



**KIT** Royal  
Tropical  
Institute



Country report: PANAMA

## NEEDS ASSESSMENT ON SAFE ABORTION ADVOCACY

*FOR THE PANAMANIAN SOCIETY OF GYNAECOLOGY AND OBSTETRICS (SPOG)*

COMMISSIONED BY THE INTERNATIONAL FEDERATION OF GYNAECOLOGY AND OBSTETRICS (FIGO)  
CONDUCTED BY THE KIT-ROYAL TROPICAL INSTITUTE – DEPARTMENT OF HEALTH

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## Table of contents

Executive summary.....	i
1. Introduction.....	1
1.1 Needs Assessment Purpose.....	1
1.2 Needs Assessment Objectives .....	1
2. Methodology .....	2
2.1 Literature review .....	2
2.2 Online survey .....	2
2.3 Interviews .....	2
2.4 Workshop with key actors .....	2
2.5 Challenges and limitations.....	3
3. Results .....	4
3.1 Literature review .....	4
3.2 Online survey .....	8
3.3 Semi- structured interviews.....	11
3.4 Workshop with key actors .....	13
4. Conclusions.....	17
5. Recommendations.....	18
6. References .....	19
7. Appendices .....	20
Appendix 1: List of interviews.....	20
Appendix 2: Workshop program .....	21
Appendix 3: Additions to the literature review .....	23
Appendix 4: Response to the online survey .....	26
Appendix 5: Social networks and alliances .....	27
Anexo 6: SWOT analysis.....	28
Appendix 7: Plan of action .....	29

## Executive summary

This needs assessment had the objective to identify and analyse the capacities and needs of the Panamanian Society of Obstetrics and Gynaecology (SPOG) when it comes to the advocacy of safe abortion. This research forms part of a multi-country needs assessment of the advocacy of safe abortion, involving ten countries, and has been realized at the request of the International Federation of Gynaecology and Obstetrics (FIGO).

The assessment was realized based on a review of the literature about abortion in Panama; an online survey which was completed by 62 members of SPOG; and 14 in-depth interviews with representatives of SPOG, the Panamanian Ministry of Health, the United Nations Population Fund, the Panamanian Society for Family Planning (APLAFA), the Social Security Bank (Caja de Seguro Social), and gynaecologists, obstetricians and general practitioners of level II and III hospitals. In addition, a participative workshop with key actors was held to identify needs and tangible priorities for the advocacy of safe abortion in Panama, as well as to generate input for SPOG's plan of action.

The results of the literature review, the interviews and the workshop with key actors confirm that – in spite of the legality of therapeutic abortion and the decrease of insecure abortion through the growing use of medical abortion – access to safe abortion is restricted in Panama, especially for women with less resources and women who do not live in the capital. This can be explained by the disinformation concerning the legal framework and the technical norm of therapeutic abortion that is shared amongst medical staff members, potential users, and the general public. Other explanations can be found in the strong and general stigma attached to abortion and the time limits of legal abortion in cases of rape. Consequently, secrecy prevails around abortion in Panama, which causes both health risks for women and a lack of visibility on the prevalence of abortion due to the absence of data and records.

The recommendations of this study are as follows:

- **To ensure better and more extensive use of the existing legal framework** and extend the access to safe abortion via the diffusion of the National Guide about the Treatment of Pregnancy Complications, via the debate about the interpretation of the concept of health, and via the development of Technical Guides about the Treatment of Pregnancy in cases of Sexual Violence.
- **To promote the transformation of attitudes with regard to safe abortion on all levels**, especially amongst medical professionals, including gynaecologist-obstetricians, general practitioners, nurses, and mental health specialists (psychologists and psychiatrists).
- **To expand the support network for access to safe abortion** through the involvement of new sectors like the academic, legal and social sectors.
- **To ensure the generation and registration of abortion data**, as well as the translation of these data in communication materials to support efforts in the advocacy of safe abortion.
- **To strengthen SPOG and the Group of Sexual and Reproductive Health** both on the organizational level as on the level of its tangible advocacy capacities, especially with regard to the development of communication skills and the clarification of values amongst its members.

## 1. Introduction

This country report is the result of a needs assessment conducted by KIT Royal Tropical Institute with the Kenya Obstetrical and Gynaecological Society (KOGS) regarding Safe Abortion Advocacy. Kenya is one of the ten countries participating in a broader Needs Assessment for an upcoming multi-country FIGO-led project that aims to increase the capacity of national obstetrics and gynaecology societies to become national leaders in safe abortion advocacy work.

### 1.1 Needs Assessment Purpose

This Needs Assessment is the first phase of an upcoming safe abortion project and should provide a better and more in depth understanding of the capacities and needs of KOGS, to then identify the main needs in relation to safe abortion advocacy that the following multi country project could address. Also, it should provide more clarity on how FIGO can strengthen more effectively the capacities of national societies, in this case KOGS. This includes the provision of recommendations on the content of the capacity building program by developing country action plans with budget, as well as a comprehensive program proposal for the whole ten countries.

### 1.2 Needs Assessment Objectives

The specific objectives are that by the end of the needs assessment in ten countries, FIGO should have:

- Insights on the situation of abortion in each country
- Understanding of the capacity and needs of each National Obstetrics and Gynaecology Society on abortion advocacy
- Plans of Action for each National Obstetrics and Gynaecology Society developed through a collaborative process
- Recommendations on FIGOs role to strengthen the capacity of the ten National Societies as abortion advocates, translated into a comprehensive proposal

## 2. Methodology

This needs assessment used a participative approach and had a formative character. Throughout the assessment of needs there was constant and clear communication with SPOG in order to develop a common understanding of the objectives of the assessment. During the entire process inputs were shared by means of mutual feedback, which improved the collaboration and the quality of the joint work.

The methods used to reach the objectives of the needs assessment were the following:

### 2.1 Literature review

The literature review was realized between February and March 2018 and was based on a common guide tool developed for the 10 countries. SPOG shared a selection of documents and articles about the context of abortion in Panama. Also, reports of international and national key actors in reproductive health – like the United Nations Population Fund and the Panamanian Ministry of Health – were consulted. Furthermore, a search of academic articles in scientific journals was conducted. Additionally, grey literature was taken into account in order to complement the different areas of the theoretical framework of this needs assessment.

### 2.2 Online survey

A self-administered online survey was sent to the 285 members of SPOG using the Survey Monkey platform. The survey was originally designed in English for all ten countries. Therefore, the inputs of SPOG were requested to make sure that both the Spanish terminology and the questions were appropriate for the Panamanian context. Due to privacy restrictions of SPOG, which do not allow SPOG to share the contact details of its members, the survey was directly sent by SPOG via a web link. As a safety measure, participants were required to fill in a password to get access to the survey. The password was shared by SPOG in a separate e-mail.

The survey was open for response for two months – from February 20 to April 20 – with the objective to obtain additional respondents during the national congress of SPOG, which took place from the 16th to the 20th of April. SPOG sent about ten reminders via e-mail. The survey obtained 62 responses, corresponding to a participation rate of 22%. The estimated rate of completion was of 71%.

### 2.3 Interviews

The majority of the 14 interviews were conducted on the 7th, 8th, and 9th of March in Panama City. Some interviews were conducted on later dates in the Chiriquí region with the objective to include members of regional SPOG subsidiaries. The interviewees consisted of representatives of SPOG, the Panamanian Ministry of Health, The United Nations Population Fund, the Panamanian Society for Family Planning, the Social Security Bank (Caja de Seguro Social), gynaecologist-obstetricians from level II and III hospitals, and general practitioners. The interviews were conducted in the office spaces of the different organizations and medical centres. The duration of the interviews was of approximately 45 minutes on average. All interviews were recorded with the consent of the interviewees and during the interviews notes were made. Afterwards, these notes were edited and complemented using the audio fragments. The interview notes were thoroughly examined and divided into different themes which correspond to the themes presented in the outcome section of this report.

### 2.4 Workshop with key actors

In collaboration with SPOG and the Panamanian Ministry of Health, a two day workshop with key actors was organized in the Occidental Hotel of Panama City on the 12th and 13th of March. The purpose of the workshop was to identify necessities and priorities for the advocacy of safe abortion in Panama in order to generate inputs for SPOG's plan of action, according to the FIGO project which aims to develop a needs assessment in ten countries.

The specific objectives were as follows:

- To discuss and identify the opportunities and obstacles for doing advocacy of safe abortion in Panama based on the review of documents and the personal experience of participants.
- To explore, based on professional ethics, personal and professional values related to abortion and to identify activities to improve access to safe and legal abortion as well as post abortion attention services.
- To explore the implications of the political and legal framework related to abortion.
- To discuss the concept of advocacy and to identify challenges and obstacles of the advocacy of safe abortion in Panama.
- To identify the strengths and weaknesses of SPOG when it comes to advocacy of safe abortion.
- To provide points of action for a project of advocacy of safe abortion

On the first day of the workshop there were 28 participants, on the second day 23. These numbers include representatives of the Ministry of Health, of SPOG, of the Social Security Bank, the United Nations Population Fund, and the national police. During the workshop SPOG also took a facilitating role by giving a presentation about the progress of safe abortion over the past years. Appendix 1 gives a detailed oversight of the workshop program.

