

UNDERSTANDING ABORTION STATISTICS

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1) INTRODUCTION: ABOUT ABORTION STATISTICS

Where do abortion statistics come from?

Each year, the Department of Health collects statistics for abortions carried out in England and Wales. The statistics are taken from the abortion notification forms (HSA4), which all doctors are legally obliged to fill out. Official statistics have been gathered since 1968, when abortion was first legally available in England and Wales.

The most recent statistics, for 2010, are available to download for free [here](#). Some older statistics, going back to 1991, are available [here](#). Separate statistics are produced for Scotland, and are available from ISD Scotland, [here](#). Abortion is not legal in Northern Ireland, except in very exceptional circumstances.

The DH statistics includes all abortions that *take place* in England and Wales, and separates the figures on abortions to women *resident in* England and Wales.

What the statistics can tell us

The national abortion statistics provide a useful and accurate way of assessing how many legal abortions are carried out in England and Wales in any given year, and how these statistics have changed since 1968. They can also tell us the legal grounds under which abortions were carried out under the 1967 Abortion Act. However, numbers never tell the whole story, and care should be taken in interpreting the stats.

What the statistics cannot tell us

The national statistics cannot tell us the reasons why women have abortions: they can only tell us the grounds under which doctors decided that an abortion was legal. Nor can they tell us the extent of illegal abortion. We do not know how many abortions took place before 1968, for example. Nor do we know how many abortions take place illegally today - for example, by women using drugs bought off the Internet.

However, given the steady rise in official numbers of legal abortions since 1968, and the improvements in access to abortion (discussed in the following sections), we can assume that the vast majority of abortions carried out in England and Wales today are legal ones, and that the national statistics provide us with an accurate picture.

Some abortion statistics - often those that catch media attention - need to be treated with particular caution, and these are examined below. These include repeat abortions, and abortions carried out to women who have travelled to England and Wales from abroad.

2) NUMBER OF ABORTIONS

How many abortions are there?

In 2010, there were 189,574 abortions to women resident in England and Wales. This is roughly the same (a rise of 0.3%) from 2009. The highest recorded number of abortions to women resident in England and Wales was in 2007, with a total of 198,499.

The total number of abortions carried out in every given year includes non-residents: that is, women who come to England and Wales from abroad. In 2010, the total number of abortions (residents and non-residents) was 196,109. The highest recorded total was in 2007, with 205,598 abortions.

There has been a steady rise in abortion numbers and the abortion rate since abortion became legal in 1968. The past three years has witnessed a small decline from 2007; however, the 2010 figures indicate that the current figures are relatively stable.

The number of abortions is presented in Table 1 of the official statistics. The figures below give a snapshot of the number of abortions to residents of England and Wales over the past four decades.

- 1969: 49,829
- 1979: 120,611
- 1989: 170,463
- 1999: 173,701
- (2007: 198,499)
- 2010: 189,574

The extent of abortion can best be summed up by the observation, noted by the [Royal College of Obstetricians and Gynaecologists](#), that 'at least one third of British women will have had an abortion by the time they reach the age of 45 years'.

What is the abortion rate?

The number of abortions in England and Wales reflects the changing size of the population, in that if the population grows, the number of abortions will grow. This means that there are more women having abortions, not necessarily that women are having more abortions. The age-standardised abortion rate, calculated per 1,000 women residents aged 15-44, is a more accurate measure of the extent of abortion than the numbers alone.

In 2010, the age-standardised abortion rate was 17.5 per 1,000 women residents aged 15-44, the same as in 2009. This means that of every 1,000 women living in England and Wales, seventeen and a half of them can be expected to have an abortion.

The abortion rate has been generally rising since 1968. However, as with the number of abortions, it fell slightly in 2008, from 18.2 per 1,000 women. The highest recorded rate to date was in 2007, of 18.6 per 1,000 women residents aged 15-44.

The abortion rate began to be calculated in 1969, and has generally risen since then.

- 1969: 5.2 per 1,000 women
- 1979: 11.5 per 1,000 women
- 1989: 15.1 per 1,000 women
- 1999: 16.8 per 1,000 women
- (2007: 18.6 per 1,000 women)
- 2010: 17.5 per 1,000 women

The abortion rate is shown in Figure 1 of the national statistics: 'Age-standardised abortion rate per 1,000 population aged 15-44, England and Wales, 1970 to 2010'.

What is the birth rate?

[Official fertility rates](#) for 2009 give an average number of 1.96 children per woman in England and Wales. This represents a slight decrease in fertility from 1.97 children per woman in 2008. The 2009 figures represent the first annual decrease since 2001, when the average number of children per woman was 1.63.

In 2009, there were 706,248 live births in England and Wales, compared with 594,634 in 2001.

[Figures from the Office for National Statistics](#) show that there were an estimated 896,300 conceptions in England and Wales in 2009, an increase of 0.9 per cent from 2008. The conception rate for 2009 also increased slightly from 2008, to 80.9 conceptions per 1,000 women aged 15–44. There has been an overall downward trend in the conception rate for women under 20 over the last decade.

The proportion of all conceptions resulting in a maternity in 2009 was 79%: a proportion that has remained fairly stable over the last two decades. The percentage of conceptions leading to a legal abortion varies by age group. Over the past decade, this figure has generally increased for women aged under 20, remained stable for women in their twenties, and decreased for women aged 20 and over. In 2009, 60% of conceptions to women under 16 ended in abortion, as did 12% of conceptions to women aged 30-34 and 29% to women aged 40 and over.

How many women come to Britain from overseas to have an abortion?

