In this issue

Abortion: barriers and inconsistencies

This issue of the Journal contains several articles on the subject of abortion. This was not pre-planned, but rather a response to a wealth of submissions that we received within a short time frame. Studies came in with data from England, Scotland, Australia, Nepal, South Africa, Tunisia, Colombia and New Zealand, addressing questions such as: Why are women in the UK, where the incidence of induced abortion has risen by over 5% in 10 years, requesting abortion? How many choose to take up counselling when it is offered? How easy is it for women actually to access abortion across a range of countries where it is legal? And what are the barriers to accessing abortion in developed countries?

A repeating theme running through these otherwise disparate papers is one of barriers and inconsistencies. There is, it seems, wide medical, legal and organisational variation between and within societies in terms of access to abortion. For example, despite mifepristone being listed as an essential medicine by the World Health Organization since 2005, some countries such as Sweden and Switzerland use it widely; while in others, such as Canada, it is not licensed at all (see Doran and Nancarrow). While Scotland carries out nearly all abortions within National Health Service (NHS) settings, in England the equivalent figure is less than half, arguably with consequences for staff training and stigma (see Astbury-Ward). And while most European countries offer unrestricted access to abortion within the first 12 weeks, a minority including the UK require a medical indication (see Rowlands). However views might differ as to which system is preferable, the inconsistency between countries is striking.

Even where abortion is relatively freely available, it seems a range of barriers make access inequitable. These include practical challenges such as geographical distance, lack of staff training or costs, hurdles such as compulsory counselling, unnecessary tests, or spurious requirements relating to marital status, or husband consent, but also deeper cultural obstacles such as moral opposition to abortion, staff harassment and stigmatisation (see Gerdts *et al.*, Rowlands, Doran and Nancarrow, Baron *et al.*).

Unwanted pregnancy is a vulnerable moment in a woman's life, and one that deserves to be treated with the utmost care and respect. But what does that care and respect look like in practice? It is easy to agree, on the one hand, that the abortion of an unwanted pregnancy is less acceptable than its prevention, and on the other, that legal abortion is a relatively safe intervention which has saved many lives worldwide.

But beyond such simple statements, many more subtle questions remain about the complex and sensitive processes that lead to women's decision to opt for or against abortion (see Wokoma *et al.*). How, for example, might the requirement for a doctor's approval affect a woman's sense of autonomy in reaching a decision about abortion, or influence her capacity to acknowledge her own ambivalence? Is this requirement more than a bureaucratic barrier to timely treatment – a rubber-stamping exercise carried out by clinicians with no particular psychological qualifications or knowledge of the individual woman? Or can the requirement for a health-related indication drive a respectful, serious-minded, health-promoting conversation and, if so, how? These are questions that cannot reasonably be answered with dogma based on so-called 'pro-choice' or 'pro-life' rhetoric, but by open-minded, well-designed, woman-centred research, which addresses and acknowledges complexity.

Sandy Goldbeck-Wood
Editor-in-Chief

Women across continents continue to be denied access to legal abortion

There is evidence that women who are denied legal abortion suffer adverse outcomes, whether or not they continue with their pregnancy. A four-country study by Gerdts *et al.* shows that women are sometimes denied abortion even where it is legal. In South Africa, almost half of women are turned away – for example, because their pregnancy is too advanced, for lack of staff, or because they are unable to pay. In both Nepal and Tunisia, one in four women is unable to obtain a legal abortion, whereas in Colombia, almost all can access a legal abortion. ***See page 161***

Inconsistency in abortion laws across Europe

While the countries of Europe are increasingly working together for socio-economic advancement, abortion laws are neglected and inconsistent, writes Sam Rowlands in his Viewpoint article. Summarising wide variation in the legal treatment of abortion across Europe, Rowlands argues that the small minority of countries such as the UK, which still require a medical indication, need liberalisation of laws, to bring them into line with other countries. Abortion remains constrained by a lack of political will for change and by religious interference, he argues. ***See page 164***

Abortion 'on the NHS': why the geographical discrepancy?

Two-thirds of abortions in England and Wales are carried out outside NHS settings (with most funded by the NHS), while in Scotland the figure is only 0.3%. In her Personal View article, Edna Astbury-Ward argues that the widespread provision of abortion care in independent organisations leads to invisibility of abortion in NHS health care situations. This may perpetuate the notion that abortion is uncommon and deviant, she argues, and could contribute both to stigma and to a lack of NHS staff well trained in abortion care. ***See page 168***

Obstacles in accessing abortion: a systematic review

Even in the developed world, women encounter barriers in accessing first-trimester abortion services. In a systematic literature review, Doran and Nancarrow identified numerous obstacles, and grouped them into four major themes: training of providers, financing of services, timely access, and the provision of equipment or medication. Understanding the barriers can help providers to enhance access to services and reduce the stress that many women experience, these authors argue. ***See page 170***

Should pre-abortion counselling be mandatory?

