

Meeting the need for induced abortion

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This article is based on the text of a presentation made at the RCOG on March 13th 2000 to launch the Royal College of Obstetricians and Gynaecologists' guideline on induced abortion.

Summary

Induced abortion should be freely available as part of the strategy to prevent unwanted pregnancy and particularly to reduce teenage maternities. The service is an important public health measure and should be easily accessible to all women, especially those who live in socially deprived communities. In the short-term abortion rates may rise and this should be seen as a positive outcome of the strategy to reduce unwanted maternities. In the medium-term the need should reduce, as there is increased use of routine and emergency contraception. Providers of NHS abortion services have an important role to play in the implementation of the Teenage Pregnancy and National Sexual Health Strategy.

Key words

abortion, abortion rates, accessibility, sexual health strategy

Key message points

- Early and safe abortion must be available as part of a local sexual health strategy.
- Abortion must be free for those who cannot afford to pay.
- Increases in abortion rates may be inevitable in the short- to medium-term, and as such should be considered as a positive health outcome.
- Longer-term reduction in abortion rates will depend on more accessible and effective routine and emergency contraception.

Introduction

On 13th March 2000 the Royal College of Obstetricians and Gynaecologists launched their guideline on induced abortion. This guideline had been developed by a multi-disciplinary group under the auspices of the College's guidelines initiative. It is one of a series, and is available to provide guidance to clinicians and healthcare providers about clinical practice, and also to provide a quality framework for commissioners of services to include in their contracts and long-term service agreements.

I was invited to the launch to make a presentation from the perspective of a commissioner of services, and also to look at the issues within the broader context of public health. In the discussions that followed, clinicians from both the community and hospital services expressed their interest in the perspective of a Director of Public Health. In particular, they welcomed the view that induced abortion is an important and necessary service if we are to reduce unwanted pregnancies, and that there is a responsibility to the public to have a high quality service provided free of charge so that inequalities in health can be reduced. In subsequent months it has become apparent that the Government is particularly concerned with the development of a national sexual health strategy which will inevitably address the need to provide accessible, safe and

free induced abortion for all women who need such a service. In addition to a national sexual health strategy, the government's Teenage Pregnancy Unit has already asked that each local health community should develop its own teenage pregnancy strategy. This strategy has to ensure that a full range of health, social and educational services are available to reduce the current levels of teenage pregnancy and support young mothers and their children.

The current situation in Nottingham

Over the last 12 months in the Nottingham health district, a number of important issues to do with women's health and fertility have been at the top of the commissioning and public health agenda. These have included:

- developing a long-term service agreement for infertility services
- developing a medical abortion service
- initiating a teenage pregnancy strategy
- developing a section on sexual health in our Health Improvement Programme
- developing multidisciplinary gynaecological cancer teams in the cancer centre
- discussions on the manpower crisis in obstetrics
- introducing a different test for Down's screening in pregnancy
- the monitoring and management of a safe and effective cervical screening programme
- integration of maternity services.

In addition to this huge range of issues, we have also had to develop more robust arrangements for the commissioning of abortion services. From a public health perspective the issues relating to abortion services are:

- improving public health and meeting health targets
- providing fair access to high quality services
- reducing mortality and morbidity associated with abortion
- reducing inequalities in health and access to healthcare.

Improving public health and meeting health targets

Ever since the publication of the health strategy *The Health of the Nation*¹ in 1990, targets have been set by the Department of Health for the reduction of teenage pregnancy. Some other related targets are:

- reducing maternal mortality
- reducing the number of unplanned and unwanted children
- improving the quality of life of families and their children
- providing access to a safe method of fertility control
- health improvement.

