Bioethics and Reproduction With Insights From Uruguay

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Summary and Keywords

As time goes by, the world experiences advances and setbacks in the field of sexual and reproductive health and rights. But new challenges appear in terms of professional performance and implementation of services created by newer laws and policies. The development of new ethical frames in dialogue with disputed value systems is one of the main obstacles to ensuring universal access and comprehensive services to guarantee the exercise of these rights.

Since 2002, Uruguay has been one of the few countries in Latin America and the Caribbean that has achieved significant advances regarding sexual and reproductive rights by recognizing them as human rights. The passage of several laws has resulted in the implementation of programs in SRHS and legal abortion as being considered mandatory for the National Health System. The follow-up and monitoring of this process by the Observatory of Mujer y Salud en Uruguay (MYSU) has demonstrated how changes in the legal framework led to a new stage for health-care providers, politicians, and decision makers and also for the social movement that has historically advocated for this agenda, all now facing new problems and challenges—some of which are completely unexpected. The high prevalence of conscientious objection exercised by physicians and OB/GYNs in refusing the provision of care in SRHS is one of the ethical dilemmas that needs to be discussed to innovate solutions to the problems and promote best practices from a gender equity and human rights paradigm.

Keywords: sexual and reproductive health, SRHS, abortion, sexual and reproductive rights, conscientious objection, refusal to provide care, bioethics, ethics in health care

Context and Background

Since 2001, as summarized in Table 1, Uruguay has undergone a series of legislative reforms in the field of sexual and reproductive health and rights, accompanying international and regional commitments on population and development and human rights (MYSU, 2014), such as the International Conference on Population and Development (ICPD) (El Cairo, 1994), or its regional expression in the Montevideo Consensus (ECLAC, 2013). This

process has intensified over the last decade, with the incorporation of multiple services into the Integrated National Health System (INHS) (MYSU, 2017).

Uruguay is the second smallest country in Latin America with a total area of 176,215 square kilometres and a population of 3,456,750. It underwent its first demographic transition at the beginning of the 20th century, which has determined a demographic profile similar to that of developed countries; now it is experiencing its second demographic transition, with fertility rates below replacement since 2005, reaching a global fertility rate of 1.6 in 2018. It is a democratic republic with a presidential system.[1] It is a strongly party-centric country (Caetano, Rilla, & Pérez, 1987) with a low volatility and a moderate multiparty system (Sartori, 1992).[2] Since 2005, it has been governed by the Broad Front (*Frente Amplio*, in Spanish), a left-wing party with strong ties to several social movements. The presence of the Broad Front in the government has opened a window of opportunity for solidifying demands in this field. This process has not been without its barriers and dead ends, however (Wood, Abracinskas, Correa, & Pecheny, 2016). Being formally separated from the Roman Catholic Church since 1919, Uruguay is a highly secularized country.[3] It has a low level of religious affiliation, among the lowest in Latin America with 38% Catholics, 41% atheists and agnostics, 14% other religions, and 7% evangelicals.[4] All of these factors have been crucial for making advances in the field of sexual and reproductive rights.

Uruguay has played a key role in the development of this agenda, positioning itself at the forefront of a region that has one of the most advanced interstate agreements on the recognition of sexual and reproductive rights as human rights. The regional social monitoring of the implementation of the commitments assumed through the Montevideo Consensus, called Mira Que Te Miro, has observed that Uruguay "has made significant progress … particularly with regard to recognizing and fulfilling sexual and reproductive rights (SRR), and in the prevention of maternal mortality, with legal frameworks that are a reference for the region" (Miraquetemiro, 2018, p. 44), ranking the country as the second most advanced on this agenda, behind Cuba.[5]

The wide range of legislation on sexual and reproductive health and rights in Uruguay covers, among other things, abortion, contraception, comprehensive sexual education, gender-based violence and LGBTIQ+ rights (as summarized in Table 1). This process of legal reform and recognition of what is called the "new rights agenda" is, in turn, part of a process of the national health sector reform, which establishes the universality of coverage and mandatory sexual and reproductive health services for both private and public health institutions (MYSU, 2017).

These changes in the legal framework, and in particular the legalization of abortion, have been "the fruit of more than two decades of advocacy, led by feminist organizations in alliance with trade unions, student groups and other actors, including the medical sector and key political leaders" (Wood, Abracinskas, Correa, & Pecheny, 2016, p. 1).