In 2010, there were 189,574 abortions carried out to residents of England and Wales: 97% of all abortions. The remainder (6,535; 3%) were to non-residents. 'Non-residents' means women who come to England and Wales for abortions because the procedure is illegal in their own country: in 2010, they principally came from Northern Ireland (17%) and the Irish Republic (67%). Non-resident women do not receive abortion treatment on the NHS.

The number of abortions to non-residents in 2010 is the lowest recorded since 1969. However, these numbers have in fact been falling gradually since 1973, when 56,581 abortions were recorded to non-residents. These numbers should be treated with caution, as they can be affected by the availability of abortion in other European countries, and also by the funding of abortion by the NHS in England and Wales.

How many women have 'repeat' abortions?

Figures on 'repeat abortions' often provoke shocked headlines in the press. But these statistics need to be treated with caution for a number of reasons.

In 2010, one third (34%) of women undergoing abortions had one or more previous abortions: the same as in 2009. The proportion of 'repeat abortions' has risen from about 29% since 1998. Also as in 2009, one quarter (25%) of abortions to women aged under 25 were 'repeat abortions'.

The phrase 'repeat abortion' implies that women are having serial abortions: this is not the case. The phrase used by the national statistics is '*previous abortion*', which is a more accurate and less sensational description of the issue.

The statistics show that one third of women (34%) who have abortions have had 'one or more' previous abortion. The proportion of women who have had *more than one* previous abortion is roughly 8 per cent. When one considers that, in England and Wales, there are an estimated 2million acts of heterosexual coitus in women per day, it is striking that only one in 1000 acts of sex result in an abortion. (See ['Is repeat abortion a problem?'](#), by Sam Rowlands. In *Abortion Review Special Edition 2: Abortion and Women's Lives.*)

In modern Britain, women may require more than one abortion because they are exposed to greater risk of unwanted pregnancy than women of previous generations. This is because more women choose not to have children, and those who do choose motherhood tend to delay having children until their late 20s or early 30s. The existence of a longer 'window' between women becoming sexually active and starting their families may mean that women are more exposed to unintended pregnancy.

Abortion has become more widely available, and less stigmatised. This means that women may well be more likely to report having had a previous abortion than they would in the past. Policymakers' interest in the rate of previous abortions has also encouraged the assiduous collection of these statistics, and flagged 'repeat abortion' as an issue of media interest. Because statistics on previous abortions are reported voluntarily by the woman undergoing abortion, we should be aware that the 'repeat abortion' statistics reflect an emphasis on reporting as much as they reflect the numbers of procedures taking place.

The fact that '25% of abortions to women under 25 were repeat abortions' is often used to present repeat abortion as a problem of feckless young people. However, it should be borne in mind that the abortion rate is highest (at 30 per 1,000 women) for women aged 20-24, who are at the peak of their fertility and increasingly less likely to be actively considering starting a family. Abortions to women under 25 account for over half of all abortions, so it is not surprising that a significant proportion of previous abortions are accounted for by this age group.

The discussion of 'repeat abortion' tends to focus on teenagers, but as the national statistics note, this is 'a complex issue associated with increased age as it allows longer time for exposure to pregnancy risks'. Simplistic attempts to stigmatise 'repeat' abortion ignore the fact that women who will have more than one abortion are less likely to be teenagers than older women who have had previous abortions when they were younger.

Research on repeat abortion suggests that women who have more than one abortion are no different to those who have one abortion: they are no less likely to use contraception, and are certainly not using abortion as a means of contraception.

What factors affect the abortion rate?

It is widely accepted that no one factor 'causes' women to have abortions. In all societies, women have experienced unwanted pregnancies, and sought to induce abortions using drugs, implements, herbal remedies or methods based on 'old wives' tales'. We can assume that the legalisation of abortion makes the abortion rate rise, simply because women and doctors are able to seek and practice the procedure without fear of criminal prosecution. However, we should not assume that if abortion were illegal, women would not have abortions.

Illegal abortion

Where abortion is illegal, it is impossible to determine the extent of the practice. The only statistics there are to go on are from the complications arising from illegal abortions that damaged women: successful abortions that did not harm women were not recorded.

In the **bpas** publication [*Pioneers of Change*](#) Peter Diggory, one of the doctors who played a key role in bringing the 1967 Abortion Act into existence, recalls that the hospital in which he worked in 1961 'admitted more than 400 women every year suffering from complications of criminal abortion'.

Diggory explains:

'How big a problem was criminal abortion? Accurate statistics will never be available. The medical establishment pretended that the numbers were small though the general practitioners knew that this was untrue because they frequently saw women suffering from its complications. Amongst the general public everybody knew a friend or relative who had resorted either to a backstreet abortion or a legal one and the press carried lurid stories of the perils. Women who actually had abortions were very silent about their experience and often displayed great loyalty towards the abortionist, refusing to disclose names even when seriously ill and questioned by the police.'

Legal abortion

As we can see from the abortion statistics for England and Wales, the number of abortions and the abortion rate has risen steadily from the time when it became legally available, in 1968. There were five times as many abortions recorded in 1971 as there were in 1968 (126,777, compared to 23,641), which indicates the impact that legalisation had on the extent of abortion.

However, it should be borne in mind that the statistics gathered since legalisation only show the number of abortions recorded, not those carried out. We can assume that in England and Wales today, most women have legal rather than illegal abortions, and that the statistics therefore represent the number of abortions actually taking place. But in 1968, the official statistics would have sat alongside unrecorded illegal abortions.

Available abortion

The availability of abortion is linked to its legalisation. Legal abortion means that women and doctors are able to seek and practice the procedure without fear of criminal prosecution. However, if there are no doctors prepared to perform abortions, or there are no facilities in which legal abortions can be carried out, women will not be able to have abortions – whatever the law says.