## 2.5 Challenges and limitations

Although SPOG provided a preliminary list of potential interviewees including e-mail addresses and phone numbers of many of these people, it was a challenge to schedule the interviews. In some cases, gynaecologist-obstetricians denied directly or indirectly to participate in the interview because of their position against abortion. The representatives of some organizations required formal requests from the directive level in order to be able to participate in the interview. After proceeding with these requests, some organizations conceded to the interview, but others gave no response. Thus, one of the principal challenges was the inclusion of perspectives of the highest possible variety of actors.

The principal methodological limitations were the low response rate of the online survey and the over-representation of testimonies in favour of safe abortion. The online survey had a response rate of 22% in spite of the multiple reminders. Illustratively, all reminders sent out from one week after the workshop onwards did not result in new responses. Both during the interviews and during the workshop, input from people who are in favour of the advance of safe abortion was received. This positive attitude towards safe abortion, however, does not seem to be representative of the position of the majority of the general population nor of the position of the majority of SPOG members.

## 3. Results

### 3.1 Literature review

The principal findings of the literature review are presented in the following subsections: demographic and socio-economic situation; sexual and reproductive health; the legal and political context; the stigma attached to abortion; the provision of services.

#### 3.1.1 Demographic and socio-economic situation

According to estimations of the National Institute of Statistics and Census (INEC), Panama has an estimated population of 4.185.378 people, consisting of 2.085.950 men and 2.072.833 women. The highest population density is to be found in the province of Panama, with an estimated 2.186.747 inhabitants. The life expectancy at birth is 78 years; 75 years for men and 81 years for women.

Panama has a medium to high level of human development, with big inequalities. Low development is concentrated at indigenous and rural sections of the population and young women in general. According to data of the World Bank<sup>1</sup>, Panama has been one of the fastest growing economies of the last decade (with a growth rate of 7,2% between 2001 and 2013). Although the country has experienced a reduction in general poverty from 21% to 17% between 2011 and 2015, this reduction has been unequally distributed. Extreme poverty is 27% in rural areas versus 4% in urban areas. In indigenous territories poverty rates are over 70% and extreme poverty rates are over 40%.

The Panamanian health system is governed by the Ministry of Health, which – besides from establishing norms – provides services to people without insurance and executes the tax financed state budget. The Social Security Bank provides health services to the insured population and manages the funds contributed by workers and patrons.

#### 3.1.2 Sexual and reproductive health

##### *a) Maternal mortality*

In spite of the progress Panama made with respect to the decrease of maternal and perinatal deaths, the country has not managed to meet objective 5 of the Millennium Development Goals. According to data of the National Institute of Statistics and Census, the rate of maternal mortality went from 64.9 deaths for every 100.000 births in 2012 to 49.2 in 2016. However, these numbers show large temporal oscillations. For example, in 2009 the rate was 42.4 deaths for every 100.000 births, whilst in 2006 the rate was of 83.6 deaths. In 2016, the provinces with the highest rates of maternal mortality were Guna Yala (339.6), Darién (206.2), and Ngäbe Buglé (162.5). Colón (18) and Panama (18.5) showed the lowest rates of maternal mortality (INEC, 2016a).

According to 2016 data of the Ministry of Health, the causes of maternal death in the Republic of Panama consisted of: complications related to the puerperium (27%); complications related to childbirth and the labour of childbirth (21.6%); toxemia, proteinuria and hypertensive disorders in pregnancy, delivery and puerperium (16.2%); other non-classified obstetric disorders (16.2%); pregnancies terminated with abortion (10.8%); maternal treatments of possible delivery problems related to the state of the foetus and the amniotic cavity (8.1%) (INEC, 2016b).

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<sup>1</sup><http://www.bancomundial.org/es/country/panama/overview>



More detailed data on maternal deaths caused by the termination of pregnancy by abortion in the years 2000, 2005, 2010, and 2015, indicate that ectopic pregnancy forms the most common reason followed by non-specified abortions (INEC, 2016c)

**Cuadro 221-12. DEFUNCIONES MATERNAS EN LA REPÚBLICA, SEGÚN CAUSA: AÑO 2016  
EN COMPARACIÓN CON LOS AÑOS 2000, 2005, 2010 Y 2015**

Código (1)	Causa (1)	Defunciones maternas (Complicaciones del embarazo, parto y puerperio)				
		2000	2005	2010	2015	2016
	<b>TOTAL</b>	<b>40</b>	<b>42</b>	<b>41</b>	<b>40</b>	<b>37</b>
<b>O00-O08</b>	<b>Embarazo terminado en aborto</b>	<b>5</b>	<b>1</b>	<b>6</b>	<b>3</b>	<b>4</b>
O00	Embarazo ectópico	1	1	1	2	4
O01	Mola hidatiforme	-	-	2	-	-
O03	Aborto espontáneo	1	-	-	-	-
O05	Otro aborto	-	-	2	-	-
O06	Aborto no especificado	3	-	1	1	-

### *B) Family planning and adolescent pregnancies*

The National Survey of Sexual and Reproductive Health of Panama (2009) reveals that 27.4% of women who are married or in a relationship have unsatisfied needs for family planning. This unsatisfied need is larger in indigenous territories, amongst women without education, and amongst women with lower incomes. The data show that the unsatisfied need has mostly to do with the limitation of family size (20.1%) rather than the need of spreading out childbirths over time (7.3%). The district of Ngöbe Bugle presents the largest unsatisfied needs for both the limitation and the spreading out of childbirths (50.9% and 24.3% respectively); whilst the province of Los Santos presents the smallest need for spreading out childbirths (4.1%), and Herrera presents the lowest need for family size limitations (4.3%). A recent needs assessment about family planning in the population of Ngöbe Bugle identified lack of economic resources and limited access as the principal barriers for obtaining family planning services (Longacre, 2017).

According to 2016 data of the Ministry of Health about the treatment of adolescent pregnancies per province, district and judicial area, 29.3% of pregnant women hospitalized for control treatments were between 10 and 19 years old. According to the data, the provinces of San Miguelito, Chiriquí, and the region of Panama Metro have the highest incidence of cases, whilst the rest of cases is distributed over the other provinces of the country. According to ENASSER (2009), 17.3% of women between 15 and 19 years old is already mother. The same data indicate that one out of every five pregnant women in Panama is adolescent. In indigenous areas one out of three pregnant women is adolescent. The educational level plays an important role in adolescent pregnancies: 43.65% of the surveyed women without education reported to have been pregnant at least once, whilst for women with higher education this percentage was far lower (11%) (ENASSER, 2019).

### *C) Abortion*

Due to the illegality and secrecy surrounding abortion, there are no precise and reliable data about the prevalence of abortion in Panama. The studies and reports about abortion in Panama are limited and the most recent information comes from registers of health centres of the Panamanian health system or from denunciation registers of the Panamanian judicial system. In 2008, a collaboration amongst SPOG, FIGO, UNPF, the International Planned Parenthood Federation (IPPF), and the Panamanian Society for Family Planning, resulted in a national report about unsafe abortion in Panama. One of the highlights of this reports consists of the fact that 84.9% of foetal deaths in 2007 were caused by abortions, of which 84.6% were codified as incomplete abortions, 7% without a specific diagnose, 4.2% as incomplete infected abortions, and 4.2% as complete abortions (UNFPA, SPOG, IPPF, APLAFA, FIGO, 2008).

**TIPOS DE ABORTOS SEGÚN AÑO DE OCURRENCIA**  
**AÑO 2007**

TIPO DE ABORTO	TOTAL	%
Aborto incompleto	6,112	84,6
Aborto infectado	301	4,2
Aborto completo	302	4,2
Aborto inducido	1	0,01
Aborto legal	2	0,02
Desconocidos	516	7
<b>TOTAL</b>	<b>7,234</b>	<b>100</b>

Fuente Documental: Registro de defunciones fetales. Año 2007.

Fuente: Estadísticas Vitales. Contraloría General de la República. Año 2008.

**TOTAL DE ABORTOS PROVOCADOS EN EL**  
**ÁREA METROPOLITANA, SEGÚN AÑOS**  
**DE OCURRENCIA. AÑOS 2003 - 2007**

Años de Ocurrencia	Total	%
<b>Total</b>	<b>443</b>	<b>100.0</b>
2003	69	16.0
2004	62	14.0
2005	89	20.0
2006	107	24.0
2007 <sup>(P)</sup>	116 <sup>(P)</sup>	26.0

Fuente: Estadísticas del Departamento Investigación Judicial.

