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From bad to worse: global governance of abortion and the Global Gag Rule

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Abstract: *The Trump Administration's* Protecting Life in Global Health Assistance *(PLGHA) significantly expands the "Global Gag Rule" – and, in so doing, weakens the global governance of abortion. By chilling debate, reducing transparency, ghettoising sexual and reproductive health and rights work, and interfering with research, PLGHA makes an already bad context demonstrably worse. Individual women suffer the most, as PLGHA inhibits ongoing efforts to reduce abortion-related morbidity and mortality.* DOI: 10.1080/26410397.2020.1794411

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Introduction

On 23 January 2017, President Trump issued *Protecting Life in Global Health Assistance* (PLGHA) – an expansion of the Mexico City Policy, or "Global Gag Rule", last implemented under George W. Bush. PLGHA blocks US global health assistance to any foreign non-governmental organisations (NGOs) that: perform abortions, except in cases of rape, incest, or threat to the life of the woman; provide counselling on or referrals for abortion; or lobby for the liberalisation of abortion law. Earlier iterations of the rule (1985–1993, 1999–2000, 2001–2009) applied only to US family planning assistance; PLGHA applies to all US global health assistance. PLGHA was further expanded in March 2019, when US Secretary of State Mike Pompeo announced that the policy would also apply to foreign NGO sub-grantees, even if the organisations themselves do not receive any US global health assistance. For example, if an organisation receives a grant from USAID and Foundation X, and then sub-grants to a foreign NGO with funds from Foundation X, that foreign NGO is now gagged.

Researchers have found three crucial areas of impact of PLGHA: decreased stakeholder coordination and a "chilling" of discussion related to sexual and reproductive health and rights (SRHR); reduced access to contraception, with attendant increases in unintended pregnancy and induced abortion; and negative outcomes beyond SRHR, including weakening of overall health system functioning. These consequences are all associated with adverse maternal health outcomes.[1] To complement these findings, this paper will examine the evolution of global governance of abortion, with a focus on new research that illuminates how PLGHA impacts global governance. By "global governance", we are referring to global multilateral and multi-stakeholder efforts to establish, fund, and address shared human rights and global health priorities.

In what follows, we first establish safe abortion as a component of the right to health, then examine the inadequacy of existing governance efforts, many of which have been further weakened by PLGHA. The paper will then discuss how, by chilling debate and reducing transparency, PLGHA fractures health systems and contributes to the ghettoisation of SRHR work. All of this both harms women and worsens already glaring gaps in abortion data. The consequences for global governance of abortion are extreme.

Methods

To assess existing governance efforts, the authors reviewed primary source documents and relevant secondary literature. Using peer-reviewed articles identified in PubMed, we compiled a list of jurisprudence, declarations, and frameworks related to human rights, as well as to global health and development. We then shared this list with expert colleagues to ensure that we were not missing any relevant frameworks.

To assess the impact of PLGHA on these efforts, we conducted 27 semi-structured interviews with individuals involved in abortion governance at the global level. Our respondents included employees of multilateral agencies ($n = 5$), bilateral donors ($n = 2$), foundation donors ($n = 3$), NGOs ($n = 14$), and academic institutions ($n = 3$). Many interviewees were involved with international, multi-stakeholder SRHR coordination forums, including the Inter-Agency Working Group on Reproductive Health in Crises and FP2020. Our interview guide asked about the interviewee's experiences of PLGHA, with particular emphasis on if and how the policy was affecting global standard- and agenda-setting, global health funding, and scientific debate.

Before each interview, a member of the study team requested participation, read an informed consent script, and obtained verbal consent. The research team conducted all interviews by phone or Zoom between July 2018 and August 2019 (meaning that most interviews were already complete at the time of the Pompeo expansion). All interviews but two were recorded and transcribed. Two respondents declined to be recorded; in these cases, the interviewer took detailed notes. This study received ethical approval at Columbia University Medical Center.

Interview transcripts were imported into Dedoose, a qualitative analysis software. Four team members read the interviews and developed an inductive codebook, focused on how PLGHA impacts global governance of abortion. Two primary coders coded all of the transcripts, with double coding as necessary to check for bias and differential code application. The codes were subsequently grouped into themes.

