Abortion Review

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ABORTION LAW AND CLINICAL PRACTICE: THE ARGUMENTS FOR CHANGE

By Ann Furedi, Chief Executive of BPAS

The House of Commons Science and Technology Committee's (STC) pragmatic and sensible report into 'Scientific Developments relating to the Abortion Act 1967' (1) is a valuable reference point for anyone who is thinking seriously about how modern abortion care should be provided.

As I have argued in the *Journal of Family Planning and Reproductive Health Care* (2), the Abortion Act 1967 was well crafted, and to date has served women and their families reasonably well. It is also true that a liberal interpretation of the law has enabled safe, legal abortion services to develop far more effectively in Britain than in many other countries with legislation that appears less restrictive.

However, an evidence-based report like that issued by the STC shows up the forty-year-old Abortion Act, which was framed in different era of medicine, as now looking a little threadbare. Laws should be able to respond over time to permit doctors and nurses to offer the best possible practice. There are several areas where the law impedes good clinical practice, which the STC report usefully considered.

The 'two doctors' rule

The STC supported the removal of the requirement for two doctors' signatures before an abortion can be carried out, stating its concern that this requirement may be causing delays in access to abortion services, and finding no evidence of its value in terms of safety. We all know that our doctors' and GPs' time is precious, so why retain a clinically useless administrative burden on them to double-sign abortion forms? This 1960s requirement can delay women from getting the earliest and least invasive treatment possible - while sending a pretty poor message about how women's decision-making is looked upon.

RCOG guidelines state that women should be able to access a termination as early as possible because, the earlier in pregnancy an abortion is performed, the lower the risk of complications. Ideally, the guidelines state, the abortion should be able to take place within 7 days of the decision being agreed and with a minimum standard of the procedure within two weeks. (3) The legal requirement that two registered medical practitioners certify that a woman meets the legal grounds for abortion frustrates this by creating the potential for unnecessary delay.

It is important to note that the legal requirement for two doctors' signatures to confirm that the woman meets the legal grounds for abortion is a separate legal exercise to a clinical assessment of the patient to determine the most appropriate treatment. This conflicts with established medical ethical principles of the autonomy of competent patients and is redundant in medical terms. No medical benefit is conferred to the woman by its retention, as it only serves to confirm that the abortion is being undertaken within the terms of the 1967 Abortion Act.

The British Medical Association (BMA) in 2007 voted for the removal of the 'two doctors' requirement, arguing that abortion (in the first trimester) should be provided on the basis of informed consent as other medical treatments are. But why not support this position being adopted up until the current legal time limits? A woman's clinical assessment for treatment and confirmation that she meets the legal grounds for abortion does not require more doctors in the second trimester than in the first. There is no reason why the confirmation of the legal grounds for abortion requires more doctors in the second trimester than in the first.

Furthermore, as two doctors can already confirm at all gestations within the current legal limits that a woman meets the legal requirements on the recommendation of a nurse, it would seem logical for nurses to be able to sign in their own right if such a form is required. This would be sensible especially where pertaining to what are currently already virtually nurse-led methods, such as early medical abortion (EMA).

The role of nurses and midwives

The STC report argues that 'Nurses and midwives with suitable training and professional guidance, should not be prevented by law from carrying out all stages of early medical and early surgical abortion', noting that there is no evidence that this would compromise patient safety or quality of care.

Despite an acknowledged shortage of doctors willing to carry out abortions (4), nurses and midwives are currently prevented from carrying out procedures, such as manual vacuum aspiration, because the Abortion Act specifies that abortion is only lawful when carried out by a 'registered medical practitioner', which is interpreted as a GMC-registered doctor only. This remains the view of the Department of Health, despite challenges that the law could be interpreted differently. (5)

Forty years ago when the Abortion Act was drafted, the methods of early medical abortion and manual vacuum aspiration were not available and the nursing role was much more restricted. We believe it

Inside this issue: *Abortion Law Reformers: Pioneers of Change*
UN Overview of World Abortion Policies

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With EMA, there is no clinical justification for two separate visits to a clinic

would be appropriate for suitably trained nurses and midwives to be permitted to perform early abortions in Britain as they do in other countries, such as the United States and South Africa. Greater involvement of nurses in early abortion care would also increase national capacity at early gestations and so reduce treatment delays.