(P)/... Cifras preliminares.

To give an estimation of the number of unsafe abortions, the report mentions - according to data of the General Direction of Judicial Investigation (DIJ) – a number of 443 induced abortions between the years 2003 and 2007. According to the register of police incidents, 33 induced abortions were registered in 2013 (0.1%) and 43 (0.1%) in 2014 (Ministerio Público, 2017)

The data about safe and legal abortions are more precise. This is especially true for therapeutic abortions, considering the fact that all of these abortions need to be approved by the National Multidisciplinary Commission of Therapeutic Abortion. According to the registers, the Commission received a total of 16 requests in 2015, 34 in 2016, and 41 in 2017, of which 14, 33, and 39 were approved respectively. Most of these therapeutic abortions were cases of congenital malformations (see appendix 3). The hospitals also keep registers of the number of abortion treatments, including incomplete abortions, and for every foetal loss a Certificate of Foetal Death must be filled in – regardless of the gestational age – and send to the General Control department of the Republic. According to the 2016 Statistical Bulletin of the Ministry of Health, 6015 abortion treatments were provided in the installations of the Ministry. Hospital Santo Tomás provided the largest number of abortion services (1688), followed by Hospital San Miguel de Arcángel de San Miguelito (1211) and Hospital José Domingo de Obaldía de Chiriquí (1017) (MINSA, 2017) (see appendix 3).

### 3.1.3 Legal and political context

In Panama induced abortion is penalized with 1 to 3 years in prison in for women who provoke the abortion and 3 to 6 years for those who realize the abortion, even when this happens with the consent of the women (penal code, articles 141-143). However, since 1982 the legal framework for decriminalized abortion has been liberalized by including two legal causes: rape and health – in the case that the mother's life or the product of conception is in danger. Specifically, article 144 about legal abortion establishes that penalizations will not be applied if:

1. If the abortion is realized with the consent of the pregnant woman in order to provoke the destruction of a product of conception caused by carnal violation, duly accredited by the authorities.
2. If the abortion is realized with the consent of the pregnant woman, for severe health causes that endanger the life of the mother or the product of conception.

The same article indicates that, in cases of carnal violation, the crime needs to be reported to the competent authority and that abortion can only be realized in the first months of pregnancy. Abortions for health reasons depend on the authorization of a multidisciplinary commission appointed by the Ministry of Health and can be realized within the first 22 weeks of pregnancy. Additionally, the article grants doctors the right to object to the realization of abortion and to refrain from realizing the abortion procedure for reasons of personal conscience.

The functioning of the Multidisciplinary Commission has been specified in resolution number 1 of the Ministry of Health from April 1989. The pregnant woman needs to present a written request, combined with a doctor's diagnose that justifies the request and with – in cases involving under-aged women – the consent of a legal representative. The director of the hospital's Gynaecology-Obstetrics service verifies the request and transmits it to the Multidisciplinary Commission. The commission examines the case as quick as possible and emits a written

authorization if the case is approved. The composition of the commission – according to Ministry of Health resolution 02007 of the 2nd of August 1988 – includes different medical specialists and a representative of the Ministry of Health’s legal department. In addition, the commission can request support from other health professionals if they consider this to be desirable.

In 2009 the Pregnancy Complications Treatment Guide was approved. This guide is designed for health professionals as to ensure that women receive quality treatment in all cases related to pregnancy complications. Chapter 3 of the updated version of 2015 details the approach to abortion and its complications, with emphasis on post-abortion care and the manual vacuum aspiration (AMEU) technique already used in health facilities (MINSA & CSS, 2015). Appendix 3 presents the classification and definition of abortion according to this treatment guide.

Over the past years, various committees of the United Nations have spoken about the legal and political context of abortion in the Republic of Panama. In 2001, the Committee on Economic, Social and Cultural Rights (CESCR) asked the state to promote the reduction of illegal abortion rates (CESCR, 26th extraordinary period, April 2011). In 2008, the Committee of Human Rights expressed their concern about the restrictive abortion legislation in the Penal Code, especially about the fact that abortion in cases of rape needs to be executed within two months of pregnancy and documented through judicial processes (Committee of Human Rights, 26th extraordinary period, April 2011). Finally, in 2010, the Committee on the Elimination of all Forms of Discrimination against Women (CEDAW) urged the State of Panama to establish regulations for the execution of existing laws concerning women’s rights to abortion and invited the Ministry of Health to conduct a profound investigation on abortion in risk full cases. (CEDAW, 45th period of sessions, February 2010).

### 3.1.4 The stigma attached to abortion

Studies about the stigma attached to abortion in Panama are practically non-existent. According to an investigation about abortion in Latin America and the Caribbean conducted by the Latin American Consortium against Insecure Abortion (CLACAI, 2015), the stigma attached to abortion is a new and undeveloped field of inquiry globally, and especially in Latin America. The study argues that the social condemnation of abortion is related to the fact that this practice is a blow for the traditional gender roles according to which women are to play a maternal role. Moreover, the study indicates that there exists a correlation between the perception of the social stigma and the legal status of abortion in Latin America. The study indicates that the social perception of the stigma needs to be evaluated both on the level of women as on the level of health professionals.

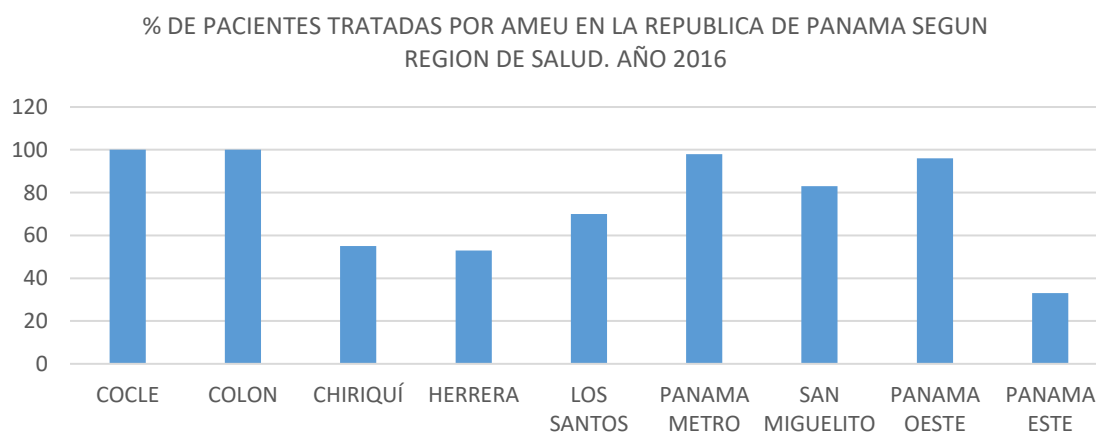
A study about the opinions of gynaecologists and obstetricians about abortion in Panama concluded that 22.3% did not agree with abortion, even if the woman’s life would be in danger (Flores Castro et al., 2015). The reasons for the termination of pregnancy that received the highest approval rates were: malformations incompatible with extrauterine life (87.7%), pregnancies or deliveries that endanger the mother’s life (77.7%), rape cases of women younger than 15 years old (66.6%), rape cases of adult women (61.1%), cases of mental retardation or dementia of the mother (55.5%), and pregnancies caused by family members other than the partner (34.4%). The majority believed that the law also had to criminalize abortion in cases of adverse social and economic conditions (74.4%) and a significant percentage believed that abortion should also be penalized in cases of rape (23.3%) or in all possible cases (20%). Various respondents considered intrauterine devices as a method of abortion and did not see this contraceptive as a valid pregnancy prevention method (Flores Castro et al, 2015).

### 3.1.5 The provision of services

Proportionally, Panama allocates a high percentage of its gross domestic product to health care (8.2% in 2013). The country has a total of 910 health facilities, 831 facilities of the Ministry of Health and 79 of the Social Security Bank. 37 of these 910 health facilities are hospitals, 18 of the Ministry of health, 15 of the Social Security Bank, and 4 are realized by patronage.

Regarding abortion methods and the treatment of incomplete abortions, the technical and administrative norms and treatment protocols of the program of integral women's health indicate that, preferably, procedures that cause minimal damage to the dilation of the cervix are to be used: the use of misoprostol and/or manual vacuum aspiration (AMEU) – as is established in the National Guide about the Treatment of Pregnancy Complications. Since 2004, Panama has worked on the formation of a modern post abortion treatment model and, especially since 2008, on the implementation of a model of post abortion treatment for manual vacuum aspiration treatments. This model also includes post abortion advice and the promotion of contraceptive methods of long duration. In this context, the relative use of manual vacuum aspiration increased from 67.5% in 2007 to 79.1% in 2008. Hospital registers give evidence of the fact that, in 2016, in the majority of the regions a relatively large number of patients received manual vacuum aspiration treatments instead of intrauterine curettage. In various regions 100% of treatments involved manual vacuum aspiration, in many regions this percentage was over 80%.