Public health practitioners acknowledge the importance of the 1967 Abortion Act in providing safe and high quality abortion services, and recognise this as being one of the most important contributors to the reduction in maternal mortality over the last 30 years. Abortion is still needed, as it is one of the effective ways to reduce the number of unwanted and unplanned pregnancies. Reducing unwanted pregnancy will ensure that families have a better quality of life. In addition to this, however, a good abortion service will reduce the likelihood of serious infection and its

sequelae, and will also provide good psychological support for those who use the service.

In 1990 one of the health targets in *The Health of the Nation* was to reduce total conception rates in under 16s (this is the total number of abortions and maternities to people aged under 16 at conception) by at least 50% by 2000. In the guidance given to health authorities in 1993 there was surprisingly little reference to abortion services and little mention of the acute sector in its role as providers of abortion. The emphasis for teenage pregnancy was almost entirely based on prevention of conception as exemplified in the Key Area Handbook on HIV/AIDS and Sexual Health² produced by the Department of Health in 1993. More recently, the national targets were changed in *Saving Lives - Our Healthier Nation*³ to reducing conceptions in all teenagers aged under the age of 18. The current target for health authorities and their partner organisations is to reduce by half the number of teenage conceptions in under 18 year olds by 2010. Both the last and present Governments claim that reducing teenage pregnancy will have a positive effect on family life and the aspirations of children and young people.

Providing fair access to high quality services

Over the last 30 years there have been tremendous changes in the attitude to abortion and the availability of services. These changes are:

- better access to NHS abortion
- access to earlier abortion
- higher quality services
- less judgmental attitudes from the medical profession.

Over the last three decades we have seen increased access to NHS abortion, and particularly access to earlier abortion, with higher quality services provided both within the NHS and private sectors. However, each year publication of the statistics about the legal abortions carried out in England and Wales leads to media interest. It is usual for the media to consider increased abortion rates to be ‘bad news’ and a measure of failure of education and the health service. We do not see a similar level of negative media interest when we publish the figures for the increase in number of hernia repairs carried out, or the number of intra-uterine devices inserted by doctors!

A review of health statistics enables us to understand more about what has been changing in the need for abortion over the past 30 years and does not always support the perceptions of the media.

Looking at conception rates between 1990 to 1997, we can see from Table 1 that the conception rate in women aged under 16 years has not risen and that the conception rate in 20-24 year olds has fallen. For those women aged 30-34 years the rates have risen slightly, and there has been an increase in the conception rate in women aged over 40. These figures do not support the media’s perception that an increased proportion of teenagers are getting pregnant. The data do, however, show an overall increase in age of women who embark on a pregnancy.

Table 1 Conception rates 1990 to 1997 per 1000 women - England and Wales

Year	Under 16	20 – 24	30 – 34	Over 40
1990	9.5	124	90	6.6
1993	8.1	111	92	7.6
1997	8.7	108	95	8.7

Sources – Office of Population Censuses and Statistics – Population Trends and Monitors, Public Health Common Data Set and Office of National Statistics Compendium of Clinical and Health Indicators.

Table 2 Abortion rates 1971 to 1998 per 1000 women - England and Wales

Year	Under 16	29-24	30-34	45 and over
1971	3.5	13.1	10.0	0.3
1981	4.5	19.4	10.3	0.4
1991	5.6	24	12.7	0.3
1993	5.3	25.5	12.6	0.3
1998	6.1	30.4	14.5	0.3

Sources – Office of Population Censuses and Statistics – Population Trends and Monitors, Public Health Common Data Set and Office of National Statistics Compendium of Clinical and Health Indicators.

When we look at Table 2, which represents abortion rates over the past three decades, we can see that the abortion rate amongst women aged less than 16 years has risen, as has the rate for women aged 20-34. Only for women aged over 45 has the abortion rate stayed the same. However, the abortion rate is highest for women aged 20-24 years.

What has also changed over the years is the percentage of conceptions which result in abortion, as illustrated in Table 3.