Early medical abortion (EMA) is available up to 9 weeks' or 63 days' gestation. This increasingly popular non-invasive method relies on the administration of two sets of prescribed medication. During the 16 years that BPAS has provided EMA, we have developed a nurse-led service which has minimised the role of the doctor. This development was in response to observations that nurses are better able to deliver this service as they can often develop a greater rapport with clients. The EMA method requires particularly open and clear communication as the patient is central to the participation in, and management of, her treatment. The legal requirements are met by the doctor signing the prescription for the medication, after it has been confirmed by two doctors that the legal grounds for abortion have been met.

If nurses became legally able to perform some methods of abortions, it would then be possible to develop a nurse-prescribing protocol or a 'Patient Group Direction' that would allow an abortion nurse to take full responsibility for treatment, as nurses do in other areas of medicine. In BPAS' view, reducing the involvement of doctors would enable them to use their time in the clinic most efficiently and would reduce costs of the procedure without compromising the quality of care.

Manual vacuum aspiration (MVA) is a method of early surgical abortion (offered from 4 weeks' to 12 weeks' gestation), which involves the removal of the contents of the uterus using a gentle hand-operated suction pump. The level of technical skill required to do this is of a similar level to fitting a contraceptive 'coil' (IUD/IUS) which BPAS' and NHS family planning trained nurses already routinely do.

In other areas of more technically-skilled NHS practice, such as gastro-enterology and dermatology, trained nurses have for several years been permitted, for example, to pass investigation camera equipment (endoscopes) into the body and to take skin biopsies. In sexual and reproductive healthcare, nurse hysteroscopists are able to examine the uterus with a camera and nurse colposcopists can examine the cervix with a camera and also take tissue biopsies. It seems anomalous for the law to prevent appropriately-trained nurses in abortion care from developing their roles similarly.

Later gestation medical induction abortion is a method where the woman has chosen to go through induced labour rather than undergo a surgical termination of pregnancy. This is often chosen in situations of termination for fetal abnormality. Midwives are particularly appropriate to carry out this procedure, which involves offering the woman ongoing emotional support as well as professional technical expertise in labour care. BPAS' view is that it is not justifiable legally to permit midwives to take responsibility for births at term, but not abortions, which take place at an earlier gestation and are safer than labour and delivery of a full-term pregnancy.

Early medical abortion at home

Women undergoing early medical abortion (EMA) with mifepristone and misoprostol are required to make additional, unnecessary clinic visits because both medications are regarded as abortifacient and so must be administered in a hospital or licensed premises. In other countries, such as the USA, it is possible for women to administer the misoprostol herself at home, thus reducing the cost and inconvenience of the procedure. (6) On this issue, the STC concludes that 'there is no evidence relating to safety, effectiveness or patient acceptability that should deter Parliament from passing regulations which would enable women, who chose to do so, taking the second stage of early medical abortion at home', and advocates 'the necessary legislative change that would enable this to be pursued or at least piloted'.

At present, the EMA method involves the woman swallowing a mifepristone tablet at a BPAS clinic, after which she may either return home or can occupy herself for a few hours nearby to the clinic. This medication blocks the pregnancy hormones so that the pregnancy ceases to be viable. At least 6-8 hours later, or on the following day, she is required to return to the clinic, where the second part of the treatment, a dosage of the drug misoprostol, is then administered vaginally with a tampon, or is swallowed. Misoprostol causes the uterus to contract and to expel the pregnancy much like a miscarriage. Women go straight home from the clinic after taking misoprostol, in order to make themselves comfortable before this process starts.

Women are obliged to make a second journey back to the clinic to take the second medication (misoprostol) solely because the law specifies that an abortion may only be carried out in hospitals or a specially approved location. There is no clinical justification for two separate visits to a clinic. The requirement for two clinic visits can be burdensome for women with caring or other responsibilities to manage at home and can mean that women without a local EMA service near their homes are not able to choose EMA at all. The requirement to administer the misoprostol at a second appointment in a registered place adds unnecessary cost to the procedure.

Self-administration of misoprostol at home is common in most countries where EMA is available. From a clinical perspective, arguably it would be more appropriate for women to administer the misoprostol at home, as the time from treatment to the expulsion of the pregnancy can be variable and unpredictable. There is no evidence that self-administration of tablets is unsafe, or that home-use is unacceptable to patients. UK women in other medical situations can already self-administer misoprostol at home. For example women who have experienced a spontaneous miscarriage are given a dose of misoprostol to take home and insert vaginally themselves, in order to ensure the prompt and safe expulsion of the miscarried pregnancy. BPAS sees no reason why abortion patients should continue to be excepted from this provision.

