this week

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GPs criticise prostate cancer search scheme

Local NHS schemes have attempted to increase prostate cancer diagnosis—but doctors fear a national case finding programme is "screening by stealth"

EXCLUSIVE NHS England is set to launch pilots of prostate cancer case finding across the country, with the aim of closing the "treatment gap" created during the pandemic and improving early identification and diagnosis.

A slide deck prepared by NHS England and NHS Improvement, seen by *The BMJ*, says the pilots will target men at risk, defined as all men over 50, men with a close relative who has had prostate cancer, and black men over 45. It will invite these men for a prostate specific antigen (PSA) test, "counselling conversations and onward PSA testing" (see box on p256). During the pandemic 13 000 fewer people than expected started treatment for prostate cancer, NHS England has said.

But GPs expressed concern, arguing that case finding is a term used to circumvent the review process and evidence base needed to approve a screening programme.

Julian Treadwell, a GP in Oxford, said the scheme amounted to "screening by stealth." He told *The BMJ*, "Relabelling this activity as case finding does not stop it being screening. Defining all men aged 50 or over as 'high risk' should make this obvious. Men with a family history or higher risk due to ethnicity may well be more interested in PSA screening than others, but seeking out asymptomatic patients is still screening."

The Glasgow GP Margaret McCartney called the pilot "outrageous." She said, "People use 'case finding' because they think it will absolve their public health sins. Case finding is screening and usually an excuse for bad science and practice. Why does this group think they are better than an expert committee [the UK National Screening Committee] who commission systematic reviews of the evidence, make best practice evidence based judgments on cost effectiveness, and publish their results?"

The UK has no national screening programme for prostate cancer because the benefits are judged to not outweigh the risks. Additionally, PSA tests have been shown to be unreliable, leading to both false positive and false negative results. Around one in seven people with prostate cancer have normal PSA concentrations.

In its screening guidance the charity Cancer Research UK has said the "evidence so far suggests that routinely screening people who have a high risk of prostate cancer doesn't help prevent deaths." It added that screening could "lead to men having treatment for prostate cancer even

(Continued on page 256)

LATEST ONLINE

- Groundbreaking anti-smoking laws advance in Malaysia and New Zealand
- Covid-19: One in eight adults develops long covid symptoms, study suggests
- Monkeypox: Concerns mount over vaccine inequity

SEVEN DAYS IN

Tavistock gender identity service to face possible clinical negligence claims

The Tavistock and Portman Trust in London is facing possible clinical negligence claims by former patients of its Gender Identity Development Service (GIDS) for children and adolescents with gender dysphoria. The law firm Pogust Goodhead hopes to bring a group action and has called for former patients of the service to come forward.

GIDS, the sole service in England providing the service, has been accused of being too ready to prescribe puberty blocking hormones to young people and is to be closed after a critical interim report from an independent review by Hilary Cass. Services will be provided through regional hubs with multidisciplinary teams.

Tom Goodhead of Pogust Goodhead, said, "Children and young adolescents were rushed into treatment without the appropriate therapy and involvement of the right clinicians, meaning that they were misdiagnosed and started on a treatment pathway that was not right for them. Those responsible must be held accountable."

A Tavistock trust spokesman said it had worked with young people on a case by case basis, "with no expectation of what might be the right pathway, and only the minority of young people who are seen in our service access physical treatments while with us."

Clare Dyer, *The BMJ* Cite this as: *BMJ* 2022;378:o2016

Covid-19

"Insufficient data" for UK to buy Evusheld

The UK government has said it will not procure the covid-19 drug Evusheld—a combination of two long acting antibodies, tixagevimab and cilgavimab—because of "insufficient data" on the duration of protection it provides against omicron and its subvariants. The decision was based on independent advice from Rapid C-19, a multi-agency initiative including NHS England, the Medicines and Healthcare Products Regulatory Agency, the National Institute for Health Research, and NICE, as well as other health bodies from Scotland, Wales, and Northern Ireland.