According to Baron *et al.*, the answer is 'No'. In a survey of women requesting abortion in Edinburgh, they found that fewer than 10% of respondents had used any form of pre-abortion counselling, most reporting that this was because they were certain of their decision. Policies aimed at mandatory counselling would be contrary to women's wishes, say the authors, who argue that counselling should be targeted to the few women with identifiable risk factors for psychological complications. *See page 181*

Why women in Hull request TOPs

With a growing number of UK women requesting abortion, it is important to understand their underlying reasons. In a questionnaire study of 274 women in Hull, UK, one of Northern Europe's poorest cities, 527 reasons were given. The most common reason was financial constraints, followed closely by contraceptive failure. Variation between areas is to be expected, but a greater understanding of the reasons for termination of pregnancy (TOP) requests will allow commissioners and clinicians to match care with need. *See page 186*

Medical abortion drugs: under or over the counter?

Mifepristone and misoprostol have greatly improved the availability and safety of abortion. But little is known about the extent of their use – whether prescribed or not prescribed – worldwide. Phil Harvey describes how useful information collected from pharmaceutical sales data and other sources could inform family planning programmes worldwide. But he also cautions about the risks of seeking too much information in countries where abortion is officially severely restricted. *See page 193*

Uptake of post-abortion LARC increases in New Zealand, following free provision

The introduction of government funding for levonorgestrel implants in addition to copper intrauterine devices (IUDs) in New Zealand has increased the range of long-acting reversible contraception (LARC) available to women. Rose and Garrett studied the uptake of LARC immediately after abortion over a 5-year period that included the start of free implant provision, and found that LARC use increased significantly, particularly in nulliparous women and the under-20s. They conclude that the removal of cost barriers to LARC provision is likely to contribute to a reduction in the rate of unintended pregnancy. *See page 197*

A new approach to retrieving lost IUDs

While many IUDs and intrauterine systems with non-visible threads can be retrieved by simple and well-established methods, some are more difficult to locate or remove. This article describes the use of an ultrasound scanner and very fine hysteroscopic forceps to locate and grasp the threads or the device itself, allowing quick, easy removal. If the appropriate equipment and skills are available, this technique may reduce the number of women with non-visible threads who require more complex interventions, argues the author. *See page 205*

Hormonal contraception, and what bleeding means to individual women

Many kinds of meaning are important in health care, not only those that come from biomedicine. We know irregular bleeding is a common side effect of hormonal contraceptives, but how closely do we attend to what bleeding means for each individual woman? In a qualitative exploration of women's views about menstruation and contraception, Newton and Hoggart found that despite a widely held view that menstruation can be inconvenient, many women actually value having a regular bleed. For some it is an important marker of non-pregnancy, or an innate part of being a woman. Some want to experience a 'natural' menstruating body and consider bleed-free contraception acceptable only if natural periods are painful, while some women view bleeding as a form of natural cleansing. Since we know irregular bleeding is a key reason for discontinuation, this study reminds us to take women's individual perspectives – even those that appear at odds with biomedical understanding – seriously, if we want to offer effective contraceptive services. *See page 210*

A rise in contraceptive prescriptions for adolescents is not only about contraception

Contraceptives are not always prescribed for contraception, particularly in young adolescents. In their primary care-based retrospective study of prescriptions for contraceptives to 12–18-year-olds during a 10-year period, Rashed *et al.* found prescription rates increased from 3% to 5% in 2011 in the younger age group and from 26% to 35% in 16–18-year-olds, with a fall in the proportion prescribed for contraceptive reasons. Coupled with an increase in LARC prescriptions, the authors suggest that these findings might partly explain the decreasing conception rate in this age group. *See page 216*

Noteworthy statistics: Poisson regression

The article by Rashed *et al.* mentioned above employs Poisson regression as a statistical tool. The purpose of these brief explanatory notes written by Pam Warner, the Journal's Statistical Advisor, is to provide readers with some supplementary explanation of this useful statistical method. *See page 223*

Women's experiences of endometriosis

Endometriosis is common but often undiagnosed, or its symptoms dismissed. Young and colleagues have systematically reviewed qualitative literature reporting women's personal experiences of the condition, and identified four major themes: effects on all areas of life, symptoms, experience of medical care, and 'self'. They propose techniques that health professionals can use to gauge the true impact of endometriosis on their patients. *See page 225*

FGM: UK health professionals' knowledge and opinions

For her latest Consumer Correspondent article, Susan Quilliam invited a number of UK-based health professionals, from varying sexual health fields and cultural backgrounds, to voice opinions (based on their knowledge of colleagues' attitudes as well as their own) on the currently high-profile topic of female genital mutilation. The results of her survey make for interesting reading. *See page 235*