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Introduction

Sam Rowlands

Abortion can be looked at in many ways ranging from an historical viewpoint from ancient times to the present; from the individual woman and her relationships to society as a whole; from medical and nursing care and counselling through to public health and epidemiology; from basic science such as drug development and ultrasound scan technology through to service delivery to a local population; medical versus surgical techniques; from ethical, human rights and criminal law perspectives. All these interlink. Our understanding and our ability to make improvements depend on integrating all the knowledge and skill accumulated in these many disciplines. For those whose professional lives involve working in abortion care or with the issue of abortion, it is this need for working across the boundaries of various disciplines that is often both the hardest challenge but also the greatest reward.

Global issues

Unsafe abortion has been described as a preventable pandemic [1] and unfortunately this still holds true today predominantly in the developing world. Forty-nine per cent of abortions worldwide are unsafe; this amounts to 22 million unsafe abortions per year [2]. Unsafe abortion accounts for 13% of maternal mortality; it results in 47,000 deaths annually, 98% of these in low-resource countries [3]. As many as five million women in low-resource countries are admitted to hospital each year as a result of complications of unsafe abortion [4]; it has been estimated that in one year (2006) this cost between 460 and 550 million US dollars [5].

It is encouraging that harm-reduction programmes such as the *Initiativas Sanitarias* in Uruguay [6] have been developed which demonstrably reduce morbidity and mortality. It is, however, disappointing that we still see the wealthiest (US) donors (USAID, Bill & Melinda Gates Foundation, for example), who fund reproductive health projects designed to reduce maternal mortality, specifying that not a single dollar can be spent on any activity that could possibly be construed as relating to abortion. This even applies to women who have been raped in zones of conflict. Fortunately some high-resource Western European countries have no such inhibitions: examples are the Swedish International Development Cooperation Agency (Sida) and the UK Department for International Development (DFID) as well as funds from Denmark, Finland, the Netherlands and Norway [7].

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Attitudes to abortion

Attitudes play an enormously important part in abortion care – among society in general, politicians, policy makers, health professionals and women themselves. Attitudes to abortion tend to be very polarized in a minority of the population. This is manifest in groups at opposite extremes: for instance those pressing for further liberalization of the law and those organizing anti-abortion protests outside clinics. We should never forget the dedicated healthcare providers who have been subjected to violence (including assassination) by anti-abortion extremists in North America and Australasia [8,9].

Opinion polls consistently show a majority of the population in favour of women's access to abortion on health and socio-economic grounds in most European countries, but politicians are sensitive to extreme anti-abortion views among their constituents and, predominantly in countries in which Roman Catholic doctrine holds sway, to the views of the church. When it comes to voting in Parliaments, politicians can be very conservative.

When women request an abortion, they may come up against hostile attitudes among their family and friends and from healthcare professionals. These pervasive attitudes are based on how society and its laws and policies represent abortion. Women often internalize the stigma which leads to unhealthy self-censorship and secrecy. Those providing abortion care need to be careful that the settings in which they work are, to the greatest extent possible, free from stigmatization of the women coming through their services. It is shocking that the shame and secrecy associated with abortion pushes women into seeking clandestine procedures, thereby contributing to maternal morbidity and mortality especially in the developing world.

Evolution of methods, types of provider and service models

Vacuum aspiration can be traced back as far as the 1860s when it was described by James Young Simpson of Edinburgh [10]. The concept of having an abortion without being admitted to a hospital bed overnight was developed in the 1970s. The development of manual vacuum aspiration has been a big advance, because of its simplicity and cost-effectiveness, although in many settings it has still not been widely adopted.

The concept of medical abortion was not present in medical practice when many countries' current abortion laws were passed. We have seen the development and introduction of drugs (prostaglandins in the 1960s and mifepristone in the 1980s) that have radically changed the face of treatment options. Hence, in countries with less restrictive abortion law, medical abortion under the care of health professionals but at home can be offered; even in countries with highly restrictive abortion laws self-administration of medical abortion drugs without the involvement of health professionals leads to reduced abortion-related morbidity and mortality [11].

In terms of service provision, it seems that criticisms of over-medicalization and over-reliance on doctors have been heeded. Engagement of non-physicians (mid-level providers) is now well-established and such services evaluated as not inferior in terms of safety and acceptability. This kind of multidisciplinary collaboration makes for more holistic and cost-effective care and is highly acceptable to women.

There have been many other valuable developments in models of service delivery.