Fetal viability, fetal pain and late abortion

There are some areas of the existing law that the STC, with good reason, argued to uphold. On the question of viability, the Committee concluded that 'while survival rates at 24 weeks (the

Abortion should be available to women who request it

current upper limit for abortion) and over have improved since 1990, survival rates (viability) have not done so below that gestational point. The Committee concludes that there is no scientific basis - on the grounds on viability - to reduce the upper time limit'. It further argued that any debate on the impact an alteration to the upper time limit would have on those women who present late for abortion 'would be better informed if there was improved collection of information relating to the reasons why women come forward at this late stage and about how many women travel overseas for late abortions'.

At BPAS our experience is that a small number of vulnerable women in especially complex, difficult situations request treatment at these later stages. We support the call for additional research about these women's needs.

On the emotive issue of fetal pain, the STC notes that the evidence suggests that while fetuses have physiological reactions to stimuli, this does not indicate that pain is consciously felt, especially not below 24 weeks. It further concludes that 'these factors may be relevant to clinical practice but do not appear to be relevant to the question of abortion law'. The STC also argues that 4D imaging techniques, which have been used by some of those in favour of further restrictions on abortion to add emotional power to their arguments, are a 'useful tool in diagnosis of fetal abnormality', but that there is 'no evidence they provide any scientific insights on the question of fetal sentience or viability.'

A flexible, fit-for-purpose law

Releasing the STC's report on 'Scientific Developments relating to the Abortion Act 1967', Phil Willis, committee chairman, said:

'Abortion is a complex issue. Legislative decisions are informed by ethical, moral, religious and political views, case law, scientific and medical evidence. As a Science and Technology Committee, we have focused on the science, and have done so rigorously. In our inquiry we have attempted to sift the evidence on scientific and medical developments since the last amendment of the law in 1990 and since the 1967 Act. We urge all MPs and the public to study the evidence we have taken and the conclusions we have reached.'

Now that this committee has provided a rigorous review of the scientific debate about abortion, we can hope and expect that there will be a more open debate about the moral and political issues in the coming months. In this spirit, we should consider one aspect of the abortion law that is ripe for reform: its denial to women of abortion on request.

Doctors' ability to interpret statutory ground C (section 1(1)(a)) of the Act liberally to allow the abortion of unwanted pregnancies has allowed the law to meet the needs of modern society. But this openness to interpretation means that women can never be confident that their abortion request will be viewed sympathetically. Often, women feel they need to exaggerate their distress and to pretend that they will be psychologically damaged by their pregnancy, while their doctors pretend to believe them. This is a charade that demeans them both.

It would be far better to have a law that specifically allows a woman to end a pregnancy that is unwanted without further justification, and permits abortions to be carried out by persons, and in premises, that are able to provide adequate care and support. In short, abortion should be available to women who request it, and regulated by the same principles and standards as other clinical procedures.

We can all agree that it would be better if unwanted pregnancies were prevented, and that increased use of long-acting reversible methods of contraception may contribute to this end. However, these methods are not suitable for, or acceptable to, all women. The rising number of abortions demonstrates that abortion is necessary as a back-up to other methods of birth control, and this is likely to remain the case in a society that has a liberal attitude to sexual activity and values planned parenthood. Our experience is that the social stigma of abortion is lessening in pragmatic response to this.

Women, and their doctors, deserve a flexible, fit-for-purpose law accepting that restrictions on abortion should be solely to protect health. The STC Report and the forthcoming discussion of the Human Tissue and Embryos (draft) Bill provide an opportunity for MPs to align our abortion law with modern thinking.

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Not all of the 'science' cited about abortion says the same thing

SHOULD ABORTION BE AN 'EVIDENCE-BASED POLICY?'

By Jennie Bristow, editor, *Abortion Review*

The Science and Technology select committee's inquiry into Britain's abortion law, carried out during October 2007, considered written evidence from 50 submissions by interested parties. These included the Department of Health, abortion providers, pro-choice campaigns, anti-abortion campaigns and individuals from both sides of the abortion debate.

The committee's report has provided a solid and useful summary of where the science of abortion is at: what has changed since the law was first developed in 1967 and last amended in 1990, and how the legal approach to abortion might best reflect new scientific knowledge and clinical developments. This is likely to have an impact on policy. When Prime Minister Gordon Brown was asked about his thoughts on abortion as the committee hearings began, the Prime Minister's spokesperson replied that 'his general view was that these were matters that should be guided by scientific evidence'. (1)

But while scientific and medical developments are crucial to the *practice* of abortion, informing such decisions as how the abortion is performed and who is able to perform it, it remains the case that the *principle* of abortion is a moral and political question, which cannot be resolved by science.