In England and Wales, abortion is widely available. The proportion of abortions funded by the National Health Service (NHS) has risen steadily, and in 2010 96% of abortions were funded by the NHS, compared to 94% in 2009. The availability of abortion in England and Wales has been assisted by the fact that 59% of abortions are carried out in approved independent sector places (such as clinics run by **bpas** and Marie Stopes) but publicly paid for, showing a trend towards giving women increasing access to specialist services outside the general NHS. This trend is represented in Figure 2 of the national statistics: ‘Abortions by purchaser, England and Wales, 2000 - 2010’.

There remain issues to do with recruitment and training of doctors in England and Wales who will carry out abortions, particularly to later gestations. These issues tend to impact upon the availability of abortion in relation to the *choice of method* available to women seeking abortion, and the availability of *later-gestation abortions* to women with particular health conditions or fetal anomalies. These issues are discussed in sections 3 and 5 of this briefing.

Economic environment

There has been some discussion about whether the recent global economic recession would affect the abortion rate. Some have argued that the recession would force the abortion rate up, as couples would not be able to support a child, or more children; others have argued that the abortion rate would be forced down, by women losing their jobs and deciding to have a ‘recession baby’.

While both these arguments seem plausible, there is no evidence that broad economic conditions have a particular effect on the abortion rate. Historically, the birth rate has tended to fall in conditions of major recession; but the reasons for this decline are impossible to quantify. We do know that poverty itself does not ‘cause’ abortion, in that couples with low incomes choose to have children as much as do those with higher incomes. We also know that as societies have developed, and become wealthier, the birth rate has historically tended to fall.

Britain since the recession has experienced no dramatic changes in either the abortion rate or the birth rate. We should be wary about attempting to draw any conclusions about the relationship between macro-economic conditions and reproductive outcomes.

Personal circumstances

Women, quite rightly, do not have to state a particular reason for why they need an abortion; and the national statistics do not tell us anything about ‘why’ women have abortions. However, research and experience tell us that the reasons why women have abortions are primarily to do with their personal circumstances. These include:

- They may have fallen pregnant unintentionally, and know that raising a child would be difficult at this point in their lives;
- Their contraception may have failed;
- Their relationship with their partner may have broken down, turning a wanted pregnancy into an unwanted pregnancy;
- Their financial or other life circumstances may have changed;
- Health or other problems with their other children;
- Problems with their own physical or mental health;
- A prenatal diagnosis of fetal anomaly, meaning that if they continued their pregnancy to term the baby might be stillborn or born with a disability.

This is by no means an exhaustive list. There is a wide variety of reasons why women decide that they need an abortion, and these decisions are highly personal ones to make.

Under British law, abortion is a decision that is made by a woman and her doctors. In many other countries, women have the right to abortion 'on request' up to a certain gestation of pregnancy. These 'woman-centred' laws recognise that it is the woman (not her partner) who will carry the pregnancy and give birth to the child. However, this does not mean that women's decisions about abortion are always made on their own, or that their relationships with partners and other family members are unimportant. Research, and experience gathered from **bpas** clients, is that most partners of women seeking abortion are supportive of their decision, and that most women are supported through the procedure by friends and family members.

Relevant commentary

England and Wales: Abortion statistics 2010. This **bpas** briefing highlights key trends from the latest national statistics. *Abortion Review*, 24 May 2011

<http://www.abortionreview.org/index.php/site/article/960/>

'Are there too many abortions?' by Ann Furedi, and 'Is repeat abortion a problem?', by Sam Rowlands. In *Abortion Review Special Edition 2: Abortion and Women's Lives*.

http://www.abortionreview.org/images/uploads/AR_SpecialEdition_2.pdf

USA: Research finds that most men supportive of abortion decisions. Eighty-two percent of women obtaining abortions in the United States report that the men by whom they got pregnant knew about the abortion, and nearly eight in 10 perceived these men to be supportive, research by the Guttmacher Institute shows. *Abortion Review*, 2 February 2011

<http://www.abortionreview.org/index.php/site/article/917/>

Keeping abortion decisions in context. Ann Furedi, writing in BioNews, examines the revelation that some assisted conceptions end in abortion. *Abortion Review*, 14 June 2010

<http://www.abortionreview.org/index.php/site/article/767/>

Why do people get pregnant (when they don't want to be)? The 2010 BPAS annual lecture was given by Kristin Luker, the foremost American sociologist researching contraceptive use and risk taking around unplanned pregnancy in the USA. *Abortion Review*, 30 July 2010
<http://www.abortionreview.org/index.php/site/article/772/>

Ireland: Illegal abortion sends the problem abroad, by Ann Furedi. *Abortion Review*, 10 December 2009 <http://www.abortionreview.org/index.php/site/article/638/>

Abortion rates - it's not the economy, stupid, by Jennie Bristow. Some thought the new abortion stats for England and Wales, released today, would show a link between the recession and rising abortion rates. They were wrong. *Abortion Review*, 21 May 2009
<http://www.abortionreview.org/index.php/site/article/552/>

Will the global recession lead to a 'baby bust'? Jennie Bristow examines the concerns and the evidence. *Abortion Review*, 14 May 2009
<http://www.abortionreview.org/index.php/site/article/509/>

Is a lower abortion rate better? Access to contraception doesn't bring the abortion rate down. Restricting access to abortion services does. Jennie Bristow looks at some of the implications of the USA's declining abortion rate. *Abortion Review*, 8 October 2008
<http://www.abortionreview.org/index.php/site/article/415/>

Abortion: A solution to a problem. Ann Furedi analyses the 'problem' of Britain's rising abortion rate. *Abortion Review*, 11 March 2008 <http://www.abortionreview.org/index.php/site/article/301/>

Why don't abortion rates decline? Ellie Lee puts abortion rates in their social context. *Abortion Review*, 10 March 2008 <http://www.abortionreview.org/index.php/site/article/302/>

Abortion Law Reformers: Pioneers of Change. Interviews with people who made the 1967 Abortion Act possible. BPAS 2007 [http://www.abortionreview.org/images/uploads/Abortion_Pioneers_\(1\).pdf](http://www.abortionreview.org/images/uploads/Abortion_Pioneers_(1).pdf)

3) GROUNDS FOR ABORTION

Abortion is legal in England and Wales if it is certified by two registered medical practitioners under one or more of seven grounds: A, B, C, D, E, F, G. The grounds are detailed in section 1.4 of the [official statistics](#).

