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Special article

FIGO society survey: acceptance and use of new ethical guidelines regarding induced abortion for non-medical reasons

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Abstract

Objective: FIGO's *Ethical guidelines regarding induced abortion for non-medical reason*, offer guidance concerning women's right to safe abortion services and the medical community's attendant responsibilities. Ipas surveyed FIGO constituent societies to determine their agreement with the *Guidelines'* recommendations and their readiness to use them to improve and expand services. *Method:* Ten months after the *Guidelines* publication in IJGO, a ten-item questionnaire was mailed to 283 Officers of the 101 FIGO societies, with follow-up prompts to non-respondents. *Results:* Officers of 59 societies responded, divided evenly between those in countries whose laws permit induced abortion on non-medical grounds and those in countries prohibiting it. In 'permitting' countries all responding societies supported the recommendations, and 85% said they should adopt them or had already done so. Two-thirds in 'prohibiting' countries supported the recommendations, but less than half believed their FIGO society, or their government, should adopt them. However, 20% in the 'prohibiting' countries had adopted or formally considered the recommendations and 23% had already brought them to the attention of their governments. *Conclusion:* The FIGO constituent societies showed overall strong support for the recommendations, but efforts need to be made to encourage those in 'prohibiting' countries to promote implementation of the recommendations.

Keywords: Survey; FIGO societies; Ethical guidelines; Abortion

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1. Introduction

In March 1999 a report appeared in the IJGO from the FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health titled: *Guidelines regarding induced abortion for non-medical reasons* [1]. In the *Guidelines* were listed eight recommendations touching on women's right to safe abortion services and to measures that can be taken to protect them from harmful practices. The report marked the first time this prestigious professional association had directly and publicly addressed the highly controversial issues related to women's rights and the responsibilities of physicians in elective abortion. In September 2000, at the FIGO XVI World Congress in Washington, DC, the FIGO General Assembly adopted the report of the pre-Congress workshop, including the recommendation of the FIGO Ethics Committee that 'after appropriate counseling, a woman had the right to have access to medical or surgical induced abortion, and that the health care service had an obligation to provide such services as safely as possible.'

As noted in the *Guidelines*, it is well known that unsafe abortion constitutes one of the major causes of maternal deaths and disabilities, while induced abortion by trained health professionals in approved facilities carries very low risk. It is also well known that maternal deaths and injuries are more frequent where women have difficulty obtaining an induced abortion from a trained and qualified provider. Poor access to safe abortion procedures is one result of legal restrictions, and high maternal mortality is most common in those countries where law prohibits non-medical reasons for induced abortion [2,3].

The obstetrics and gynecology profession worldwide exerts strong influence in matters of women's health, both in government policy formation and in providing standards for medical practice. The issuance of the *Guidelines* offered the FIGO medical community a new and potentially significant instrument for advocacy. An important question remained: to what extent were FIGO's constituent societies prepared to seize this new opportunity to promote greater access to abortion services that are safe and responsive to women's needs? Ipas's long standing concern with the global problem of unsafe abortion prompted a survey to answer that question.

2. Survey method

The survey questionnaire was a single page containing 10 questions on FIGO society members' acceptance and use of the eight recommendations contained in the *Guidelines* (the questions are shown in Table 2). Questionnaires and copies of the Ethics Committee recommendations were mailed to 283 officers of the 101 FIGO societies worldwide listed in the July 1999 issue of the IJGO, plus one that became affiliated later. It was assumed that all of the officers had received the IJGO issue containing the *Guidelines* 9 or 10 months earlier and thus had time to consider actions related to them. A second mailing followed the initial one, with e-mailed or faxed prompts to the Presidents of the non-responding societies. In the written request for their participation, the FIGO officers were assured that the report of the results would not contain their names or their countries' names.

3. Results

3.1. Survey return rate

Survey questionnaires were received from 59 of the 101 societies between February and October 2000, as shown in Table 1. Two were discarded that did not answer the questions but simply noted their governments' firm restrictions on abortion. The return rate of 58% was much higher than normally expected with mailed surveys. The surprisingly full return and the large number of thoughtful written observations show the serious consideration given to the issues by FIGO society officers.