More evidence of safety of mRNA vaccine in pregnancy

Pregnant women experienced lower rates of significant adverse events after vaccination with a covid-19 mRNA vaccine than a group of similarly aged non-pregnant women, a Canadian study concluded. The study, published in *Lancet Infectious Diseases*, found that 7.3% of pregnant women experienced health events requiring time off work or school or needing medical attention within a week of the second dose of an mRNA vaccine, compared with 11.3% of non-pregnant women.

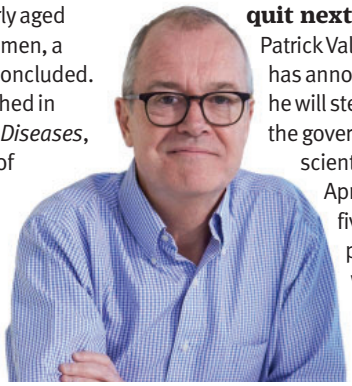
General practice

GP died by suicide "after pressure from job"

The recent suicide of a Surrey GP has been blamed on the "overwhelming" pressure of her job. Gail Milligan, 47, died last month. Her husband, Christopher Milligan, said, "Her job as a partner at a GP surgery became overwhelming. The pressure of not making mistakes, and the endless emails and paperwork, meant that for the last few years of her life she'd been neglecting herself." Her death has prompted GPs' leaders to call on the government to do more to tackle the spiralling workload in general practice.

Government

Chief scientific adviser to quit next year



Patrick Vallance (left) has announced that he will step down as the government's chief scientific adviser in April 2023 after five years in the post. Vallance, who became a household name during the pandemic, was a consultant physician in the NHS. He then moved into academia as a professor of medicine at University College London and later became president of research and development at the drug company GlaxoSmithKline.

Cybercrime

Ransomware attack sparks data security investigation

The scale of an NHS data breach is under investigation after a ransomware incident on 4 August. The digital services company Advanced, which was targeted, launched an immediate investigation after a cyberattack affected digital platforms used by the NHS and operated by Adastra, Caresys, Odyssey, Carenotes, Crosscare, Staffplan, and eFinancials. Advanced, which works with 140 trusts, said its healthcare systems were isolated, and monitoring indicated that the incident had been contained. It had also rebuilt and restored any affected systems in a separate and secure environment.

International news

Gunman may avoid trial through legal euthanasia

A court in Spain ruled that Marin Eugen Sabau, who was paralysed in a gunfight with police after he shot three work colleagues, may avoid trial and end his life through legal euthanasia. Lawyers for the victims criticised the decision, but the court said euthanasia was a fundamental right in Spanish law. The law, passed last year, allows adults to seek euthanasia if they have "serious and incurable" conditions that cause "unbearable suffering."

Elective care

NHS drastically cuts number of "longest waiters"

NHS England said that by the end of July the first milestone in its elective recovery plan had been met by drastically reducing cases of patients waiting two years or more. At the start of 2022 this included 22 500 people, and a further 51 000 were set to breach two years by the end of July. The number has been cut to just 2777, of whom 1579 opted to defer treatment and 1030 have very complex cases.

MEDICINE

Myocardial infarction is more effectively treated in London than in other parts of UK

Cardiology

Marked regional inequality in MI treatment

The Institute for Fiscal Studies highlighted considerable regional inequality in the effectiveness of doctors treating patients with myocardial infarction (MI) in different parts of England from 2005 to 2018. Its research examined the records of more than 500 000 NHS patients. MI deaths total around 330 a year in the North East of England region and around 550 a year in the East of England. Over 80 of these patients could be saved in each region if the average effectiveness of cardiologists in those regions matched the level in London, the study found.

Surgical training

Adopting new technology is crucial, says report

Technology enhanced surgical training should be widely adopted alongside hands-on experience to support surgeons in training, advised a report published by the Association of Surgeons in Training and the Royal College of Surgeons of England. It noted that more than 1.5 million fewer operations had involved a trainee surgeon than in equivalent periods before the covid pandemic, and as many as 35% of trainees had had their training extended after the pandemic. It said that technology enhanced training would be an important addition to tackle continued deficits in training surgeons' log book numbers.

