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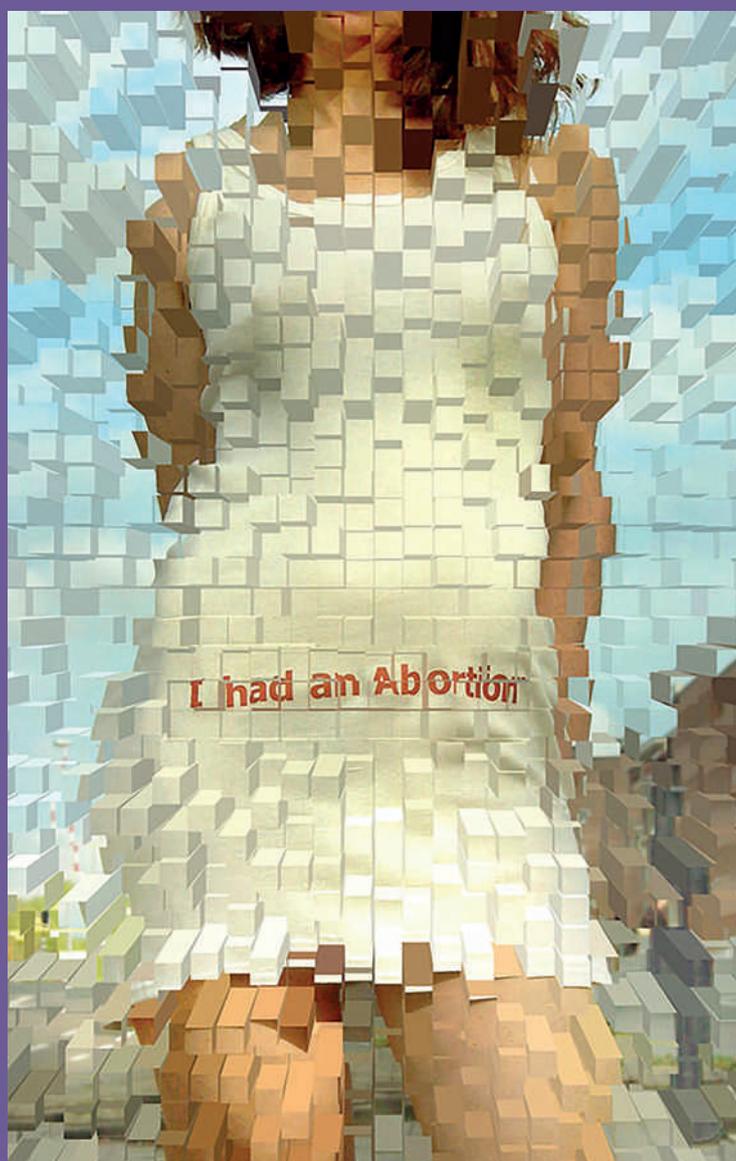
WHO DECIDES? We trust women

Abortion in the developing world and the UK

A report by the UK All-Party Parliamentary Group (APPG) on
Population, Development and Reproductive Health

EXECUTIVE SUMMARY

March 2018



Acknowledgements

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The UK All-Party Parliamentary Group on Population, Development and Reproductive Health

The UK All-Party Parliamentary Group (APPG) on Population, Development and Reproductive Health is a cross-party platform for Peers and MPs. Its purpose is to raise awareness on key development and rights issues, with a specific focus on population and sexual and reproductive health and rights. The group was established in 1979 and is one of the oldest APPGs in Westminster. It has more than 80 members with representation from all major political parties, and from both Houses in the UK Parliament.

FOREWORD

My mother, during the Blitz in the Second World War suddenly realised that she had not had a period for some time. With two little boys already and Hitler expected to invade within a few weeks, she wondered how on earth she could bring another child into what seemed a very dangerous situation. Her elder sister reassured her and said that a hot bath and plenty of gin would soon start her period. It didn't and I was the result – with a lifelong love of gin!



Other women in even more desperate situations would have risked their lives by having unsafe abortions, as they still do in many parts of the world. Gin ('Mothers' Ruin'), coat hangers, syringes, soapy water – a selection of methods used to induce miscarriage at various times and places – are all dirty and dangerous, leading to death for many women.

It is not widely known that abortion rates are roughly the same in countries where it is legally available (34 abortions per 1,000 women of childbearing ageⁱ) and countries where it is banned (37 per 1,000) and yet, 68,000 desperate women die from unsafe abortion every year in countries with no provision for safe abortion procedures. It is disgraceful that they are so condemned by their governments' failures.

There is hope however, in the increasing use of medical abortion before 12 weeks, when abortion can be safely carried out in the woman's own home. Roll on the day when a quick prescription for someone in my mother's situation all those years ago, will end the need for such intrusive medical intervention.

I hope our country will follow where Canada has led and bring our laws up to date, and encourage other countries worldwide to do likewise.

Women deserve to make their own decisions and be in control. We trust women.

Jenny Tonge

ⁱ According to the Guttmacher Institute, women of childbearing age include those aged 15 to 44 years.

EXECUTIVE SUMMARY

“It is no longer politically or morally acceptable for governments or international bodies to use arguments of culture or religion to avoid creating a supportive policy and legal framework for safe abortion that would eliminate a major cause of maternal death and injury.”

