

FIGO position statement on the recent prohibition of induction of fetal asystole for legal abortions in Brazil

In many countries around the world, women and girls facing the need for abortion at advanced gestational ages encounter significant barriers to accessing safe services. These women and girls are among the most vulnerable, are often subject to heightened stigma and persecution, and experience more severe complications and higher mortality rates when forced to resort to unsafe abortion practices. Restrictive laws that deviate from World Health Organization (WHO) recommendations against imposing time limits, coupled with a shortage of trained providers, further exacerbate injustices towards these individuals.

In regions where legislation allows for safe abortion services in later stages of pregnancy, it is the ethical and professional obligation of health care professionals to uphold access and quality, and to challenge any barriers that aggravate existing structural factors.

In Brazil, induced abortion is legal in three circumstances: when pregnancy is derived from rape, when there is risk to the pregnant woman's life, and when there is a diagnosis of fetal anencephaly. Under these three circumstances, there is no gestational age limit to access the right to a safe abortion in the text of Brazilian law. However, the Brazilian Federal Council of Medicine recently issued a resolution that prohibits[†] the induction of fetal asystole for legally induced abortions, undermining these rights.

Prohibition is unethical and contradicts medical evidence

FIGO expresses deep concern regarding the recent resolution issued by the Brazilian Federal Council of Medicine that prohibits the induction of fetal asystole for legally induced abortions. This prohibition in Brazil is unethical and contradicts medical evidence.

For abortion procedures that are performed after 20 weeks' gestation, scientific evidence supports considering the induction of fetal asystole to prevent signs of life during medical (induced) abortion or fetal expulsion after cervical priming but before a planned dilatation and evacuation (D&E) procedure. The likelihood of transient neonatal survival after expulsion increases with gestational age and the interval between cervical priming and abortion. For medical abortion beyond the viability limit,[‡] induction of fetal asystole should always be an option.

[†] Although a prohibition of induction of fetal asystole by the Federal Council of Medicine does not constitute a law in Brazil, it is valid throughout the national territory to all Brazilian doctors. As in Brazil legally induced abortions should only be provided by doctors according to the text of the law, the resolution published by the Federal Medical Council ends up restricting medical practice towards induced abortions.

[‡] The concept of viability is variable and depends on the context and technology available.

Prohibition impedes access to quality abortion care for women with advanced pregnancies (beyond viability) who are otherwise entitled to legal abortion in Brazil. The induction of fetal asystole in advanced induced abortions is an essential component of standard quality care and aligns with the intended outcome of abortion, which is never a live birth.^{1, 2}

Prohibition prevents obstetricians and gynaecologists from adhering to the ethical principle of beneficence. It is well-established that induced safe abortion is safer than childbirth, even at advanced gestational ages.³ Termination of pregnancy without induction of fetal asystole constitutes an induction of a preterm live birth (which is by definition not an abortion). Without induction of fetal asystole, abortions beyond the limit of viability become impossible to provide and women will be forced to either continue their pregnancy and assume the risks of childbirth at term and of forced motherhood, or resort to very unsafe abortions. Thus, the prohibition violates women's right to access and benefit from modern scientific technologies for safe abortion.⁴

Prohibition contravenes the ethical principle of non-maleficence by potentially subjecting women and a newborn to the harms of prematurity if advanced pregnancies are terminated without inducing fetal asystole. Terminating an advanced pregnancy without the induction of fetal asystole could result in transient signs of life or even in survival, with all the complications associated with prematurity (including respiratory distress, patent ductus arteriosus, severe intraventricular haemorrhage, necrotising enterocolitis, late-onset sepsis, bronchopulmonary dysplasia requiring supplemental oxygen and retinopathy).⁵ Fetal asystole induction is therefore necessary to prevent avoidable risks to newborns and ensure non-maleficence, as well as to avoid legal implications for doctors facing care obligations towards neonates with signs of life.