Respiratory

Rise in non-covid winter infections is predicted

The number of non-covid-19 respiratory infections should be expected to rise this winter, scientists warned. A study led by the University of Bristol, published in *Lancet Regional Health—Europe*, found that over 55% of hospital admissions for respiratory disease during the pandemic's peak were caused by non-SARS-CoV-2 infections. This was based on data collected from 135 014 admissions from two large hospitals in Bristol from August 2020 to November 2021 as part of AvonCAP, an ongoing surveillance project funded by Pfizer.

Breastfeeding

Returning NHS staff "lack support"

NHS staff returning to work after maternity leave and wishing to continue to breastfeed did not believe they received the support they needed, in a survey of 1201 staff by Hollie Hearfield, a specialty trainee year 6 child and adolescent psychiatrist at Ancora House, Cheshire and Wirral Partnership, and Jennie Collier, a specialty doctor at Wirral Child and Adolescent Mental Health Services. Some 79% of responders were breastfeeding when they returned to work, and 59% wanted to continue, but only 7% said their employer had informed them of its policy. Just 6% had a risk assessment on their return to work, and more than half did not have access to the basic facilities needed to breastfeed.

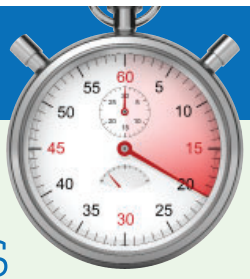
CAREERS, page 292

Cite this as: *BMJ* 2022;378:o2027

WINTER

The NHS in England will create an extra **7000** beds to tackle pressures this winter. This will include **2500** "virtual ward spaces" with patients monitored at home

[NHS England]



SIXTY SECONDS ON . . . MEDICAL GASLIGHTING

A SEQUEL TO INGRID BERGMAN'S FILM?

That would be the 1944 film *Gaslight*, which tells the story of a man who manipulates his wife to such an extent that she doubts her own sanity. Since then, the term gaslighting has been widely used to describe any form of emotional abuse that makes someone question their own grasp of reality.

SO WHAT'S THIS MEDICAL VERSION?

It's used to describe when a medical professional wrongly blames a patient's symptoms on psychological factors or tells them they are not really sick.

COULD YOU BE IMAGINING THAT?

No. Patients are sharing stories of medical gaslighting on social media with the hashtag #medicalgaslighting. And two articles in the *New York Times* this year have prompted thousands of responses. In one a woman described going to a cardiologist with chest pains and being told to exercise more. Another woman who described weight loss, losing her hair, and developing a full body rash in her 20s was told by her male doctor that she was "young, healthy, and just lazy." She was later given a diagnosis of the autoimmune disorder Graves' disease.

ARE WOMEN PARTICULARLY AT RISK?

Women have reported that conditions such as endometriosis, fibromyalgia, and irritable bowel syndrome are often downplayed by doctors. And studies have shown that compared with men, women face longer waits to be given a diagnosis of cancer or heart disease, for example. But black people, older patients, and LGBT+ people are also more likely to have symptoms dismissed.

SO IT'S DOCTORS DISSING PATIENTS?

Not just that. A female Canadian doctor described being gaslit by colleagues. She described specialist colleagues using their status to try to convince her of something she knew to be false or not in the best interests of her patients.

IS IT BECOMING MORE COMMON?

The term has been used widely in connection with long covid. Some patients still experiencing symptoms months after infection thought they were not treated seriously, or investigated fully, by doctors.

Jacqui Wise, Kent

Cite this as: *BMJ* 2022;378:o1974

(Continued from page 253)

though that cancer wouldn't have caused any problems or symptoms."