Grounds C and D apply to pregnancies before 24 weeks' gestation. Ground E applies to pregnancies up to full term, but only in the case of severe fetal anomaly. Grounds A, B, F, and G apply to pregnancies up to full term, but only in cases of severe risk to a woman's life or physical or mental health: these grounds are rarely used – together they account for 1% of all abortions.

The vast majority (98%, in 2010) of all abortions take place under Ground C: 'the pregnancy has not exceeded its twenty-fourth week and that the continuation of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman'.

Ground D – 'the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing children or the family of the pregnant woman' – accounted for 1 % of all abortions in 2010. Grounds A and B together accounted for less than a quarter of one per cent of abortions.

How are the legal grounds applied in practice?

Ground C is often referred to as 'the mental health clause', and is perceived as the way in which doctors certify abortion 'on request', or 'social abortions'. It is certainly the case that, despite the lack of a formal right to abortion in England and Wales, the abortion law is interpreted liberally to enable women to access abortion when they need it.

However, the construction of the British abortion law still presents a problem for women and doctors. It is not the case that the majority of women seeking abortion are necessarily at risk of damaging their mental health if they continue their pregnancy. But it is significant that, because of the law, women and their doctors have to indicate that this is the case.

It is also important to bear in mind that because Ground C is the most common legal ground for abortion, doctors may be likely to cite it in circumstances where other grounds might be more applicable. For example, if a diagnosis of fetal anomaly is made at a gestation of under 24 weeks, a woman or her doctors may feel more comfortable certifying a termination under the more common Ground C, rather than the Ground E clause. Similarly, it is notable that abortions performed under Ground E have risen as those performed under Ground D have declined: this does not tell us that women's reasons for seeking abortion have changed, merely that doctors certify the procedure on slightly different grounds.

In general, the national statistics do not, and cannot, reflect the real reasons why abortions are considered necessary. They can only reflect the grounds that are cited to make them lawful.

How common is termination of pregnancy for fetal anomaly?

Advances in pre-natal screening and diagnostic testing, alongside trends in later motherhood, mean that more women are faced with a diagnosis of fetal anomaly in the second trimester of pregnancy. Many women opt for abortion in these circumstances: for example, 94% of pregnancies with a prenatal diagnosis of trisomy 21 (Down's Syndrome) will be terminated. This indicates the continuing need for the provision of second-trimester abortion services, and that women are offered a choice between medical induction and surgical methods of abortion. (National Down Syndrome Cytogenetic Register <http://www.wolfson.qmul.ac.uk/ndscr/>)

One issue of concern to **bpas** is that women seeking abortions for fetal anomaly in the second trimester of pregnancy can choose the method of abortion that is best for them. Most abortions for fetal anomaly take place in the NHS, where medical induction is often the only method available: for those women who would prefer a surgical procedure, it is important that their doctors are able to refer to the NHS-funded independent sector when appropriate.

Under UK law, it is legal to terminate a pregnancy beyond 24 weeks' gestation if a woman and her doctors agree that this is necessary, reflecting the fact that a diagnosis may not be made until the second trimester of pregnancy or later, and that women need time to decide what to do. This is a humane reflection of the personal nature of the abortion decision: women are not told to have an abortion following a diagnosis of anomaly, and women are not forced to continue a pregnancy that is likely to end in a disabled child. Those women for whom antenatal screening picks up a diagnosis of fetal anomaly need and deserve understanding and support, whether they decide to terminate the pregnancy or continue it to term.

The focus on the statistics of abortion for fetal anomaly obscures the more subtle and complex *reasons* why women come to their decisions, which are unique to them and affected by their circumstances. But the statistics do show that abortion for fetal anomaly account for a tiny proportion of all abortions: only 1% are carried out on Ground E (risk of 'serious handicap') and less than 0.1% of all abortions take place after 24 weeks' gestation – 147 abortions in total in 2010.

In 2010, of abortions carried out under Ground E:

- 522 were for congenital malformations of the nervous system (including hydrocephalus and spina bifida)
- 572 were for other congenital malformations, including those of the cardiovascular system and the musculoskeletal system
- 831 were for chromosomal abnormalities, of which 482 were for Down's syndrome
- 365 were for other conditions, including 'fetus affected by maternal factors' (115) and multiple gestation (22)

Only 147 abortions were carried out over 24 weeks' gestation. Despite the ongoing debate about fetal viability and proposals to reduce the 'time limit' for abortion, this statistic indicates how rare third-trimester abortions are in Britain.