Results and discussion

Literature review

Safe abortion as a component of the right to health

Safe abortion has been recognised as a component of sound health care and the right to health in key international agreements. The right to health was first articulated in the 1946 Constitution of the World Health Organization, then reaffirmed in the 1966 International Covenant on Economic, Social, and Cultural Rights. Furthermore, the 1966 Covenant explicitly acknowledged that the right to health includes entitlement to maternal, child, and reproductive health services; the provision of health-related education and information; and access to essential medicines.[2]

The 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the 1989 Convention on the Rights of the Child (CRC) established specific protections for the rights of women and girls, guaranteeing the right "to decide freely and responsibly on the spacing of their children and to have access to the information, education, and means to enable them to exercise these rights".[3] The 1994 International Conference on Population and Development (ICPD) in Cairo went one step further, establishing women's autonomy – rather than population control – as the primary driver of this right. At the same time, the ICPD specified the right to services related to abortion, such as post-abortion counselling and education, as well as high-quality care for the management of abortion complications.[4] A year later, the Platform of Action for the Beijing Conference on Women affirmed that "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence" (Article 96).[5]

The right to appropriate healthcare services, including abortion, is also reinforced in General Comment 15 of the Committee on the Rights of the Child, which states that "the interventions

that should be made available across this continuum include … safe abortion services and post-abortion care".[6] The Committee on Economic, Social, and Cultural Rights similarly includes medicines for abortion and post-abortion care among their list of essential medicines.[7]

UN treaty-monitoring bodies have further emphasised that access to abortion is a human rights matter, and that bans on abortion represent a barrier to women's health care. In line with this, CEDAW General Recommendation No. 24 states: "When possible, legislation criminalising abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion".[8] The Beijing Platform of Action includes parallel language, urging countries to "consider reviewing laws containing punitive measures against women who have undergone illegal abortions" (Article 106(k)).[5] Many others have also interpreted existing human rights treaties as establishing a right to abortion.[9–11]

Monitoring of abortion

Human rights and global health governance frameworks emphasise the importance of three interrelated concepts: (1) conducting and disseminating research relevant to health priorities, (2) maintaining transparency via access to information about government programme performance, and (3) sharing the benefits of scientific advancement. Article 27 of the Universal Declaration of Human Rights states that "everyone has the right to … share in scientific advancement and its benefits"[12] and multiple frameworks emphasise the importance of research, data-driven decision-making, open debate, and transparency.[4,13,14] Furthermore, UN declarations and other normative documents often directly link the right to share in scientific advancement to the right to health.[15–17]

However, with regard to abortion, global actors often disregard these principles. The UN Millennium Development Goals (MDGs) contain eight quantifiable and time-bound targets to operationalise the Beijing Platform of Action and UN General Assembly commitments. Despite unsafe abortion's direct impact on maternal morbidity and mortality, access to safe abortion and death due to unsafe abortion were excluded from the MDG metrics. Similarly, while the 2015 Sustainable Development Goals (SDGs) include Indicator 5.6.2 – which aims to "increase the number of states with laws and regulations that guarantee women aged 15–49 access to sexual and reproductive healthcare, information, and education" – this indicator does not track access to abortion as part of sexual and reproductive health care.[18,19]

Many of the surveys and frameworks developed by multilateral actors also either ignore abortion as a component of SRHR or solely track the legal status of abortion. This means that multilateral actors are rarely assessing the availability and quality of services, or the rates of induced or unsafe abortions. The Demographic and Health Surveys (DHS) – which are nationally representative surveys conducted every five years by ICF International and USAID – are a prime example. The DHS includes a survey specific to family planning, but that survey has no indicators related to abortion or associated morbidity and mortality. Health facility assessments, like the Service Provision Assessment (SPA), are similar: the SPA utilises registers to collect data on services rendered at facilities, but does not include abortion data.[20]

The World Health Organization (WHO) has the most robust abortion portfolio. It provides guidance and technical support on safe abortion, maintains a global abortion policies database, and attempts to monitor unsafe abortions. WHO's work on abortion is conducted through the UN Development Programme/UN Population Fund/WHO/World Bank Special Programme of Research, Development, and Research Training in Human Reproduction (HRP). One of HRP's current projects is the WHO Multi-Country Survey on Abortion (WHOMCS-A), which is being undertaken to address gaps in data. The study collects data at the facility and individual level, and aims to address the burden of abortion complications, as well as institutional capacity for the provision of safe abortion and individual experiences of care.[21] This is a significant advance, but one that is limited to those countries selected to participate.