Treadwell, a National Institute for Health and Care Research doctoral research fellow at Oxford University, said the initiative was not the solution to a drop in diagnoses. He said, "The National Screening Committee, like other similar bodies around the world, has come to the conclusion it is likely to be ineffective and harmful. Whatever the problems may be post-pandemic, introducing a screening programme by stealth is not the answer."

Treadwell added that the last thing strained cancer services needed was to be "distracted by low value screening and investigation such as this."

But Prostate Cancer UK has said it supports the pilot. Chiara De Biase, a director of the charity, said, "This is a targeted pilot aimed only at the highest risk groups. NHS guidance entitles men to a PSA test if they have made an informed choice, but they can only make this choice if they are made aware of their risk.

"We understand concerns around overdiagnosis, but the introduction of multiparametric MRI has helped to significantly reduce these harms, while the percentage of men with low risk disease who are overtreated has reduced by two thirds in recent years."

An NHS England spokesperson said, "This pilot is not a screening programme but will hopefully encourage men to have a discussion about their level of risk, to weigh the advantages and drawbacks of testing, and to make an informed choice about whether they want a PSA test or not."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2022;378:o2015

HOW THE PILOTS WILL WORK

The pilot sites are being selected, with the initiatives set to launch from October. Up to £2.5m has been made available to cancer alliances (regional bodies that bring together clinical and managerial leaders from across the local NHS) to cover the revenue costs in 2022-23, with further funding to be made available for 2023-24.

Three potential delivery models:

- Mobile vans or stationary community centres in areas convenient to the target population
- Independent sector negotiating access to local primary care networks or general practices to search for and identify high risk groups, with individuals then contacted and encouraged to book into an independent sector community base
- A wholly GP based strategy.

Where patient records are being searched to identify potential patients, NHS England said the criteria should be limited to black men over 45 and white men over 50 with a close family history of prostate cancer. Primary care networks don't have to take part, but those that do will meet their enhanced services contract requirement to "increase the proactive and opportunistic assessment of patients for a potential cancer diagnosis in population cohorts where referral rates have not recovered to their pre-pandemic baseline," NHS England said.

Remifentanil shortage forces anaesthetists to relearn old techniques

Continuing remifentanil shortages are disrupting anaesthetists' work and forcing them to relearn about drugs and techniques they were using 10 to 15 years ago, *The BMJ* has learnt.

Remifentanil is a short acting synthetic opioid drug used for general anaesthesia and in critical care, that allows patients to recover quickly from anaesthesia. While alternative drugs are available, they often result in a slower recovery time and can cause side effects to last longer.

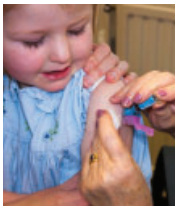
An "impending disruption" to the supply was flagged by the Royal College of Anaesthetists in June, in a joint statement with the Association of Anaesthetists, the Intensive Care Society, and the Faculty of Intensive Care Medicine. It advised, "Trusts will only be able to order an allocated amount to ensure equity of supply of the remaining stock . . . Urgent action should therefore be taken by clinicians, pharmacists and managers to preserve supplies of remifentanil for use for priority indications."

Speaking to *The BMJ*, Mike Nathanson, president of the Association of Anaesthetists (UK and Ireland), said the shortage had become noticeable last month.

"Although there are a number of suppliers within the UK, they all source the drug from the same plant," he said. "It's a national shortage. We've been told that the amount available is somewhere between 25% and 50% of normal levels. And it is a key drug that's used both as part of general anaesthesia and also in critical care, for sedation of patients."

Shortages have also been reported in Australia and in the US, where two of three suppliers (Hikma and Mylan Institutional) did not provide a reason for the shortage, while Fresenius Kabi said it was due to increased demand.

Polio vaccine is offered to all children in London aged 1 to 9



Vaccination is the best course of action, and the decision for a booster dose is great
Kathleen O'Reilly

The NHS will offer a booster or catch-up polio vaccine dose for children aged 1 to 9 years after poliovirus was detected in sewage in north and east London.