Relevant commentary

Fetal anomaly and the distortion of the abortion debate, by Jennie Bristow. The anti-abortion lobby's obsession with 'Ground E' terminations reveals its vindictive use of statistics. *Abortion Review*, 3 May 2011. <http://www.abortionreview.org/index.php/site/article/959/>

A Doctor's Right to Choose: The dishonesty of English abortion law, by Sally Sheldon. *Abortion Review*, 6 November 2009 <http://www.abortionreview.org/index.php/site/article/629/>

Autonomy and the UK's law on abortion. Summary of a chapter by Laura Riley and Ann Furedi in the book *Regulating Autonomy: Sex, Reproduction and Family*. *Abortion Review*, 19 June 2009 <http://www.abortionreview.org/index.php/site/article/577/>

Prenatal screening: What do women need to know, and why? Jennie Bristow reports on the launch of the NHS Fetal Anomaly Screening Programme. *Abortion Review*, 29 May 2009 <http://www.abortionreview.org/index.php/site/article/554/>

Down's Syndrome, live births, and statistics. The claim that a more 'caring' Britain has led to an increase in births of babies with Down's is just wrong. So why did it receive so much coverage? By Jennie Bristow. *Abortion Review*, 26 November 2008 <http://www.abortionreview.org/index.php/site/article/452/>

Free fetal DNA testing: Implications for the abortion debate. Jennie Bristow examines the collision of scientific advances in prenatal testing with prejudices about abortion for fetal abnormality. *Abortion Review*, 6 November 2008 <http://www.abortionreview.org/index.php/site/article/441/>

4) AGE, MARITAL STATUS, PREVIOUS CHILDREN, AND ETHNICITY

Most abortions are carried out for women between the ages of 18 and 29. In 2010 women aged 20-24 had 55,481 abortions and the highest abortion rate (30 per 1,000 women). There were 40,800 abortions to women aged 25-29, and 37,227 to women aged 15-19; the rates were 23 per 1,000 women and 22 per 1,000 women respectively.

Although abortion numbers are largely concentrated within the middle of the reproductive life-span (age 15 to 44), a relatively small number of women at both ends of this spectrum require abortions. In 2010, there were 1,042 abortions to girls under the age of 15, and 665 abortions to women between the ages of 45 and 49. There were 21 abortions to women aged 50 and over.

Over recent decades, a great deal of attention has been paid to 'teenage' pregnancy and abortion rates. It should first be noted that the category 'teenage' does not distinguish between girls who are pregnant at the age of 14, and those at the age of 19. In 2010, the under-16 abortion rate was 4 per 1,000 women, and the under-18 abortion rate was 16 per 1,000 women. The under-18 conception rate is estimated to be the lowest rate since the early 1980s, and half of conceptions to girls under 18 now end in legal abortion. This indicates that younger women are gaining an increased ability to manage the causes and consequences of unintended pregnancy.

One interesting development has been a rise in the abortion rate for 'older' women - those over the age of 25. Following the release of the 2010 statistics, it was [noted that](#) 8,179 women aged 40 and over had had abortions.

Ann Furedi, chief executive of **bpas**, commented: 'I think women are generally remaining sexually active for longer, and women in their 40s increasingly see themselves as sexual players – whether or not they are in relationships – in a way that they didn't even a decade ago.' Many older women, especially those who came off the contraceptive pill because of their age, were inclined to take chances with contraception, only to be 'stunned' when they found themselves pregnant. The figures include women who had opted for abortion when antenatal screening disclosed a high chance of abnormalities such as Down's syndrome, the risk of which rises with age.

Abortion and fertility rates

The focus on abortion and young women can obscure the need for abortion indicated by women in their twenties, at a time where many women are starting their families later. The abortion rate remains highest for women aged 20-24, at 30 per 1,000 women; for women aged 25-29 the rate is 23 per 1,000 women, and the rate is 22 per 1,000 women aged 15-19. Given the trends towards delayed motherhood, we can expect a continuing need for abortion amongst women in their twenties.

In 2009, the average age of women giving birth was 29 years (28 years at first birth), and 20% of babies born had mothers aged 35 and over. Between 2008 and 2009, conception rates among women aged 30-34 and 35-39 rose by 3.5% and 3.4% respectively. The existence of a longer

'window' between women becoming sexually active and starting their families may mean that women are more exposed to unintended pregnancy.

The rising age of motherhood has a number of implications for abortion. It means that women are less likely to have children at the peak of their fertile years, leading to a greater need to control their fertility through contraception and abortion. The trend towards delayed motherhood confirms that women *are already doing this*: it can be assumed that most women are sexually active for some time before starting their families. Later age of motherhood is also associated with an increased risk of fetal anomaly. This does not mean that women diagnosed with fetal anomalies will necessarily terminate their pregnancies, but a greater proportion of women will face that decision.

Marital status

In 2010, the vast majority (81%) of women who had an abortion were classified as 'single' (Table 3): an increase from 75% in 2002. However, this relates only to *marital* status. The proportion of women who described themselves as 'single with partner' increased from 17% in 2002 to 49% in 2010, while 26% described themselves as 'single no partner': compared to 25% in 2002.

Women who were married or in a civil partnership accounted for 16% of all women who had abortions in 2010. The proportions that were separated or divorced remained fairly constant over the decade, at around 2% and 1% respectively.

Previous children

In 2010, half (50%) of women who had abortions were already mothers – a proportion that has been relatively constant for a decade. Sixteen percent had had a previous pregnancy resulting in spontaneous miscarriage or ectopic pregnancy. It is often thought that women who have abortions do not want children: these figures indicate that the reality is more subtle, and many women have abortions because they don't want, or cannot manage, any more children.

Ethnicity

The ethnicity of women who had abortions has remained fairly constant since 2002. In 2010, 76% of women having abortions were white; 10% were Black or Black British; 9% were Asian or Asian British; 2% were 'Chinese or other ethnic group'; and 3% were 'mixed'.