The regional distribution of returned questionnaires was also satisfactory, with at least 50% responding from each of four large geographical

Table 1
Survey response rates from 101 FIGO constituent societies

	Africa	Asia, Oceania	Latin America, Caribbean	Europe, North America	Total
Responding societies					
Total number responding	10	13	11	25	59
From countries permitting abortion for non-medical reasons	1	9	0	19	29
From countries prohibiting abortion for non-medical reasons	9	4	11	6	30
Average MMR[a] in countries of the responding societies	876	144	146	18	215
Non-responding societies					
Total number not responding	9	13	10	10	42
From countries permitting abortion for non-medical reasons	1	2	1	10	14
From countries prohibiting abortion for non-medical reasons	8	11	9	0	28
Average MMR[a] in countries of the non-responding societies	723	254	273	25	305

[a] MMR, maternal deaths per 100 000 live births.

divisions. This was considered important, given the large variation observed among between regions in maternal mortality ratios (MMR: maternal deaths per 100 000 live births) [3,4]. In Table 1, and in subsequent tables, countries are divided between those that permit abortion for non-medical reasons ('permitting' countries) and those that prohibit it ('prohibiting' countries). Over all regions, 67% of FIGO societies responded from 'permitting' countries and 52% from 'prohibiting' countries.

The Ethics Committee did not clearly define 'non-medical' reasons, simply suggesting that they are 'social' reasons. For purposes of this survey, non-medical includes 'economic and social reasons' and 'on request' plus five other reasons defined in widely recognized reference sources that list legal grounds for induced abortion in all countries of the world [4–8]. Countries defined here as 'prohibiting' do not accept the two social reasons, but they may legally accept any or all of the other five listed, which are: 'to save the life of the woman,' 'to preserve physical health,' 'to preserve mental health,' 'in cases of incest or rape,' and 'fetal impairment.'

3.2. Responses of constituent societies to survey questions

Table 2 shows the responses to the 10 questionnaire items about each FIGO society's awareness of the recommendations, the overall acceptability of the recommendations and use of the recommendations in influencing women's health policies in their respective countries.

From the table it can be seen that the majority of responding FIGO society officers indicated that they were aware of the *Ethical Guidelines* before receiving the survey and overwhelmingly (82%) stated that the recommendations are acceptable to their members. They also believed them to be acceptable to their governments' health authorities, although to a lesser extent. Additionally, most (65%) respondents agreed that their FIGO society and the government health authorities should adopt the recommendations. In written responses they showed their concern with the problem of unsafe abortion in developing countries and the high levels of maternal mortality to which it contributes.

The FIGO society members and government

Table 2
Responses to Ipas survey questions

Questions:	All countries $N = 57$	'Permitting' countries $N = 27$	'Prohibiting' countries $N = 30$
1. Were you aware of the recommendations before receiving this survey?			
% 'yes'	60	67	53
2. What has your ObGyn Society done regarding the recommendations?			
% 'adopted' or 'discussed' at meeting	32	44	20
3. How strongly would your ObGyn Society support adopting the recommendations?			
% 'strong' or 'moderate' support	82	100	67
4. Which recommendations would *not* be acceptable to your ObGyn Society? (see Table 3)			
5. Should your ObGyn Society adopt all of the recommendations?			
% 'yes'	65	85	43
6. Has your ObGyn Society brought them to the attention of health officials?			
% 'yes'	37	52	23
7. How strongly would the government health officials support the recommendations?			
% 'strong' or 'moderate' support	67	93	43
8. Which recommendations would *not* be acceptable to your government health officials? (see Table 3)			
9. Should your government act to adopt all of the recommendations?			
% 'yes'	65	89	43
10. What are legal grounds on which induced abortion is permitted in your country?			
% with correct knowledge of laws	67	81	53

health authorities from 'permitting' countries appeared to be nearly unanimous in their support of the recommendations and believed both their society and their government should adopt them. Although not as positive, a solid majority of FIGO society officers from 'prohibiting' countries also believed that their members would support the recommendations.

More than two-thirds of those who responded positively to questions about whether or not the FIGO society or the government should adopt the recommendations (questions #5 and 9), provided comments as to why they agreed. One-third of them stated that the recommendations were already in place in their countries, while the others observed the following:

- 'majority of men and women in the community probably agree with sentiment expressed';
- 'would promote women's access to safe abortion ... reduce incidence of complications and deaths';
- 'reasonable recommendations ... balanced';
- 'conform with the mission of the society...providing comprehensive reproductive health care';
- 'the right of women in our country';
- 'to provide a safe method ... in favor of women's health';
- 'major problem is deaths associated with unsafe abortion';
- 'illegal abortions are taking place';
- 'the best solution'.

