

| Abortion in Australia | Public Health Perspectives |

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PUBLIC HEALTH ASSOCIATION
of Australia Inc

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| Abortion in Australia |

Access to safe abortion services is an important public health issue for women and their families and should be considered in the framework of women's health and human rights.

The Public Health Association of Australia (PHAA) supports the 2004 World Health Organisation statement that the highest priority in relation to unsafe abortion is the prevention of unplanned pregnancies. WHO state that 'this can be achieved by improving access to quality family planning services, followed by improving the quality of abortion services and (where legal) post abortion care' (WHO, 2004).

PHAA believes that reducing unplanned pregnancy in Australia is a complex challenge requiring careful planning. It would be greatly assisted by the development of a national comprehensive sexual and reproductive health strategy. This would include equitable access to affordable contraception, comprehensive sexual health education, comprehensive uniform national data collection and decriminalised abortion services in a community climate of tolerance and understanding. PHAA supports post abortion care which includes woman-focussed pre and post abortion counselling, addressing a wide range of issues, including women's relationships, finances, abuse and violence, work situation and access to childcare.

PHAA strongly believes the criminal law is an inappropriate vehicle – both in principle and practice – for regulating the provision of abortion. PHAA contends that all reference to abortion should be removed from the criminal laws and codes of the States and Territories of Australia, and should be regulated, as are all other medical services, under the health care legislation. Further PHAA believes that adequate index-linked Medicare rebates for abortion are important to ensure equitable access to safe abortion for all Australian women.

World Health Organisation. 'Unsafe Abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000. 4th edition. Geneva, 2004

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PUBLIC HEALTH ASSOCIATION
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| PHAA Abortion Policy |

The Public Health Association of Australia recognises that:

- 1| Access to abortion services is an important women's health issue and there is a wide range of ethical and religious beliefs regarding abortion in the Australian community.

The Public Health Association of Australia notes that:

- 2| The health status of women and their children is enhanced when safe, reliable methods of fertility control are available.
- 3| Before 1971, abortion was a major cause of pregnancy-related deaths in Australia. Since then, abortion deaths have been very rare, and usually occurred in women with multiple pre-existing health problems.¹
- 4| Complication rates associated with abortion are reduced when abortion services are readily available and abortions are done early in pregnancy.
- 5| A significant proportion of all Australian women undergo an abortion at some stage during their reproductive lives. Therapeutic abortion is the third most commonly performed gynaecological procedure.
- 6| The Australian legal framework does not allow the decision to abort a pregnancy as a matter for individual conscience and medical advice. The law pertaining to abortion is located in the criminal statutes and codes. The criminal law is an inappropriate vehicle - both in principle and practice - for regulating the provision of abortion.

The Public Health Association of Australia resolves that:

- 7| The primary public health goal in the area of unplanned pregnancy must be prevention. Educational, social and health service programs are required to improve information and access to planned parenting choices.
- 8| All reference to abortion should be removed from the criminal laws and codes of the States and Territories of Australia. Abortion should be regulated, as are all other medical services, under the health care legislation. There is no case for singling out the abortion procedure in any area of legislation.
- 9| Abortion services should be made available, safe and equitable.
- 10| Medicare rebates for abortion should provide adequate recompense.
- 11| The Executive Committee of the Association should undertake immediate action to ensure that all members of the Senate and House of Representatives are made aware of the views of the Association and the health consequences of any restriction of access to safe, affordable abortion services.

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Adopted at the 1989 Annual General Meeting of the Public Health Association of Australia, amended at the 1996 Annual General Meeting and reaffirmed by the PHAA Board in 2005.

FACT SHEET 1|

Abortion in Australia: Facts and Figures

There are currently no complete national statistics on abortion in Australia. Statistics are inferred either from Medicare data, from representative surveys or data from those states where abortion is notifiable under state legislation, such as South Australia. As methods for quantifying national abortion numbers, these methods all have serious limitations.