Relevant commentary

UK: Rise in abortions among women over 40. The number of women having abortions in their 40s has risen by almost one third in a decade, according to national statistics. *Abortion Review*, 29 May 2011 <http://www.abortionreview.org/index.php/site/article/971/>

Motherhood, abortion and parenting culture. At a recent conference, academics from the UK and USA came together to discuss new challenges to women's autonomy. Jennie Bristow reports. *Abortion Review*, 19 July 2010 <http://www.abortionreview.org/index.php/site/article/793/>

Teenagers and 'repeat abortions': contraception is not a magic bullet. Commentary by Lisa Hallgarten, director of Education For Choice. *Abortion Review*, 18 June 2010 <http://www.abortionreview.org/index.php/site/article/770/>

Young People in London: abortion and repeat abortion. Research report by Lesley Hoggart and Joan Phillips, Policy Studies Institute, January 2010

<http://www.bpas.org/js/filemanager/files/tpyoungpeopleinlondonabortionandrepeatabortion.pdf>

Motherhood in the 21st Century. Two recent conferences raised important questions about the way that medical discourse is framing concerns about the 'optimal' time and circumstances in which women should reproduce. By Jennie Bristow. *Abortion Review*, 25 September 2009

<http://www.abortionreview.org/index.php/site/article/601/>

'What I really really want'. Does having a child make you more or less inclined to support the idea of abortion on demand - or indeed have one yourself? Viv Groskop reports for *The Guardian* (London).

Abortion Review, 23 April 2009 <http://www.abortionreview.org/index.php/site/article/541/>

USA: Abortion and good motherhood. A new study finds that in many cases, women choose abortion because they are motivated to be good parents. *Abortion Review*, 11 January 2008

<http://www.abortionreview.org/index.php/site/article/280/>

5) GESTATION, METHOD AND COMPLICATION RATES

'Early' abortion

The 2010 abortion statistics show a continuation of the trend towards abortions taking place earlier in pregnancy. Over three-quarters (76%) of NHS-funded abortions now take place at under 10 weeks' gestation, compared to half (51%) in 2002. At **bpas** in 2010, over half of first trimester abortions were performed at under 8 weeks' gestation. The proportion performed within the first six weeks increased from just 9% to 29% in the last decade. Almost two thirds (62%) of abortions at under 8 weeks' gestation are performed by organisations like **bpas**, in the independent sector under NHS contract.

Highly sensitive tests, which can diagnose pregnancy just 8 days after conception, mean that women who suspect a pregnancy can confirm this much sooner, while increasing numbers of Primary Care Trusts (PCTs) now allow self-referral, so that a woman can access services without the delays that might be caused by waiting for a referral from her GP. But it is the increasing availability and acceptability of Early Medical Abortion, also known as the 'abortion pill' - a method pioneered in the UK by **bpas** - that has played a key role. Early medical abortion now accounts for half of all abortions performed nationally at gestations of under 9 weeks.

The increased proportion of 'early' abortions funded by the NHS is a reflection of Department of Health policy over the past decade: that that 'women who are legally entitled to an abortion should have access to the procedure as soon as possible'. This reflects clinical evidence that the risk of complications from abortion is lower in earlier gestations than in later ones.

Later abortion

The rise in 'early abortion' does not reduce women's need for abortion at later gestations. In 2010, approximately 9% of abortions took place in the second trimester of pregnancy – a similar proportion to previous years. This reflects the variety of reasons that contribute to women's need to seek 'later' abortion, which range from delays in suspecting/confirming a pregnancy to relationship breakdown, diagnoses of fetal anomaly, and difficulty accessing services. (See [Second-Trimester Abortions in England and Wales](#), by Roger Ingham, Ellie Lee, Steve Clements and Nicole Stone, University of Southampton 2007.)

The national statistics indicate the significant role played by NHS-funded independent sector in providing access to abortion and choice of methods for women. The majority of abortions at 13 weeks and beyond are carried out by the independent sector, which is usually able to offer women a choice of either medical (labour induction) or surgical abortion. For women who can only access abortion within NHS settings – either due to local contracts or medical reasons such as a high Body Mass Index (BMI) – choice may be restricted, with 79% of NHS hospitals providing abortion offering medical methods only after 13 weeks. This may be due to a lack of surgical skills, conscientious objection among clinicians, or hospital policy.

[Research by Kelly et al \(2010\)](#) found that women undergoing second trimester abortions found surgical methods less painful and more acceptable than medical, with more than half of those

undergoing medical reporting the experience to be worse than expected. The authors also noted that there was 'urgent need to introduce novel training strategies' if women were to be offered the method most suited to them.

Abortion for fetal anomaly is also an important reason why women may need to access services in the second trimester of pregnancy. The increased sophistication of prenatal screening and diagnosis, and the rise in factors contributing to increased risk of fetal anomaly – for example, maternal age – means that the need for later abortion services is likely to expand in this regard.

Methods of abortion

The methods of abortion available to women fall into two broad categories - medical induction, and surgical abortions. For medical induction, women take a combination of drugs that have the effect of inducing a miscarriage. At early gestations (under 9 weeks of pregnancy), this is a nurse-led service where women take the drugs in a clinic, and miscarry at home. After 9 weeks' gestation, medical induction is more closely supervised, and may sometimes involve an overnight stay in a clinic.

Surgical abortions in early gestations are relatively swift procedures, which are performed by doctors and usually require either general or local anaesthetic. Manual or electric vacuum aspiration (suction) is used in early procedures. At gestations of over 15 weeks, a method called Dilatation and Evacuation (D&E) is used.

The protocols used for medical and surgical methods vary according to the gestation of the pregnancy. These are clearly explained in the Royal College of Obstetricians and Gynaecologists' (RCOG) [evidence-based guideline](#), *The Care of Women Requesting Induced Abortion*. A brief summary of the methods offered by **bpas** is provided [here](#).

Which method is best?