In 2008, a cost benefit study was conducted to compare the relative costs of manual vacuum aspirations with those of intrauterine curettage. This study found that the average stay in the hospital was 1.66 days for cases of intrauterine curettage, 1.83 days for cases of combined curettage and manual vacuum aspiration treatments, and 0.97 days for manual vacuum aspiration treatments. The estimated costs of hospitalization were 332 USD for cases of intrauterine curettage, 526 USD for combinations of curettage and manual vacuum aspiration, and 194 USD for manual vacuum aspiration. These estimations do not include the additional costs of intrauterine curettage treatments caused by more complex and expensive anaesthetics, nor do they include the possible opportunity costs of the operation rooms, the depreciation of anaesthetic equipment, the costs of additional staff in operation rooms, and the specialized treatments of complicated cases of intrauterine curettage (UNFPA and SPOG, 2008)



## 3.2 Online survey

Although the response rate of the survey was low and the results of the survey are not representative of SPOG in its totality, the results do provide valuable information about the position of SPOG members when it comes to strengthening the organization and their attitude towards abortion. Appendix 4 provides a visualization of all answers to the questions of the survey.

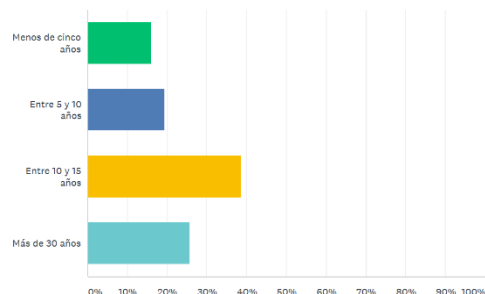
### 3.2.1 SPOG members

The results indicate that the age of SPOG members varies, that SPOG membership tends to start a couple of years after working as a gynaecologist-obstetrician and that young medical professionals form part of SPOG. The respondents indicated to have been active as gynaecologist-obstetricians for 10-15 years (39%), more than 30

years (26%) and between 5 and 10 years (19%), and less than five years (16%). They reported to have been members of SPOG for between 15 and 30 years (40%), between 5 and 15 years (32%), for less than 5 years (23%) and for more than 30 years (5%).

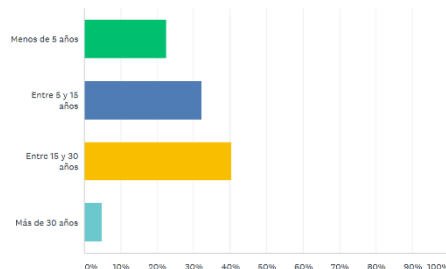
¿Cuánto tiempo hace que es obstetra / ginecólogo/a?

Answered: 62 Skipped: 0



¿Cuánto tiempo hace que es miembro de la Sociedad Panameña de Obstetricia y Ginecología?

Answered: 62 Skipped: 0



In addition, 66% reported to be members of other professional organizations apart from FIGO and FLASOG. Some of the more frequently mentioned organizations are the Medical College of Panama, the American College of Obstetrics and Gynaecology, and the Central American Association of Gynaecology and Obstetrics Societies.

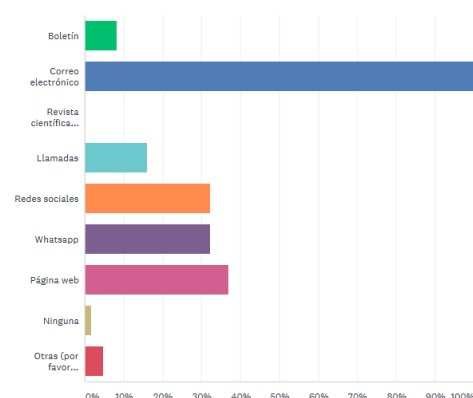
### 3.2.2 Involvement and communication with SPOG

The majority of respondents confirmed to be involved with SPOG (very involved, 11%; involved, 19%; moderately involved, 45%). The most attended activities are conferences (66%), regular meetings (56%), thematic meetings (47%) and trainings (39%). Everyone who mentioned to be involved in 'other ways' referred to congresses.

The communication between SPOG and generally occurs via email (100%). Some respondents also mentioned the web page (37%), WhatsApp (32%), social networks (32%), phone calls (16%) and the bulletin (8%). The majority of communication turned out to be of a monthly character (68%), and, in general, the members reported to be satisfied with the existing communication methods, although many reported SPOG's communication can be strengthened (69%).

¿Cuáles son las rutas de comunicación existentes entre la Sociedad Panameña de Obstetricia y Ginecología y sus miembros? (puede marcar multiples respuestas)

Answered: 62 Skipped: 0

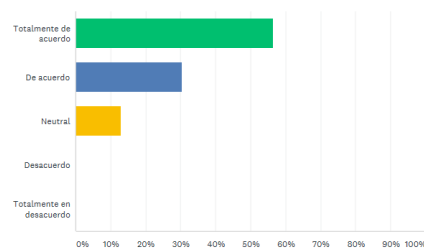


### 3.2.3 About SPOG's position on abortion

The results suggest that there is little clarity amongst the member of SPOG when it comes to SPOG's position on abortion. 41% of the respondents reported that they did not know whether such a position exists, and 15% said that a clear position is non-existent. Although 44% reported that a clear SPOG position does exist, they offer two different explanations of SPOG's position in their descriptions. One group of respondents mentioned safe abortion and women's right to safe abortion without reference to the legal framework, another group emphasized that safe abortion is only allowed when it occurs within the legal framework.

¿En qué medida está usted de acuerdo o en desacuerdo con la posición de la SPOG respecto el aborto seguro?

Answered: 23 Skipped: 39



The majority of respondents reported to be in agreement with SPOG's position (57% was completely in favor, 30% in favor). Although 13% of respondents reported to hold a neutral attitude towards SPOG's position, none of them reported to oppose SPOG's position. Likewise, the majority (70%) considers that SPOG keeps its members informed about its position and that it does so mainly in meetings (90%) and training sessions (63%).

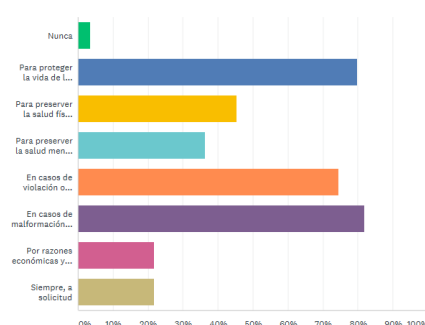
### 3.2.4 Information about abortion and position towards abortion of the respondents

Answers to the question whether SPOG informs its members about new findings and materials related to abortion were diverse; 40% said yes, 26% said no, and 33% did not know. Nevertheless, the majority (95%) would like to receive more information about topics related to abortion. A more detailed view on these topics reveals that the respondents have various interests, of which the most common are: aspects of the legal framework of abortion in Panama, medical abortion, the concept of safe abortion, and experiences in other countries.

When asked about the situations in which safe abortion should be permitted and legal, the respondents generally answered in line with the causes that are already legal in Panama: 80% of the respondents saw the protection of the woman's life as a valid reason, 82% malformations of the foetus, and 75% sexual violence. Other situations that were seen as valid by a high percentage, though not a majority, of the respondents were: the preservation of physical health (45%) and the preservation of mental health (36%). Furthermore, 22% of the respondents indicated that safe abortion should be authorized for economic and social reasons and 22% indicated that abortion should always be authorized as long as it is properly requested. Finally, 2 respondents (4%) indicated that safe abortion should never be legal nor permitted.

¿En qué circunstancias cree que el aborto seguro debería ser permitido / legal?(puede marcar múltiples respuestas)

Answered: 55 Skipped: 7



Regarding the role of health professionals as suppliers of abortion services, the respondents reported to agree with the following affirmations (from major to minor degree of agreement):

- The post abortion treatment forms part of the medical treatment and should not be separated from the rest of the treatment.
- Health workers need to be obliged to provide post abortion treatment to all women, without distinguishing between legal and illegal cases of abortion.

- Health workers have to play a role as advocates of safe abortion.
- Health workers need to have the right, following their personal values and stance towards abortion, to decide whether to realize safe abortions or not.
- Safe abortion forms part of the medical treatment and must not be separated from the rest of the treatment.
- Health workers who are opposed to and refuse to realize safe abortion should be obliged to bring the women in contact with health workers that will realize safe abortions.
- Health workers need to inform the respective authorities of cases with indications of illegal abortion.
- Specialized health workers (gynaecologists and obstetrics) have to be obliged to realize safe abortions in cases in which the law permits to do so.

