FULFILLING WOMEN’S REPRODUCTIVE INTENTIONS

Abortion, social inequity, and women’s health: Obstetrician-gynecologists as agents of change

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Abstract Unsafe abortion persists as a serious health problem for women. It is rooted in poverty, social inequity, and denial of women’s basic human rights. As experience from Latin America and other regions demonstrates, obstetrician-gynecologists can be leaders in supporting reproductive rights and access to safe abortion, through their professional societies and also by way of their roles as providers, academicians, and advocates. Ob-gyns are often most effective when working in partnership with women’s organizations, lawyers, and other stakeholders.

1. Introduction

Every year, women around the world experience unsafe abortions, unnecessarily risking their lives and health. Unsafe abortion gained prominence in the international community in 1994 when its consequences for maternal mortality were identified as a critical public health problem at the International Conference on Population and Development (ICPD) in Cairo [1]. Tragically, nearly three-quarters of a million women have died since then due to abortion-related complications, and tens of millions more have suffered major as well as minor injuries and a variety of disabilities from unsafe abortion. The vast majority of these deaths and injuries could easily be prevented using known technologies.

In today’s world, unsafe abortion is closely associated with poverty, social inequity, and the persistent, systematic denial of women’s human rights. It is but one manifestation of the larger constellation of problems faced by women without resources, who all too often lack access to the most basic preventive reproductive health care information and services. Many also suffer sexual abuse and physical and/or emotional violence. One population-based survey in Colombia, for example, found that among ever-married women who had been pregnant in the preceding five years, 38% had...
experienced physical or sexual violence and, among these, 22% had suffered sexual abuse, almost always along with physical abuse [2].

Women who turn to unsafe abortion after considering the alternatives are desperate not to bring a pregnancy to term. Despite this, women who seek care for abortion complications are routinely subjected to punitive attitudes of providers. In a number of countries, women who undergo abortions are treated as criminals by health authorities and the justice system, an egregious violation of their human rights and of governments’ obligations to respect, protect, and fulfill these rights.

The deeper causes of unsafe abortion that lie in poverty and powerlessness must ultimately be addressed in order for this problem to be eliminated. The Millennium Development Goals (MDGs) have established a framework and set of targets for reduction of poverty and achievement of gender equality. One of the eight MDGs is to reduce maternal mortality by three-quarters by 2015. Globally, unsafe abortion is estimated by the World Health Organization (WHO) to account for 13% of maternal mortality; in a number of countries, that percentage is much higher. Based on a recent World Bank analysis, 90% of abortion-related maternal mortality could be reduced simply through the provision of safe abortion care [3].

In this context, leadership from obstetrician-gynecologists (ob-gyns) to prevent unsafe abortion and ensure women’s access to comprehensive sexual and reproductive health care, including contraception and safe abortion, is a professional and ethical imperative. As a professional group and also as individuals, ob-gyns are in a unique position to support and advocate for women. Ob-gyns can speak with credibility about the health needs of women and the clinical interventions that can save lives and protect women’s health. Moreover, they have significant social capital — resources, social connections, and expertise — all of which often allow them privileged access and special influence with policymakers and other elite groups, as well as the media and other health professions.

It appears that the vast majority of ob-gyns support abortion in some circumstances, as studies have found recently, including a large-scale survey in Brazil [4]. Some ob-gyns have limited understanding of relevant laws and policies and how to interpret them, however. In addition, some have yet to clarify their own values and ethical perspectives with respect to women’s reproductive decision-making. Dialogue within the profession is nevertheless increasing, with support from legal experts, ethicists, representatives of women’s groups, and others. For ob-gyns, no position on this vital social issue is neutral. Whether they stand aside, or engage in the debate, they will have a profound impact on women’s lives. Fortunately, ob-gyns have often been in the forefront as leaders in protecting women’s sexual and reproductive rights, including their access to safe abortion.

2. Abortion and social inequity

The close connections between abortion, poverty, and social inequity are evident from the distribution of abortion-related maternal mortality. Globally, 85% of deaths due to unsafe abortion are in the countries of Sub-Saharan Africa and South Central Asia — countries which also tend to have the lowest per capita income in the world [5]. These deaths often occur even in countries with liberal laws, such as India and Zambia, because of limited access to safe abortion care. Deaths in Latin America and the Caribbean are estimated at 3700 annually. In contrast, in Europe and North America, the number of deaths is negligible.