The type 2 vaccine derived poliovirus (PV2) was detected in the boroughs of Barnet, Brent, Camden, Enfield, Hackney, Haringey, Islington, and Waltham Forest. The Joint Committee on Vaccination and Immunisation has advised that children in these areas and where vaccination rates are low be prioritised in the vaccine rollout to ensure a high level of protection and help reduce spread of the virus.

Type 2 poliovirus was detected earlier this year at the Beckton sewage treatment works in east London, while further sampling identified 116 PV2 isolates in 19 sewage samples collected in London between 8 February and 5 July this year, with a few classified as vaccine derived poliovirus.

England's health and social care secretary, Steve Barclay, said, "I want to reassure people that nobody

Nathanson added, "Although there are alternatives, they don't have quite the same advantage that this drug has, in that patients recover from it very quickly. We've heard reports that anaesthetists are having to relearn drugs or techniques that they might have used 10 or 15 years ago."

He added that, while these older techniques and drugs were not a safety risk, the drugs tended to stay in the body for longer, so side effects—such as sleepiness or feeling sick after an operation—persisted for longer.

Possible shortage of alternatives

Switching to alternative drugs can also cause further shortages. Nathanson said, "If a drug disappears and you start using alternatives you then have to be sure there's enough of the alternatives available, because there aren't necessarily stocks of the alternatives kept.

"We've not heard of any instances where people just have run out and said we can't do our job, but clearly they've had to change their practice, and people are concerned that they can't use their favoured drugs."

IT'S A national shortage. We've been told the amount available is between 25% and 50% of normal levels

Mike Nathanson

Remifentanil is just one of many drugs affected by shortages, along with hormone therapies, thrombolytic and osteoporosis drugs. These shortages are such that pharmacists have warned they are affecting patient safety. A survey conducted by the *Pharmaceutical Journal* in July found more than half (847/1562) of UK based pharmacists said shortages had put patients at risk in the past six months.

Nathanson said of the wider shortages, "It is an important part of delivering healthcare to have resilience in the system. The health service and manufacturers need to work together to ensure these shortages don't exist in the future." He added that importing drugs from abroad was not necessarily a solution because it required countries to have spare stock and to meet certain regulatory standards.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2022;378:o2018

has been diagnosed with the virus and the risk to the wider population is low. I would encourage families to ensure they are up to date with their routine jabs and to come forward for the booster as soon as they are contacted by the NHS."

Nationally, the risk of paralytic polio is low, as most children are vaccinated, but child vaccination rates are lower in London than in the rest of the country. The last case of polio in the UK was in 1984.

Jane Clegg, chief nurse for the NHS in London, said, "We are reaching out to parents and carers of children who aren't up to date with their routine vaccinations, who can book a catch-up appointment with their GP surgery."

Increased surveillance

Clegg said sewage surveillance had been increased to assess the extent of the spread of the virus. Eight more sites in London were being sampled and 10 to 15 sites outside London will also be monitored.

Kathleen O'Reilly, associate professor in statistics for infectious disease and an expert in polio eradication at the London School of Hygiene and Tropical Medicine, said, "Vaccination is the best course of action, and the decision for a booster dose is great and is not especially different from that taken by other high income countries.

"Until all polioviruses are stopped globally, all countries are at risk, highlighting the need for polio eradication and continued global support for such an endeavour."

The UKHSA and WHO are working with agencies in New York and Israel to investigate links with the poliovirus in London.

Zainab Hussain, *The BMJ*

Cite this as: *BMJ* 2022;378:o2007

FIVE MINUTES WITH . . .

Emmanuel Oyelami

A Nigerian student at one of the UK's newest medical schools discusses widening participation

"Medicine was something I always wanted to do, but I didn't know how to get into it. I remember hearing quite a lot that the only people who went into medicine were those who either had someone in their family study medicine or had a very close connection to the medical field.