- Access can be facilitated by use of appointment systems that allow women direct access without referral by a primary healthcare professional.

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- Communication and consultations by telephone, fax, email or video-link can reduce delays and long journeys and this can be particularly valuable for women with medical conditions who will need more specialized care, allowing them to be identified at an early stage and directed along an appropriate care pathway.
- When there is no legal imposition of a 'cooling-off period', assessment and treatment can often be combined on the same day thereby further reducing delays and journeys.
- Use of cervical preparation reduces complications of abortion and makes procedures easier and quicker.
- Contraception can be initiated on the day of abortion in most cases.
- Follow-up regimens can be simplified to reduce the number of consultations required without compromising safety and effectiveness and allow women to move on with their lives swiftly after the event.

Regulation by laws and policies

About 26% of all people live in countries in which abortion is generally prohibited: abortion permitted to save the woman's life only or prohibited altogether applies in 69/203 jurisdictions [12]. The most restrictive laws tend to be in the countries of Central and South America, Africa, the Middle East and the Far East.

Regulation by criminal law is still the case in all countries except Canada and three Australian states (Australian Capital Territory, Tasmania and Victoria) [12]. This perpetuates a chilling effect on clinicians taking part in abortion care and on women with unwanted pregnancies who continue to look towards clandestine providers or increasingly nowadays drugs on the internet. For example, in Northern Ireland (part of the UK) doctors feel they cannot offer abortion to a woman with an anencephalic fetus because of uncertainties in interpretation of the law. It is inhumane that women around the world continue to be sent to prison for procuring their own abortion.

Alongside medical advances, we have seen significant shifts in legal and policy approaches to abortion. Following several decades of progressive liberalization of abortion laws in many countries, there has been a backlash in a few European countries (Macedonia, Russia and Slovakia – and threatened in Lithuania and Spain). Those in power who resist liberalization should appreciate not only is it the case that where abortion is legal on broad socio-economic grounds and at a woman's request, both unsafe abortion and abortion-related mortality and morbidity are reduced [13]; but also, that the proportion of women living under liberal abortion laws is inversely related to the abortion rate in the regions of the world [2].

However, a liberal law is not everything. India and Zambia are examples of countries that have had liberal abortion laws since the 1970s but, due to poor services and procedural barriers, safe abortions are hard to come by [14]. Either interpretation of the law or how a country's Health Department/Ministry decides to deal with abortion can to a great degree determine the actual availability of abortion services. Necessary conditions include the dissemination of knowledge about the law to providers and women, the development of guidelines for abortion provision, the willingness of providers to obtain training and provide accessible services and government commitment to provide the resources needed [2]. Obstacles may well be encountered; International Planned Parenthood Federation have developed a tool for assessing procedural barriers to the provision of and access to safe abortion services [15]. On the international stage the influence of the United Nations

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treaty bodies, with its extension from public health concerns to a dignity-based approach, is increasingly being felt.

Making abortion legal, safe and accessible does not appreciably increase demand for abortion [1]. Rather, the principal effect is to reduce the number of clandestine and unsafe procedures, in favour of legal, safe abortions. By reducing or eliminating the need for unsafe procedures, the liberalization of abortion law increases women's chances of surviving the procedure and improves their subsequent health.

Aims

This book attempts to assemble the main evidence to date on abortion care. The authors sincerely hope that dissemination of this evidence will contribute to improved effectiveness and safety of treatment for women. It is acknowledged that the book does not cover all the practicalities of how to provide a service. Readers are directed to a comprehensive chapter in the World Health Organization guidance on this [13] together with the *Clinical Practice Handbook for Safe Abortion* [16].

The book title is Abortion Care, not Abortion Treatment, to signify the need for clinicians to be concerned, not just with effective treatment, but with quality of care based on compassion, respect and acknowledgement of an individual's autonomy and dignity. It is hoped that the multidisciplinary approach to abortion care reflected in this book will inspire readers and stimulate thought, research and action to provide even better care for women in the future.

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Chapter 1

An historical perspective

James Drife

There are many possible perspectives on the history of abortion, but this chapter will limit itself to three interlinked questions. Did past generations of women have access to effective methods of abortion? How commonly was abortion practised? And what were society's attitudes towards it? All three questions are hard to answer until we come to the nineteenth century. Up till then historical sources were written mainly by men and tell us little about women's reproductive health. Indeed, until the late twentieth century, abortion was carried out in secret and rarely mentioned in medical texts.