The WHO 2018 Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) Policy Survey is an additional source of information. It examines whether national policies or guidelines on reproductive health care have provisions related to abortion or post-abortion care, while also assessing whether safe abortion is accessible to survivors of gender-based violence. The RMNCAH Indicator and Monitoring Framework calls for data to be disaggregated by setting, including humanitarian settings. However, even this survey does not capture the number of induced or unsafe abortions.[22]

There are also other glimmers of progress. While the ICPD Global Survey of 2003 only measured country-level commitments to providing post-abortion care (finding, in 2012, that only 50.4% of countries were committed to "providing access to safe abortion services to the extent of the law"),[23] the United Nations Economic Commission for Europe (UNECE) Monitoring Framework for the ICPD Programme of Action Beyond 2014 has an explicit indicator on abortion. This indicator, which is grouped under "meeting the need for sexual and reproductive health services", tracks the number of induced abortions per 1000 live births.[24]

While these efforts represent progress for the global monitoring of abortion, issues remain with the feasibility, availability, and quality of data collection.[25] PLGHA may also be actively eroding existing global governance efforts.

Interviews

Even multilateral actors fail to monitor abortion adequately – and PLGHA is exacerbating the problem

Multilateral organisations, such as UN agencies, are not formally bound by PLGHA. But several affiliated respondents reported that these organisations are self-censoring their work so as not to raise the ire of the US government – perhaps understandably, as the United States wields substantial influence as the world's largest donor to global health, with contributions exceeding $11 billion in 2019.[26] As one interviewee noted:

"We're careful about including the abortion work, sometimes, in documents and things – not that it would directly impact our funding. It's more just like we don't want to raise the ire of – we're still doing what we're doing, but we're just not, maybe – it's not in your face."

A respondent from a different multilateral similarly reported that the organisation routinely excises the word "abortion" from policy documents and commitments, even though it is under no formal obligation to do so. Still another respondent saw the failure to track access to abortion under SDG Indicator 5.6.2 as a direct result of both PLGHA and the Trump Administration's hostility to abortion:

"On some of the work regarding monitoring for SDGs … UNFPA suddenly was receiving this onslaught. They've become extremely cautious, not only to the extent that they will block anything with even the remotest of references to the a-word in the document, but they were also proactively acting, almost unknowingly so, as the agents and enforcers of the global gag rule, to the extent that they did not include abortion as part of the review methodology for SDG 5.6. And how do you actually do monitoring of the SDG target on reproductive rights without including abortion in it?"

In addition, there is broad, ongoing concern that PLGHA is creating a hostile climate for research, undermining efforts to link scientific advancement to sexual and reproductive health. "*What they call the sensitive political environment*", which, one interviewee noted, "*was really used to justify an unusual level of involvement of the implementing organizations and of the donor in our research, and was used as a way to say we couldn't do this and we couldn't do that*".

PLGHA chills debate, reduces transparency, and contributes to the ghettoisation of SRHR work

PLGHA creates a hostile context for both global governance of abortion and the larger field of SRHR. Multiple interviewees in all categories noted that the US is actively retreating from human rights commitments and trying to roll back consensus related to SRHR. In withdrawing from the UN Human Rights Council, removing the reproductive rights section from the State Department's annual human rights reports, and urging a limited interpretation of SRHR in UN fora, the US government is threatening fragile gains related to comprehensive sex education, sex work, sexual violence, and adolescent health. We have discussed, above, the effects that this larger policy stance has on multilateral monitoring efforts, and the ways that PLGHA reflects and exacerbates the "SRHR hostile" context have also been discussed in several other publications.[27,28] What follows focuses on how PLGHA chills debate, reduces transparency, and contributes to the ghettoisation of SRHR work.

Chilled debate and reduced transparency

Chilled debate refers to the proscription of both people and topics, and many of our respondents noted that organisations that refuse to certify PLGHA, their employees, and the topic of abortion are now excluded from important global SRHR discussions. Recent expansions to PLGHA have also reduced transparency, in terms of what

compliance with the policy actually means; this has generated significant confusion and apprehension among both "gagged" and "un-gagged" organisations. As one interviewee explained: "*What feels different is that with the last time around it felt much … easier to interpret in terms of who was affected, what programming would be affected … it didn't bleed into all the different areas of health*".