MEDICARE DATA

Abortion services are currently provided in a variety of settings, including in public and private hospitals, freestanding clinics and directly through specialist practitioners. Abortions for which a Medicare fee rebate is claimed are recorded by the Health Insurance Commission. While there is no specific Medicare Benefits Schedule Code for abortion, it is believed that most are classified under the code 35643 (evacuation of the contents of the gravid uterus), or code 16525 (management of second trimester labour, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease). The limitations of collecting data this way are:

- An unknown number of 35643 and 16525 claims are performed for procedures other than termination of pregnancy, for example treatment of miscarriage.
- Abortions may be classified under other Medicare Codes, as codes are for procedures and not diagnoses
- Medicare data do not include:
 - Public patients in public hospitals
 - Patients who do not make a Medicare claim (estimated at between 13-33% of women undergoing a termination [Nickson, Smith and Shelley, 2004]).
 - Terminations conducted after 24 weeks.

In 2004 there were just under 73,000 Medicare claims made for procedures which could have been abortions (see HIC website in References). Over the last decade, the number of Medicare claims under these codes has decreased by 22%.

Current methods of quantifying national abortion data in Australia are inadequate

A comprehensive uniform national abortion data collection strategy should be a policy priority for broad consultation within an overall national sexual and reproductive health strategy

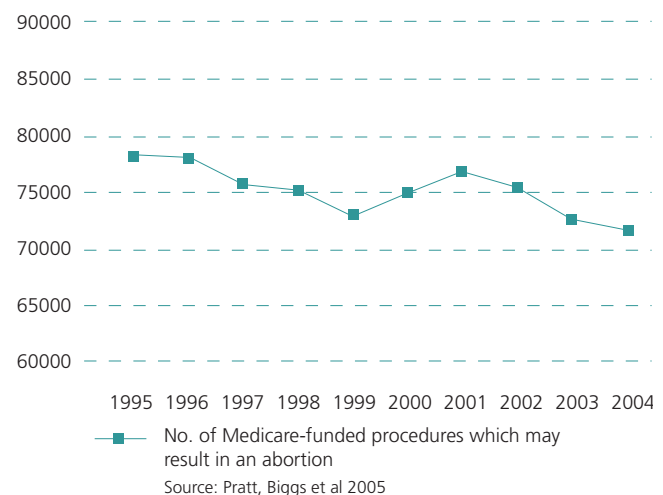
Rates of abortion have fallen over the last decade

Second and third trimester abortions constitute a tiny proportion of those performed annually

Teenage abortion rates are high, but the overall teenage pregnancy rate has been declining

Index-linked universal health insurance is essential to access and equity in abortion provision

Medicare claims from procedures which may result in an abortive outcome, 1995 - 2004



SOUTH AUSTRALIAN STATE DATA: TEENAGE PREGNANCY AND ABORTION RATES

Data from the South Australian Pregnancy Outcome Unit, Department of Human Services, South Australia, indicate that over the past 30 years, teenage women have been accounting for a declining proportion of pregnancies in South Australia: in 1995-99, they accounted for 9.1% of all pregnancies, 5.4% of births and 21.3% of abortions. An increasing proportion of the diminishing number of teenage pregnancies is being terminated, from 21% in 1970-74 to 53.8% in 1995-1999 (van der Klis, Westenberg et al, 2002).

SURVEY DATA

Surveys of women's reproductive histories are another source of information, although such data can only generate an estimate of the number of women having terminations.

The Australian Study of Health and Relationships (Smith, Rissel, et al 2003) surveyed a large representative sample (n=9134) of Australian women aged 16 to 59 and found that nearly one in six women (17%) had had an abortion.

The highest percentage was found in the peak reproductive age group (20-29 years). One explanation for the low rate found in the 50-59 year old age groups, is the lower availability, political, legal and social acceptance of abortion during the lifetime of women of this age. 4% of 16-19 year olds had ever had an abortion.

These methods of national abortion data collection have serious limitations. In order to facilitate the accurate collection of national abortion statistics, abortion should be removed from the Criminal Code in all Australian states and territories (see Fact Sheet 5). Following a comprehensive consultation, recommendations should be made to all state health departments to ensure reporting of all terminations from any practitioner or health facility to state based public health information data units. Such a data collection strategy should be coordinated and reported at the national level as part of a more comprehensive national sexual and reproductive health strategy.

SECOND AND THIRD TRIMESTER ABORTIONS

First trimester termination of pregnancy is always preferable, because of a lower risk of complications. It is less expensive and less burdensome for women, and there may be more time to prepare for the procedure.

The number of abortions performed after 20 weeks gestation represents a very small percentage of abortions performed each year.