The tension between science and politics has become clear as the Science and Technology Committee's (STC) hearing progressed. On 15 October, the *Guardian* reported that the clerk of the committee had written to several of those who had submitted evidence to the inquiry, requesting that they disclose their links to any relevant organisations. (2) It was revealed that 'at least eight submissions of written evidence have come from medical professionals who have not disclosed their membership of Christian groups opposed to abortion on faith grounds': for example, six of the doctors are linked to the Christian Medical Fellowship (CMF), an organisation that has given its own evidence to the inquiry. Evan Harris MP, the Liberal Democrats' science spokesperson and a member of the STC, said: 'This inquiry is specifically about the scientific evidence not moral or religious arguments and our witnesses need to be evidence-led not ideologically or theologically driven. The CMF risk undermining the inquiry by getting people called as expert scientific witnesses when they are not.'

As anybody familiar with the abortion debate knows, whether the issue at stake is fetal pain or breast cancer, fetal viability or women's mental health, the 'scientific evidence' cited by those who disapprove of abortion differs wildly from that cited by respected medical bodies such as the Royal College of Obstetricians and Gynaecologists (RCOG), the British Medical Association (BMA) and the Royal College of Nursing (RCN), and that contributed by pro-choice organisations and abortion providers. The STC inquiry provides a classic example of this clash.

For example, the *Daily Telegraph* on 16 October reported on a 'row' that broke out at the hearing over the 24-week 'time limit' for abortion and the question of fetal viability. (3) According to Epicure 2, a major ongoing UK study of outcomes for pre-premature babies born at gestations of less than 24 weeks, the chance of survival for such infants lies between 10 and 15 percent – a rate that has not changed between 1995 and 2006. The Epicure study has also found extremely high levels of disability among the small numbers of pre-prematurity survivors. (4) Dr Bryan Gill, honorary secretary of the British Association of Perinatal Medicine (BAPM) which carried out Epicure 2, has clearly stated: 'Our conclusions to the limits of viability debate is that, if the Select Committee is basing assumptions on the need to lower the limit of viability on improvements to outcome for babies born below 24 weeks, then the present evidence does not support this.'

However, according to evidence given to the committee by John Wyatt, Professor of Neonatal Paediatrics at the University College London, survival rates in centres such as the one Professor Wyatt is involved with may be as high as 42 percent at 23 weeks' and 72 percent at 24 weeks' gestation. 'Since 1995, there have been very significant and wide-reaching improvements in the quality of care provided,' he said. 'The data from recent studies indicate that there has been continuing improvement in the survival of extremely preterm infants over the last 15-20 years with … infants now surviving at 23 and 24 weeks of gestation. Survival at 22 weeks is unusual but has been observed in a number of neonatal centres.' (5)

The argument that the 'time limit' on abortion should be reduced to 22 weeks, or 20 weeks, or whatever gestation takes a particular campaigner's fancy, has been popular with the anti-abortion lobby for several years. By focusing on the problem of 'late' abortions, carried out at a stage where fetuses in the womb (it is argued) look and behave like babies, can feel pain, and are claimed to have the potential to survive outside the womb before accepted thresholds of viability, the anti-abortion lobby hopes to gain more public and parliamentary support than it would if it stuck to its more honest, but less palatable, argument that all abortions are wrong.

The key thing to note is that whatever the science might say to support such arguments – and as the current viability row indicates, not all of 'the science' cited in this inquiry says the same thing – the argument to reduce the time limit is a political argument, based on a particular moral outlook. The question of abortion cannot be resolved at a scientific level, according to what is more or less bad for the fetus – it is a political issue about women's need for abortion in a society committed to women's equality and individual autonomy.

To commemorate the fortieth anniversary of the 1967 Abortion Act, BPAS has republished *Abortion Law Reformers: Pioneers of Change*, a book of interviews with the campaigners, doctors and politicians who made legal abortion possible in Britain. Diane Munday, a key figure in the landmark abortion law reform, recalls that in the 1960s 'the arguments of the anti-abortion lobby were, I would say, honest. They thought that abortion was wrong and immoral, equivalent to sticking a knife in a two-year-old.' But as anti-abortion campaigners found that such arguments failed to convince, they shifted their emphasis onto 'scientific' claims about how dangerous the operation was for women. As Munday says: '[A]ll you have to say to them in the end is, "What if it was clearly shown that abortion was good for women. That their hair grows curly, their skin becomes clear and they feel fantastic, would you agree with abortion then?" And they have to say no, because their real concern is for the fetus.'