Of all age groups, adolescents are particularly vulnerable: they have a relatively high risk of unwanted pregnancies and in many countries are least likely to be able to obtain a safe, legal abortion. In Africa, one-fourth of those having unsafe abortions are very young women aged 15—19. In Latin America, young women aged 15—19 have a lower abortion rate than women aged 20—39. It is still a concern, however, that for every 100 pregnancies ending in live births, another 28 end in unsafe abortions [6].

Almost anywhere in the world, a woman with resources can obtain a safe termination of an unwanted pregnancy, regardless of the law. On the other hand, a woman without resources usually finds that a safe procedure is beyond her means. Her only alternative to terminate the pregnancy may be to turn to an unskilled provider, putting at risk her own life and health, and often the lives and health of her other children and the well-being of her family. Even where the abortion law is liberal and the procedure is supposedly available in the public sector, such as in India, a study of poor, rural women found that 34% had to pay substantial fees, i.e., over 500 rupees, if they even had access to a public sector provider. Fees in the private sector are much higher [7].

If a woman experiences complications from an abortion that is incomplete or in other ways unsafe, she is likely to find herself hospitalized, often at high cost to herself and her family and to the health care facility where she is treated. In Bolivia, a study in 2003 of 201 women who presented with incomplete abortions at 7 public hospitals found
that 65% were in the lowest income quintile, and another 15% in the next lowest quintile. Forty percent had to pay additional fees for care they received that should normally have been free [8]. Treatment costs for unsafe abortion in the developing world fall on health systems that are already overburdened. These costs run into billions of dollars annually — resources that could otherwise be directed to other medical needs.

3. The global response to unsafe abortion

Following more than thirty years of struggle by the feminist movement and enlightened leaders in government and the UN system, the international community has committed itself to women’s human rights. In 1979, governments signed the Convention on the Elimination of Discrimination Against Women (CEDAW). Subsequent agreements, including ICPD, established women’s rights to reproductive health, and called for access to safe abortion as allowed by law [1,9]. The Fourth World Conference on Women further recommended that governments consider reviewing punitive abortion laws, a position also supported by the Committee to implement CEDAW [10,11].

Despite such policy-level commitments, much remains to be done. Organized opposition to abortion is often led by religious groups who seek to defend restrictive laws, or, where these do not exist, to have conservative new laws enacted and enforced by governments. Globally, such groups have found a significant ally in the current government of the United States, which has pursued an anti-abortion foreign policy since 2001. The policy includes a prohibition on most abortion-related activities by private groups in developing countries that receive U.S. family planning assistance, known by its opponents as the "Global Gag Rule [12]."

Overcoming opposition from U.S. representatives, the World Health Organization (WHO) identified reducing unsafe abortion as one of the five priorities for the organization’s reproductive health strategy in 2004 [13]. WHO has established norms and standards for care including: preferred methods such as manual vacuum aspiration, the role of midlevel providers, and the key elements of a rights-based approach to safe abortion care [14]. In addition, WHO supports clinical research on abortion methods and provides technical assistance to national health systems. In 2005, WHO approved the addition of the mifepristone/misoprostol combined regimen (also known as medical abortion) to the Model List of Essential Medicines, which includes essential medicines for priority diseases or health conditions [15]. The significance of this decision for women’s ability to exercise their reproductive rights cannot be overstated. MVA and medical abortion are complementary, relatively simple technologies that offer great potential for increasing options for women and equitable access to care.

Other international bodies have also taken definitive positions recently. For example, after studying the issue of unsafe abortion, the Task Force on Child Health and Maternal Health of the Millennium Project concluded in 2005: “For abortion, as for other areas of sexual and reproductive health, governments and other relevant actors should review and revise laws, regulations, and practices that jeopardize women’s health” [16]. The Project, established to advise the UN Secretary-General on the MDGs, supported a comprehensive analysis through its task forces of the health problems most closely associated with poverty and the reforms in health systems and policies required to address these problems.

At the national level, a number of countries have liberalized their laws in the past decade (including South Africa, Ethiopia, Nepal, and Cambodia), and advocacy movements are increasing in every region, usually with the involvement of ob-gyn leaders [17]. Use of the courts may also increase women’s access, as in the recent Constitutional Court decision to overturn Columbia’s abortion ban. Additionally, some countries have taken steps at an administrative level to implement existing laws and ensure that women can obtain services to which they are entitled. For example, Mexico City has implemented a 2000 law that decriminalized abortion in cases of rape, fetal impairment, or risk to the woman’s health. A number of public hospitals under the City’s jurisdiction have developed protocols and providers have been trained to provide a legal termination of pregnancy [18].

4. Obstetrician-gynecologists as clinicians and academicians

Ob-gyns around the world are already working to support women’s access to safe abortion, most often within their usual daily roles. Examples of these actions include the following.