When only responses from 'prohibiting' countries are considered, most still agreed that their societies support the recommendations, but fewer believed they would be approved by the government or that they should be adopted by the FIGO society or the government. Nearly three-quarters of those who answered 'no' to the questions about adopting the recommendations (questions #5 and 9) provided comments as to why they disagreed. The comments were split between cultural, religious and legal reasons, as seen in the following examples:

- 'Abortion is still a very sensitive issue.'
- 'The cultural and national feelings are not adequate for consideration of abortion for non-medical reasons.'
- 'Due to social and cultural barriers limited abortion and specific conditions should be allowed.'
- 'The medical society in [our country] is very conservative.'
- 'Religion problem.'
- 'Society bylaws do not permit to adopt recommendations that might be against national laws.'
- '[in the] constitution in this country . . . life begins from conception.'
- 'Only parliamentary members can do such a thing in [our country].'
- 'The termination of pregnancy for non-medical reasons is not legal in [our country].'
- '[My country's] law forbids induced abortion whatever the circumstances.'
- 'bringing the recommendations to the attention of the [country's] Ministry of Health would be unsuitable.'

3.3. Maternal mortality and abortion restrictions

As one of the respondents wrote: 'Illegal abortions are carried on regardless of the law, killing many women.' Two of the main arguments often given for restriction of abortion are: (1) that it would reduce the frequency of abortion; and (2) that it would protect women's lives. However, neither of the two reasons is supported by data. In regard to the frequency of abortion, applying the best available estimates of abortion rates [4,9,10] there are essentially no differences between the 'prohibiting' and 'permitting' countries in the survey sample; the average abortion rate is 23 (per thousand women of reproductive age) in both groups. In regard to protecting women's lives, to the contrary, women die from abortion and other pregnancy-related causes at a vastly higher rate in countries where abortion restrictions are severe, as is illustrated clearly in Fig. 1.

Based on global data from 156 countries [3,4], Fig. 1 shows that countries with more restrictive laws have higher MMR. Only one of 37 countries with the world's highest MMR legally permits induced abortion on non-medical grounds; that country liberalized its law in 1997 so its MMR may now be lower than the estimate used in this report. Across all 'permitting' countries the average MMR is less than 30. In 'prohibiting' countries the rate of maternal deaths is more than 20 times higher, with an average MMR of over 600.

Many factors other than abortion restrictions contribute to the differences in MMR among the countries. Countries with high MMR are far below those with low MMR on all indicators of human development, health status, and health financing and infrastructure [11]. In many of those countries even legally acceptable reasons for induced abortion are denied, and women are unable to obtain the permitted services in safe public health facilities at affordable cost.

One principal function of the FIGO *Ethical Guidelines* is to provide global medical consensus on standards for service quality that professional societies can use to influence health decisions. In more than half of the 'prohibiting' countries with high MMR the survey found that the FIGO society leaders did not believe the recommendations should be approved by their professional society, and fewer than one-quarter had taken action on the recommendations at the time of the survey.

3.4. Acceptability of individual recommendations

Table 3 shows the non-acceptability of each of the recommendations, as asked in the question