Table 1. Sexual and Reproductive Health and Rights Legislation in Uruguay
Law No. 17.386 on Accompaniment during Childbirth (2001)
Law No. 17.514 on the Eradication of Domestic Violence (2002)
Law No. 17.515 on Sex Work (2002)
Law No. 17.815 on Commercial or Non-Commercial Sexual Violence against Children, Adolescents or Incapable Persons (2004)
Law No. 18.211 on the Establishment of the Integrated National Health System (INHS) (2007)
Law No. 18.246 on Concubinary Union (2007)
Law No. 18,426 on the Defence of the Right to Sexual and Reproductive Health (2008)
General Education Law No. 18.437 (2008)
Law No. 18.987 of Voluntary Termination of Pregnancy (2012)
Law No. 19.075 on Equal Marriage (2013)
Law No. 19.161 on Maternity and Paternity Leaves in the Private Sector (2013)
Law No. 19.167 Assisted Human Reproduction (2013)
Integral Law No. 19.580 on Gender-Based Violence and Violence Against Women (2017)
Law No. 19.643 on the Prevention and Combating of Human Trafficking (2018)
Integral Law No. 19.684 for Trans People (2018)

Despite ranking the country as the second best in the region, Mira Que Te Miro identified a number of weaknesses, obstacles, and deficits to overcome such as lack of campaigns to disseminate rights and services; properly allocated and labeled budgets for SRH, abortion, and gender-based violence care; inter-institutional coordination to address the different dimensions of gender-based violence; and strengthening accountability mecha-

nisms to evaluate results and address challenges (Miraquetemiro, 2018). These are challenges the country must face in the implementation of its public policies and services in order to comply with human rights standards.

The new services in sexual and reproductive health, particularly with the incorporation of legal abortion services and attention to LGBTIQ+ population requirements, generate new ethical dilemmas for health care and professional practice, challenging the health world to review gender biases and prejudices about sexual orientation and diverse gender identities.

Sexual and Reproductive Health Services in Uruguay: Implementation Gaps in Policies

Although national legislation has been updated and now mostly complies with the human rights agreements and commitments assumed by the state at the regional and international levels, ensuring these changes translate into public policies poses new challenges and unexpected problems. All public policies have gaps between legislative design and implementation (Grindle, 1980), so it is essential to follow up and monitor them. The legal and normative changes will only have the intended effects, if the benefits and services created are within reach and adequately respond to the requirements of the population they must serve.

Taking into account the need to generate from civil society a political and technical tool with enough efficiency and methodological robustness to influence the improvement of access to sexual and reproductive health (SRH) services with gender equity, universality, quality and comprehensiveness, MYSU created its National Observatory on Gender and Sexual and Reproductive Health in 2007.[6] Its central mission is to follow up on sexual and reproductive health and rights policies and to monitor the functioning of legal abortion services since their implementation in 2013.

One of these challenges is that provision of these services is mandatory for the providers in the INHS since 2010, but SRH training has not been included in the training curricula of the professionals involved (gynaecology, social services, and psychology). There were basic courses offered by the Ministry of Public Health for the SRH reference teams, but their main objective was to adhere to the legal and the clinical guidelines created to frame the intervention of the professional teams.

Regarding contraceptives, health services have implemented a wide selection. Methods of contraception such as male and female condoms, intrauterine devices (IUD), and emergency contraception can be obtained free of charge on the public health subsystem and with a minimal fee from private providers (CSPD, 2017; MYSU, 2017). Despite this, contraceptive services continue to be primarily directed at women and/or used by them, while promotion of contraceptive services within the framework of SRH care has not had a consistent communication strategy. Therefore, information about the various methods,

promotion of their use, and ways to obtain them do not always reach those who need or desire it (MYSU, 2017).

There is a growing promotion of humane childbirth services both from the standards and from the practices recommended by the Ministry of Public Health. Despite this, the percentage of births by Caesarean section in Uruguay (44%) is one of the highest in Latin America, higher than in developed countries, and with a much higher rate than that recommended by WHO (15%) (Cóppola, 2015). For this reason, the Ministry of Health defined the reduction of unnecessary Caesarean section by 10% as one of its goals for the five-year period 2015–2019 (MSP, 2017).

In addition, there are difficulties in preventing obstetric violence, a phenomenon that is repeated in the accounts of women and their partners, despite the existence of regulations to support good practices during childbirth care, including the possibility of labor companions (MYSU, 2017) and a long tradition of mother-child policies with hospital delivery care for almost all births in the country.

The institutions in the INHS, both public and private, in complying with legislation, are required to create interdisciplinary SRH teams made up of professionals in the areas of obstetrics and gynecology, mental health, and social work. The follow-up to the implementation of the services found that all the providers present in the districts of the country have at least one team located in the capital city or most important population in each department of the country (CSPD, 2017; MYSU, 2017).[7] The State Health Services Administration (ASSE, in Spanish), the country's largest health provider, has 35 sexual and reproductive health services (SRHS) and 70 voluntary termination of pregnancy (VTP) teams in place in the 19 departments in which the country is organized geopolitically and administratively (CSPD, 2017).