Table 3 Percentage of conceptions terminated by abortion - England and Wales

Year	Under 16	20-24	30-24	40 and over
1990	50.8	22.3	13.8	43.2
1993	49.9	22.8	13.6	40.2
1997	49.7	26.7	14.2	38

Sources – Office of Population Censuses and Statistics – Population Trends and Monitors, Public Health Common Data Set and Office of National Statistics Compendium of Clinical and Health Indicators.

However, for under 16 year olds the percentage has stayed very much the same over the last decade. In the context of preventing teenage maternities this should be a welcome trend. For women aged over 40 the rate has gone down. This supports the evidence of an increase in maternities to older women. Table 4 shows the gestation of abortions over the last three decades. We can see a significant reduction in the gestation at which abortions are carried out.

Table 4 Abortions: gestation in weeks 1971 to 1998 - England and Wales

Year	Under 9 weeks	9 - 12 weeks	13 - 19 weeks	20 + weeks
1971	17	58	22	1
1986	33	54	11.5	1
1998	41	48	10	1

Sources – Office of Population Censuses and Statistics – Population Trends and Monitors, Public Health Common Data Set and Office of National Statistics Compendium of Clinical and Health Indicators.

The gestation at abortion has gone down over the last 30 years, with the majority now being carried out at 9-12 weeks and only 11% after 12 weeks gestation. This makes a large contribution to reducing mortality and the morbidity, both physical and psychological, associated with abortion.

The lesson from these data analysis is that we cannot always believe what the media says. Health professionals should be aware of the true facts and figures.

In summary, recent trends are:

- total conception rates have gone down in women aged under 30 and risen in those aged 30-40
- abortion rates have risen for all ages
- gestation at abortion has fallen from 17% at less than 9 weeks to 41% at less than 9 weeks

- the percentage of conceptions terminated has risen for the 20-24 year olds, fallen for the over 40s and stayed the same for under 16s and 30 - 34 year olds.

The questions we do have to ask ourselves when planning services are why do the abortion and conception rates change, and are the changes related to changes in access or effectiveness of services? There are a number of important contributory factors, three of the most important being:

- more effective contraception, but adverse effects of ‘Pill scares’
- more use of emergency contraception - in the future more nurse and pharmacist prescribing with the introduction of progestogen-only preparations
- greater access to medical termination to allow choice of method of abortion.

All these issues need to be considered when planning services or monitoring fertility rates. The availability of safe and legal abortion has significantly improved public health over the last 30 years and will continue to help us meet health targets related to teenage conceptions. However, in order to meet these targets there must be fair access to services and a further continuation of the reduction in mortality and morbidity associated with induced abortion.

Fair access and reducing mortality and morbidity

Health authorities at present, and in future the PCTs, will be responsible for commissioning comprehensive sexual health care services. The responsibilities are:

- to ensure services are available and accessible - free if required and sensitive to local needs
- to provide information to the public e.g. NHS Direct, phone lines, etc
- to monitor quality, waiting times, etc
- to use a range of providers if necessary to allow individual choice and best value.

Reducing inequalities in health and access to health care

There is a variation in access to NHS abortion across the country, with the highest NHS rates being in Scotland and the lowest in some districts in the Midlands and South East (Figure 1).

Figure 1 Access to NHS abortion

- Scotland: almost 100%
- East Norfolk: 93%
- North Cumbria and Northumberland: 96%
- Northern, Yorkshire and Trent regions: 80 to 90%
- North and South Thames: 60 to 70%
- Solihull: 45%, Berkshire: 52%, Kingston and Richmond: 51%

Source – Office of National Statistics Compendium of Clinical and Health Indicators 1999

One could conclude that in areas of relative affluence there is not the need to have such widespread access to NHS abortions and that this may be the situation in areas such as Solihull, Berkshire, and Kingston and Richmond. However, we should not assume that even in these affluent areas all young women needing abortion could afford to pay for it. It is not certain whether NHS services are not required, or not provided. However, many health authorities have set criteria for NHS abortion and some of these are listed in Figure 2.