Today abortion is widely debated and the main problem for the internet user is to distinguish fact from misinformation (see Chapter 19). In the past, however, the subject was taboo, which tends to give us the impression that the history of abortion dates from some time in the twentieth century. This idea is swiftly dispelled by a brief search of *The Lancet* and the *British Medical Journal* (BMJ), whose online archives stretch back to the 1830s and 1840s respectively. These have provided much of the information in this chapter, giving it a mainly UK perspective. The chapter will be limited to the time before the British Abortion Act of 1967.

Methods of abortion

Throughout history, drugs taken as abortifacients have ranged from poisons to placebos. Intravaginal honey and crushed dates were mentioned in the Ebers papyrus from ancient Egypt, and herbs and mercury in Chinese texts. The Greek philosopher Plato (428–348 BC) wrote that midwives, 'by means of drugs and incantations are able to … cause abortions at an early stage if they think them desirable' [1]. Methods taught by Hippocrates (*c*. 460–370 BC) and Soranus (second century AD) included physical exercise, massage of the uterus, a tight belt, diuretics, enemas and venesection – all of them ineffective. More than half the surviving medical texts from ancient Rome [2] gave methods for abortion, some of which may have worked. Silphium, an abortifacient plant from North Africa, was harvested to extinction, and hellebore ('Christmas rose'), which was potentially lethal to the pregnant woman, was an ingredient of 'abortion wine'.

The choice between ineffective and harmful medication continued for the next two millennia. In Britain in 1843 the *Provincial Medical Journal (PMJ)*, forerunner of the *BMJ*, recorded that a woman aged 17 almost died after a mid-trimester abortion produced by 'pills of unknown composition'. (Trying to save her life, the doctors treated her with mercury,

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opium and venesection – a combination probably more dangerous than the original pills.) In 1844, a report of the trial of an abortionist listed fatalities resulting from the use of savine (juniper) or ergot of rye, and counselled against the use of either (for references, see Drife [3]).

Surgical intervention in ancient times was probably limited to late pregnancy. Surgeons' tools included an annular blade and a hook for extracting the fetus, which were used in obstructed labour when the pregnant woman's life was in danger. 'Such apparatus', said one author, 'was possessed by Hippocrates … and even the milder Soranus.' Instructions for instrumental abortion are contained in Persian texts of the tenth century [4].

After that we have little information about surgical abortion until the nineteenth century. It was specifically outlawed in England in 1803, so it must have been practised before that time. In the 1850s there were reports of the death of a woman after surgical abortion by a 'quack' doctor, and the prosecution of 'two persons calling themselves surgeons'. These cases helped to bring about the establishment of the UK medical register in 1858 [5]. Thereafter surgical abortion was practised by both qualified and unqualified men. In 1869 *The Lancet* recorded a criminal conviction after a non-medical 'abortion-monger … passed some instrument into the uterus', and in 1885 a Mr Sprow was convicted of procuring abortion: his 'terms were £15 a year for any number of operations required to keep a married woman free from children' [3].

Prosecutions of women were rare, perhaps because they preferred medical methods, although in 1896 a midwife was sentenced to death for procuring an abortion which ended with the death of the woman. Earlier, in 1843, a leading article in the *PMJ* stated: 'We have heard of a French hag, living somewhere near Marylebone Lane, who enjoys no small share of fame for her success, the means which she employs consisting in the daily administration of the oils of pennyroyal and savine, with a violent cathartic at intervals of two or three days' [6].

Self-abortion came to public attention only when it had a fatal outcome. In 1831, for example, *The Lancet* reported a case from Paris in which a woman, pregnant with her fifth child, had injected sulphuric acid into her vagina on the advice of a female neighbour. The pregnancy nonetheless went to term. With the vagina obliterated, caesarean section was attempted (a drastic step in that pre-anaesthetic era) but mother and baby died.

Infanticide was an option for some. In 1837 *The Lancet* recorded that 'bodies of infants are often found in parts of dwelling houses, not infrequently in privies, or in gardens adjoining houses' [7], and in 1869 the *BMJ* reported 'mill-ponds, in the neighbourhood of factories, that have been made the receptacles for many a new born child'. In 1873 the British Medical Association (BMA) lobbied for the legal registration of stillbirth, asserting that 'children killed during birth and after birth are doubtless buried as still-born'. It cited a case 'at Plymouth, where one midwife appeared at a cemetery so constantly with the bodies of children for burial as still-born, that suspicion was excited'. Stillbirth registration, however, was not introduced in England and Wales until 1927 [3].