There is a great deal of confusion and misinformation about some medical questions surrounding abortion, and the STC inquiry has presented a welcome opportunity to clear some of these up. Some definitive statements can be made: for example, abortion does not cause breast cancer, or make women mentally ill. Early medical abortion (the 'abortion pill') is a very safe method, including when nurses prescribe the drugs and when women take the medication at home. The Committee has done sterling work in setting the record straight on some of these questions, and this will help the provision of good information to women requesting abortion.

But as the discussion about reforming the abortion law rumbles on, we should be clear about the balance of science and politics in abortion policy today. Women who need abortions should be able to have them: some people agree with this, and others do not. Scientific evidence, however sound it may be, will never tell us what society should do about abortion.

The written evidence for the STC inquiry into 'Scientific Developments Relating to the Abortion Act 1967' is available at: http://www.parliament.uk/documents/upload/SDAevidenceforwebsiteupload.pdf

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NEW BPAS PUBLICATION:

ABORTION LAW REFORMERS: PIONEERS OF CHANGE

Interviews with people who made the 1967 Abortion Act possible

Introducing this new pamphlet, reissued by BPAS for the 40th anniversary of the 1967 Abortion Act, Ann Furedi writes:

> 'The 1967 Act was a product of its times. It reflected and codified the concerns of the 1960s and was shaped by the debates and controversies of its day. Public discussion about abortion in the 1960s took place in the context of the social reforms and more liberal attitudes that have come to be regarded as characteristic of that period.'

Abortion Law Reformers: Pioneers of Change presents frank interviews with many of the activists, doctors and parliamentarians who brought the 1967 Abortion Act into being, providing an inspiring sense of the spirit in which the Act was conceived and thoughtful reflections on how well the law has worked subsequently.

> 'I embraced the abortion issue as an issue of fundamental importance in a free society. It really moved things forward in terms of women's expectations and feeling in control of their lives.' DILYS COSSEY OBE

Former secretary to the Abortion Law Reform Association, former trustee of Birth Control Trust, and former chair of the Family Planning Association

> 'I rejected the view that a woman, once pregnant, had an obligation to society to continue her pregnancy. It seemed to me that if you really felt that women should have equal status and rights then they should have total control over their fertility, and that this was only really possible if there was legal abortion.' DAVID PAINTIN FRCOG

Former chair of Birth Control Trust and Emeritus Reader in Obstetrics and Gynaecology, Imperial College School of Medicine at St Mary's, London

> 'I did not see it primarily as a women's issue. I saw it as an issue of justice and hypocrisy really, because you could get round the law if you had enough money and contacts to persuade somebody in the private sector to carry out an abortion under some other title.' THE RT HON THE LORD STEEL OF AIKWOOD KBE PC DL

Member of Parliament (Liberal, Liberal Democrat) from 1966 to 1997 and sponsor of the Private Member's Bill which became the 1967 Abortion Act

> 'The Abortion Act was a highly successful piece of social legislation. It has certainly saved lives which would otherwise have been lost by criminal abortion and, even more importantly, it has done away with a very large amount of illness and guilt. It is easy to take its benefits for granted since medical students and young doctors no longer see cases of criminal abortion and it is hard for them to realise what a degrading and dangerous thing it used to be.' PETER DIGGORY FRCOG

Former medical adviser to David Steel MP and the Abortion Law Reform Association

Abortion Law Reformers: Pioneers of Change also contains interviews with:

DIANE MUNDAY - Women's rights campaigner and former general secretary and vice-chair of the Abortion Law Reform Association

MADELEINE SIMMS - Author of Abortion Law Reformed (with Keith Hindell) and founding trustee of Birth Control Trust

ALASTAIR SERVICE CBE - Chief parliamentary lobbyist during the passage of the 1967 Act through Parliament, author, and former chair of the Family Planning Association and the Abortion Law Reform Association

LADY VERA HOUGHTON CBE - Former chair of the Abortion Law Reform Association and founding chair of Birth Control Trust

PROFESSOR MALCOLM POTTS MB BChir Phd - Former member and executive committee member of the Abortion Law Reform Association, and professor of Population and Family Planning, University of California, Berkeley