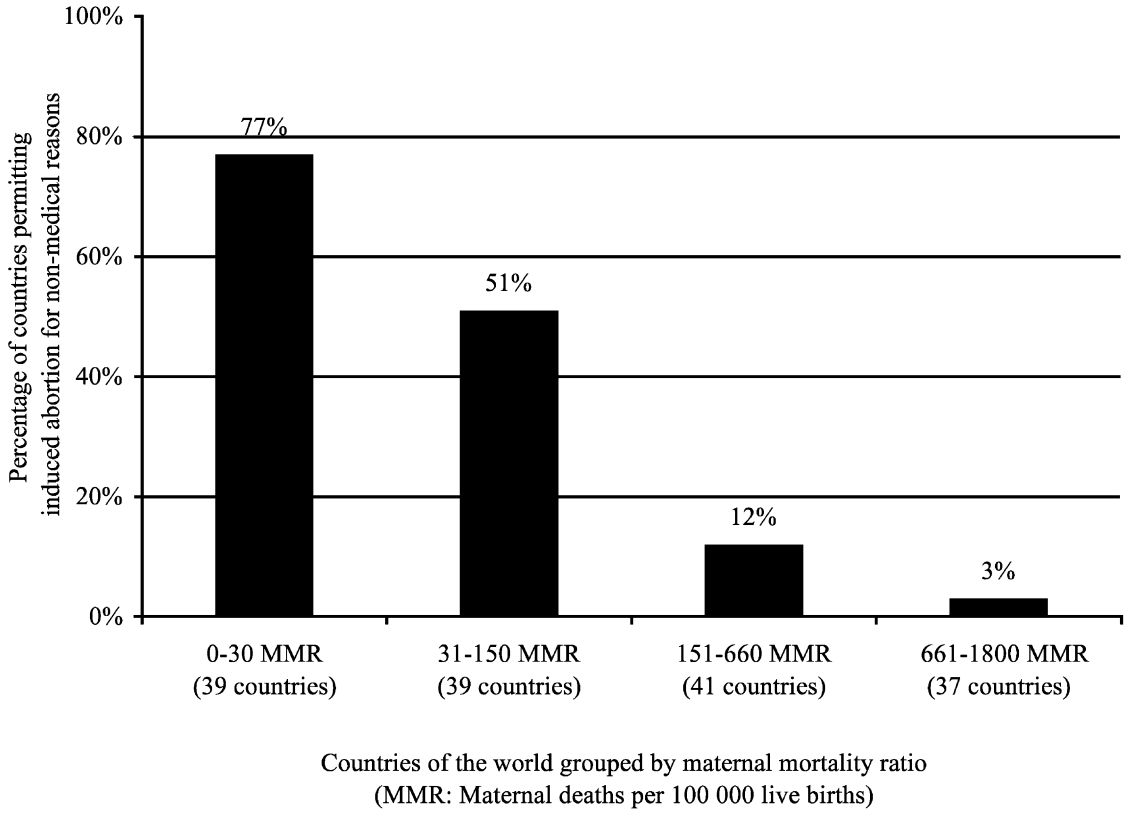

Fig. 1. Relation of abortion restriction to maternal mortality.

about FIGO society responses (question #4) and the question about the probable government health authorities' responses (question #8). To conserve space the recommendations have been paraphrased; the full text is included in Appendix A.

Among the recommendations most acceptable to the ObGyn respondents were those that deal essentially with *prevention* of unwanted pregnancies through contraception and provision of sensitive and rational advice to both adults and minors seeking to control their fertility (recommendations #1, 2, 5 and 6).

There appears to be little difference between the response pattern of the FIGO society leaders and what they believed to be that of the government health authorities in the 'permitting' countries. To those societies, all but the recommendation dealing with women's right to autonomy (recommendation #3) were almost unanimously accepted or already adopted. The five disagreeing with the one recommendation are from three different regions and gave four cultural and religious reasons.

Greater differences and greater disagreement are evident in the 'prohibiting' countries although the majority of FIGO societies in those countries accepted the recommendations. Among the 'prohibiting' country respondents, acceptability was highest for what appear to be *prevention* recommendations (#1, 2, 5 and 6), but only the one promoting family planning (recommendation #1) appeared to be unanimously acceptable. Nevertheless, if only this one recommendation out of the eight were to be fully adopted and implemented in those countries, the impact on women's lives could be great. The other *prevention* recommendations should also be legally adoptable in nearly all countries.

On the four recommendations that touch di-

Table 3
Acceptability of each recommendation: FIGO constituent society responses to survey questions #4 and 8 (see Table 2)

Recommendations:	All countries		'Permitting' countries		'Prohibiting' countries	
	Q4 $N = 57$	Q8 $N = 57$	Q4 $N = 27$	Q8 $N = 27$	Q4 $N = 30$	Q8 $N = 30$
1. Governments should take measures to help women prevent unintended pregnancies. Abortion should never be promoted as family planning.						
% responding '*not* acceptable'	0	4	0	4	0	3
2. Women have a right to decide whether or not to reproduce and should have access to contraception.						
% responding '*not* acceptable'	5	11	0	0	10	20
3. Safe abortion is justified by women's right to autonomy and need to prevent unsafe abortion.						
% responding '*not* acceptable'	26	35	19	19	33	50
4. Doctors are not obligated to perform abortion, but are obligated to refer women to colleagues.						
% responding '*not* acceptable'	19	21	4	0	33	40
5. Counselors have no right to impose religious or cultural convictions on women with different views.						
% responding '*not* acceptable'	7	11	4	7	10	13
6. When competent to give informed consent, minors' wishes should be respected. If not competent, other appropriate advice should be considered.						
% responding '*not* acceptable'	9	18	7	7	10	27
7. Abortion for non-medical reasons plus counseling on fertility control is best provided on a non-profit basis.						
% responding '*not* acceptable'	25	26	4	7	43	43
8. After appropriate counseling a woman has a right to abortion, and the healthcare service is obligated to provide it safely.						
% responding '*not* acceptable'	21	30	4	4	37	53