The VTP Law, passed in 2012, regulates the practice of abortion—under a system of deadlines and conditions—establishing requirements to perform the procedure legally within the framework of the INHS.[8] Since then more than 55,000 women have accessed free and legal abortion services, about 8,000 per year.[9] Official figures differ significantly from those estimated before the legal change, with 33,000 annual abortions estimated in 2003 (Sanseviero, 2003). Figures for 2018 from the Ministry of Public Health show just over 10,000 legal abortions that year. These results contradict the warnings and forecasts made by opponents of legal change: There was no increase in the practice once legal services were in place, and women did not make it a practice to use abortions as a means of family planning. The provision of voluntary pregnancy interruption services incorporated into the comprehensive SRH care scheme, although problematic, would be strengthened by access to a broad array of contraceptive methods in all health-care institutions. Studies have recorded that, in general, the teams in charge of providing abortions are the same teams that formed for SRH care. These teams end up focusing exclusively on direct care, supplying abortion services; and in some cases they dispense contraception (MYSU, 2017).

While most providers of SRHS have conformed to standards, they usually do not function as referral teams. This results in a lack of clarity among professionals working in this area and contributes to the fragmentation and verticality of SRH efforts in general (MYSU, 2017). This lack of a holistic approach to SRHS means that dimensions of people's sexual and reproductive lives such as STI/HIV prevention and care, care in situations of domestic and/or sexual violence, comprehensive adolescent health care (among others), are isolated or not considered by the teams that should be referents for health-care providers and the other health and social welfare professionals.

The VTP law also provides for the possibility of professionals engaging in conscientious objection for philosophical or religious reasons. It further creates and introduces the concept of "objeción de ideario," which is a type of "institutional conscientious objection" that also has the effect of recognizing "conscience" for institutions, something unheard of in the Uruguayan legal framework prior to the law and has been frequently questioned (Juvenal, 2013; MYSU, 2017; IWHC-MYSU, 2018). This concept was incorporated in the Chilean legal reform on abortion, in 2017, which also raised concerns about its legitimacy (Cabello-Robertson & Núñez-Nova, 2018).

Two private health care providers have resorted to "objeción de ideario" in order to exempt themselves from providing abortion services.[10] However, they are obliged to provide a solution for women who require an abortion through agreements with other institutions.

High levels of conscientious objection (more than 60%) has been found in four departments in the country (out of 10 being monitored), as well as cities with 100% of objectors and 52% in ASSE's Primary Care Network in the Metropolitan Area of the country (the city of Montevideo and nearby urban areas) (MYSU, 2017; CSPD, 2017).[11] These high percentages of professionals unwilling to provide abortion services present one of the primary obstacles to the implementation of legal abortion services affecting women living in small localities or in rural areas with a lack of professional resources required to integrate VTP teams and/or overburdening the members of the teams that provide the service.

The evolution in Uruguay of historical mother-child policies toward a holistic and integrated conception of SRH has confronted the Uruguayan health system as well as professional resource training institutions with challenges that require special attention and the articulation of the tasks of diverse actors. Health as a right, centered on people with emphasis on promotion and prevention—and from a perspective of gender equity and rights—is a frame of reference for health reform that poses new ethical dilemmas for health authorities: the criteria for the functioning of service provider institutions, as well as for training and professional practice entities.

The traditional model of mother-child care based on the "mother-child dyad" has been called into question as a hegemonic view of the role of women in family health care, in

the absence of the male-father and his reproductive responsibility (López Gómez, Benia, Contera, & Güida, 2004).

The issue of health and disease brings into play political and social issues of the first order, for example, those that have to do with forms of autonomy and social relations of subordination, the social construction of the body, individuation, and citizenship: “In the case of sexual and reproductive health, as in the case of most of those who relate body–health–rights, issues related to autonomy (information, consent, confidentiality, competence, decision-making) are crucial, personal and sometimes very problematic” (Brown, Pecheny, Tamburrino, & Gattoni, 2013, p. 38). The same happens with chronic diseases and palliative care, as they are deeply personal. The link between human rights—and in particular sexual and reproductive rights—and health is complex, as the health arena becomes a field for the exercise of rights and generates new relationships between health personnel and the population that uses the system. The population with health-care requirements is in the process of reconfiguring from occupying the role of patients (passive subjects) to users of health services, as citizens with rights (Pecheny & Manzelli, 2003).

The autonomy of people to make decisions in the field of SRH acquires special significance in the face of biopolitical transformations also in the field of health and disease. Some elements of these transformations are linked to the passage from the traditional clinic to an evidence-based medicine approach, new claims and associative movements of patients (people with HIV, as an example), the judicialization of health linked to the emergence of malpractice trials, and transformations in the role of the state with respect to the formulation of health policies as opposed to the conception of health as a commodity (Paiva, Ayres, Capriati, Amuchástegui, & Pecheny, 2018).