Between 1998 and 2002 in Western Australia, 95% of all abortions were performed before 20 weeks gestation (Dickinson 2004). Of the abortions performed after 20 weeks, 74% of these were performed between 20 and 23 weeks gestation. In South Australia, between 1994 and 2002 the vast majority of abortions took place before 14 weeks gestation and less than 2% of abortions took place at or after 20 weeks (Pratt, Biggs et al, 2005).

Lifetime termination experiences			
9,134 women	Ever Pregnant (%)	Termination (% of those ever pregnant)	Ever had a termination (% of all respondents)
AGE			
16-19	16%	22%	4%
20-29	44%	34%	15%
30-39	87%	24%	21%
40-49	92%	24%	22%
50-59	94%	14%	13%
TOTAL	76%	23%	17%

(N.B. Table generated for this paper)

Perinatal deaths as a result of termination of pregnancy in Victoria, 2003 by cause and type.

	Number	%
Congenital abnormality	116	53
Psychosocial indications*	103	47
TOTAL	219	100

Source: The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2004.

*50% of these are to women residing outside Victoria.

The definition of psychosocial indications differs within the legislation among different states. When psychosocial reasons for second and third trimester abortions are cited, this generally refers to serious mental illness of the mother.

An increase in the number of second and third trimester abortions being performed is likely to be due to women choosing to have babies at an increasingly older age, and the improvement of screening and testing for congenital abnormalities during pregnancy. As a result of increasing uptake of prenatal ultrasound and diagnostic procedures, congenital abnormalities are now frequently being diagnosed and leading to termination of pregnancy (CCOPMM, 2004). 88% of Australians are in favour of termination when there is likely to be a birth defect (Kelley and Evans 2003).

Socio-demographic characteristics associated with termination of pregnancy - poverty, access and equity.

An association between socioeconomic disadvantage and higher levels of termination has been found (Tennant, Hetzel and Glover 2003). Young Australian women in abusive or violent relationships (also more likely to be disadvantaged) are four or five times more likely to seek abortion than women not in such relationships (Taft, Watson, et al 2004).

Maintaining an adequate Medicare rebate linked to the Consumer Price Index is particularly critical for vulnerable women on low incomes. Any restrictions to the Medicare rebate would force more women into delayed decision-making because of financial difficulties. This could result in later and more harmful abortion. Restrictions would bring back the gross inequities of the pre-Medicare era, when economically secure women could always get safe abortions, but less well off women could not. If Medicare rebates were not available for abortion, then those most disadvantaged will be women already in poverty. Teenage women, rural women and women from minority or ethnic groups.

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FACT SHEET 2| Abortion in Australia: Community and Health Practitioner Attitudes

COMMUNITY ATTITUDES

The recent 2003 Australian Survey of Social Attitudes which canvassed the views of a random sample of 4,219 Australian voters (discussed in Betts 2004) found that 81% of those surveyed believed a woman should have the right to choose whether or not she has an abortion.

This finding has been replicated in other recent studies. The majority of respondents in a community study in Queensland, commissioned by Children by Choice, found that 85% believed the decision about abortion should be left to the individual and her doctor, (Children by Choice 1999). The Australian Election Survey conducted in 2001 found that 58% believed a woman should be able to get an abortion readily, with a further 36% supporting abortion in certain circumstances (de Vaus 2004). The figure of 58% support for ready access to abortion represents an increase from 39% in the 1987 Election Survey.

Other commercial public opinion polls carried out from the mid 1970s through to the mid 1990s also demonstrate that the proportion of Australians giving unqualified support for access to abortion rose from around 30% percent to around 50% (in Betts 2004).

There is evidence that public opinion has remained steady in support of women's right to access abortion services rather than wanting further restrictions (Kelley and Evans 2003) or become increasingly liberal (Betts 2004; deVaus 2004).

Income and education are also influential in shaping opinion, with graduates and those on higher incomes being more supportive of a woman's right to determine whether or not she has an abortion (Betts 2004). There are few differences in views between men and women in any of the studies conducted.

Religion appears to be the most influential factor, with 93% of people who have no religion supporting a woman's right to choose compared to 77% of those who do have religious affiliations (Betts 2004). Nevertheless, 72% of Catholics agree that a woman should have the right to decide whether she has an abortion, with only 15% favouring restriction. The most marked difference is for evangelical protestants (Baptists, Lutherans and Pentacostalists) where 36% disagreed with a woman having the right to choose. On the other hand, even within this conservative group, the majority supported a woman's right to choose (53%).