rectly upon *provision of abortion services* (recommendations #3, 4, 7 and 8), the level of disagreement becomes greater, ranging from 33 to 43%. Three of the four recommendations show even higher levels of disagreement in the hypothetical government health authorities' responses from those countries, with more than half expected to reject the recommendation affirming women's right to safe abortion services and the health system's obligation to provide them (recommendation #8). This presents a serious dilemma for the FIGO society members in some 'prohibiting' countries, who must balance strong social, religious and personal beliefs against abortion, with the obligation to recognize women's rights. The right to access medical care is recognized as a human right according to international treaties of the United Nations, two of the most prominent being the 1948 United Nations Universal Declaration of Human Rights and the 1979 Convention on the Elimination of All Forms of Discrimination Against Women.

It is also clear from the written survey responses as well as the percentages shown in Table 3 that the four *abortion service* recommendations will be difficult to implement in the 'prohibiting' countries. The reasons given by the FIGO society leaders for their disagreement with those recommendations were the same as the cultural, religious and legal reasons for survey questions about adopting the recommendations (questions #5 and 9). However, to those were added financial reasons, including the following:

- 'It incurs to the government additional expenses.'

- 'Even if government were to endorse abortion, it must be paid for like other services.'
- '[our country's] health system is free: already are burdened financially.'
- 'Health providers in [our country] do not finance non-medical abortions.'
- 'Health care system is already overloaded with work.'
- 'Private clinics/hospitals are providing safe abortion services, and they cannot do it for free.'

3.5. Understanding legal restrictions

One of the pathways to improved services and greater access is through offering safe abortion services to the fullest extent of the law. To institute action toward this end, the legal status of abortion must be well understood. However, the survey results show considerable misunderstanding of the laws by the FIGO society leaders. This is seen in Table 2 for the question designed to test the national societies' knowledge of the grounds for legal pregnancy termination within their own country (question #10). Full and accurate knowledge of the laws was indicated correctly in barely half of those from 'prohibiting' countries. Among those missing the mark, the tendency (over 70%) was in the direction of *underestimating* the range of reasons legally acceptable for induced abortion, in both permissive and restrictive settings. This means that for some societies interested in taking action on the recommendations, greater knowledge of all options available to them could increase their effectiveness.

In at least half of the countries with high MMR (those with MMR above 100) laws permit abortion for reasons other than saving the life of the woman. The health systems in those countries should provide safe and ample services for all legal indications, including protection of women's physical and mental health and in cases of rape, incest or fetal impairment. The constituent societies should play a pivotal role in promoting such action as well as encouraging policy change.

This type of collaboration is being carried out successfully with the Brazilian ObGyn society, who has helped establish more accessible abortion services in state medical facilities for women requesting the services for legal reasons, in particular for women who are victims of sexual violence. Through a process involving the collaboration of a large number and wide spectrum of people, organizations and social sectors, legal abortion services have increased 10-fold in 4 years [12].

4. Discussion

The data from Ipas's survey show strong support throughout the FIGO constituent societies for the Ethics Committee's recommendations on induced abortion for non-medical reasons. Even in countries where abortion for non-medical reasons is prohibited, two-thirds of the constituent societies supported the recommendations in general and believed the governmental health authorities would do so as well. This support follows from their recognition of the close interrelation of restrictive policies, unsafe abortion practices and high levels of maternal mortality. However, in countries prohibiting abortion for non-medical reasons there was less support for the recommendations and less action to use them to change policies.

The highest level of support was found for the four recommendations regarding prevention of unsafe abortion. The weakest support was found for the recommendations acknowledging women's right to safe abortion services and the obligation of the medical community to provide them on a non-profit basis. Because the 'prohibiting' countries are those where support for the *Guidelines* is most sorely needed, this is a dilemma that should be addressed by the FIGO societies.