By the twentieth century most abortions carried out by British doctors were surgical. The royal gynaecologist, writing in 1921, stated that in 35 years of private practice he had carried out only 57 abortions, all of them for life-threatening indications such as placenta praevia, breast cancer and 'mental aberration' leading to intractable vomiting. For late abortion he used a specially made bag to dilate the cervix and induce labour, adding: 'I know of no more difficult vaginal operation than the removal of a 16–20 weeks' pregnancy by means of ovum forceps after rapid dilatation' [8].

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For criminal abortion a wide variety of methods were used. Of 23 cases reported in Glasgow 14 involved drugs, including ergot, and 9 the use of instruments including a knitting needle, a crochet hook and a catheter. A survey in Liverpool classified methods as: (1) general violence, including rolling downstairs; (2) internal administration of drugs (which had to be given in large enough doses to endanger the life of the woman); (3) direct violence, including uterine sounds and umbrella ribs; and (4) injection of fluids such as soap solutions. In cases fatal to the pregnant woman, death was either quick, due to shock or air embolism, or a lingering process due to sepsis [9].

In 1950 a large review in a working-class suburb of London reported that most abortions were self-induced, either medicinally or with douching, usually with soapy water, and that 'a curious specialty of the district was a tablespoon of powdered ergot taken in a wineglassful of hot port' (an echo of 'abortion wine'). The report added that 'midwives and others acting as professional abortionists' usually preferred a douche but some 'stirred up' the uterine contents with a long sound. All but one of the six deaths in this review followed douching, rather than intrauterine manipulations [10]. One woman had injected fluid from a syringe with such force that she ruptured her uterus.

A description of a typical British abortion service appeared in 1951. It was organized around a dance hall: clients were directed to the railway station where they were met by a car and given further instructions. 'The gentleman who carried out the abortions charged anything from 20 to 100 guineas', and the method was evidently surgical: of the 89 deaths in this report the commonest cause was peritonitis. By then, however, many abortionists provided prophylactic sulphonamides, and the proportion of deaths caused by haemorrhage and air embolism was increasing [11]. The fees varied according to the woman's means. In the USA, Kinsey reported that the financial cost of abortion 'appears to vary directly with the age of the patient but is least for hospital staffs' [3].

Frequency of abortion

Estimates of the incidence of abortion can be made when relevant data are available, which limits them to classical and recent times. In the early Roman empire the population declined despite an apparently ample food supply, suggesting effective methods of fertility control were being used. The decline was restricted to upper-class Romans, according to one authority, who concluded that they used both effective and ineffective contraceptives in addition to 'the unashamed practice of abortion' and perhaps also infanticide [2].

Population records in Britain show rapid growth during and after the industrial revolution, but give little detail about the wretched conditions in which workers lived. The population of Manchester grew from under 330,000 in 1801 to over 2,350,000 in 1901. Slum-dwellers could not cope with large numbers of children and the size of the average UK family decreased from 5.5 children in 1871 to 2.4 in 1921. This seems to have been due to a combination of contraception (mainly coitus interruptus) and abortion, which had become common by the mid nineteenth century. It was not necessarily associated with a high maternal mortality rate by the standards of the time. In 1843 the *PMJ*, commenting on the prosecution of an abortionist, added: 'we cannot help thinking, both from our own experience and from that of many of our professional friends, that the number of instances in which this crime is perpetrated successfully, and without detection, is out of all proportion to the comparatively small number of cases that are found out and punished' [6].

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Although the availability of abortion must have been common knowledge, it was off-limits for nineteenth-century writers of fiction. Elizabeth Gaskell (1810–65) showed her readers harsh reality in the seduction, prostitution and suicide of the heroines of her novels, but abortion would have been a step too far. She was the wife of a Unitarian minister in Manchester but she knew about abortion: when her friend Charlotte Brontë died in early pregnancy from hyperemesis gravidarum, Mrs Gaskell wrote in a letter: 'How I wish I had known! I do fancy that if I had come, I could have induced her, – even though they had all felt angry with me at first, – to do what was so absolutely necessary, for her very life. Poor poor creature!' [12].