"Edge Hill [University Medical School, which opened in 2019 with a remit to widen the social profile of medical students] gave me the opportunity. We were the first cohort to start at the college. The foundation year is very important, especially if you feel you don't have the right academic requirements. It helps you think of things in a scientific way and is very useful if you took a few years out of education. It brings you into the routine and academic mind that you need to get into the full five year course.

"My lecturers are supportive and very receptive to what we have to say. They want the course to develop in a way that is profitable for other students, so they are keen to hear of the developments and changes we want to see.

"I want to study psychiatry and cardiology, but that could all change. I love psychology and how the many decisions we make are decided by the brain. Last year, while on placement to a cardiology unit, I enjoyed seeing how the doctors communicated and found alternative methods to treat problems of the heart.

MY LECTURERS ARE SUPPORTIVE AND VERY RECEPTIVE TO WHAT WE HAVE TO SAY

"The hardest part of my journey was interview preparation. It was very difficult to know what sort of questions might be asked, but I had some helpful teachers who tried to get me books that had questions that come up in interviews.

"Representation in medicine is important. Not only to represent more of the population, but also it means we can be a role model for those who come from similar backgrounds and with a similar history.

"After graduation, hopefully I will be located in a hospital and working for the NHS. Medicine is a long and tough career, but if you work hard, you're determined, and you put in the effort to get the results you need, you will achieve your goals."

Emmanuel Oyelami is a second year medical student at the Edge Hill University Medical School in Lancashire

Melina Zachariou, London

Cite this as: *BMJ* 2022;378:o1982

Health and
Wellbeing Team

The Royal London Hospi
Emergency Department
Children's Hospital Entra
Main Entrance
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THE BIG PICTURE

Parched ground, but staff take on water

As the Office for National Statistics latest figures revealed total excess deaths of 1680 in the week ending 22 July—during which temperatures hit 40°C in England—staff in the NHS were again facing the heat last weekend as temperatures across the UK rose to highs of 36°C.

Advice to keep themselves, as well as patients, hydrated with water and cool, sometimes with ice cream donated by local businesses, seems to have helped this time around.

But for Hassan Ali Beg, a cardiology registrar at the James Cook University Hospital, part of the South Tees Hospitals Trust, it's the future the NHS needs to be looking to. "We have to be cognisant of climate change and the extra heatwaves that are going to come with that. We need to make sure hospitals have good ventilation," which he added will also help deal with covid and any future pandemics.

Zainab Hussain, *The BMJ* BMJ 2022;378:o2036

MARK THOMAS

NEWS ANALYSIS

US doctors report being fearful, harassed, and confused since the overturning of Roe v Wade

Early last month a pregnant 10 year old girl was brought from her home in Ohio to Indiana for an abortion after she had been raped. It was too late for her to be treated in Ohio, forcing her to travel 280 km across the state boundary.

The story drew national and international attention and was denounced as fake. It turned out to be true. A 27 year old man was arrested and charged with rape.

Caitlin Bernard, an Indianapolis obstetrician and gynaecologist and assistant professor at Indiana University, treated the girl with a medication abortion.

Abortion was legal in Indiana, but the state has now banned it, with exceptions only for rape, incest, fatal fetal anomaly, and if there is a serious risk to the pregnant woman's health or life. The law goes into effect on 15 September.

Todd Rokita, Indiana's attorney general, denounced Bernard as an "abortion activist acting as a doctor with a history of failing to report" and said that he would "be looking at her licensure."

Bernard, a respected physician, had filed the required reports. A colleague published a supportive opinion piece in the *New York Times* and started a fund to help pay her legal expenses. Bernard is reported to be considering suing Rokita for defamation.

Threats

Bernard defended herself in the *Washington Post*, saying, "My mission has always been to provide the best care to each patient who comes to me. But for the past few weeks, life has been hard—for me and my family. I've been called a liar. I've had my medical and ethical integrity questioned on national television by people who have never met me. I've been threatened."