Gillian Kane, Ipas

“Access to therapeutic or induced abortion is essential to allow women to participate fully in modern life and bear only the children they wish and feel able to raise.... Women will take things into their own hands if you do not assist them and I know from bitter experience that they can die in the process.”

*Wendy Savage, retired UK obstetrician and gynaecologist,
Doctors for Choice*



Abortion rates are roughly the same in countries where abortion is legally restricted (37 per 1000 women of childbearing age) as in countries where it is readily available (34 per 1000 women)ⁱ. Restrictive abortion laws do not prevent women from seeking abortion; they only endanger women’s health and lives as women seek unsafe procedures. There is a correlation between restrictive abortion laws and higher rates of maternal mortality and morbidity. Abortion and maternal mortality rates from unsafe abortion are the lowest in Western Europe, where the most permissive abortion laws are foundⁱⁱ. The World Health Organization (WHO) has approved self-use of medical abortion pills with appropriate information and medicines: “After initial contact with a trained person to assess eligibility, women can self-manage the medical abortion process without direct supervision of a provider”ⁱⁱⁱ. Safe abortion services carry very low health risks.

Canada decriminalised abortion completely in 1988 rather than have a list of conditions that specified under what circumstances abortion was ‘legal’. Canada’s abortion rate is lower than the UK’s and Canada enjoys the lowest maternal mortality rate from abortion in the world.

Canada has managed abortion as part of standard health practice for several decades and there is no control by any civil or criminal law.



In the UK, it is time for change. The 1967 Abortion Act is now seen as outdated and no longer fit for purpose—partly as a result of new abortion technology. Patient autonomy and respect for women to make their own decisions is now seen as more important than in 1967. Paternalistic frameworks are no longer relevant in current UK healthcare and there is widespread recognition that women have the right to make decisions about their own lives and bodies.

In developing countries, the proportion of maternal mortality that is due to unsafe abortion ranges from 8 to 18%^{iv}. Maternal morbidity from the consequences of unsafe abortion is common, especially when abortion is restricted. Developing countries, particularly in Africa, bear the brunt of unsafe abortion deaths, estimated to be 22,500 to 44,000 in 2014^v. In the group of countries where abortion is completely banned or allowed in narrow circumstances, only one in four abortions are safe. Young women, poor women, and women in conflict situations are particularly vulnerable. There are many obstacles to safe abortion care including religion, stigma, lack of access, lack of information and trained personnel and anti-choice activity.

Medical abortion is making huge inroads globally and making more abortions safer. While this is good news, there is considerable work to do to train health providers and pharmacists and to ensure women know their options. While some developing countries have liberalised their abortion laws, this careful policy work continues to need support.



The UK APPG on Population, Development and Reproductive Health summary recommendations:

INTERNATIONAL

The UK Department for International Development (DFID) is commended for taking a global leadership position in abortion and for its broad portfolio of global work

1. DFID should do even more to support willing countries to expand access to safe and legal abortion
2. Expand availability of medical abortion globally
3. Work to broaden the laws to permit community and primary care health workers, pharmacists, nurses and midwives to provide abortion
4. Continue to ensure access to safe abortion to the full extent of the law, particularly in developing countries and in conflict situations
5. Increase funding for family planning and the wider sexual and reproductive health and rights agenda to 10% of official development assistance and 10% of national development budgets
6. DFID should reiterate its 2014 policy concerning abortions in conflict situations and international humanitarian law to humanitarian and other partners
7. The UK should use their voice to reinforce the importance and centrality of abortion to women's human rights and equality
8. Ensure adolescent girls and young women have access to youth-friendly and non-judgmental sexual and reproductive health services, including abortion care
9. Work to take abortion out of the criminal law and towards the release of all imprisoned women and girls and healthcare professionals who are incarcerated because of punitive abortion laws
10. Support comprehensive sexuality education through in-school and out-of-school programmes for adolescents that promote comprehensive sexuality education including information on contraception and abortion

UK

1. Decriminalise abortion completely — as Canada has done
2. The Department of Health should follow WHO guidelines and define the home as a safe place to take abortion medication in England (as is already taking place in Scotland)
3. If there are National Health Service (NHS) contracts to independent providers, they must include a commitment to training with joint contracts that allow clinicians to move seamlessly across both the independent and NHS sectors
4. Follow WHO guidelines to allow primary care workers such as nurses and midwives to manage both surgical and medical abortion in the first trimester
5. The National Institute for Health and Care Excellence (NICE) is best placed to develop appropriate clinical care pathways
6. Coordinate NHS abortion planning across the nations of the UK, so that women have timely access to high quality services. For example, a fair tariff for various types of abortion services should be agreed so there is no disincentive to treat second trimester and complex cases
7. Stop the erosion of family planning and sexual health services and instead ensure family planning and sexual health services are readily available, reducing the need for abortion overall
8. Increase understanding among politicians and policy makers with better education and information about abortion and the impact on women of restricting it and keeping it criminalised

NORTHERN IRELAND

1. The UK Government must give clear guidance on funding and a care pathway for women travelling from Northern Ireland (NI) to England for an abortion
2. Medical professionals of NI must be clear about their legal obligations to women seeking abortions
3. Build coalitions to decriminalise abortion in NI – using the momentum of the possible up and coming changes in the Republic of Ireland
4. Support research and campaign activities to combat misinformation and myths surrounding abortion in NI



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