDDED

5.1 To implement quality SRH services in the six health centres

5.2 To evaluate the service quality using the Herramienta de monitoreo tool and looking carefully at the trained staff

OUTPUT 6: COMMITTED NATIONAL AND LOCAL AUTHORITIES

6.1 To maintain contact and good relations with the MOH authorities

6.2 To work with journalists to publicise the programme and the role of the MOH

6.3 To coordinate with other ministries and parts of government and ensure they understand and own the project

6.4 To create the Normativa de Confidencialidad (the confidentiality guidelines) and to make them government policy

6.5 To coordinate with the Comision Asesora de la Ministra through reports and monthly meetings.

APPENDIX #4

Components of the Uruguayan Law # 18-429: *LEY DE DEFENSA DE LOS DERECHOS SEXUALES Y REPRODUCTIVOS* or Defense of Sexual and Reproductive Rights passed by legislature December 2008

- Humane birthing services and Information provided pre and post delivery
- Universal access to contraceptive services
- Menopause
- Adolescent sexual and reproductive health services
- Unwanted pregnancy
- Mental health and violence
- Confidentiality and privacy
- Male involvement
- Sexually transmitted infections