On 24 June the US Supreme Court overturned Roe *v* Wade, the 1973 decision that legalised abortion and left the regulation of abortion to the states. About half the 50 states ban or severely limit abortions. Laws are changing daily.

The American College of Obstetricians and Gynecologists (ACOG) said, "Each piece of legislation is different, using different language and rationales. State legislators are taking it upon themselves to define complex medical concepts without reference to medical evidence. Some of the penalties for violating these vague, unscientific laws include criminal sentences."

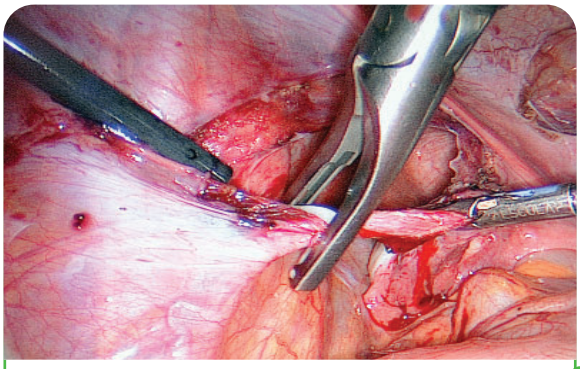
ACOG, the American Medical Association, the American College of Physicians, and more than 75 healthcare organisations have supported the right to abortion and opposed legislative interference. ACOG says, "Abortion is an essential component of comprehensive medical care, and people need unimpeded access to the full spectrum of reproductive health care options."

Doctors are confused and fearful

Katie McHugh, an obstetrician and gynaecologist in Indianapolis, where abortion is legal only until 15 September, told *The BMJ* about a patient who arrived from another state with a miscarriage.

"A fetal heartbeat could still be detected. The local hospital sent her home and told her to come back if she became very sick." Instead she travelled two and a half hours by car to McHugh.

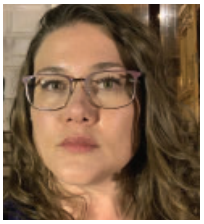
"I don't blame the physicians in [the other state]. I don't know if abortion is legal now a trigger law is in effect. They could face lawsuits. As a physician, it's unacceptable to have to watch the news to know what's legal



"Maternal morbidity—including conditions such as clinical chorioamnionitis and hemorrhage—occurred in 43% and of those 32% required intensive care admissions, dilatation and curettage, or readmission. One patient required a hysterectomy after presenting at 20 weeks 6 days with hemoperitoneum from uterine rupture owing to a placenta accreta spectrum. "Expectant management resulted in 57% of patients having a serious maternal morbidity compared with 33% who elected immediate pregnancy interruption under similar clinical circumstances reported in states without such legislation."

Letter, 5 July, American Journal of Obstetrics and Gynaecology

I've had my medical and ethical integrity questioned on national TV and I've been threatened
Caitlin Bernard



As a physician, it's unacceptable to have to watch the news to know what's legal and how to practise
Katie McHugh

A pro-choice campaigner protests as the Indiana state house considered limiting abortion rights a month after the Roe v Wade ruling

BSIP/ANDREW CABALLERO-REYNOLDS/THE WASHINGTON POST/GETTY; JEREMY HOGAN/SIPA/ALAMY

and how to practise," said McHugh. She added, "After the ban I'll consider moving my practice out of state even though I'm a lifelong resident of Indiana, with family here. I have a daughter and a son: [it's] difficult for them to grow up where women are valued less.

"My colleagues are devastated. Thousands of healthcare workers are forming the 'Good Trouble Coalition' to fight back.

"It's not just abortion. it's emergency care, normal medical care, patients' ability to make decisions. Patients are becoming aware legislators answer to influencers rather than citizens. One said, 'I had no idea politicians were so bad and cared so little about people.'"

Increase in maternal morbidity

As abortion laws change, US doctors worry about performing a legally justifiable abortion. "In an emergency, hospital care moves so quickly. There's no lawyer on call at four in the morning," Laura MacIsaac, a complex family planning specialist with the Mount Sinai Health System in New York, told the *New York Times*. And Kimberly Mutcherson, a law professor at Rutgers University and expert in bioethics and reproductive justice, said, "You don't want lawyers making these decisions."