The majority of the Australian population and Australian GPs agree that all women should have access to abortion services

Research shows that support for abortion services has either remained steady or become more liberal over the last few decades

The strength of community views about a woman's right to access abortion is influenced by the reasons for which an abortion is sought:

94% in favour if the woman's health is in danger

92% in favour for the victims of rape

88% in favour if there is likely to be a birth defect

65% in favour in situations of poverty

63% in favour for unmarried women

59% in favour for married women wanting no more children

(Kelley and Evans 2003)

It is overwhelmingly clear that the majority of Australians support liberal access to abortion.

HEALTH PROFESSIONAL ATTITUDES

A recent study of 2,495 general practitioners in all Australian states and territories found that 85% of Australian GPs believe that women should have access to abortion services (Marie Stopes International 2004).

Of concern was the finding that 37% of Australian GPs feel that they do not fully understand the abortion laws in their state or territory, and only 25% are aware of laws in their state or territory relating to abortion services for minors.

There is some evidence of clinician support for later trimester abortion. De Crespigny and Savalescu report a survey of Australian clinical geneticists and obstetricians specialising in ultrasound that found approximately 75% support for termination for fetal dwarfism at 24 weeks (de Crespigny and Savalescu, 2004).

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FACT SHEET 3|

Sexual Health Education

Achieving the public health goal of reducing the number of unwanted pregnancies is a complex process. The provision of comprehensive, honest and open sexual health education to all adolescents in Australia, including information on a diverse range of contraceptive options is firmly supported by PHAA. Equally important is ready access to a range of affordable contraceptive options, including emergency contraception.

Sexual health education in schools is the responsibility of individual state and territory education departments, and currently the nature and amount of sexual health education provided varies across Australia (Skinner & Hickey, 2004; Williams & Davidson, 2004). The Commonwealth-funded classroom resource *Talking Sexual Health* (ARCSHS, 1999) was endorsed by all states and territories in 1999, but the focus of this framework document is education about STIs, HIV/AIDS and blood-borne viruses. There continues to be no uniform, national sexual health curriculum in schools.

Of countries with reliable statistics, the Netherlands has the lowest abortion rate, and the lowest teenage pregnancy and abortion rate (UNICEF 2001).

Some of the reasons advanced to explain these lower rates in the Netherlands include that:

- sexuality is considered a normal and healthy part of life for adults and adolescents;
- sexual health education begins at an early age, is positive and non-judgemental, and not aimed at scaring adolescents; and
- contraceptives have been readily and inexpensively available to people of all ages since the 1970s (Ketting and Visser 1994).

In contrast, the teenage pregnancy rate in the US is almost eight times higher than in the Netherlands (UNICEF 2001). For some time federally-funded programs in the US aimed at reducing the teenage pregnancy and abortion rates have promoted abstinence-only-before-marriage. Reviews of these programs show that they fail to delay sexual activity, sometimes lead to increased sexual activity and have been shown to increase pregnancy rates in partners of male participants (DiCenso et al 2002; Minnesota Department of Health, 2004).

The rate of teenage pregnancy in Australia is lower than in the US, but still four times higher than in the Netherlands (UNICEF 2001). For sexual health education in Australia to be optimally effective, it is important that programs:

- are provided consistently nation-wide;
- are based on available evidence about what makes sexual health education effective;
- provide students with a wide range of contraceptive and service options;
- are open and non-judgemental; and
- become more comprehensive and less disease-focused and compatible with the ways in which young people currently live their lives (Chan and Bradford 2004).

A nationally uniform schools sexual health curriculum including a focus on reducing unwanted pregnancy is recommended.

Sexual health education should embrace positive relationships and sexuality, options for contraception, the prevention of sexually transmitted infections, and issues of abuse and violence.

Rigorous evaluation of sexual health education programs continues to be critical to assess effectiveness in achieving public health objectives, including the reduction of unwanted adolescent pregnancy.

However it needs to be acknowledged that evidence to date about the effectiveness of sexual health education for improving reproductive health outcomes such as unwanted pregnancy, has been mixed.