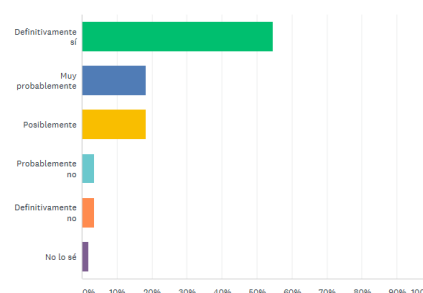
The respondents reported to disagree with the following statement:

- Safe abortions must only be realized in private clinics and not in the public health system

Finally, the majority of respondents affirmed that they would support SPOG in the advocacy of safe abortion: 55% of respondents reporting “definitely yes” to this question, 18% “probably yes”, 18% “possibly”. A minority of the respondents answered “definitely not” (4%) or “probably not” (4%), whilst one respondent did not know what he/she would do.

¿Apoyaría a la Sociedad Panameña de Obstetricia y Ginecología en la defensa del aborto seguro?

Answered: 55 Skipped: 7



### 3.3 Semi- structured interviews

Based on the analysis of the 14 conducted interviews, the outcome is structured and presented using the following points:

- The context of abortion in Panama
- Methods of abortion
- Post abortion treatment
- Positions with respect to abortion
- Challenges and opportunities for the advocacy of safe abortion
- SPOG's role in safe abortion

#### 3.3.1 The context of abortion in Panama

The interviewees explained that the majority of the population thinks that abortion is illegal and that it is criminalized. Also, many people are unaware of the decriminalization of abortion in cases of rape. Various interviewed gynaecologist-obstetricians indicated that the majority of legal abortions are realized for health reasons, involving mainly cases of congenital malformation. Legal abortion in cases of sexual violence seems to be less common, due to the lack of denunciations and the fact that it is difficult to realize the necessary processes within the 8-week time frame for abortion in cases of rape. Approved abortions are realized in public hospitals of the second and third level. The gynaecologist-obstetricians indicated that abortion treatments were initially concentrated at the Santo Tomás Hospital but nowadays more and more abortions are realized at other hospitals

There exists a register of abortion cases for health reasons approved by the Therapeutic Abortion Commission of the Ministry of Health. Also, the hospitals aim to keep track of the number of realized manual vacuum aspiration treatments. Nevertheless, there exists a lack of sufficient data for making accurate estimations about the magnitude of abortion in Panama. There is little visibility and information about induced abortions. The taboo

and stigmatization attached to abortion create a situation of secrecy and make it difficult to find out where these induced abortions occur, under what conditions they take place, amongst which groups they are common, and what their general complications are. Various interviewees mentioned that it is well known that private clinics provide abortion services, but there are no data about this phenomenon.

In general, all interviewees indicated that there exists a strong Panamanian stigma with respect to abortion, which is heavily influenced by religious beliefs which do affect much more than just people's attitude towards abortion. Topics like sexual education, family planning, and gender cause a lot of tension in the country because they are regarded as threats to the traditional concept of family.

### 3.3.2 Methods of abortion

At this point in time, Misoprostol and manual vacuum aspiration are the most common abortion methods.

In the 1990s the first attempts were made to introduce the method of manual vacuum aspiration without much success. From 2004 onwards people succeeded to introduce this technique as a treatment model and realized studies about the potential cost and health benefits of using manual vacuum aspiration instead of intrauterine curettage. The interviewees highlighted the significance of the progress made in Panama when it comes to both training and the distribution of necessary equipment for the realization of manual vacuum aspiration services. Although, in general, gynaecologist-obstetricians are responsible for manual vacuum aspiration, some general practitioners are trained to provide this service in hospitals where such specialists are absent. The technique of curettage is still in use, but is no longer the most common method.

The majority of the interviewees indicated that the number of unsafe abortions has decreased, given the fact that the number of septic infections in the hospitals has also decreased, and pointed at the rise in the use of misoprostol to explain this trend. However, some interviewees emphasized that the use of Misoprostol is not free of complications and that many women arrive at the hospital with haemorrhages and incomplete abortions due to the use of incorrect doses, which are consumed without medical advice or regard for the gestational age. Some interviewees criticized the fact that Misoprostol is overused and used as a family planning method. Misoprostol is strictly registered for its use in gastroenterology and cannot be used for purposes of gynaecology and obstetrics, but it is available on the black market for a price between 10 and 40 USD. Albeit with a low frequency, there are still cases of unsafe abortions involving the introduction of objects, especially probes.

### 3.3.3 Post abortion care

The interviewees explained that post abortion treatment is obliged by law and covers the treatment of both spontaneous and induced incomplete abortions. Legally, medical professionals need to report provoked cases of incomplete abortion to the Public Ministry, since the penal code sanctions both the woman who provokes the abortion and the medical professional who offers her help. However, various interviewees indicate that the reporting processes of the Public Ministry are long, bureaucratic processes with little follow-up and, therefore, often do not lead to sanctions for the woman in question. Additionally, some interviewees choose to avoid – to the degree that this is possible – said reports by giving priority to the perspective of professional confidentiality.

Following legal prescriptions, post abortion – just like therapeutic abortion – is realized using the manual vacuum aspiration treatment model. This model is based on the idea of integrality and includes advice and the provision of family planning methods, with special emphasis on contraceptive methods of long duration.

### 3.3.4 Positions with respect to abortion

On the organizational level, SPOG recognizes that it does not have an explicit position with regard to abortion, considering the fact that abortion is not even mentioned in SPOG's statutes. However, SPOG's implicit position in favour of safe abortion is reflected in documents related to different projects. Since different opinions on abortion



prevail amongst its members, SPOG emphasizes that important work remains to be done with respect to sensitization on the concept of safe abortion.

Within the Ministry of Health the attitudes towards abortion are diverse and are publicly little open to abortion. However, within the National Program of Reproductive Health there seems to exist a possibility to open the debate about the amplification of the currently permitted abortion reasons. Doing work in the creation of an integral concept of health – which includes also mental health – seems to offer one way to increase the number of approved therapeutic abortion cases. Simultaneously, the National Program of Reproductive Health aims to continue strengthening long term family planning, inform all the institutions in the country about the legal framework and the therapeutic abortion guide, and to tackle conscientious objection and the reference systems of the medical personnel in a more profound manner.

The strategy of international organizations like UNPF is focused on family planning, the prevention of adolescent pregnancies and the analysis of abortion from a perspective of maternal mortality. On a personal level, the majority of interviewees were in favour of therapeutic abortion and abortions for legal reasons, emphasizing the importance of maintaining efforts aimed at the expansion of safe abortion within the current legal framework.

### 3.3.5 Challenges and opportunities for safe abortion advocacy

All interviewees pointed at the different opposition groups as the principal obstacle in the advocacy of safe abortion. These groups have the capacity to mobilize large segments of the population and have influence on decisionmakers' policies related to sexual and reproductive health, like family planning and sexual education. Some of the mentioned challenges related to safe abortion are: the education and training of first level medical personnel; the coordination with the Public Ministry to speed up the process time of abortion requests in cases of rape; and the transformation of the abortion concept and its stigmatization. In addition, some see the current development of the law about reproductive health as an opportunity to generate more and more profound debates on safe abortion.

### 3.3.6 SPOG's role in safe abortion

SPOG is seen as a technical and scientific organization with a high level of credibility amongst specialists in gynaecology-obstetrics and with good relationships with the Ministry of Health. The leaders of SPOG consider that the character of the society has been more technical/scientific than political. In other words, SPOG has mostly been active as a consultant on technical norms and training. Some interviewees expressed the willingness to play a more active role, which would combine the scientific aspects with political ones, and would seek new alliances with – for instance – the academic or legal sector.

## 3.4 Workshop with key actors

The following section presents the principal findings from discussions and activities in the different sessions of the workshop.

### 3.4.1 Personal positions and professional responsibilities

All participants showed to be in favour of safe abortion for reasons that are approved under the current legal framework of Panama. Outside of this legal framework, participants indicated that the approach of improving family planning and promoting sexual education should have priority. Some participants showed more open attitudes towards abortions, which included the right on abortion in cases of failing long-term contraceptive methods or the right on abortion for socio-economic reasons. There also exist particular ideas concerning broad interpretations of the concept of health. These broad interpretations could expand the number of cases in which access to safe abortion can be granted following the existing legal framework.

Regarding professional responsibilities, the participants indicated that conscientious objection does not form a problem in Panama thanks to the centralization and management of the approval process of therapeutic abortions. Consequently, all approvals are assessed by professionals who are not opposed to abortion. However, this does not mean that there are no medical professionals who are opposed to safe abortion, nor does it reveal much about the potential obstacles to safe abortion hidden in the process prior to the arrival of the request at the National Abortion Committee.