Evidence indicates that, in general, medical and surgical methods are equally safe, effective, and acceptable. Surgical abortions at later gestations require particular training, which may be one reason why they are not widely offered within the NHS. The main reason for offering a choice of method, where possible, is that some women have strong preferences. Some women feel that medical induction is more 'natural' and less invasive; other women prefer surgical because it is quicker, or because they prefer to be asleep during the procedure.

bpas has produced some short films indicating what is involved in each method of abortion. These can be viewed here:

- Consultation <http://www.bpas.org/bpaswoman.php?page=310>
- Early Medical Abortion (the 'abortion pill')
<http://www.bpas.org/bpaswoman/Abortion%20pill%20treatm>
- Surgical abortion (awake) <http://www.bpas.org/bpaswoman.php?page=313>
- Surgical abortion (asleep) <http://www.bpas.org/bpaswoman.php?page=312>

Both surgical and medical methods are appropriate for abortions at all gestations of pregnancy, and in theory women have a choice of method at all gestations. In practice, choice of method - particularly in later gestations - can vary according to whether abortions are provided by NHS hospitals or by the independent sector under NHS contract, for the reasons discussed above.

How safe is abortion?

Induced abortion today is a very safe procedure. The RCOG notes that it is generally safer than carrying a pregnancy to term. But as will all medical procedures, abortion carries a risk of complications: these include haemorrhage, uterine perforation and/or sepsis. The official statistics note that complications were reported in 287 cases in 2010, a rate of 2 per 1,000 abortions. Deaths from induced abortion are extremely few, less than one per year. (See Table 8 of the national statistics).

There is an ongoing debate about whether induced abortion has a negative impact on women's mental health. This question has been a major focus of research in the USA, and a [major review](#) by the American Psychological Association in 2008 found no causal link between induced abortion and mental health problems. A review of the evidence [recently published for consultation](#) by the Royal College of Psychiatrists had similar findings.

In the UK, the [RCOG's draft evidence-based guidance](#), published for consultation in 2011, states that 'Women should be informed that most women who have abortions do not experience adverse psychological sequelae', and further notes that 'the most rigorous studies support the view that any observed associations between abortion and mental health problems do not appear to be related to abortion itself but to pre-existing conditions and co-occurring risk factors. Although abortion can be associated with a range of feelings, long term feelings of sadness, guilt and regret appear to linger in only a minority of women.'

Relevant commentary

Clinical Update: Very early surgical abortion. By Patricia Lohr, Medical Director, **bpas**. *Abortion Review*, 3 May 2011. <http://www.abortionreview.org/index.php/site/article/958/>

Abortion is not a mental health problem. A new review of the evidence finds no causal link between abortion and depression. Now can we move the discussion on? Commentary by Jennie Bristow. *Abortion Review*, 7 April 2011 <http://www.abortionreview.org/index.php/site/article/951/>

UK: Anti-abortion lobby reacts to doctors' guidance. Draft guidance from the Royal College of Obstetricians and Gynaecologists advises that women should be presented with scientific evidence about the health effects of abortion. Would critics prefer that women are lied to? By Jennie Bristow. *Abortion Review*, 1 March 2011 <http://www.abortionreview.org/index.php/site/article/931/>

New RCOG guidance highlights advances in abortion care. *Abortion Review*, 26 January 2011 <http://www.abortionreview.org/index.php/site/article/909/>

Misoprostol and the transformation of the 'abortion pill', by Jennie Bristow. Britain was one of the earliest countries to use early medical abortion. In a strange twist of legal and medical history,

British women are now being penalised for it. *Abortion Review*, 26 January 2011

<http://www.abortionreview.org/index.php/site/article/908/>

Let's make it easier to take the abortion pill. Ann Furedi explains why she is taking the UK Department of Health to court over early medical abortion. *Abortion Review*, 13 January 2011

<http://www.abortionreview.org/index.php/site/article/905/>

A moral defence of late abortion, by Ann Furedi. *Abortion Review Special Edition*, Winter 2010

http://www.abortionreview.org/images/uploads/AR_LateAbortion_Dec2010.pdf

Clinical Update: Treatment of obese clients. By Patricia Lohr, Medical Director, **bpas**. *Abortion Review*, 1 November 2010 <http://www.abortionreview.org/index.php/site/article/835/>

Clinical Update: Home management of Early Medical Abortion. By Patricia Lohr, Medical Director, **bpas**. *Abortion Review*, 24 May 2010 <http://www.abortionreview.org/index.php/site/article/759/>

Clinical Update: Vacuum aspiration under local anaesthetic. By Patricia Lohr, Medical Director, **bpas**. *Abortion Review*, 17 February 2010 <http://www.abortionreview.org/index.php/site/article/689/>

Clinical Update: Reducing serious infection following early medical abortion. By Professor James Trussell, Director of the Office of Population Research, Princeton University. *Abortion Review*, 2 October 2009 <http://www.abortionreview.org/index.php/site/article/614/>

A depressingly narrow debate. The 'yes it does / no it doesn't' reaction to claims that abortion damages mental health distracts from the more useful and difficult questions about women's experience. By Jennie Bristow. *Abortion Review*, 5 December 2008

<http://www.abortionreview.org/index.php/site/article/459/>

Why do women have late abortions? An important new study finds that indecision is a major factor in delay. Jennie Bristow reports. *Abortion Review*, 19 April 2007

<http://www.abortionreview.org/index.php/site/article/169/>

The mental health 'risks' of abortion. Ellie Lee examines the basis for claims in the *Times* (London) that 'abortion exposes women to higher risk of depression'. *Abortion Review*, 31 October 2006

<http://www.abortionreview.org/index.php/site/article/91/>

Increase in early medical abortion: A good news story, by Ann Furedi. *Abortion Review*, 7 August 2006 <http://www.abortionreview.org/index.php/site/article/59/>

Do people really want to ban late abortions? The *Observer* claims, on the basis of a new poll, that 'a majority of women in Britain want abortion laws to be tightened to make it harder, or impossible, for them to terminate a pregnancy'. Ann Furedi is not convinced. *Abortion Review*, 19 March 2006

<http://www.abortionreview.org/index.php/site/article/3/>

6) PROVISION, FUNDING AND GEOGRAPHICAL LOCATION

Who provides abortions?