Several of our interviewees emphasised that fear of discussing abortion has increased, with one interviewee reporting: "*there's a silencing effect, in that people don't dare talk about abortion, [because they are] afraid of losing funding or losing their job*". Many NGOs are also concerned about misinterpreting the policy, or alienating a key donor in a shrinking funding climate. This leads to both over-interpretation of PLGHA and self-censorship by relevant organisations. As one respondent noted:

"The language is intentionally obtuse. Not having agreed-upon definitions, agreed-upon best practices leaves a ton of room for over-interpretation, over-restriction."

On a more granular level, multiple interviewees reported that non-certifying organisations, or organisations that sacrifice US funding by refusing to sign on to PLGHA, are being purposely excluded from global standard- or agenda-setting meetings, as well as from conference panels on SRHR-related topics, despite having relevant expertise in these areas. Representatives of one non-certifying organisation said that they had been excluded from global processes dedicated to promoting family planning and ensuring contraceptive security. The reported reason for this exclusion was to prevent tension with participating US-government appointees.

Many organisations have also begun to either avoid certain global meetings or curtail their involvement in these meetings. Several interviewees reported that certifying organisations did not attend or contribute to global coordination or evidence-review meetings where abortion – or even SRHR more broadly – would be discussed. Certifying organisations also avoided similar events at the 2018 International Conference on Family Planning (ICFP) and USAID personnel reportedly did not attend ICFP sessions where abortion was on the agenda. Participation in these meetings is not restricted by PLGHA, but the lack of clarity surrounding the expanded policy still breeds nervousness in vulnerable organisations. One interviewee described the decision-making process within these organisations:

"To even have a training on sexual and reproductive health and rights by the UN was, by some, seen as potentially dangerous for those organizations which have … agreed to abide by the global gag rule, because so many of their programs rely on U.S. funding. So they had to make a very difficult decision [about attending]."

This bifurcation between certifying and non-certifying organisations undermines robust, dispassionate public health debate. And while conference organisers have begun relegating abortion to side-events or special committees in order to ensure that both certifying and non-certifying actors can participate in policy-setting processes and global events, this simply exacerbates the "chilling effect" on abortion. A member of one international SRHR working group explained that participants now have to "opt in" to email discussions and meetings related to abortion. A respondent from another global SRHR standard-setting committee similarly reported: "*The other thing that we've been sensitive about at these meetings that we organize is that we can talk about safe abortion, but in smaller groups, not in plenary sessions*". These responses to PLGHA clearly both divide SRHR organisations and restrict the free exchange of abortion-related information.

The ghettoisation of SRHR work

Chilled debate, reduced transparency, and the widening chasm between compliant and non-compliant organisations also leads to the isolation and effective "ghettoization" of SRHR work. This fragments health systems (running counter to decades of concerted effort by Ministries of Health, UN agencies, donors, and other stakeholders) and also breeds damaging inefficacies that undercut patient-centred care. As one respondent noted:

"For the last 20 years, the whole development community has tried to increase efficiency in the health sector, and [has] work[ed] toward integrating services and reducing vertical funding, trying to create one-stop shops where patients could come and get all the full service that they need … I think the big inefficiency with [PLGHA] is that it goes against this trend, for the last 20 years, where we try to create integrated health systems, and it now forces systems to disintegrate, [and puts] some SRHR services in a separate track."

Another interviewee echoed this sentiment, while expressing concern about the effect that PLGHA was having on smaller NGOs:

"The concern is that [local NGOs] can't address sexual and reproductive health and rights comprehensively, which is something that they've always tried to do … you have to look at all the pieces of the puzzle in order to address it and how this is starting to fragment those approaches and also the partnerships that they had with other civil society organizations in the past where, suddenly, they aren't talking anymore."

