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EDITORIAL

What can we do as gynecologists/obstetricians to reduce unsafe abortion and its consequences? The Uruguayan response

As healthcare professionals, we are often confronted with situations in which we feel powerless to deal with the suffering, illness, and death of individuals whose care is our responsibility, particularly in public health facilities. The most common reaction is to protest against the authorities that have failed to provide the necessary resources or to implement the measures required to rectify situations that penalize almost exclusively those most economically disadvantaged. These health problems and their consequent mortality have remained the same for decades, largely because the individuals suffering from them have neither the power nor the political influence to trigger changes that could improve their situation.

Unsafe abortion—with its dramatic consequences for the poorest and most helpless women in countries with restrictive abortion laws—is one of the clearest and most persistent examples of a severe problem that impels us to protest against the authorities that have failed to resolve it.

A small group of physicians from the Pereira Rossell Hospital in Montevideo, Uruguay, decided that they could no longer wait for an external solution nor remain indifferent to the successive deaths of healthy women who found themselves with no option other than to resort to an unsafe abortion. Those doctors decided to implement an original preventive intervention to resolve the problem in an attitude that could have appeared a utopia doomed to fail: they had no resources, no adequate physical space, and no designated personnel for the task they were proposing to undertake. Furthermore, they were exposing themselves to the risk of being accused of performing illegal activities that could have led to legal prosecution and sanctions. Nevertheless, none of these hurdles deterred them from what they considered to be their ethical and professional duty to protect the health of the women under their care.

The results described in this Supplement show that this was not an impossible utopia and that the sensitivity and courage of these professionals—inspired by the wise words of Professor Mahmoud Fathalla when he invited all gynecologists and obstetricians to cease being *part of the problem* and start being *part of the solution* [1]—achieved what seemed a miracle, namely to reduce maternal deaths from abortion (the primary cause of maternal death in Uruguay at that time) practically to zero.

They simply applied the concept of reducing the risk and harm of unsafe abortion and transformed what would have been high-risk abortions to low-risk abortions by informing women with unplanned and undesired pregnancies about the risks of backstreet abortion, and providing them with publicly available information on the use of misoprostol—information which these women would not have had access to without this intervention.

Since this initiative was developed in the country's principal university teaching hospital, its political impact and power of dissemination was great. The protagonists of this public health process provide a detailed description of the successful creation and implementation of this initiative for the prevention of unsafe abortion and its dissemination throughout most of the country.

An unexpected effect of the implantation and dissemination of this health initiative and of its rapid effect in reducing abortion-related mortality was to bring to the surface the drama of women with unplanned pregnancies who saw no alternative other than a backstreet abortion, unsafe up to that time for women with no economic means. The public view of abortion as a problem that had to be confronted and that remained uncontrolled by prohibitive legislation facilitated debate on the need to change the legislation that culminated with the approval by the Parliament and the President of the Republic of a law permitting abortion on demand within reasonable limits of gestational age.

This Supplement also describes how Uruguay succeeded in making safe, legal abortion accessible to the entire population almost immediately after the legislation was put into force. This is unlike in various other countries that have gone through the same process in recent decades, where it has taken many years to guarantee the provision of safe, accessible, and legal pregnancy termination services. In some countries, implementation of these services is delayed even now.

The various articles included in this Supplement describe the obstacles faced and how they were resolved. Analysis of the rapid downward trend in maternal deaths and the finding that implementation of the law had no effect on adolescent fertility suggests that the only change that occurred as a result of the new law was the substitution of high-risk abortions for safe abortions. These articles also describe the low abortion rate registered in Uruguay two years after broad application of the new legislation.

This low abortion rate may decrease even further in the near future, since another paper describes failings in the application of the strategy used to prevent repeat abortions through counseling and by offering effective contraception prior to discharging any woman who requests a legal abortion. Identification of this shortcoming, in addition to highlighting the honesty of the authors who made no attempt to conceal their oversight, allows the necessary measures to be adopted to correctly apply this intervention, which is the most effective for reducing the number of abortions in a population.

Finally, Argentinian colleagues describe how this model was successfully replicated on the other side of the Rio de la Plata, in the Province of Buenos Aires—the most populous province in Argentina, with 16.5 million inhabitants. The difference is that in the Province of

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Buenos Aires the risk reduction strategy was applied at primary care level by general practitioners and midwives, with similar success rates to those achieved in Uruguay where it was applied in hospitals by gynecologists, albeit also with the participation of midwives. This proof that the model is replicable is an important message to colleagues in other countries where conditions are similar to those found in Uruguay at the beginning of this century.

In essence, this Supplement is an invitation and a challenge to answer the call of Professor Fathalla that we should stop being part of the problem and start being part of the solution, without waiting for all the conditions to be right to do so. Neither in the initial Uruguayan model nor in that implemented in the Province of Buenos Aires were specific new resources provided with which to perform this intervention. The only resource available was the moral support of the higher authorities and the determination of colleagues to allocate part of their time to protect the lives of the women under their care. The articles in this Supplement show that this is possible; the initiative saves lives and alleviates the suffering of the most marginalized women requesting our help in the public healthcare services of low-resource countries with restrictive abortion laws.

Reading the articles in this Supplement should lead to reflection on whether it would not be better to ask ourselves what we can do right now other than protest and wait for a solution to come from outside; whether we agree to go on being part of the problem or decide to start being part of the solution.

Conflict of interest

Professor Faúndes is the Chair of the FIGO Working Group for the Prevention of Unsafe Abortion.

Reference

[1] Fathalla MF. Conclusion. Workshop on Obstetric and Maternity Care Delegation of Responsibilities in Maternity Care in Developing Countries. Int J Gynecol Obstet 1992;38(Suppl):S75–7.

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