THE RT HON THE LORD JENKINS OF HILLHEAD OM - Member of Parliament (Labour) from 1948 to 1976 and Home Secretary from 1965 to 1967. Member of Parliament (Social Democratic Party) from 1983 to 1987

THE RT HON THE LORD HOUGHTON OF SOWERBY CH - Member of Parliament (Labour) from 1949 to 1974 and chair of the Parliamentary Labour Party from 1967 to 1974

RENEE SHORT - Member of Parliament (Labour) from 1964 to 1979

DR JOHN DUNWOODY - Member of Parliament (Labour) from 1966 to 1970 and general practitioner

THE HON MRS GWYNETH DUNWOODY MP - Member of Parliament (Labour) from 1966 to 1970 and from 1974 to the present day and Member of the European Parliament from 1975 to 1979

SIR GEORGE SINCLAIR - Member of Parliament (Conservative) from 1964 to 1979 and unofficial Conservative lobbyist during the 1967 Act's passage through Parliament

PETER M JACKSON - Member of Parliament (Labour) from 1966 to 1970 and unofficial lobbyist in the Labour Party during the 1967 Act's passage through Parliament

To obtain a copy of *Abortion Law Reformers: Pioneers of Change*, please contact marketing@bpas.org

or

download a copy from the Abortion Review website. http://www.abortionreview.org/images/uploads/Abortion_Pioneers_(1).pdf

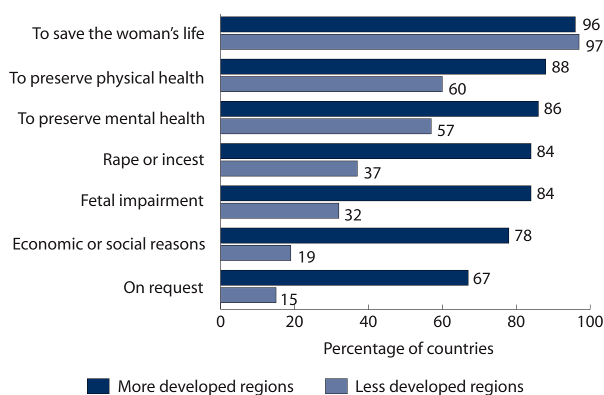
OVERVIEW OF WORLD ABORTION POLICIES

The UN publication *World Abortion Policies 2007* provides up-to-date information on the legal status of induced abortion for the 195 Member and non-Member States of the United Nations.

To complement this information, data on abortion rates, contraceptive prevalence, total fertility and maternal mortality are also provided. The information below is reproduced from the wall chart presenting the UN's findings.

The overwhelming majority of countries, 97%, permit abortion to save the woman's life. In five countries, abortion is not permitted. Abortion laws and policies are significantly more restrictive in the developing world. In developed countries, abortion is permitted for economic or social reasons in 78% of countries and on request in 67% of countries. In contrast, 19% of developing countries permit abortion for economic or social reasons, while in 15% of developing countries abortion is available on request.

Grounds on which abortion is permitted (percentage of countries)



Many countries have additional procedural requirements that must be met before an abortion may be legally performed. Additional requirements may relate to the gestational limits within which abortion may be performed, mandatory waiting period, parental or spousal consent, third-party authorisation, the categories of health providers permitted to perform abortions, the types of medical facilities where abortions may be performed and mandatory counselling. In addition, even when abortion is legally permitted, access to abortion services may be limited.

Grounds on which abortion is permitted

The UN has identified a total of seven grounds on which abortion is permitted:

(1) to save the woman's life;
(2) to preserve physical health;
(3) to preserve mental health;
(4) in case of rape or incest;
(5) for fetal impairment;
(6) for economic or social reasons; and
(7) on request.

Each of these grounds is described below.

(1) To save the woman's life. The performance of abortion is most commonly permitted on the grounds of saving the life of the woman. Although some countries provide detailed lists of what they consider life-threatening situations, in general, these situations are not explicitly specified and are therefore left to the judgement of the physician or physicians performing or approving the abortion. The overwhelming majority of countries, 97% in the less developed regions and 96% in the more developed regions, either explicitly permit abortion to be performed when a pregnancy threatens a woman's life or allow it under the general criminal law principle of necessity. Exceptions include Chile, El Salvador, the Holy See, Malta and Nicaragua, all of which have provisions restricting the performance of abortion. However, even in these countries, it is unclear whether a defence of necessity would be rejected by a court in serious cases involving a threat to the life of a pregnant woman.