Although some published reviews have found that sexual health education:

- does not lead to earlier sexual behaviour (Baldoet al 1993; Kirby 2001);
 - increases both the intention to use condoms, and the actual use of condoms (Kim et al 1997; Franklin et al 1997; Kirby 2001); and
 - may decrease the number of sexual partners (Kim et al 1997; Jemmot & Jemmot 2000);
- the combined findings from randomised trials have been less positive.

A systematic review of 26 school, community and clinic-based programs tested in trials from the US and Canada, (DiCenso et al 2002), and two subsequent large trials in the UK - one of a specialised teacher-led program (Wight et al 2002) and the other of peer-led sex education in schools (Stephenson et al 2004) - found that participation in the intervention programs:

- did not delay the initiation of sexual intercourse, (except for girls in the peer-led trial);
- did not improve the use of birth control; and
- did not reduce pregnancies in young women.

Many of the school-based trials evaluated new programs aimed at improving existing sex education and compared these with the current programs. It may be that additional benefits are hard to achieve. Students were more satisfied with peer-led education, but over half the girls wanted single-sex classes (Stephenson et al 2004).

Attempts to improve sexual health education must continue to be rigorously evaluated to ensure changes result in improved effectiveness. Moreover, improving sexual health education in schools must be seen as just one part of a broader public health strategy to reduce unwanted pregnancies in adolescents and in the wider community. Easy access to affordable contraception and appropriate contraception advice services remain critical.

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FACT SHEET 4|

Contraceptive Use and Failure

A reduction in the number of unwanted pregnancies is the key issue when attempting to reduce abortion rates. Ensuring access to a comprehensive range of fertility control options is therefore vital to achieving this public health goal.

Australian women of childbearing age actively use the available contraceptive methods.

The most commonly reported methods in 1995 were the oral contraceptive pill (60%) and the condom (27%) (Ford, Nassar et al, 2002). The pill is now less popular. A more recent Australian study found that 95% of 6,278 women aged 16-59 at risk of unplanned pregnancy (currently having vaginal intercourse and not trying to conceive) were using the forms of contraception listed below.

Despite the high levels of contraceptive use found, there were still issues about adequacy of access to contraception. 23% of non-users said that unwanted side-effects were a reason for non-use. This suggests that these women may not have access to an appropriately diverse range of contraceptive options.

Given the relatively high level of contraceptive use and knowledge in Australia, many unplanned pregnancies are thought to be due to method failure or inconsistent method use (Richters, Grulich et al. 2003). Even when used correctly and consistently, all contraceptive methods can fail. Almost one in four (23.8%) of 10,173 Australian men who have used condoms in the last year reported having experienced at least one condom breakage (de Visser, Smith, et al 2003).

The role of method failure in unplanned pregnancies in Australia suggests the need for improved access to emergency contraception. From January 2004, the progesterone only emergency contraceptive pill (ECP), an effective and well tolerated form of emergency contraception (Trussell, Koenig et al, 1997), became available over-the-counter in Australian pharmacies. ECP is not an abortifacient, but is thought to prevent implantation. Due to its recent availability over-the-counter, accurate data on the use of ECP in Australia is not yet available. There is thought to be a low level of knowledge and awareness of ECP in Australia and overseas (McDonald and Amir, 1999; Jamieson, Hertweck et al, 1999) and financial barriers may be an issue for some women. However there is no current monitoring or evaluation of this policy.

Equitable and affordable access to a full range of contraceptive methods is essential to the prevention of unwanted pregnancies

All contraceptive methods can fail or may not be used at all times, therefore abortion as a last resort is required when this occurs

Methods of contraceptive use*

Oral Contraceptives	33.6%
Tubal ligation/hysterectomy	22.5%
Condom	21.4%
Vasectomy of partner	19.3%
Withdrawal/safety periods method	8%
Progestogen injection or implant	2.6%
IUD	1.2%
Diaphragm or cap	0.9%
Other	0.3%

*Percentages add to more than 100% as women can use more than one method.
(Richters, Grulich, de Visser, Smith and Rissel 2003)

The PHAA recommends that ECP be placed on the PBS list and its use properly monitored and evaluated.