4.1. As clinicians

- Becoming informed about the applicable laws and interpreting them with due regard to
considerations of ethics, precedent, and the human rights and health needs of each woman.

- Becoming informed about the preferred methods for uterine evacuation (e.g., vacuum aspiration and medication abortion) and offering women a choice of methods.
- Engaging the full health care team in the ob-gyn’s hospital, clinic, or private practice — including midlevel providers where there are not enough physicians — in providing high-quality, woman-centered care.
- Identifying ways to reduce procedural barriers in facilities (such as spousal consent requirements), improve privacy and confidentiality, and improve the organization of services (such as steps to reduce waiting times).
- Facilitating efforts to reach women with accurate information through the media and community channels about their options for obtaining safe abortions.

4.2. As academicians

- Ensuring that curricula for pre-service training of ob-gyns as well as other physicians and midlevel providers includes opportunities for hands-on clinical experience in uterine evacuation procedures using preferred methods.
- Participating in and encouraging on-site in-service training and refresher training and/or continuing medical education courses in safe abortion care for practicing physicians and midlevel providers.
- Undertaking and disseminating research on clinical and service delivery issues to improve abortion care.

In some instances, ob-gyns become parliamentarians, ministers of health, or other elected or appointed officials. In this latter capacity, their influence and potential is magnified even further. When Dr. Pascoal Mocumbi became Minister of Health, and later the Prime Minister of Mozambique, for example, he was in a position to sanction women’s access to safe abortion in the main hospitals as a measure to save lives, despite the country’s restrictive law.

5. The role of ob-gyn societies

Ob-gyn societies have assumed a leadership role in advancing women’s access to safe abortion care and encouraging dialogue within the profession. At the global level, through its triennial Congress and monthly journal, the International Federation of Gynecology and Obstetrics (FIGO) has helped ensure that relevant information on scientific, clinical, and service delivery issues is widely shared. The FIGO Committee on Women’s Sexual and Reproductive Rights, formed in 2001 from a pre-existing study group, has sponsored panels and pre-Congress workshops addressing women’s rights, including access to abortion [19].

A major development was the adoption by the 2003 FIGO General Assembly of the Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights. The statement calls on ob-gyns to “advocate for the right of women to have access to the information and education needed to allow them to determine the timing of their reproduction in keeping with the ethical principle of autonomy and the human right to freely choose if and when to have children.” Specific ethical guidelines, Ethical Aspects of Induced Abortion for Non-medical Reasons, were disseminated by FIGO in 1998 and form part of the body of recommendations available from FIGO’s Committee for the Ethical Aspects of Human Reproduction and Women’s Health. These recommendations include the following statement: “Providing the process of properly informed consent has been carried out, a woman’s right to autonomy, combined with the need to prevent unsafe abortion, justifies the provision of safe abortion [20].”

Regional-level and national-level ob-gyn societies have also been active. Based on reports and personal communications to the authors, a number of examples can be cited. In India, Federation of Obstetric and Gynaecologic Societies of India (FOGSI) the national association of local and state societies, sponsored a theme for the year 2001 of “Safe Abortion Saves Lives,” and facilitated workshops in nearly every state and district society on this theme to encourage ob-gyns to support women’s access to safe, high-quality services. FOGSI has also helped disseminate information and increase awareness of both MVA and medication abortion as preferred methods through workshops, videos, and support of new guidelines in the public health system. In Nigeria, Ethiopia, and Kenya, national ob-gyn societies have provided a forum to raise awareness with policymakers and the public about the health consequences of unsafe abortion, and ob-gyn leaders advocated for policy change. Also in Ethiopia, ob-gyns and other medical, public health, and women’s leaders worked together successfully with leaders in Parliament and relevant government ministries to adopt a law in 2004 significantly expanding legal indications for abortion.  

In the Latin American region, where laws tend to be most restrictive overall, the involvement of
Federation of Latin American Societies of Obstetricians and Gynecologists (FLASOG), the Latin American federation of ob-gyn societies, as well as its national-level counterparts, has been particularly important. In 2002, and again in 2005, the FLASOG General Assembly adopted conclusions from pre-Congress workshops on Sexual and Reproductive Rights, recommending that ob-gyn societies work with civil institutions to promote legal changes that guarantee legal protection and personal health [21,22]. The FLASOG Committee on Women’s Sexual and Reproductive Rights recently joined with Ipas in producing a manual for physicians on misoprostol for all gynecological uses, including pregnancy termination [23].