The control over sexuality and reproduction has been particularly challenged by the normative changes generated but also by the new conceptions of health called for by the demands of women’s health movements from a feminist and human rights perspective.

The freedom and autonomy to decide on reproductive matters demands the recognition of a female sexuality freed from motherhood as an inevitable destiny. Abortion as a health requirement incorporated into SRH care challenges the belief systems of professionals, as socialized subjects in a culture that condemned their practice, and the stigmas associated with it that need to be overcome. The role and conduct of men in the exercise of responsible sexuality demands the promotion of protected practices and mutual care, incorporating men as the target of health actions in a field that has historically only been directed at women since the conception of maternal health.

The autonomy of patients is framed in a context of general structural and other conditions of the health and disease field and depends on the “agency” of the patient-subject, which can be analyzed in terms of available resources and discursive and practical knowledge (in a broad sense: information, beliefs, values).

Ethical Dilemmas in the Implementation of Services

Never before in the history of humanity have so many rights been recognized for all people. This is a formidable expansion of human rights, which have been in force and enforced for a few decades. Nation-states are responsible for the fulfilment of rights to which they were obligated, and per the subsidiarity principle, regional systems have been built to protect them. In Latin America and the Caribbean, according to the regional system of human rights protection, each person has the right to sue the state in which they live if their human rights were actively violated or if these rights were not guaranteed in the face of abuse by third parties (CLADEM, 2002).

For sexual and reproductive rights, it is a historic moment because they have achieved a potentially powerful but still fragile public status. The stereotypes involved in claims for these rights challenge not only gender stereotypes but also the ways in which other differences and structures of subordination are sexualized (Miller & Roseman, 2011; CLADEM, 2002).

On a global scale, the importance of recognizing the strength of the intersections of race, gender, class, and sexual identity in public debates about sexual and reproductive rights has been accepted. Any human rights framework must address the weight of the confluence of multiple forms of discrimination and the provision of sexual and reproductive health services in its multiplicity of components, is not without such a challenge. The power of the relation between sexual and reproductive rights combines the advantages of a positive demand for conditions for enjoying sexual and reproductive health with a commitment to question where power and prejudice lie. It places the ethical dilemmas that shape new obligations under international and national normative frameworks at the heart of the patriarchal power structures that dominate the lives of women and people of sexual diversity. This is particularly challenging at a time that has seen the rise of ultraconservative forces in opposition to this rights agenda (Douglas, 2018; Franklin & Ginsburg, 2019; Stefanoni, 2018; Semán, 2019) in everything related to the demands and requirements for the full exercise of sexual and reproductive rights, without discrimination.

In the sphere of ethnographies—especially those related to the subject of gender relations, and because of the power of un-naturalistic criticism they contain, organized social movements have taken up an opposition to any form of moral absolutism (Dinis, 2001). This new form of humanism proposes the defense of individual rights as the guarantee of cultural and moral protection to certain more vulnerable groups. With more force than all the naturalist discourses that preceded it, the culture of human rights has spread throughout the world; even into the 21st century it is an obligatory reference for almost all the nation-states and superior entities that regulate them. Feminist-inspired theories are those that most disturb the tranquillity of bioethics, which has traditionally distanced itself from gender studies and feminist ethical studies (Dinis, 2001).

In Uruguay, the high level of institutionalization of childbirth and the history of maternal health care have allowed for a sustained decrease in maternal and infant mortality in the country; but this situation has also led to difficulties with implementing a comprehensive model of sexual and reproductive health: one in which one's right to choose confronts the rules of medical and institutional functioning (Abracinskas & López Gómez, 2004). The predominance of the mother-child approach in the design of public policies placed women in their role as mothers, resulting in the development of programs focused on pregnancy and childbirth care and on the mother-child dyad. This generated epidemiological indicators in maternal and perinatal health of good performance but also made invisible other aspects linked to the integrated health of women and to the responsibility and participation of men in reproductive decisions by ignoring their involvement. For a long time, health services did not incorporate abortion situations into their models of care, although women with post-abortion complications were assisted. The reactions of services and staff varied considerably insofar as there were no health regulations or legal framework to guide professional practice. Thus, silence and concealment characterized the practice of abortion and continue to pose professional and ethical dilemmas in the face of the obligatory nature of the establishment of legal services: "The decriminalization of voluntary abortion as a matter of human rights, public health, social justice and democratic coexistence confront other conceptions with different ideological and religious grounds that point more to ontological aspects and particularistic belief systems" (UDELAR, 2011, p. 17).