### 3.4.2 Advocacy

In spite of the consensus with respect to the conceptualization of the word *advocacy*, an adequate concept was not found in Spanish. In addition, while some opted for the use of the word ‘access’ and took a more confrontational position in the advocacy of safe abortion, others argued that it could be more adequate to speak in favour of the integral treatment of safe abortion without explicitly mentioning the word ‘access’. The principal topics, roles and levels at and for which SPOG realizes advocacy of safe abortion were the following:

#### a) Themes

In general, the participants argued that the debate about safe abortion should be approached from the perspective of abortion as a problem of public health and human rights. Some of the most widely discussed and concrete topics to effectively approach the advocacy of safe abortion were:

- The diffusion of the legal status of therapeutic abortion and abortion for legal reasons.
- The promotion of integral abortion treatments involving manual vacuum aspiration (AMEU) and contraceptive methods of long duration.
- The registration of Misoprostol
- The law of sexual and reproductive health and sexual education

#### b) Roles

SPOG’s role as an educator was defined as its current predominant role. This role consists in the generation, use, and diffusion of technical knowledge about abortion amongst professionals, colleagues and professional organizations. Possibilities to operate as a persuader in public policy were identified, especially with respect to the registration of Misoprostol. The role of witness was barely mentioned and when possible activities to use the experience of professional practice arose, the scope of these proposed activities never transcended that of dealing with colleagues and other medical professionals.

### 3.4.3 Social Networks

During the workshop a plenary session was held to map out organizations, allied groups and people, potential allies, and opponents, and to discuss how these entities could be reached. Appendix 5 presents the mapping of actors in more detail.

### 3.4.4 Strengths, Weaknesses, Opportunities and Threats

The principal findings of the SWOT analysis, realized in groups, are presented in Appendix 6.

### 3.4.5 Plan of Action

Based on the discussions and the outcome of the different sessions of the workshop, it was agreed to centre the plan of action on five principal areas: i) the legal and political framework, ii) inclusion and alliances, iii) the transformation of attitudes, iv) the generation and use of knowledge, and v) the strengthening of SPOG. In addition, it was agreed that every group received a copy of the first draft of SPOG’s 2016 plan of action, as to take this action plan into account. The first draft of this plan of action can be found in Appendix 7.

**1. Diffusion, revision and possible improvements of the existing legal and political frameworks**

- More diffusion of the legal status of abortion for medical reasons (therapeutic abortion) and the legal status of abortion in cases of rape.
- To revise the National Guide of the Treatment of Pregnancy Complications and to consider developing additional didactic materials about therapeutic abortion or creating a specific guide for the treatment of therapeutic abortion.
- To develop a national guide for the treatment of women who are victim of sexual violence.
- To promote the approval of the use of Misoprostol for obstetric purposes.
- To revise the established time frames for the approval process of abortion in cases of sexual violence and to argue in favour of a broader time frame.
- To include professionals in mental health in the National Committee for Therapeutic Abortion.

**2. More inclusion and stronger alliances**

- To generate stronger ties with Societies of other specialties, like those of Psychiatry and paediatrics
- To create a map of media and journalists that are better attuned to the topic of safe abortion and to transmit messages via these channels.
- To cooperate with entities of the legal sector in order to discuss and revise how to improve and speed up the processes related to the access to safe and legal abortion in cases of sexual violence.
- To strengthen the coordination and involvement of allies within the field of sexual and reproductive health in Panama: the Ministry of Health, SPOG, Social Security Bank, UNPF, and the Pan American Health organization.
- To create new alliances with organizations of civil society that are active in the field of women's rights and sexual and reproductive rights, especially when it comes to abortion and family planning.

**3. To promote the change of attitudes towards safe abortion on all levels**

- To facilitate workshops in which the values of gynaecologist-obstetricians and SPOG members are clarified.
- To train professionals in gynaecology and obstetrics in the technique of manual vacuum aspiration as the principal and integral treatment model of abortion.
- To include general practitioners and nurses in training and sensitization activities related to safe abortion.
- To develop culturally acceptable communication materials, directed both at potential users and the general public, about the integral approach to safe abortion, the legal status of therapeutic abortion and the legal status of abortion in cases of sexual violence.
- To extend the post abortion advisory services and to augment the use of (long duration) contraceptive methods amongst women who receive post abortion treatment.
- To strengthen the perspective of abortion as a saviour of lives, instead of the perspective of abortion as a terminator of lives.

**4. The generation and use of knowledge**

- To collect studies realized by SPOG members about safe abortion and medical abortion and to consider their publication.
- To provide evidence of the relation between safe abortion and the decrease in maternal mortality.
- To give evidence of the prevalence of abortion in Panama (therapeutic, for medical reasons and others)
- To publish evidence of the health and economic benefits of the integral abortion treatment model
- To stimulate the registration and monitoring of the supply of family planning methods in hospitals.

**5. The strengthening of SPOG**

- To improve the ties with SPOG subsidiaries across the countries to ensure their participation in different activities and to have specific focus point for all regions.
- To improve the communication skills of SPOG members.
- To provide advocacy training
- To look for alternatives as to avoid the centralization of responsibilities on a select number of people who have large back-logs of work.

Appendix 6 includes a preliminary plan of action based on the inputs of the participants of the workshop. This plan contains potential objectives and specific activities for the coming three years. The further elaboration of this plan will occur in tight collaboration with SPOG and FIGO.

## 4. Conclusions

The results of the literature review, the interviews and the workshop with key actors confirm that – in spite of the legality of therapeutic abortion and the decrease of insecure abortion through the growing use of medical abortion – access to safe abortion is restricted in Panama, especially for women with less resources and women who do not live in the capital. This can be explained by the disinformation concerning the legal framework and the technical norm of therapeutic abortion that is shared amongst medical staff members, potential users, and the general public. Other explanations can be found in the strong and general stigma attached to abortion and the time limits of legal abortion in case of rape. Consequently, secrecy prevails around abortion in Panama, which causes both health risks for women and a lack of visibility on the prevalence of abortion due to the absence of data and records.

In this context, work focused at the improvement and extension of access to safe abortion is necessary, relevant and pertinent. Although there exist opportunities for SPOG to lead this work in advocacy of access to safe abortion, there also exist multiple challenges that make it difficult to make progress. The evaluation highlights the following opportunities and challenges:

### *Opportunities:*

- **The existing legal framework.** The reasons for which abortion is permitted according to Panama's legal framework (health and sexual violence), allow for many more cases of safe and legal abortions than the current number. On one hand, the 'health' reason is primarily focused on cases of congenital malformation, whereas a better diffusion and a wider interpretation of said 'health' reasons, would allow for a larger number of legal and safe abortions in a larger variety of cases. In addition, the possibility to work on an integral interpretation of the 'health' concept exists, which would include the concept of mental health and would enable the amplification of the number of legal abortion cases for health reasons. On the other hand, legal abortion in cases of rape does not occur often due to procedural limitations, especially those involving the 8-week time frame established for the request procedures. Without a change in the penal code being necessary, an improvement and acceleration of these administrative processes would expand the access to safe and legal abortion for women who are rape victims.
- **Strong ties with the Ministry of Health** through both the National Program of Reproductive Health and the existence of the sexual and reproductive health group, form an opportunity for SPOG to play a more active role in the advocacy of safe abortion.
- **Achievements of the integral treatment model involving manual vacuum aspiration** offer a starting point for continuing to expand the access to safe abortion. Also, the systematization of data about these advances can support future efforts in advocacy of safe abortion.

### *Challenges:*

- **The general stigma attached to abortion.** This stigma contributes to the fact that the general population is largely unaware of the legal status of therapeutic abortion and abortion in cases of rape. Also, the stigma results in hostile attitudes towards abortion, even for legal causes, amongst some medical professionals and public silence about abortion amongst political leaders.
- **Conservative and religious groups** opposed to topics related sexual and reproductive health that are well positioned, have influence on decision makers, and have a strong capacity to mobilize segments of the population. The opposition of these groups goes further than just abortion and is especially fierce with respect to family planning, sexual education and the so-called 'ideology of gender'. Some more recent achievements of these groups consist of the annulment of sexual education guides and a massive march against same sex marriage.

## 5. Recommendations

In order to strengthen SPOG and position the organization as a leading actor in the advocacy of safe abortion, while taking into account both the Panamanian abortion context and the organizational strengths and weaknesses of SPOG, the following general recommendations are formulated:

- **To ensure better and more extensive use of the existing legal framework** and extend the access to safe abortion via the diffusion of the National Guide about the Treatment of Pregnancy Complications, the debate about the interpretation of the concept of health, and the development of Technical Guides about the Treatment of Pregnancy in cases of Sexual Violence.
- **To promote the transformation of attitudes with regard to safe abortion on all levels**, especially amongst medical professionals, including gynaecologist-obstetricians, general practitioners, nurses, and mental health specialists (psychologists and psychiatrists).
- **To expand the support network for access to safe abortion** through the involvement of new sectors like the academic, legal and social ones.
- **To ensure the generation and registration of abortion data**, as well as the translation of these data in communication materials to support efforts in the advocacy of safe abortion.
- **To strengthen SPOG and the Group of Sexual and Reproductive Health** both on the organizational level as on the level of its tangible advocacy capacities, especially with regard to the development of communication skills and the clarification of values amongst its members.