By the beginning of the twentieth century requests for abortion to obstetricians were apparently becoming commonplace. Letters to the *BMJ* claimed that: 'The crime is now looked on in fashionable circles as no crime at all, and women are not a bit ashamed of asking a physician to commit the crime of foeticide' and that 'the diminishing birth-rate is due in a very large measure to the unblushing, wholesale and systematic practice of inducing abortion'. The number rose in hard times. In 1920 *The Lancet* noted 'the increase of the practice of abortion during the circumstances produced by the war, the public conscience being dead to it' and in Germany in the 1920s criminal abortion increased 'with the proportion of abortions to births reaching 1 to 2 in Hamburg and over 4 to 5 in Berlin' [3].

In England in 1932, a professor of midwifery wrote, somewhat coyly: 'The man in the street knows perfectly well that on the Continent he can arrange for an undesired pregnancy to be terminated, and I have heard it stated that if he knows his way about it he need not trouble to leave this country; the necessary medical indication will be found.' He pointed out that according to the League of Nations, 'as a cause of maternal deaths abortion has become more important than delivery at term'. Mentioning a British woman who died after an illegal abortion, he added: 'I cannot help feeling that, had that para-8 consulted her own doctor, the pregnancy might very rightly, properly, and safely have been terminated, not illegally, but after full consideration of the medical indications involved' [13].

In 1937 a Ministry of Health inquiry into the high rate of maternal mortality in Britain noted 'frequent assertions … that women became debilitated … as a result of the repeated and prolonged use of aperients and other drugs taken with the object of terminating pregnancy' and 'it seems evident that the practice of artificially induced abortion is increasing, is more prevalent in some districts than in others, and is not restricted to any one social class'. The enquiry concluded that 14% of all puerperal maternal deaths were due to abortion, 'excluding deaths from abortion classed as criminal' [14].

Others estimated that abortion accounted for 25% of maternal mortality in England at that time. Similar concerns had emerged in New Zealand. Evidence of the frequency of abortion in England in the 1950s comes from the Confidential Enquiry into Maternal Deaths (CEMD), established in 1952. In its first report abortion was the third leading cause, after hypertensive disease and haemorrhage. Over 80% of maternal deaths from abortion were among married women. Only two women were classed as 'well to do', suggesting that the rich consulted experts working in clean premises (Figure 1.1) [15]. Deaths from other causes continued to fall, and after 1958 abortion became the leading cause of maternal death by an increasingly large margin.

In 1959 a television programme featuring two girls who had had illegal abortions estimated the incidence as '150 a day in Great Britain'. In 1966 estimates varied from 87,000 annually to 100,000, which was the figure published in the Official Report of Parliament, Hansard. It seems likely that the rapid increase of legal abortions in 1968–72 after the

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Table XI

Circumstances	*Single*	*Married*
Well to do … …	1	1
Comfortable … …	12	42
Poor … … …	3	20
Destitute … …	—	1
Not noted … …	6	21
	—	—
	22	85
	—	—

Figure 1.1 Social class and death from abortion, England and Wales, 1952–4 [15].

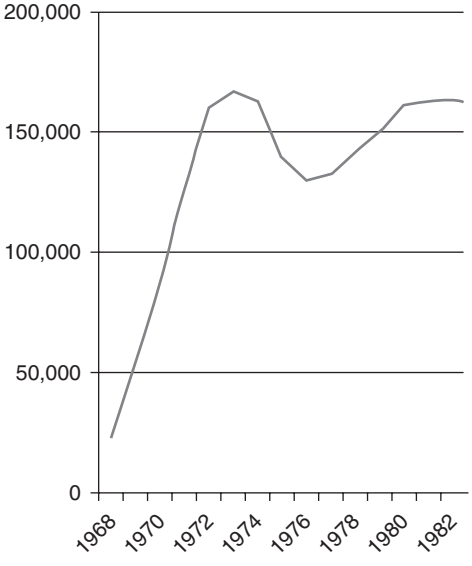

Figure 1.2 Number of legal abortions in England and Wales, 1968–82 (source: 'Abortion Statistics for England and Wales' annual bulletins, Office of Population Censuses and Surveys).

Abortion Act came into force was not due to an increase in abortion but simply to the introduction of a system in which abortions were officially counted (Figure 1.2). Legalization was followed by a dramatic fall in deaths from criminal abortion and also from 'spontaneous' abortion, most of which had in fact been due to interference (Figure 1.3) [16].

Attitudes to abortion

Philosophical attitudes

Philosophy in ancient times encompassed both science and religion. Aristotle taught that the soul enters the body after conception – at 40 days in the case of a male embryo and at 90 days for a female embryo. Muslim scholarship put the process of 'ensoulment' anywhere between 42 and 120 days. Aristotle also wrote that abortion should be carried out before

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