Equally damaging, this "ghettoization" of abortion and SRHR work also extends to larger research efforts, as PLGHA limits the production of evidence to inform national decision-making and global strategies. Research is not formally included as a "gagged" activity, but two of our respondents indicated that studies have ended prematurely as a result of the loss of programmatic funding associated with PLGHA. According to one of these interviewees, who was partnering with a foreign NGO on an abortion analysis:

"Once the gag rule was put in place, even though we were not funded by USAID, and [the foreign NGO's] project on abortion was not funded by USAID, since other work that [the foreign NGO] did was, they were still – they just killed the project."

Several respondents also stated that, out of a desire to avoid "causing trouble", USAID staff have tried to censor the content of peer-reviewed articles. As one researcher reported:

"Suddenly, we had to have all of our papers reviewed by someone who's been completely uninvolved. Our papers had to be reviewed by USAID before they were published – whereas, in the past, they would be sent to USAID at the same time they were submitted to journals."

Other stakeholders with whom we spoke emphasised that even those who support abortion rights have begun to insist on an unusually high degree of confidentiality in the evaluation of SRHR projects, as they feel that they must "protect" their funding and programmes from the ire of anti-abortion actors. Unfortunately, even these efforts represent additional politicised restrictions on abortion-related research, which further undermine academic integrity and transparency.

PLGHA harms women and worsens already glaring gaps in abortion data

PLGHA's chilling effect on abortion-related research is particularly devastating, given the overall scarcity of data in this area. Global estimates of abortion are largely inaccurate, as empirical data are limited even in settings where abortion is legal. Data are least available for adolescents, populations that are criminalised, and women forced to migrate. But stigma leads to under-reporting across legal contexts – and the availability of medical abortion outside of the formal health system has further complicated tracking. Unsurprisingly, our estimates of unsafe abortion are especially poor.

There are also particular gaps related to abortion incidence in low- and middle-income countries, despite the fact that the proportion of abortions taking place in these countries has increased, from 78% in 1995 to 87% in 2014.[29] That cause-specific data for maternal mortality are also limited at the country-levels – especially for countries with high mortality levels – only exacerbates the problem.[14]

Where statistics on abortion exist, they are prone to misreporting. Misclassification of abortion-related complications in medical records, omission of private-sector abortions, under-counting of medical abortions, under-reporting of induced abortions on surveys of women, and the lumping together of spontaneous and induced abortions in the same official reports all contribute to misrepresentations in the data.[30] In countries with liberal abortion laws, surveys of women capture only 30–80% of the true incidence of abortion, as women tend to under-report induced abortions.[29] Even in the absence of restrictive abortion laws, social stigma is commonly cited as the reason for under-reporting.

Disaggregated data about abortion based on ethnicity, race, and migratory status are also poorly captured in surveys.[14] Most data consider only women 15–49 years of age: limited data exist for abortions in people younger than 15 years of age. There are also significant gaps in data for unmarried women.[14] Much of the available data focuses on maternal mortality associated with complications from abortion; there is comparatively little on morbidity. Estimates of near-miss complications, or complications that likely would have resulted in death had the woman not been admitted to a hospital, have also been rarely studied or reported.[31] Additionally, whether

abortions are classified as "safe" or "unsafe", there is a spectrum of risk that is dependent on factors like provider training, abortion method, facility type, and gestational age.[30] However, data stratified by provider, method, facility, or gestational age are extremely limited.[30,31]

Unfortunately, there is also reason to believe that PLGHA is worsening already glaring gaps in abortion-related data. The US government has significantly curtailed data collection related to SRHR, and there are signs that reporting on reproductive rights and abortion may be further restricted. As one of our interviewees explained:

"The [US] also cut reporting this past year on … sexual and gender-based violence. And as we [fight] back … on those cuts, we anticipate that one of the strategies they will engage is to re-beef up the reporting on sexual and gender-based violence, but not include anything – continue to delete the reproductive rights subsection, in an attempt to divide the community and make this about wanting broader organizations to laud the increased reporting on women's rights, quote/unquote, and split off those organizations that work on reproductive rights and abortion and isolate them from partnership … [And] if the US government is no longer reporting on and collecting stories and data and information around human-rights violations around access to family-planning information and contraception, maternal mortality, we will miss a not insignificant amount of the impact data because we're not looking for it, vis-à-vis the global gag. … They're erasing. We see this across the board … an erasure of the collection and prioritization of scientific data that backs up the impact of these harmful policies. We see the deletion of the reproductive rights sub-section as one piece of ensuring that a full picture, from a US-government data-collection standpoint, doesn't emerge on the impact of the expanded global gag."