People's bodies (in particular women's bodies) are no longer merely organic but also substantially symbolic, as well as politically, economically, and ambiguously bodies "with rights and surrounded by rights." Bodies are protected by rights but trapped by political regulations. They become the arena of combat and negotiation between the "subject of rights (person) and the 'living protected'" (Mujica, 2009, p. 108).

Following this logic, a

> doctor or any other health professional reproduces himself culturally as a subject of his profession, in which he reiterates a given "habitus" in his technical way of acting (a certain logical practice of proceeding) that causes tension and with it produces conflicts by his innovation of that same professional culture… . Health professionals seem to move with practical ease and discursive security between the dimensions of the cases they attend, which they themselves would conceive as extra-technical spheres and the treatment and assistance techniques used.
>
> (Schraiber, 2010, p. 17)

From the discursive security that characterizes the medical power in society, professionals can endow with meaning and support—borne from the value and authority assigned to science and technical prowess—ideological, political, religious, and even economic and social assessments of women and the health problems that their demands for services entail. These appraisals operate as "moral judgments," intertwined with the clinical judg-

ment itself in the health-care decisions that each professional will make (Schraiber, 2010).

Intervention based on values in the field of sexuality and reproduction is one of the most frequent barriers to the installation of SRH and legal abortion services in Uruguay, revealing technical interventions shaped by the value system of the professional actors, imbuing the health response with a discretion that violates the rights and autonomy of the woman or consulting person, even though the latter are protected by law:

> The net of protection that has been woven over the living body, and its radicality turned into supervised defense, often generates a fence that limits or suspends the person in his modern fullness. The autonomous citizen who is responsible and decides about herself/himself, who conquers rights to work with dignity, to be respected without discrimination of her/his sex, race or nationality; that modern citizen who can decide for whom to vote in a democratic election and has the capacity to order her/his own economy; that same citizen is often questioned in the possibility of deciding about her/his own body and her/his own rights.
>
> (Mujica, 2009, p. 176)

Medical power in the face of women's rights is one of the ethical dilemmas that challenges the work of health professionals, in their different disciplines and areas of action, because the evidence indicates that their actions reinforce traditional social and cultural inequalities and thus reproduce the gender stereotypes formulated throughout history. The resistance of professionals becomes a "technological excuse" (Kiss & Schraiber, 2011) because denial is rooted in the discussion of technical incompetence to deal with the demands and needs of women and sexual and gender dissidence. They act on the basis of their own ideas: Some of them criticize the gender culture and dominant ideology in their social and professional contexts; others, to the contrary, reinforce social and gender inequalities. Addressing women's specific reproductive needs in this new context of rights-based health policies continues to show that professional interventions are influenced mainly by conservative views of gender roles and relationships when the normative framework aims to respect emancipatory perspectives and decisions based on autonomy and informed consent.

Overcoming paternalistic professional interventions that underestimate the ethical capacity of women to make responsible decisions is one of the most important challenges for Uruguayan health policy: This is because the power acquired by physicians as agents of the modern state (Freidson, 1970), and as legitimate representatives of science and as bearers/guardians of the cultural authority of its social use (Starr, 1982), is enormous. The dominance of medical power has historically been constructed between technical-scientific knowledge and political and cultural-moral power of the use of that knowledge (Schraiber, 2010) with almost no external regulation of the corporate organization of physicians.

The “perspective” of technical personnel of female users condenses gender valuations (Scott, 1996) but also social class valuations. In monitoring the performance of services, there are substantial differences in the professional performance regarding women users of public services in relation to other women users of mutual and/or private health services whom the same technicians assist in their other workplace settings (López Gómez, Benia, Contera, & Güida, 2004). Poor women are often associated with irresponsibility in the exercise of maternity and in health care (i.e., neglect), which means that their decisions are more likely to be disrespected. This situation is aggravated in the case of adolescent women or women with different sexual orientations and gender identities.

How and why can ideological, religious, and moral associations be possible in technical and scientific acts? Or how is it possible to reconcile such perspectives for the same professional task?

On the one hand, changes processed in terms of health policies require a profound professional transformation so that the perspective of women who are both users of services and patients can lead to caring relationships in which power is more symmetrical and the patients or users are recognized as both subjects and citizens (Schraiber, 2010).

On the other hand, moral codes based on “God’s dictates” should no longer guide modern behavior, since human beings understand moral authority according to temporal and cultural experience. The gradual but sustained secularization of the country has allowed individuals to assume that power does not come from God but rather from citizens themselves (Lamas, 2001); and although this belief is particularly strong in Uruguayan social life, in medical practice linked to SRH this belief is unsurprisingly not that strong. The high percentage of professionals who refuse to provide legal abortion services because of their personal beliefs is an example of such contradictions.