Ob-gyn networks also came to the fore in the widely-published case of Rosa, a nine-year old daughter of migrant Nicaraguan coffee workers, who became pregnant after she was raped in Costa Rica in 2003. Her story made headlines and occasioned a standoff between Rosa and her parents, on the one hand, and authorities of both Costa Rica and Nicaragua, on the other. Despite the defense of Rosa's rights by women’s groups and human rights leaders, the lack of clarity about how to interpret the Nicaraguan law permitting therapeutic abortions allowed the authorities, under political pressure from abortion opponents, to stand in her way. In the face of the controversy surrounding the case, three ob-gyns courageously carried out the procedure to terminate her pregnancy. Professional contacts — including authorities at regional and global levels — provided scientific, technical and legal assistance to help establish the health risks of Rosa’s pregnancy and, above all, to provide ethical and moral support. Support and guidance from leaders in both the Latin American and Nicaraguan ob-gyn societies did much to assure a rapid and humane response in Rosa’s case.

Elsewhere in Latin America, national associations in Mexico and Brazil have played key roles in support of implementing legal abortion where permitted in cases of rape. FEMEGO, the Mexican ob-gyn society, sponsored the National Congress on Violence Against Women in 2001, attended by nearly 400 professionals, an event that helped to build awareness of the problem of sexual violence and the need for comprehensive treatment, including legal abortion. The Brazilian society, FEBRASGO, recently contributed to the development of national technical norms for abortion care that have been adopted and disseminated by the Ministry of Health, including taking a stand against a proposed requirement for police documentation of rapes. Throughout Latin America, national committees have been created in ob-gyn societies as counterparts to the regional and global-level committees on women’s sexual and reproductive rights.

In Uruguay, the ob-gyn society participated in the national debate on legalization of abortion and issued a statement in support of the liberal abortion law that was nearly adopted by the Uruguayan parliament in 2004. FLASOG’s sexual and reproductive rights committee provided support to local efforts to build awareness about the issue.

In El Salvador, where abortion is banned for any reason, the national ob-gyn society facilitated research and discussions to support physicians in providing compassionate and confidential counseling to women who present with incomplete abortions rather than denouncing them to authorities [24].

In Peru, in 2002, when abortion was denied to Karen Llantoy Huaman, a woman with an anencephalic fetus, FLASOG’s Committee on Sexual and Reproductive Rights and the Peruvian ob-gyn society co-signed a medical declaration on her behalf, which was presented to the UN Human Rights Committee. In 2005, the Committee ruled in favor of her right to a safe legal abortion [25].

Despite the many examples of leadership by ob-gyn societies or their committees, not all have come forward. A survey in 2001, to which 59 of 101 national FIGO affiliates responded, found that whereas two-thirds of the responding representatives affirmed support for the FIGO ethical guidelines, many societies had not yet taken action to formally adopt them [26].

As these examples suggest, leaders of ob-gyn societies have created a number of successful models for effective awareness-raising and advocacy. These include:

- Providing a forum to educate members as well as the wider public about the issues and interventions to prevent unsafe abortion;
- Creating study groups or committees on sexual and reproductive rights, and promoting dialogue among peers around ethical standards, values clarification, and issues of conscientious objection;
- Developing and issuing ethical guidelines for their members, affirming or building on those already disseminated by FIGO globally;
- Promoting the conduct and dissemination of relevant research;
- Issuing consensus statements and recommendations;
- Sending representatives to parliamentary health committees considering abortion policies as well
as to government committees drafting clinical and service delivery guidelines;
• Helping to mobilize support in individual cases such as the Rosa case in Nicaragua, or the Karen Llantoy Huaman case in Peru; and
• Speaking out in the mass media as well as engaging in broader campaigns for women’s reproductive health and rights, addressing such goals as reduction in sexual violence; comprehensive sexual and reproductive health education; and implementation of a continuum of care for maternal, newborn, and child health.

The benefits of further dialogue between ob-gyns and other stakeholders deserve greatest emphasis. Creating broader-based coalitions that include women’s health advocates, lawyers, religious leaders, and others will help mobilize public support. Moreover, by working closely with others, ob-gyns can be more assured that their policy positions are responsive to the needs of women, are ethically sound, and are politically strategic and visible.

6. Conclusion

For all women, rich or poor, decisions about whether and when to have children are among the most fundamental. No woman should have to risk her life or her health in making reproductive decisions. So long as women, particularly those who are the poorest and most vulnerable, are denied their reproductive rights, the active participation, leadership, and support of ob-gyns is urgently required. Women are counting on the partnership of ob-gyns — as providers, academicians, and members of dynamic professional networks — to pursue every possible pathway to save lives and make a better future for women, their families and communities around the world.

References