Now that the FIGO General Assembly has adopted the report of the pre-Congress workshop, including the recommendation of the FIGO Ethics Committee on induced abortion for non-medical reasons, constituent societies may pay increased attention to the recommendations and use them as a framework to advocate changes in women's health policy and services in their coun-

tries. Communication of these survey results is one way to encourage more constituent societies to use the weight of internationally recognized consensus to increase their countries' commitment to women's rights to safe abortion services.

Appendix A.
FIGO Committee Report: FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health

Ethical guidelines regarding induced abortion for non-medical reasons

1. Induced abortion may be defined as the termination of pregnancy using drugs or surgical intervention after implantation and before the conceptus has become independently viable (WHO definition of birth: 22 weeks' menstrual age or more.)
2. Abortion is a very widely considered to be ethically justified when undertaken for medical reasons to protect the life and health of the mother in cases of molar ectopic pregnancies and malignant diseases. Most people would also consider it to be justified in cases of incest or rape, when the conceptus is severely malformed, or when the mother's life is threatened by other serious disease.
3. The use of abortion for other social reasons remains very controversial because of the ethical dilemmas it presents to both women and the medical team. Women frequently agonize over their difficult choice, making what they regard in the circumstances to be the least worse decision. Health care providers wrestle with the moral values of preserving life, of providing care to women and of avoiding unsafe abortions.
4. In those countries where it has been measured, it has been found that half of all pregnancies are unintended and that half of these pregnancies end in termination. These are matters of grave concern, in particular to the medical profession.
5. Abortions for non-medical reasons when properly performed, particularly during the first trimester when the vast majority take place, are in fact safer than term deliveries.
6. However, the World Health Organization has estimated that nearly half of the 50 million induced abortions performed around the world each year are unsafe because they are undertaken by unskilled persons and/or in an unsuitable environment.
7. The mortality following unsafe abortion is estimated to be very many times greater than when the procedure is performed in a medical environment. At least 75 000 women die unnecessarily each year after unsafe abortion and very many more suffer life-long ill-health and disability, including sterility.
8. Unsafe abortion has been widely practiced since time immemorial. Today it occurs manly in countries with restrictive legislation with respect to the termination of pregnancy for non-medical reasons. Countries with poorly developed health services and where women are denied the right to control their fertility also have higher rates of unsafe abortion.
9. When countries have introduced legislation to permit abortion for non-medical reasons, the overall mortality and morbidity from the procedure has fallen dramatically, without any significant increase in terminations.
10. In the past most pregnancy terminations were undertaken surgically, however, recent pharmaceutical developments have made it possible to bring about safe medical abortion in early pregnancy.
11. In addition, the reproductive process can be interrupted before pregnancy begins by classical contraceptive methods or by recently popularized emergency contraception. The latter is not an abortificant because it has its effect prior to the earliest time of implantation. Nevertheless these procedures may not be acceptable to some people.

Recommendations

1. Governments and other concerned organizations should make every effort to improve women's rights, status, and health, and should

try to prevent unintended pregnancies by education (including on sexual matters), by counseling, by making available reliable information and services on family planning, and by developing more effective contraceptive methods. Abortion should never be promoted as a method of family planning.

2. Women have the right to make a choice on whether or not to reproduce and should therefore have access to legal, safe, effective, acceptable and affordable methods of contraception.
3. 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.
4. Most people, including physicians, prefer to avoid termination of pregnancy and it is with regret that they may judge it to be the best course, given a woman's circumstances. Some doctors feel that abortion is not permissible whatever the circumstances. Respect for their autonomy means that no doctor (or other member of the medical team) should be expected to advise or perform an abortion against his or her personal conviction. Their careers should not be prejudiced as a result. Such a doctor, however, has an obligation to refer the woman to a colleague who is not in principle opposed to termination.
5. Neither society, nor members of the health-care team responsible for counseling women, have the right to impose their religious or cultural convictions regarding abortion on those whose attitudes are different. Counseling should include objective information.
6. Very careful counseling is required for minors. When competent to give informed consent, their wishes should be respected. When they are not considered competent, the advice of the parents or guardians and when appropriate the courts should be considered before determining management.
7. The termination of pregnancy for non-medical reasons is best provided by the health care service on a non-profit-making basis. Post-abortion counseling on fertility control should always be provided.
8. In summary, the Committee recommended that after appropriate counseling, a woman had the right to have access to medical or surgical induced abortion, and that the health care services had an obligation to provide such services as safely as possible.

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