19.2% of Australian women who have had vaginal intercourse have used a form of emergency contraception at some time (Smith, Rissel et al 2003). Reasons for using emergency contraception include condom breakage, non-use of condom, and missing an oral contraceptive. Several studies have looked at the effects of providing women with an advance supply of ECP, and have shown:

- Increased use of ECP (Soon, Levine et al 2005; Ellertson, Ambardekar et al 2001; Glasier and Baird 1998; Jackson, Schwarz et al 2003)
- Earlier use (Killick and Irving 2004) which improves ECP effectiveness
- The maintenance of prior contraceptive techniques in addition to ECP (Glasier and Baird 1998; Jackson et al 2003)
- No increase in risky sexual behaviour (Ellertson et al 2001; Jackson et al 2003)
- Appropriate use (Glasier and Baird 1998)

PHAA recommends that sexual health and family planning services be equitably distributed and well funded

In early 2004, there were structural changes made to the way Sexual Health and Family Planning Australia (a major national specialist service provider) is funded. PHAA is concerned that this may reduce access to such services. Access to family planning services is often more difficult for people living in rural Australia, for adolescents, and for other vulnerable groups. Specialised services may be required for these particularly vulnerable groups. Governments can reduce the need for abortion through improving access to family planning services, and through the creation of laws which focus on the health and well being of women (WHO 2004). Abortion is nonetheless still required as a last resort as contraceptive methods may fail or not be used at all times.

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FACT SHEET 5|

The Impact of Abortion in Criminal Codes

The current criminal legislation about abortion is incapable of achieving the public health goal of preventing unwanted pregnancies, as it is inappropriate, outdated, inconsistent and in need of reform. Statutory provisions in many states and territories, based directly on 19th Century English legislation (since repealed and replaced in the UK), identify abortion as a crime. This crime can be committed either by the woman or by the person performing the abortion. Various definitions of 'lawful' exceptions to such crimes have been put into practice either through common law decisions (Victoria, New South Wales and Queensland) or legislative amendments (South Australia, Tasmania and Northern Territory). Ambiguous current laws create uncertainty for women and health practitioners, and leave both groups open to random prosecution, such as occurred in Western Australia (WA) in 1998 and which led to WA law reform.

Abortion is technically illegal in most Australian states and territories but few Australians are aware of this

The legal status of abortion affects the planning, quality and safety of services

Abortion should be removed from the Criminal Code and placed in the Health Act

The laws regulating abortion in Australian states and territories are confusing and inconsistent. Abortion should be removed from criminal codes.

In 1998, WA legislative amendments moved to allow abortion 'without restriction as to reason', as long as the woman is over 16 years of age and has received independent counselling on abortion, but severely restrict access after 20 weeks. The Australia Capital Territory (ACT) is the only Australian state or territory which does not refer to abortion in its criminal code. The ACT explicitly allows abortion 'without restriction as to reason' at all stages of pregnancy. ACT 2002 amendments, in addition to decriminalisation, created legislation governing the provision of abortion services by registered doctors in medical facilities.

The result of the current legal status of abortion is a lack of reliable, well-planned delivery of services.

The location of abortion within criminal codes has meant that it has received little serious attention in health policy development, or in planning and co-ordination of service delivery. Service provision is patchy and inequitable, with a serious under-supply of public sector services, due in part to legal uncertainties. Under supply and more difficult access are more likely to impact harmfully on the most vulnerable and disadvantaged Australian women.

Other serious consequences of the current uncertain legal situation include:

- Inadequate public access to information about abortion services;
- A reduction in the number of services available; and
- A lack of accurate data on abortion services and service users.

Only in SA and WA does legislation require the reporting of every abortion performed there, which has resulted in thorough data collection. If all states and territories were to follow the lead of the ACT and decriminalise abortion, many benefits would follow.

In the short term, women and health professionals would be clear about their legal status, and relieved from fear of criminal prosecution. Legislative clarity would allow health departments to plan for more accessible and equitable abortion service provision, and to begin collecting consistent and accurate national information about the number and characteristics and of women seeking abortion in Australia. Women could access services earlier in

pregnancy, which is safer and would reduce the numbers of abortions in second and third trimesters. In the longer term, policy makers could use such statistical information to provide improved care for women seeking abortions, and to target primary prevention programs towards those groups identified as most vulnerable.

Potential benefits of decriminalisation

Less fear and confusion

Better planning and quality of services

Improved and more equitable access earlier in pregnancy

Improved national data collection

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FACT SHEET 6|

Lessons from the Global Context of Abortion

Since the 1950s, there has been a global trend towards the liberalisation of abortion laws. Countries have increasingly turned away from regarding abortion as criminal towards the goal of improving women's health and family well-being (Cook 1989). Between 1985 and 1997, laws have been liberalised in 19 countries, including Canada, Czechoslovakia, Cambodia, Greece, Malaysia, Romania, Spain, Ghana, Botswana, Hungary and South Africa (Rahman, Katzive and Henshaw 1998).