## 6. References

- CCPR, 92º periodo de sesiones, abril 2008. CCPR/C/PAN/CO/3, 17 de abril de 2008
- CEDAW, 45º período de sesiones, Febrero 2010. CEDAW/C/PAN/CO/7
- CESCR, 26º período extraordinario, abril 2011. E/C.12/Add.64, 24 de Septiembre de 2011
- CLACAI (2016). Investigación sobre aborto en América Latina y el Caribe: Una agenda renovada para informar políticas públicas e incidencia.
- ENASSER (2009). Encuesta Nacional de Salud Sexual y Reproductiva 2009.
- Flores Castro, H.; Mendoza, A.; Grajales, B.; Ruiz, E. (2015). Opiniones de médicos gineco-obstetras sobre algunos aspectos de salud sexual y reproductiva y el aborto en Panamá. *Revista Centroamericana Obstetricia y Ginecología*, vol 20, n°2.
- INEC (2016a). Estadísticas Vitales, Volumen III- Defunciones: Año 2016. Cuadro 221-03, Tasa de Mortalidad General, Infantil, Neonatal, Posneonatal y Materna en la República, por provincia y comarca indígena de residencia: años 2012-16. Disponible en [https://www.contraloria.gob.pa/inec/Publicaciones/Subcategoria.aspx?ID\\_SUBCATEGORIA=7&ID\\_IDIOMA=1](https://www.contraloria.gob.pa/inec/Publicaciones/Subcategoria.aspx?ID_SUBCATEGORIA=7&ID_IDIOMA=1)
- INEC (2016b). Estadísticas Vitales, Volumen III- Defunciones: Año 2016. Gráfica 6, Porcentaje de Muertes Maternas de Causas según causa: año 2016. Disponible en [https://www.contraloria.gob.pa/inec/Publicaciones/Subcategoria.aspx?ID\\_SUBCATEGORIA=7&ID\\_IDIOMA=1](https://www.contraloria.gob.pa/inec/Publicaciones/Subcategoria.aspx?ID_SUBCATEGORIA=7&ID_IDIOMA=1)
- INEC (2016c). Estadísticas Vitales, Volumen III- Defunciones: Año 2016. Cuadro 221-12, Defunciones Maternas en la República, según causa: Año 2016 en comparación con los años 2000, 2005, 2010 y 2015. Disponible en [https://www.contraloria.gob.pa/inec/Publicaciones/Subcategoria.aspx?ID\\_SUBCATEGORIA=7&ID\\_IDIOMA=1](https://www.contraloria.gob.pa/inec/Publicaciones/Subcategoria.aspx?ID_SUBCATEGORIA=7&ID_IDIOMA=1)
- Longacre, M. (2017). A Needs Assessment of Family Planning Within a Ngöbe–Buglé Patient Population in Bocas Del Toro, Panama. Doctoral dissertation, Harvard Medical School.
- Ministerio Público (2017).
- MINSA(2015). Guía de Manejo de las complicaciones en el Embarazo.
- MINSA (2015). Normas Técnicas Administrativas y Protocolos de Atención. Programa de Salud Integral de la Mujer
- MINSA (2017). Boletín Estadístico: Anuario 2016. Disponible en: [http://www.minsa.gob.pa/sites/default/files/publicacion-general/boletin\\_estadistico\\_del\\_2016.pdf](http://www.minsa.gob.pa/sites/default/files/publicacion-general/boletin_estadistico_del_2016.pdf)
- MINSA & CSS (2015). Guías de Manejo de las Complicaciones en el Embarazo. Programa Nacional de Salud Sexual y Reproductiva, Programa Materno Infantil. Disponible en [http://www.minsa.gob.pa/sites/default/files/programas/guias-complicaciones-embarazo\\_diciembre\\_2015.pdf](http://www.minsa.gob.pa/sites/default/files/programas/guias-complicaciones-embarazo_diciembre_2015.pdf)
- UNFPA, SPOG, IPPF, APLAFA, FIGO (2008). Informe Nacional de la Situación del Aborto Inseguro en Panamá. El compromiso con la situación del aborto inseguro en Panamá: Un desafío Nacional.

## 7. Appendices

### Appendix 1: List of interviews

	Persona	Fecha y hora	Lugar
1	Representante de la SPOG	07.03.2018, 13.00 h	Oficina SPOG
2	Grupo SSR MINSA	08.03.2018, 09.30 h	Hospital Santo Tomás, Maternidad
3	Ginecología y Docencia Maternidad	08.03.2018, 10.30 h	Hospital Santo Tomás, Maternidad
4	MINSA- Cooperación Internacional	08.03.2018, 14.00 h	Oficinas MINSA
5	Presidente SPOG Chiriquí- Jefe de Ginecología- Hospital José Domingo De Obaldía	08.03.2018, 10.00 h	Hospital José Domingo De Obaldía- Provincia de Chiriquí
6	Hospital José Domingo De Obaldía-Secretaria de la SPGO- Chiriquí	08.03.2018, 8:00 h	Hospital José Domingo De Obaldía- Provincia de Chiriquí
7	Responsable MINSA	09.03.2018, 14.00 h	Oficinas MINSA
8	UNFPA	09.03.2018, 16.00 h	Oficinas UNFPA
9	Hospital Paitilla Clinique Femme	09.03.2018, 16:00 h	Hospital Paitilla
10	Ginecología, Complejo Hospitalario	10.03.2018, 07.00 h	Complejo Hospitalario Dr. Arnulfo Arias Madrid
11	APLAFA	10.03.2018, 9:00 h	Instalación de APLAFA-San Miguelito
12	Hospital San Miguel Arcángel	7.03.2018, 15:00 h	Hospital San Fernando
13	Hospital MAE Lewis	12.03.2018, 8:00 h	Hospital De Obaldía
14	Caja de Seguro Social	13.03.2018, 8:00 h	Complejo Hospitalario



## Appendix 2: Workshop program



## Agenda del Taller de validación y discusión de las Barreras y oportunidades para la defensa del aborto seguro en Panamá

Fecha: 12 y 13 de Marzo 2018

**Lugar:** Hotel Continental- Ciudad de Panamá

**Participantes:** 30 personas

### Objetivo general del taller.

El objetivo del taller es validar el análisis preliminar sobre el contexto del aborto seguro en Panamá y proporcionar insumos sobre oportunidades y limitantes para la defensa del aborto seguro en Panamá que alimenten los planes de acción a desarrollar para el futuro proyecto de la FIGO sobre fortalecimiento de capacidades para la defensa del aborto seguro.

### Objetivos específicos

Al final de los talleres, se habrá:

- Discutido e identificado oportunidades y barreras para proporcionar aborto seguro en el país a través de la validación de los resultados preliminares de la evaluación y testimonios sobre experiencias propias de los y las participantes
- Explorado posicionamientos personales y profesionales en relación al aborto seguro e identificado actividades para mejorar el acceso a servicios de aborto seguro y post-aborto desde la ética profesional
- Explorado las implicaciones de la ley nacional sobre el aborto y las políticas para el acceso al aborto seguro.
- Abordado el concepto de '*advocacy*' en sus diferentes niveles e identificado los desafíos y barreras para la defensa del aborto seguro
- Identificado las fortalezas y debilidades de la SPOG para la defensa del aborto seguro
- Formulado puntos de acción para un programa de fortalecimiento de capacidades en material de defensa del aborto seguro.