Unconscionable

“Conscientious objection” initially emerged primarily in Europe and North America in response to conscripted military service.[12] In the context of health care, providers invoke “conscientious objection” as a way to refuse to provide a service when they disagree with its provision, claiming it is against their religious, ethical, or other beliefs. Usually associated with SRH services, conscience claims are also used by health-care providers and pharmacists to refuse several services, such as abortion care, emergency contraception (and other forms of contraception), health services for transgender people, and sterilization and infertility treatments: “In addition, many institutions invoke “conscientious objection,” when department heads, hospital managers, or political decision-makers invoke their personal beliefs on behalf of those who work at that institution” (IWHC-MYSU, 2018, p. 8).

While no international human rights standard recognizes a right to “conscientious objection” in the context of health care (IWHC-MYSU, 2018), the high percentage of professionals who refuse to provide legal abortion care on the basis of personal beliefs becomes

one of the main obstacles to functional services. In addition, the religious anti-choice groups have appropriated the term “conscientious objection.”[13] And they extended it to the realm of health care, which helps perpetuate the stigma around the practice even in countries such as Uruguay with a long secular tradition and where norms have changed to enable legal abortion services and other SRH services:

> The stigma attached to abortion provision operates as a disincentive to providers in two ways. It manifests as a disincentive materially because providers perceive that stigma causes patients and other health care providers to shun them, which may hinder them from providing other more lucrative and ‘acceptable’ services. It also manifests itself socially, because of discrimination, isolation, and lack of respect from their colleagues and communities more broadly. In other words, providers experience incentives to refuse to treat, claiming ‘conscientious objection,’ in order to maintain their reputations, align themselves with the status quo, and to avoid the stigma and inconvenience of providing abortion services. At the same time, providing abortion exclusively in the private sector offers some doctors an opportunity to earn an income outside the public sector.
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> (IWHC-MYSU, 2018, p. 30)

There is, therefore, cost-benefit logic that could motivate professionals to make “claims of conscience” to refuse to provide a service, benefiting them both materially and socially. If we consider that health providers act as state-sanctioned monopolies when offering a service (or not), this augments the power imbalance between professionals and users. The decisions providers make benefit them in multiple ways, while their patients incur the significant risks to health and well-being and of having to search for a willing provider (IWHC-MYSU, 2018).

Professionals who refuse to provide legal abortion or other discriminatory services in Uruguay may not always meet the ethical criteria defined for such a practice. Its exercise must be nonviolent (passive) and must not be linked to any political action or struggle, since its purpose is not to modify a law it considers unjust but to protect the values and the rectitude of this person’s conscience (Juvenal, 2013). However, the number of “objector” professionals found in different localities of the country (MYSU, 2017), as well as legal resources promoted by associated obstetrician-gynaecologists to repeal articles of the VTP regulation would be closer to civil disobedience than to an exception protected by freedom of belief.[14]

The authorization to be exempted, in certain cases and under certain conditions, of a legally imposed duty, makes the “conscientious objection” a non-action, as it does not make the duty any less of a legal duty. For this reason, there must be mechanisms that effectively ensure the ethical character of the exception demanded by the professional, given that health institutions and national regulating authorities must guarantee that this exceptional behavior is not abused (Juvenal, 2013; MYSU, 2017).

The right to object always refers to a law that must be complied with, so its exercise must be personal and should be reprimanded when it is misused or does not comply with the law, and there must be valid reasons to justify the exceptionality (religious, ethical, moral, or axiological reasons) (Juvenal, 2013; Cabello-Robertson & Núñez-Nova, 2018). Their exercise, therefore, should be adequately regulated and/or subject to limitations, since there is a difficult-to-resolve conflict between the right to freedom of belief of the health professional and the legitimate health requirements and needs of individuals (IWHC-MYSU, 2018).

Acknowledging the right to object, the most important issue (which has become an ethical challenge to be resolved in Uruguay) is to define its precise scope and content. This implies setting limits to the right of "conscientious objection," constrained by the rights and interests of others, since objectors are not entitled to violate the rights of others nor can they force third parties to share their personal beliefs (Juvenal, 2013; IWHC-MYSU, 2018).

Other Dilemmas

Sexual and reproductive health care is, in general and except for complications and/or negative consequences, for healthy people whose main reason for consultation is not an illness. Women go to the gynaecologist for check-ups or for a specific matter that, in general, does not require prolonged treatment. Having social, material, symbolic, and affective resources with a high level of education and quality welfare coverage are all conditions that, a priori, would operate as facilitators of the exercise of autonomy (Pecheny et al., 2005) over decisions in health in general, and sexual and reproductive health in particular.