(2) To preserve physical health. In the majority of countries, abortion is permitted when it is necessary to preserve the physical health of the woman. The term 'physical health', however, has been defined in a number of different ways. In some countries, the definition is narrow, often encompassing lists of conditions that are considered to fall under this category; in other countries, the term 'physical health' is broadly defined, allowing room for interpretation. In the more developed regions, 88% of countries permit abortion to preserve physical health, compared to 60% countries in the less developed regions.

(3) To preserve mental health. Many countries specifically provide for the legal performance of abortions in cases involving a threat to the mental health of the pregnant woman. What constitutes a threat to 'mental health,' however, varies significantly. In some countries, the abortion law does not specify whether the term 'health' encompasses both physical and mental health, but merely provides that an abortion is permitted when it averts a risk of injury to the woman's health. In such cases, since the law does not make a distinction, both physical and mental health grounds have been coded as permitted. Eighty-six percent of countries in the more developed regions allow abortion to protect the mental health of the woman, whereas 57% of countries in the less developed regions have adopted such laws.

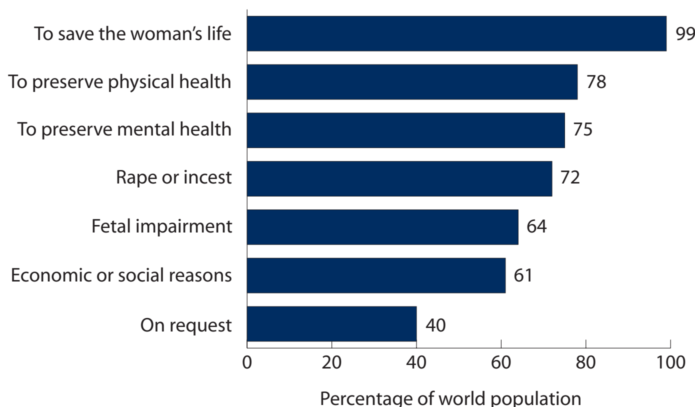
(4) Rape or incest. Permitting abortion in cases of rape or incest is a common provision. Even in countries with restrictive laws, abortion is often allowed on those grounds. Some countries specifically mention rape or incest in their legislation. Other countries refer to these as cases in which the pregnancy is the result of 'a criminal offence', with no specification of the nature of the offence. In other countries, abortions are permitted only in the case of the rape of a woman with mentally impaired functions. While 84% of countries in the more developed regions have laws that permit abortion in case of rape or incest, 37% of countries in the less developed regions have such laws.

(5) Fetal impairment. Abortions are often permitted on the grounds of fetal impairment, even in countries with restrictive abortion legislation. Several countries specify the type and level of impairment necessary to justify an abortion. In the more developed regions, 84% of countries permit abortions because of fetal impairment, whereas 32% of countries in the less developed regions do so.

(6) Economic or social reasons. The laws permitting abortions on socio-medical, economic or social grounds vary widely. Some laws specifically mention economic or social conditions while others only imply them. Most laws that permit abortion on economic or social grounds are interpreted quite liberally and, in practice, differ little from laws that allow abortion on request. While 78% of countries in the more developed regions have laws permitting abortion on economic or social grounds, 19% of countries in the less developed regions allow abortion on the same grounds.

(7) On request. In countries that allow abortion on request, a woman seeking an abortion is not required to justify her desire to have an abortion under the law. In a number of countries, she may be required to state that she is in a situation of crisis or distress. Sixty-seven percent of countries in the more developed regions have adopted such laws, whereas 15% of countries in the less developed regions make abortion available on request. For purposes of the UN's chart, if an abortion can be authorised on request, it is assumed that an abortion can be performed during the period when it is authorised on any other of the grounds listed, even if the law does not explicitly mention such grounds.

Grounds on which abortion is permitted (percentage of world population)



Abortion rate

Accurate information on induced abortion is difficult to obtain in many countries. In countries where abortion is legal under broad conditions, statistics on abortion are collected and are of reasonable completeness and accuracy. In other countries, official data are lacking or are incomplete. A common problem is that some privately performed abortion procedures go unreported and are therefore not reflected in the statistics available. Also, some countries may include spontaneous abortions in the number of reported abortions. In countries where abortion is restricted, official statistics are generally not available or highly incomplete.