One of the problems with developing criteria is that it is not always clear whether or not these are social or clinical reasons, and many of them depend on moral judgements and delays set in the system by clinicians. Ideally, there should be provision of high quality services with low waiting times, low postoperative infection rates, com-

Figure 2 Criteria for NHS abortion

- Age
- Gestation
- Rape
- Medical/psychological conditions
- Income/social circumstances
- Previous pregnancy/terminations

Source- Early report of the Survey of Health Authorities by the Abortion Law Reform Association – subsequently published in Improving Access to Abortion. A guide.⁵

prehensive postoperative follow-up and, where needed, psychological support and counselling.

A range of sexual health services must be commissioned to meet all the local needs. This will include:

- contraception in primary care and community settings
- rapid access to diagnosis and treatment of sexually transmitted infections (STIs)
- health promotion
- emergency contraception
- early pregnancy testing
- access to booked slots for abortion
- surgical and medical terminations
- counselling and follow-up
- use of non-NHS facilities if necessary.

Where these services cannot be provided within the NHS, commissioners will have to set contracts with the private sector or charities to ensure that there is universal access to services.

Reducing inequalities in health and access to healthcare

It is quite clear that there is not universal access to abortion and that this leads to inequalities in health and inequalities in access to healthcare.

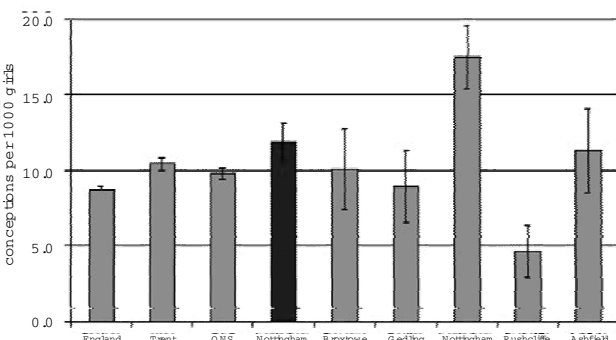
Even within a single district there are different needs and this is illustrated by looking at the different teenage conception rates across the Nottingham health district. Comparison can be made between the conception rates in one of the most affluent boroughs, Rushcliffe, with that of the inner city of Nottingham. The conception rate ranges from less than five per 1000 girls in Rushcliffe to 18 per 1000 in the City of Nottingham.

Data on the proportion of conceptions resulting in abortion can add to the picture. When one compares the same two boroughs looking at the proportion of abortions carried out in women aged under 18, one can see that 51% of conceptions in the affluent area of Rushcliffe result in abortion, whereas in the inner city of Nottingham only 24% result in abortion (Table 5).

Data from Nottingham, collected in 1994, categorised all women having a maternity or abortion by the Townsend

Figure 3 Teenage conception rates – Nottingham District

Teenage Conception Rates 1994-1996 Nottingham District, Trent and E & W



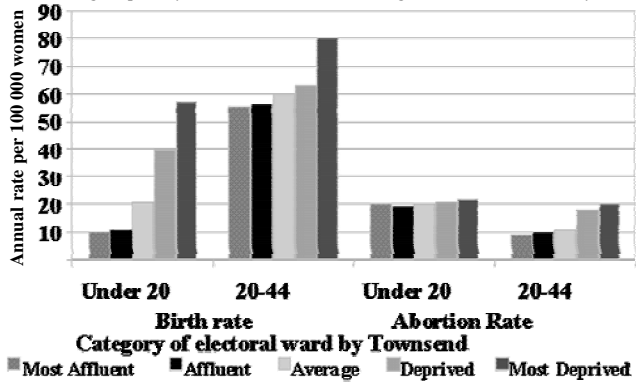
Source- Public Health Common Data Set 1998

Table 5 Nottingham district % abortion by local authority

Conceptions to women under 18 – Local Authorities: 1995 – 1997 (numbers, rates* and percentage leading to abortion):			
Area of usual residence	Number	Rate	% abortion
City of Nottingham (UA)	1022	73	24
Broxtowe	193	36	46
Gedling	259	42	46
Rushcliffe	128	22	51
Ashfield	308	54	33
England	–	44	40
Leicester (UA)	926	57	29

* rates per 1000, women aged 15 – 17 years
Source – Office of National Statistics. Population Trends. Autumn 1999.