In England and Wales, the proportion of abortions funded by the National Health Service (NHS) has risen steadily, and in 2010, 96% of abortions were funded by the NHS.

The availability of abortion in England and Wales has been assisted by the fact that over half (59%) of abortions are carried out in approved independent sector places (such as clinics run by **bpas** and Marie Stopes) but publicly paid for, showing a trend towards giving women increasing access to specialist services outside the general NHS. **bpas** currently has over 55 consultation centres and clinics throughout the UK, and cares for approximately 55,000 women a year. In 2010 **bpas** held 119 NHS contracts, and provided nearly half of the abortions provided by the independent sector (26% of all abortions in England and Wales).

The commissioning arrangements for abortion, as with other health services, may change slightly as a result of the health reforms outlined by the current Coalition Government. The exact scope of these changes is presently being worked through by the government. However, there is no indication that the level of public funding for abortion, or the role of the independent sector in abortion provision, will change significantly.

What are the geographical variations in abortion provision?

The number of abortions, and the abortion rate, is broken down by the national statistics, and presented in Table 10a and 10b respectively. Table 11 shows, by region, how NHS-funded abortions are split between NHS hospitals and the independent sector, and what proportion of the remainder are privately funded.

There are some striking regional variations: for example, in East Midlands Strategic Health Authority (SHA), 73% of NHS-funded abortions take place in NHS hospitals and 24% in the independent sector; in West Midlands SHA, only 6% of NHS-funded abortions take place in NHS hospitals and 92% are provided by the independent sector; and in East of England SHA the proportion is a more even split. In London SHA, 73% of NHS-funded abortions take place in the independent sector; in Wales, this figure is 27%.

How is abortion regulated?

Abortion in England and Wales is regulated, first, by the Abortion Act (1967), which stipulates the grounds under which doctors can certify a woman's eligibility for abortion, and the premises on which an abortion must be carried out. Beyond that, abortion is subject to a number of health regulations, including those of the [Care Quality Commission](#), and doctors and nurses are regulated by their professional codes of practice.

Best clinical practice for abortion, based on systematic reviews of clinical evidence, is provided by the Royal College of Obstetricians and Gynaecologists (RCOG), in its guideline [The Care of Women Requesting Induced Abortion](#). This guideline was produced in 2000, updated in 2004, and updated again in 2011. In 2009 the New Labour government developed, after many years of discussion, a

National Service Specification for Termination of Pregnancy Services, which lays out some of the basic standards that abortion services should meet.

Relevant commentary

Our 10-year struggle to improve abortion care. Ann Furedi reports on her fight with health officials for sensible abortion services. *Abortion Review*, 17 February 2011
<http://www.abortionreview.org/index.php/site/article/927/>

Q&A: The National Service Specification for Termination of Pregnancy Services, by Donagh Stenson. *Abortion Review*, 24 January 2011 <http://www.abortionreview.org/index.php/site/article/912/>

Do abortion services really make a 'vast amount of money'? A blog on the Liberal Conspiracy website challenges Nadine Dorries MP's claims. *Abortion Review*, 11 November 2010
<http://www.abortionreview.org/index.php/site/article/879/>

8) FURTHER RESOURCES

- An archive of news and commentary, organised by date and by theme, can be freely accessed from the *Abortion Review* website: <http://www.abortionreview.org/>
- Briefings, press releases and other information is available from the **bpas** Knowledge Centre, here: <http://www.bpas.org/bpasknowledge>
- Back issues of *Abortion Review* can be downloaded here: <http://www.abortionreview.org/index.php/site/about/49/>
- A series of special editions of *Abortion Review*, produced from the landmark **bpas** conference of 2008, examines key questions of ethics, clinics and care. These can be downloaded for free from the *Abortion Review* website:

Abortion, Ethics, Conscience and Choice – Abortion Review Special Edition 1

http://www.abortionreview.org/images/uploads/AR_SpecialEdition_1.pdf

- The problem with pain: what the fetus feels. *Stuart Derbyshire*
- The value of life: when does it begin, when does it matter? *John Harris*
- Presenting the case for conscience. *Jon O'Brien*
- Presenting the case for choice. *Kirsten Moore*
- How late is too late for providers? *Lisa H. Harris*
- Who is ethical, who is moral? *Ann Furedi*

Abortion and Women's Lives – Abortion Review Special Edition 2

http://www.abortionreview.org/images/uploads/AR_SpecialEdition_2.pdf

- Are there too many abortions? *Ann Furedi*
- Is repeat abortion a problem? *Sam Rowlands*
- How late is too late for women? *Ellie Lee*
- Why contraception fails. *James Trussell*
- The morning after – what use is emergency contraception? *Kate Guthrie*
- How important is choice and care? *Chris Plummer*
- What is different about young people? *Lisa Hallgarten*

Abortion and Clinical Practice – Abortion Review Special Edition 3

http://www.abortionreview.org/images/uploads/AR_SpecialEdition_3.pdf

- Issues in Early Medical Abortion. *Mitchell D. Creinin*

- Issues in second trimester surgical abortion. *Eleanor Drey*
- Abortion research developments. *Daniel Grossman*
- Implementing evidence-based advances in abortion care. *Mary Fjerstad*
- The role of nurses. *Kathy French*
- Who can provide abortion care? The role of the mid-level providers. *Marge Berer*

For further information about *Understanding Abortion Statistics*, email: info@abortionreview.org, or press@bpas.org.