## Agenda

Lunes 12 de Marzo del 2018		
7.30– 8.00	Bienvenida e introducción al taller	Presidente de la SPOG
8.00 - 9.45	Presentación de los resultados preliminares de la evaluación e insumos de los participantes	KIT
<i>Pausa</i>		
10-10.30	Implicaciones del marco legal en materia de aborto seguro	KIT
10.30-11.00	Posicionamientos y responsabilidades profesionales	KIT
11.00-12.00	‘Advocacy’: concepto, niveles, riesgos y beneficios	KIT
<i>Almuerzo</i>		
13.00-14.30	‘Advocacy’: roles y dimensiones de poder	KIT
14.30-15.15	‘Advocacy’ para aborto seguro	KIT
15.15-15.30	Evaluación del día	SPOG
Martes 13 de Marzo del 2018		
07.30-8.00	Bienvenida y recapitulación del día anterior	SPOG
8.00-9.00	Comunicación para la defensa del aborto seguro	KIT
09.00-09.45	Presentación sobre trabajo de la SPOG sobre aborto Seguro	SPOG
<i>Pausa</i>		
10.00-10.45	FODA	KIT/SPOG
10.45-12.00	Desarrollo de planes de acción	KIT/SPOG
<i>Almuerzo</i>		
13.00-14.30	Continuación del desarrollo de planes de acción	KIT/SPOG
14.30-15.15	Presentación y discusión de los planes de acción	KIT/SPOG
15.15-15.30	Evaluación y cierre	KIT/SPOG

## Appendix 3: Additions to the literature review

## Clasificación y definiciones de aborto según la Guía Técnica para el Manejo de Complicaciones del Embarazo

- **Aborto:** Antes de las 20 semanas de gestación o de un feto nacido que pesa menos de 500 g (OMS). Las definiciones y el punto de corte para la gestación varían.
- **Aborto espontáneo.** Interrupción de la gestación antes de las 22 semanas, sin que haya mediado alguna intervención instrumental o por medicamentos
- **Aborto inducido o provocado.** Interrupción voluntaria de la gestación antes de las 22 semanas, mediante alguna intervención instrumental o por medicamentos
- **Aborto por indicación médica o aborto “terapéutico”.** Interrupción del embarazo antes de las 22 semanas indicada por razones médicas, por causas que ponen en peligro la vida de la madre y/o causas graves que afectan la integridad del producto de la gestación, aprobados por la Comisión Nacional Multidisciplinaria de Aborto Terapéutico
- **Aborto por indicación legal:** Interrupción del embarazo de menos de 8 semanas de gestación, producto de una violación carnal debidamente acreditada en instrucción sumarial y aprobada en un juzgado.
- **Aborto criminal:** No existen causas médicas o legales para la interrupción
- **Aborto inseguro o realizado en condiciones de riesgo:** Se define como un procedimiento para interrumpir el embarazo que es realizado, ya sea por personas que no tienen las habilidades necesarias o en un ambiente donde no se aplican las normas médicas mínimas o por ambos factores simultáneos. La sepsis, la hemorragia y la perforación son las principales complicaciones de esta práctica, y se ha constituido en la mayoría de los países con legislaciones restrictivas al aborto como una de las principales causas de muerte materna
- **Aborto por indicación médica o aborto “terapéutico”:** Interrupción del embarazo antes de las 22 semanas indicada por razones médicas, por causas que ponen en peligro la vida de la madre y/o causas graves que afectan la integridad del producto de la gestación, aprobados por la Comisión Nacional Multidisciplinaria de Aborto Terapéutico

## Solicitudes de aborto terapéutico recibidas y aprobadas por la Comisión Multidisciplinaria del Aborto Terapéutico

	2015			
	APROBADO	NO APROBADO	DECISION HOSPITALARIA (+20SEM)	TOTAL
CAUSAL MATERNA	2	1 RUBEOLA 1	1	4
LEUCEMIA	1			
OSTEOSARCOMA	1			
CAUSAL FETAL	11	0	0	11
TERATOGENICOS	1	0	0	1
TOTAL	14	1	1	16

	2016			
	APROBADO	NO APROBADO	DECISION HOSPITALARIA (+20SEM)	TOTAL
CAUSAL MATERNA	3	1 Leucemia	0	4
Cardiopatía	1			
Leucemia	1			
Ca Gástrico	1			
CAUSAL FETAL	29	0	0	29
Malformaciones	28			
Zika	1			
TERATOGENICOS	1	0	0	1
TOTAL	33	1	0	34

	2017			
	APROBADO	NO APROBADO	DECISION HOSPITALARIA (+20SEM)	TOTAL
CAUSAL MATERNA	3	1	0	4
Lupus Eritematoso	1			
Glomblastoma	1			
Ca tiroides	0	1		
Ca mama	1			
CAUSAL FETAL	36		0	37
Malformaciones	35			
Zika	1			
TERATOGENICOS	0		0	0
TOTAL	39	1	0	41

## Registro de abortos incompletos atendidos en las diferentes regiones

Región/ Instalación	Abortos
Total	6,015
Coclé	270
Hospital Aquilino Tejeira	270
Chiriquí	1,017
Hospital José Domingo De Obaldía	1,017
Darién	17
Hospital San José ( La Palma)	1
Centro de Salud Materno Infantil de Boca de Cupe	4
Centro de Salud Materno Infantil Garachine	4
Centro de Salud Materno Infantil de Jaque	6
Centro de Salud Materno Infantil de Sambú	2
Herrera	271
Hospital Cecilio Castellero	271
Los Santos	114
Hospital Joaquín Pablo Franco	114
Panamá Metro	1,688
Hospital Santo Tomas	1,688
San Miguel	
Hospital San Miguel Arcángel	1,211
Panamá Oeste	
Hospital Nicolás A Solano	952
Veraguas	
Hospital Luis Fábrega	434
Comarca Kuna Yala	38
Hospital Manuel Iglesia	14
Hospital de Inabaguinya	3
Centro de Salud Carti Sugdup	3
Centro de Salud Nargara	6
Centro de Salud Ustupu	3
Centro de Salud de Playon Chico	3
Sub-Centro de Salud	3
Comarca Ngobe Buglé	3
Hospital General del Oriente Chiricano	1
Centro de Salud de Santa Catalina	2

## Appendix 4: Response to the online survey

The detailed responses to the survey are presented in the attached pdf document titled “Responses Survey Panama”

## Appendix 5: Social networks and alliances

LEVELS/ SECTORS	ALLIES	POTENTIAL ALLIES	OPPONENTS
<b>Health sector</b>	Ministry of Health – National Program of Sexual and Reproductive Health Private Clinics Social Security Bank	Health Committees of the hospitals Medical Societies of other specialties: pediatrics, psychiatry Society of Female Doctors	
<b>Organizations of panamanian civil society</b>	APLAFA (the Panamanian Society for Family Planning)	Panamanian rotary club Fundamujer Feminist and women's rights organizations	
<b>The national political sector</b>		The Ministry of Education The National Institute of women	Conservative members of congress
<b>Legal sector</b>		Association of Lawyer wives The Technical Secretary of the Social Cabinet	
<b>Academics</b>			
<b>International organizations</b>	UNPF Pan American Health Organization		
<b>Religious groups</b>			The Evangelical Alliance of Panama The Catholic Church The Pro-life foundation The Panamanian Alliance for life and family
<b>Media and communication</b>		Media	
<b>Communities</b>		Civil clubs of Panama Youths with opinions	Indigenous leaders

## Anexo 6: SWOT analysis

SWOT analysis for SPOG's advocacy of safe abortion	
<b>Strengths</b> <ul style="list-style-type: none"> <li>• Qualified and specialized personnel working in different hospitals across the country</li> <li>• Experience and achievements in the new abortion treatment model of pregnant women in by means of manual vacuum aspiration</li> <li>• Direct knowledge of the consequences of undesired pregnancy and unsafe abortion</li> <li>• SPOG is seen as a respected and technical entity</li> <li>• Strong and good ties with the Ministry of Health through the national program of Sexual and Reproductive Health.</li> <li>• SPOG is consulted for the development of national technical guides on the management of abortion</li> <li>• Diversity in age amongst SPOG members, presence of young members</li> </ul>	<b>Opportunities</b> <ul style="list-style-type: none"> <li>• To train and sensitize professional gynaecologists and obstetricians of other hospitals in safe abortion</li> <li>• To generate more knowledge amongst potential users about the reasons that permit legal and safe abortion</li> <li>• To create more effective and better targeted communication via multiple channels</li> <li>• To generate evidence about the use of Misoprostol in gynaecology to promote registration</li> <li>• To request a revision of the National Technical Guide</li> <li>• Young doctors who are more open to safe abortion, and to sexual and reproductive rights in general</li> <li>• The existence of actors in various sectors who are in favour of safe abortion and with whom alliances can be developed</li> </ul>
<b>Weaknesses</b> <ul style="list-style-type: none"> <li>• Room for improvement in internal and external communication</li> <li>• Limited economic resources for communication activities and for visiting local subsidiaries in remote areas</li> <li>• Work overloads and limited human resources for administrative and management activities</li> <li>• Heterogeneous positions with regard to abortion amongst SPOG members</li> <li>• Limited relationships with organizations of civil society and no relationships with the academic sector</li> </ul>	<b>Threats</b> <ul style="list-style-type: none"> <li>• Opposition of religious groups with the capacity to mobilize the population and to influence policy makers</li> <li>• Denunciations and personal attacks</li> <li>• Cultural barriers especially amongst indigenous people</li> <li>• Withdrawal requests affecting the existing legal framework about abortion</li> <li>• Tension surrounding topics related to family planning, sexual education and gender</li> </ul>



## Appendix 7: Plan of action

The preliminary plan of action is presented in the attached Excel file titled: “Preliminary Panamanian Plan of Action”