Prohibition violates the elimination of torture or other cruel, inhuman or degrading treatment established by the United Nations Human Rights Council. Banning fetal asystole induction may force obstetricians and gynaecologists to refuse legally requested abortion care because of their commitment to cause no harm to a newborn. Such refusal would constitute a violation of the pregnant person's right to be free from torture and other cruel, inhuman or degrading treatment or punishment.⁶

Prohibition fosters a false assumption that studies on premature infants are applicable to aborted fetuses, using the rhetoric of viability. Viability is a medical concept relevant only to neonatal care and intensive care provision in the context of spontaneous or medically indicated preterm delivery.^{7, 8} It is not relevant to induced abortions. Even under the applicable context, preterm delivery is a last-resource measure in obstetrics since any harm to the newborn, as mild as it could be, should be avoided. The studies with premature infants cited in the resolution of the Federal Council of Medicine in Brazil are related to unavoidable preterm deliveries and should not be generalised to aborted fetuses.^{9, 10} This purposeful misinterpretation also trivialises the risks of prematurity.

Prohibition will adversely affect public health indicators by potentially falsely increasing neonatal and infant mortality and morbidity rates.

Ensuring safe and respectful care

FIGO reiterates that the induction of fetal asystole must be considered and legally permitted as a therapeutic intervention to ensure a safe medically induced abortion at advanced gestational stages when extrauterine viability is possible. The practice enables care to be delivered in a way that respects the pregnant person's autonomy and protects them from harm.

Prohibiting fetal asystole – with the consequent risk of live births resulting from lawful abortion requests – undermines access to safe abortion care. In Brazil, it deprives health care professionals of the ability to uphold the rights of women and girls that are recognised by Brazilian law. Such prohibition widens social disparities and injustices: it sets a dangerous precedent for the entire region, threatening the significant progress made in this area in recent years.

References

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- ⁴ CESCR. General Comment N° 25: Science and economic, social and cultural rights. Article 15(1)(b), (2), (3) and (4) of the International Covenant on Economic, Social and Cultural Rights. United Nations, 2020 (UN Doc. E/C.12/GC/25).
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- ⁸ Romanis EC. Is 'viability' viable? Abortion, conceptual confusion and the law in England and Wales and the United States. *J Law Biosci.* 2020 Oct 9;7(1): Isaa059.
- ⁹ Brumbaugh JE, et al. Outcomes of Extremely Preterm Infants With Birth Weight Less Than 400 g. *JAMA Pediatr.* 2019 May 1;173(5):434-445.
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About FIGO

FIGO is a professional membership organisation that brings together more than 130 obstetrical and gynaecological associations from all over the world. FIGO's vision is that women of the world achieve the highest possible standards of physical, mental, reproductive and sexual health and wellbeing throughout their lives. Our work to achieve this vision is built on four pillars: education, research implementation, advocacy and capacity building.

FIGO leads on global programme activities, with a particular focus on sub-Saharan Africa and South East Asia. We advocate on a global stage, especially in relation to the Sustainable Development Goals (SDGs) pertaining to reproductive, maternal, newborn, child and adolescent health and wellbeing, and non-communicable diseases (SDG3). We also work to raise the status of women and enable their active participation in achieving their reproductive and sexual rights, including through addressing female-genital mutilation (FGM) and gender-based violence (SDG5).

We also provide education and training for our Member Societies and build capacities of those in low-resource countries through strengthening leadership, translating and disseminating good practice and promoting policy dialogues.

FIGO is in official relations with the World Health Organization and a consultative status with the United Nations.

About the language we use

Within our documents, we often use the terms 'woman', 'girl' and 'women and girls'. We recognise that not all people who require access to gynaecological and obstetric services identify as a woman or girl. All individuals, regardless of gender identity, must be provided with access to appropriate, inclusive and sensitive services and care.

We also use the term 'family'. When we do, we are referring to a recognised group (perhaps joined by blood, marriage, partnership, cohabitation or adoption) that forms an emotional connection and serves as a unit of society.

FIGO acknowledges that some of the language we use is not naturally inclusive. We are undertaking a thorough review of the words and phrases we use to describe people, health, wellbeing and rights, to demonstrate our commitment to developing and delivering inclusive policies, programmes and services.

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