The patient model, with its subjective and structural underpinnings, should ideally lead to autonomous practices but is nevertheless restricted and hindered when actually exercised. The demand for an integral professional attention, with a sexual and reproductive citizenship perspective, considering people as subjects of rights, has become clear. It is also a valid claim from the social movement that promoted and advocated for the legal change. New professional health-care standards must ensure a more humane, respectful, and horizontal health-care model, one that values the well-being of the diverse array of people using it. The rejection of medicalization and medication is becoming increasingly prevalent, and members of the medical community are being criticized for losing touch with everyday people, their environment and circumstances, as well as the conception of health as a right and not as a commodity. This change would be in accordance with the new necessities of those who are young, poorly educated, come from a harsh environment, or do not fit traditional gender stereotypes.

Another ethical, political, and legal challenge generated by this new context is the revision and improvement of approved normative frameworks. Although Uruguay is regionally exemplary in the advancement of health care, this does not mean that the quality of the promulgated norms is optimal, and the country's efforts will need improvement in the fu-

ture. The problems include the lack of universal coverage and quality of sexual and reproductive health services; the resolution of resistance to the requirements of trans-adolescent populations; the subrogation of wombs in assisted reproduction techniques restricted to direct family members; and the restriction of access to legal abortion services for foreign women with less than one year of residence in the country. Until these challenges are overcome, Uruguay will not be able to live up to its commitments to international human rights conventions.

Final Thoughts

The ethical dilemmas raised by the implementation of new health-care practices, particularly in the field of sexuality and reproduction, must be the subject of permanent reflection as solutions are needed in the face of new regulatory frameworks that recognize and guarantee conditions for the full exercise of sexual and reproductive rights.

Not only is SRH an important aspect of health, but it is also an important issue of human development and human rights for every person, with a particular impact on women as they have historically been considered subject to the control and supervision of “men of the family” as well as exposed to the decisions of political and religious leaders and the will of health professionals.

Despite the great expansion, development, and improvement in health-care services, these health systems have not been able to meet the demands in the field of sexuality and reproduction, either because the availability of services is insufficient, because they are inefficient, or because there is a lack of correspondence with the expectations and perspectives of comprehensive care. Gender equity problems need to be dealt with, and there needs to be more sensitivity to ethnic diversity and attention to sexual orientation and gender identity. On many occasions, people’s rights are violated, and their autonomy is taken away. Uruguay is no exception and must therefore face these challenges: “A truly preventive action would have to be oriented to identify those conditions and those conflicts associated to the deficient opportunity and quality of attention that precede the violation of rights itself, but also constitute a step in that direction” (Castro, 2010, p. 61). The perception and appreciation frameworks that health-care providers bring into play in every encounter with clients and with the different social actors in the institutional network of services or medical field (first and second level doctors; general practitioners and specialists; paramedics and nurses, social workers, etc.) should be developed under different patterns of interaction emphasizing respectful treatment and humane care.

Communication strategies about services and rights of the user population should be institutionally assessed and secured and not be left to the discretion of the professional team. In addition, health authorities should control the quality of information and care provided by service providers, ensuring that they comply with regulations and clinical guidelines that have been promulgated—and that should align with international standards and the normative framework of enshrined rights.

The approaches and practices that violate the rights of the user population are installed in the daily life of services and may go almost unnoticed due to their routine nature. Therefore, it would be important to strengthen the mechanisms for reviewing these logical processes in order to adapt and transform practices, given that they play a central role in overcoming this social phenomenon that has been identified as the violation of reproductive rights in the health services space (Castro, 2010).

Legislative changes are essential to recognize, respect, and guarantee rights in the field of sexuality, reproduction, and the peaceful coexistence of the diversity of genders, decisions, and forms of expression. But the best legal frameworks can only be effectively implemented if they are accompanied by the cultural changes that make them possible as well as the transformation into practices and behaviors that overcome those that have proven to be harmful:

> Bioethics has been perfecting approaches that allow it to approximate, in a responsible and thoughtful way, the valuation of facts applying the deliberative method that makes possible the rational argumentation based on scientific evidence and in a framework of fundamental rights and shared moral minimums.
>
> (Mujica, 2009, p. 61)

Although the field of SRHR is marked by ideological disputes that influence the political and social contexts in which reproductive and sexual decisions are made, there is a fruitful theoretical and scientific process that enables responsible and well-reasoned deliberation to ethically guide professional intervention, the organization of services, and the actions of political decision makers. However, the violation of rights persists—

in particular reproductive and sexual rights—because the personal beliefs and religious worldviews of those who must provide and guarantee services carry greater significance (Schraiber, 2010). Moral interventions that substitute or are confused with technical-professional interventions would be among the social determinants that have the greatest impact on the quality of SRH care provided in Uruguay, along with the lack of adequate and sufficient human and material resources and supplies.