Information on the number of abortions is available for 61 countries. Abortion rates in 26 of those 61 countries range from 10 to 20 abortions per 1,000 women aged 15 to 44 years; 16 countries have abortion rates above 20 abortions per 1,000 women aged 15 to 44, while 19 countries have an abortion rate below 10 abortions per 1,000 women.

Contraceptive prevalence

The use of contraception has been increasing steadily. Worldwide, 61% of women who are married or in union use some contraceptive method and 54% use a modern contraceptive method. In the less developed regions contraceptive prevalence averages currently 59% among women who are married or in union and it averages 69% in the more developed regions.

Total fertility

Total fertility measures the number of births a woman would have during her lifetime if she were to follow current age-specific fertility rates. In 2000-2005, total fertility at the world level stood at 2.6 births per woman. Total fertility was estimated to be 2.9 births per woman in the less developed regions and 1.6 births per woman in the more developed regions. Total fertility is greater than 5 births per woman in 35 of the 148 developing countries. Overall, the countries with fertility higher than 5 births per woman account for 10% of the world population.

Maternal mortality

Maternal mortality is a major concern in particular in less developed regions. Of the estimated 529,000 maternal deaths worldwide in 2000, 68,000 deaths were reported to be due to complications of unsafe abortion. In 2000, the maternal mortality ratio was 442 maternal deaths per 100,000 live births in the less developed regions. In contrast, the maternal mortality ratio was 20 maternal deaths per 100,000 live births in the more developed regions.

World Abortion Policies 2007 **is published by the UN's Department of Economic and Social Affairs, Population Division. It is available at: http://www.un.org/esa/population/publications/2007_Abortion_Policies_Chart/2007_WallChart.pdf**

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- The barrister Barbara Hewson discusses 'What sort of abortion law does Britain need today?'
- News and commentary round-ups about the issues generated by the Science and Technology inquiry.
- The General Medical Council's draft supplementary guidance on 'Personal Beliefs and Medical Practice' has received criticism from the British Medical Association.
- A Church of Ireland bishop has attacked the 'systemic spinelessness' of politicians in failing to enact legislation to allow for abortion following the *X* case.
- The Health Protection Agency has found that many teenagers are infected with at least one strain of the human papillomavirus (HPV).
- Amnesty International's support for legal abortion has caused splits among some of its Catholic supporters – and clashes between media commentators.
- A study in the *New England Journal of Medicine* finds no evidence that a previous medical abortion, as compared with a previous surgical abortion, increases the risk of spontaneous abortion, ectopic pregnancy, preterm birth, or low birth weight
- A study in *Obstetrics and Gynecology* modelled rates of pregnancy and repeat abortion among women choosing intrauterine contraception after an abortion when the IUD is inserted immediately after the procedure or at a follow-up visit.

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BPAS CONFERENCE ANNOUNCEMENT

25 and 26 June 2008

Abortion Care, Abortion Controversies:
Two days of discussion on law, ethics and best practice taking place in Westminster, Central London.

This conference brings together leading international researchers and practitioners presenting a range of views on abortion and contraception ethics, law, social research, policy and clinical care.

The conference is relevant for: academics, researchers, lawyers, policymakers, regulators, obstetricians and gynaecologists, general practitioners, nurses, midwives, service providers, pregnancy counsellors, NHS commissioners, leads for sexual health, leads for children, family and youth services, Teenage Pregnancy Co-ordinators, family planning leads, pharmacists, Directors of Public Health, students and journalists.

Speakers include:

Mitchell D. Creinin, MD
University of Pittsburgh School of Medicine

Mary Fjerstad, NP, MHS
Planned Parenthood Consortium of Abortion Providers

James Trussell
Princeton University

Jon O'Brien
Catholics for a Free Choice

Kirsten Moore, CEO
Reproductive Health Technologies Project

Daniel Grossman, MD (tbc)
Ibis Reproductive Health

For further information contact: Laura Riley, BPAS Press and Public Policy Manager.
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Example of current campaign. Please contact marketing@bpas.org for more details.

Student essentials

this term's 'must haves'?

mobile phone
(plan your nights)

lipstick
(look great)

money
(spend, spend, spend)

morning after pill
(just in case)

Did you know you can use the 'morning after' pill up to 72 hours after unprotected sex – but it's most effective within the first 12 hours?

However, many people can find it hard to get quickly. So although you may never need it, you might want to prepare for the unexpected by keeping one, just in case.

You can buy the morning after pill in advance from **bpas**. For more advice contact us on

08457 30 40 30 or visit www.bpas.org

Not recommended as a replacement for your regular form of contraception. Always read the label.