Figure 4 Relationship between pregnancy rate and electoral ward of residence grouped by Townsend Score: Nottingham Health Authority



Source – Trent Patient Information System – Births 1991-1993 and Abortions1/4/91-31/3/94

Score of the electoral ward in which they live. Comparison was then made of the women in the most deprived wards through to the most affluent wards. The data are presented in Figure 4. There is steep gradient from the most affluent to the most deprived wards for birth rates for women under 20 years. The rate ranges between 10 per 100 000 women in the most affluent wards to 58 per 100 000 women in the most deprived wards.

Looking at the abortion rates, it is quite clear that there is no similar relationship between the abortion rate, with women in the most affluent areas having the same rate per 100 women as women in the most deprived areas. Combining the data from these analyses demonstrates that a young women aged under 20 living in the most affluent wards of Nottingham, finding herself pregnant, is six times as likely to have an abortion as continue with the pregnancy than a women living in the most deprived wards.

The real issues for a health authority, such as Nottingham, in trying to provide access to high quality abortion services are:

- allocation of resources where there are competing demands
- sufficient and quality NHS service
- promoting prevention rather than termination of pregnancy
- placing abortion in the context of conception, contraception and childbirth.

In particular, there are a huge number of competing claims for the scarce resources available to the NHS. Many treatments have a very high profile, such as the provision of infertility treatment, beta-interferon and cancer drugs. In this situation it is usually only the health authority itself which is prepared to make a public commitment to continue to invest or increase investment in abortion services.

However, even with commitment to invest it is becoming increasingly difficult to commission adequate services, and many health authorities are having to turn to the private sector for a local service.

Health authorities are obviously more concerned with promoting prevention of unwanted pregnancy than provision of abortion services. We do have to see the provision of abortion services in the context of a range of high quality services in primary and community care for routine contraception, emergency contraception and health promotion. It is therefore very important to demonstrate to the public how abortion is part of the total picture of conception, contraception and childbirth and included in the context of a broader sexual health strategy.

The NHS will be judged on its ability to deliver a reduction in teenage pregnancy over the next 10 years. In addition, health authorities will include in their Health Improvement Programmes a number of intermediate success measures. The success measures being introduced to the Nottingham Health Improvement Programme⁴ are illustrated in Figure 5.

Figure 5 How do we measure success?

- Reduced conception rates in 2010
- Reduced prevalence of infertility in 2020
- Fewer children living in poverty and risk of abuse in 2005
- Fewer cases of STI in 2005
- Increased use of EC
- Increase in abortion rates in disadvantaged groups
- Fewer second terminations
- Fewer second visits to GUM
- Increased use of regular contraception

Source – Health Improvement Programme for the Nottingham Area, 2000-2001.⁵

We consider this approach to be the right one, emphasising that in an ideal world all sexually active young people would use effective contraception and that only where couples make a positive decision to have a child will a pregnancy be planned. We do, however, have to use interim success measures to show that the local sexual health strategy is succeeding. In the short-term, these would be:

- increased use of emergency contraception
- increased abortion rates in disadvantaged groups
- fewer second terminations
- fewer second visits to genito-urinary medicine clinics
- increased use of regular contraception.

In the medium-term we would wish there to be fewer new cases of sexually transmitted infections, fewer children born into poverty and at risk of abuse, and reduced teenage conception rates.

In the longer-term we would wish to see a reduced prevalence of infertility and a continuation of the reduction in conception rates in young women.

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