Of the approximately 46 million abortions performed around the world each year, 26 million are performed legally (Henshaw, Singh and Haas 1999). In 1997, 41% of the world's women lived in countries where induced abortion was permitted without restriction as to reason, though with some gestational limits (Rahman, Katzive and Henshaw 1998). These countries included Canada, USA, Netherlands, Singapore, Sweden, Vietnam and France. In contrast, 25% of women lived in countries where abortion was allowed only if the woman's life was in danger, such as Afghanistan, Iran, the Philippines and Ireland. For the remaining 34%, induced abortion was allowed under certain circumstances - to protect a woman's mental or physical health, or for socio-economic reasons. Legislation in Australia falls into this last category.

Worldwide, liberalisation of abortion is the trend.

Criminalisation of abortion is closely associated with increased rates of maternal morbidity and mortality

The risks associated with safe abortion are less than that of pregnancy and childbirth

The legal status of abortion affects the quality and safety of services provided.

In countries where abortion is illegal, or where affordable services are not available, women do not stop having abortions (Rahman, Katzive and Henshaw 1998). Instead, they resort to unsafe services at an increased risk to their health and lives. When women feel compelled to obtain illegal abortions, these are more difficult to access, more likely to occur in unsafe conditions, and to be undertaken by unqualified persons. The criminalisation of abortion is therefore linked to increased rates of maternal morbidity and mortality (Rahman, Katzive and Henshaw 1998; WHO 2004).

The risks associated with safe abortion are much lower than those of pregnancy and childbirth.

On the other hand, when performed by qualified personnel under hygienic conditions, abortion is a very safe procedure. In developed countries, where abortion is generally legal, abortion mortality rates are usually around 0.2-1.2 deaths per 100,000 abortions. In contrast, the rate in developing countries (excluding China where abortion is legal) is 330 deaths per 100,000 abortions (AGI 1999). If women had global access to safe abortion performed by qualified professionals, death rates could be reduced to one death per 100,000 abortions (Henshaw 1997). This risk is lower than the risk of death from pregnancy and childbirth.

The experience of Romania is striking evidence of the effects of restricting abortion. Before 1966 Romania's maternal death rate was similar to the rates in other Eastern European countries. In 1966 as part of a policy to encourage childbearing, the Romanian government banned abortion and contraception. At first the birth rate rose dramatically, though it fell to close to the previous levels during the 1970s. The maternal death rate however, continued to rise throughout the period, until in 1989 it was at least 10 times the rate of any other European country. In 1990 when the new government legalised abortion, the maternal mortality rate plummeted to 40 per cent of the 1989 level (World Bank 1993).

The Beijing Declaration and Platform for Action of 1995 (United Nations 1996) calls for countries 'to consider reviewing laws containing punitive measures against women who have undergone illegal abortions'. In 1999, a review of the UN-sponsored International Conference on Population and Development called for governments to recognize and deal with the health impact of unsafe abortion as a major public health concern by 'reducing the number of unwanted pregnancies through the provision of family-planning counselling, information and services' (United Nations 1999). Australia is a signatory to both these documents.

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ABOUT PHAA

The Public Health Association of Australia Inc. (PHAA) is Australia's leading advocate for public health policy, practice, research and training. The goal of public health practice is the prevention of illness, injury and harm and the promotion of health. The PHAA seeks to contribute practical solutions to public health problems.

PHAA has a national and multidisciplinary perspective on public health issues and aims to make major contributions to public health debate through representation on government boards, committees and other decision-making bodies. PHAA members sit on many state and territory committees contributing to a broad spectrum of public health issues.

PHAA undertakes projects and conferences on major public health issues such as immunisation, suicide prevention, food safety, health promotion, research funding and the public health workforce.

PHAA has links with public health associations world-wide and is an active member of the World Federation of Public Health Associations. PHAA produces the highly respected international journal, the Australian and New Zealand Journal of Public Health, which disseminates public health research and ideas. The Association's regular newsletter, In Touch, provides a focus for public health news and events in Australia.

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