Nor do the impacts end there. Many organisations are reporting ongoing confusion about how the PLGHA impacts their ability to gather abortion-related data, and the hostile SRHR climate has made many local NGOs nervous about engaging in research in this area. As one respondent noted:

"I know some of our partners – especially in the context of countries where we were implementing the abortion survey questions – were having conversations, locally, around whether their involvement would impact their other work, even if we were only doing data collection and they weren't directly a part of the abortion project and the funding was not coming from USAID. The further down you get in these organizations, and the further into countries you get with regard to less internationally-facing organizations, I think there's more confusion around the global gag rule and how it may impact them. People definitely had some questions with regard to whether collecting data on abortion fell within the realm of things that you could not do if you were receiving USAID funding, which many partners' organizations do, for other projects."

This effort to "erase" abortion and SRHR data will further complicate global governance efforts, and harm the health of the world's women. An estimated 54.9% of the 56 million induced abortions that occur globally each year are considered unsafe,[32] including 74.8% of those that occur in countries with restrictive laws and 75.6% of those in sub-Sahara Africa.[33,34] A WHO systematic analysis found that roughly 4.7–13.2% of maternal deaths globally are attributable to abortion.[35] There are various reasons for this: women might not receive appropriate post-abortion care; abortions may be performed in unsanitary conditions outside of authorised facilities; emergency obstetric care might not be immediately available; and women may delay seeking abortions or care for complications if their abortions are clandestine.[30] Regardless of the specific reasons operating in any individual case, further gutting of global governance efforts can only worsen the problem. As one of our interviewees emphasised:

"We're just really concerned that it's shrinking the space to talk about the importance of access to abortion and that it's really shrinking that space to advocate in the countries where we work and to just be public with the work that we do. You know that with the reintroduction of the gag rule, it's really reframing abortion access as a political issue … whereas for us, it's 100% a medical issue, and that's very much how we want to talk about it. Access to safe abortion saves women's lives … [and PLGHA] really takes away from the medical discussion, which I think is a more neutral position to discuss the issue from and it's also an evidence-based position. That's the other thing. The gag rule is not based on medical evidence. We know that it actually goes against medical evidence."

Conclusion

Safe abortion is a recognised component of sound health care and the right to health – but global governance remains weak, and even multilateral actors fail to adequately monitor abortion. PLGHA has exacerbated this problem by creating a hostile context for both global governance of abortion and the larger field of SRHR. By chilling debate, reducing transparency, ghettoising SRHR work, and compromising the integrity of the research process, PLGHA is actively harming women and widening critical gaps in abortion data. This has serious consequences for not only women, but also the global health sector as a whole. By inhibiting scientific undertakings aimed at saving lives and promoting health, PLGHA worsens a demonstrably bad context. Individual women suffer the most, as PLGHA interferes with our ability to reduce abortion-related morbidity and mortality.

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Résumé

Le programme de *Protection de la vie dans le cadre de l'aide sanitaire mondiale* de l'administration Trump élargit sensiblement la «Global Gag Rule» (ou règle du bâillon mondial) et, ce faisant, affaiblit la gouvernance mondiale de l'avortement. En étouffant le débat, en réduisant la transparence, en marginalisant le travail sur la santé et les droits sexuels et reproductifs et en interférant avec la recherche, ce programme aggrave visiblement un

Resumen

La política del Gobierno de Trump *Proteger la Vida en la Asistencia Sanitaria Mundial* (PLGHA, por sus siglas en inglés) amplía de manera significativa la Ley Mordaza y, por consiguiente, debilita la gobernanza mundial del aborto. Al paralizar el debate, reducir la transparencia, guetoizar el trabajo en salud y derechos sexuales y reproductivos, e interferir con las investigaciones, la PLGHA empeora demostrablemente un contexto ya malo. Las

contexte déjà négatif. Les femmes individuelles en souffrent le plus, puisque le programme inhibe les activités en cours pour réduire la morbidité et la mortalité relatives à l'avortement.

mujeres individuales son quienes más sufren, ya que la PLGHA inhibe los esfuerzos continuos por reducir la morbimortalidad relacionada con el aborto.