Evidence indicates that it will be difficult to ensure universal coverage and quality care in legal abortion, contraception, LGBTIQ+ population requirements, and adolescent services if the autonomy of individuals, confidentiality of services, and the attitude of health personnel are not in sync with the commitment of institutions and the responsibility of the state powers to ensure them.

Policies that promote gender and ethnic-racial equity—which incorporates gender diversity, non-heteronormativity, and respect for rights—are mandated by the new Uruguayan legislation and have to be implemented by the public and private institutions of the social protection system. However, in the curricular training of many of the professions affected, in some specializations many of these dimensions are not addressed (or only tangentially). The gap between the provisions stipulated by law and the restrictive, condemnato-

ry, or limited frameworks for SRH care, needs to be addressed in professional practice. It is necessary to correct prejudices, biases, and subjectivities that have negatively affected practices related to different identities or diverse sexual orientations.

An interdisciplinary approach and ongoing dialogue among different actors, including those who have mobilized this agenda and demand to be treated as free people with rights, is a recommendation made in interagency and intergovernmental plans and programs and in agreements that Uruguay has adhered to and promoted.

Evidence indicates that women's ability to satisfy their reproductive needs is not always respected or prioritized. In the opinion of some professionals, who have monopolistic control over certain services, non-maleficence as an ethical value does not prevent their personal beliefs from interfering with the rights of those who need their services. The VTP law in Uruguay, for example, only authorizes gynaecological specialists to provide abortion services, including the prescription of medication in order to abort. They are also the only professionals authorized to perform caesarean sections and to insert IUDs because these are deemed medical acts. Therefore, if they refuse to provide this care because of their personal beliefs, the ethical purpose of benefiting and equally favoring those who require their services will not be fulfilled, generating harmful consequences toward what should be the main motivation of medical practice: the well-being of the patient, who in SRH are fundamentally women.

Further Reading

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Notes:

(1.) Uruguay has elections every five years. It is governed by the republican principle of division of powers, with a total of three powers: Executive, Legislative and Judicial. The Executive Branch is made up of the president, vice president, and 13 ministries. The Legislative Branch consists of two chambers, a Lower House or Chamber of Representatives made up of 99 deputies, and an Upper House or Senate, composed of 30 senators and

presided over by the vice president who also presides over the General Assembly, that is, the meeting of both chambers.

(2.) Despite this, only 25% of Uruguayans affirm that they trust political parties somewhat or a lot. This is the highest percentage in the Latin American region, according to the Latinobarómetro database. Data is for 2017. The party system has three major parties: Frente Amplio (Broad Front), Partido Nacional (National Party) and Partido Colorado (Colorado Party). The Broad Front is presented as the majority option to the political left and has been in government since 2005, while the National Party is the second largest party and the main force on the right.

(3.) Since the educational reform of 1876, the laicity of education in the country was already established, being the first reference to a process of secularization that took place at the beginning of the 20th century. Other key reforms in this process were the 1907 divorce law, the administration of birth registers and cemeteries, and the obligatory civil registration of marriages (at the end of the 19th century).

(4.) Latinobarómetro database.

(5.) Internet platform accessible here; See MYSU.

(6.) See MYSU.

(7.) See Decree 293/010; and see Law 18.426.

(8.) Law 18.987.

(9.) Tendencias recientes de la natalidad, fecundidad y mortalidad infantil en Uruguay, Ministry of Public Health (Ministerio de Salud Pública), Uruguay, see online.

(10.) Círculo Católico Obrero del Uruguay and Hospital Evangélico (Uruguayan Worker Catholic Circle and Evangelical Hospital, in English).

(11.) Salto, Paysandú, Rivera and Soriano; Mercedes, Young and Castillos.

(12.) In August 2017, International Women’s Health Coalition (IWHC) and Mujer y Salud en Uruguay (MYSU) co-organized the Convening on Conscientious Objection: Strategies to Counter the Effects. Forty-five participants from 22 countries convened in Montevideo, Uruguay, where MYSU is based. Participants included activists and advocates, health care and legal professionals, researchers, academics, and policymakers. “Unconscionable: when providers deny abortion care” summarizes the main topics of discussion and conclusions from the convening.

(13.) Encyclical Letter “Evangelium Vitae,” Pope John II, 1995.

(14.) In 2016, the Contentious-Administrative Court (Tribunal de lo Contencioso Administrativo, TCA), the Uruguayan State’s controlling body and highest authority in relation to the control of the Executive Branch’s compliance with administrative and regulatory mat-

ters, issued a ruling by which several articles of Decree 375/012, which regulates the VTP law, were annulled (totally or partially). The TCA ruling responded to a nullity suit against the decree, initiated by a group of INHS gynaecologists, who held that the decree restricted “illegitimately the exercise of conscience of health personnel” recognized by the IVE law. See TCA.

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