EDITORIAL

SEXUAL AND REPRODUCTIVE RIGHTS ARE LACKING IN LATIN-AMERICA AND THE CARIBBEAN

When I received an invitation to write the editorial for this issue of the *Revista Colombiana de Obstetricia y Ginecología* I did not hesitate in accepting it, not just for the honour which it represented for me, but also for the opportunity to reiterate the Latin American Federation of Obstetrics and Gynaecology Societies (FLASOG) responsibility for defending the sexual and reproductive rights (SRR) of Latin-American and Caribbean females.

The FLASOG Assembly at the 2002 Latin-American Congress of Obstetrics and Gynaecology approved the Santa Cruz Declaration which assumed the defence of the following SRR:

- Healthy and safe motherhood without running the risk of dying;
- A sexual life free of violence and free of the risk of contracting a sexually-transmitted disease and/or unwanted pregnancy (UWP);
- Regulating fertility by ensuring access to contraceptive methods including emergency contraception (EC);
- Pregnancy–interruption within the framework of the law; and
- Making information about SRR freely available and ensuring the right to having access to SSR services.

Healthcare should be practised by adopting a human rights' (HR) approach based on respect for people's dignity. This implies equal opportunities and avoidance of discrimination in health attention.[1] People's SRR (particularly those of females) are an inalienable, integral and indivisible part of HR which are universal, interdependent and interrelated.[2] There is still great concern for deficiencies regarding matters of sexual and reproductive health (SRH), for instance resources becoming scarce, gender–based violence and other violations of females' HR.[3]

Six out of every ten females suffer physical or sexual violence during their lives, 7% to 36% of females suffer sexual violence (SV) during their childhood and 6% to 59% of females suffer from SV after reaching age 15; the intimate partner is most involved in such acts.[4] Violence's severe repercussions on females has been already been well-identified. It may lead to short- and long-term consequences on female health, including physical trauma, HIV infection, UWP and unsafe abortion. The resultant psychological trauma can have a negative effect on sexual conduct and relationships, the ability to negotiate safe sex and a potential increase in drug abuse.[5]

There is a scandalous lack of services in this field in Latin-American countries. An early response to SV is needed and integral attention for victims ought to be provided which would include:

- Reinforcing medical-legal links to allow justice to be complied with and health services to be provided;
- Providing post-violation services;
- Collecting and delivering evidence for the legal system; and
- Facilitating victim reference through standardised treatment protocols and medical-legal procedures.[6,7]

There is still a long way to go to ensure that females in our countries have the right to live a sexual life free from violence. This can be done by empowering females, implementing and/or broadening and

improving SSR services, detecting cases of violence against females in the daily routine of providing healthcare, providing early and integral attention for SV and providing coordination with other health and medical-legal services so that they do not become victimised again.

On the other hand, the great challenge facing us today is that policy-makers show little interest in maternal mortality (MM). MM is the most sensitive indicator of the level of attention regarding SRH as this usually expresses the great gaps within populations where the pregnancy of the most unprotected, excluded and discriminated against females ends in their tragic death.[8] It is known that the most effective interventions for dealing with such deaths are intra-partum care being provided in healthcare units by qualified personnel, emergency obstetric care, institutional prenatal care, bridging gaps in access to healthcare services, an intercultural approach to delivery, post-natal care, family planning and abortion in safe conditions.[9]

Regarding the last two aspects, it is worth stressing that family planning (FP) and contraception play an important role in reducing MM due to today's technology by reducing the fecundity rate and thereby reducing the number of UWP and the risks represented by pregnancy and giving birth.[10] It can be stated that 1/4 to 2/5 of MM can be eliminated if such pregnancies are avoided.[11] Advances have been made in Latin-America but there are still groups of the population in which there is an important unsatisfied demand for FP.[12] These services must thus be broadened, a greater range of contraceptives must be made available (including emergency contraception - EC), good logistics must be ensured and the quality of attention must be improved.[13]

In spite of the high prevalence of contraceptive use and the existence of safe and efficient methods of abortion, there were 42 million induced abortions around the world in 2008, 21.6 million of them being unsafe abortions. There are more than 4 million unsafe abortions in Latin-America, making this figure the highest in the world (31 for every 1,000 fertile aged females), in turn leading to important MM figures, in spite of morbidity caused by abortion having been reduced, probably due to greater access to and use of misoprostol. Abortion is more frequent in countries having a lower prevalence of safe contraceptives and restrictive legislation, such as in Latin-American ones.[14, 15, 16]

A recent WHO publication[17] has shown important advances regarding the maternal mortality ratio (MMR) in most regions of the world, except for Africa. However, this has not been sufficient to reach the Millennium Goals (MDG) of reducing MM by ¾. This can be achieved by emphasising complementary intervention such as:

- Mobilising MM committees;
- Improving records;
- Using the international code of diseases (ICD);
- Empowering females by ensuring that better information is made available to them and that they have access to education;
- Ensuring equal opportunities;
- Recognising their rights to take their own decisions;
- Broadening and improving the quality of services;
- Providing humanised attention during pregnancy and delivery through an integral approach; and
- Providing special care for those pregnancies and UWP where women's lives are put at risk. The *Population Reference Bureau* thus states that all pregnancies should be wanted and that fecundity must result from choice.

FIGO has identified this serious health problem and has put into motion an initiative called "Preventing Unsafe Abortion" (described by Pío Iván Gómez for Colombia in this issue) which is currently operating in 43 countries around the world, 16 of them from LAC. The mandate is to reduce the number of abortions and, consequently, maternal deaths;[18] this deals with providing integral intervention in an attempt to prevent UWP through FP and sexual education, providing females with access to safe abortion in the terms established by the law in each country and

providing suitable, preferentially outpatient, rapid, post-abortion attention and providing post-abortion contraception.[19] Progress has been made by taking advantage of facilitating factors and identifying barriers as these must be overcome so that we can try to get close to the millennium goals by 2015 [20] and thus some tasks must still be undertaken: commitment must be obtained from decision-makers and health professionals, a greater provision of resources must be stimulated, records must be improved, suitable technologies must be used, complying with current legislation must be improved and it must be reviewed when necessary. All the foregoing must be born in mind and acted on to avoid deaths and unnecessary suffering to bring us closer to having greater respect for HR and, therefore, respect for SRR.

Dr. Luis Távara Orozco
FLASOG Sexual and Reproductive Rights Committee Coordinator, Regional Coordinator for South-American countries regarding FIGO's "Preventing Unsafe Abortion initiative".

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