The effect of abortion restrictions has already been seen in Texas.

Protesters in Indianapolis, and Dr Franz Theard (right) at his clinic that offers abortion services in New Mexico

In a research letter published on 5 July in the *American Journal of Obstetrics and Gynaecology*, doctors at Clements University Hospital and Parkland Hospital, large safety net hospitals for Dallas County, looking at outcomes among pregnant women, reported that after the Texas ban maternal morbidity was almost double that among women in states without similar laws.

Texas Senate Bill 4, passed in September 2021 (before Roe *v* Wade was overturned), says that a doctor who performs an abortion, even in a maternal medical emergency, is committing a felony and faces jail time and a fine of $10 000 (£8200) unless there is an immediate threat to the pregnant person's life.

This study showed that the law had increased maternal morbidity. The researchers looked at 28 women with an indication for abortion, such as preterm premature rupture of membranes, pre-eclampsia with severe features, or vaginal bleeding.

The current national standard of care for such patients allows for expectant management or immediate delivery after shared decision making. But after Senate Bill 4 was passed physicians were not intervening so quickly. Patients were managed expectantly for about nine days before they developed a complication that qualified as an immediate threat to life.

THIS WEEK, pp 262-70

Janice Hopkins Tanne, New York

Cite this as: *BMJ* 2022;378:o1920

TEXAS SENATE BILL 4 says that a doctor who performs an abortion, even in a maternal medical emergency, is committing a felony and faces jail time and a fine of **$10000** unless there is an immediate threat to the pregnant person's life

EDITORIAL

Ending women's constitutional right to abortion

US ruling threatens rights to health, bodily integrity, and equality across the world

On 24 June 2022, the US Supreme Court overturned Roe *v* Wade, a landmark decision that established a constitutional right to abortion before fetal viability. The court's regressive ruling stands in stark contrast to global trends expanding abortion rights. Half of Americans will no longer fully possess human rights to health and bodily integrity, and the ruling will exacerbate already unconscionable health and economic inequities.

Reversing a half century of precedent, the Supreme Court ruled in Dobbs *v* Jackson Women's Health Organization that there is no constitutional right to abortion, which is not "essential to ordered liberty."[1] Constitutional rights to contraception, same sex marriage, and same sex intimacy rely on similar reasoning so could be jeopardised in future rulings. For the first time since it was established in 1789, the court withdrew a fundamental human right. Abortion will be banned or severely restricted in at least half the states, and access to essential health services will depend entirely on where a person lives.

Since 1994, 59 countries have expanded abortion rights, with only three adding more restrictions—El Salvador, Nicaragua, and Poland.[2] Total abortion bans are growing rarer, with most countries permitting abortion up until a certain point in pregnancy or under broad exceptions.[3] The Dobbs ruling could have profound consequences for abortion access globally. High profile Supreme Court cases have the power to influence courts and legislatures in many countries—potentially stalling expansion of abortion access or even reversing hard won gains.

The ruling may inspire similar rollbacks of human rights on politically charged issues such as LGBT+ rights, including marriage equality. The European parliament condemned the ruling, demanding that the EU's fundamental rights charter enshrine abortion rights.[4]

Human rights law

International human rights law protects abortion rights in multiple ways. The right to health includes sexual and reproductive rights.[5] Abortion restrictions cannot jeopardise women's and girls' health and lives or subject them to physical or mental suffering that can amount to cruel, inhuman, or degrading treatment.[6] Denial or delay of safe abortion and forced continuation of pregnancy constitute both discrimination against women and gender based violence.[7 8]

In response to the decision, Michelle Bachelet, the UN High Commissioner for Human Rights, stressed that "abortion is at the core of women and girls' autonomy about their bodies and lives, free of discrimination, violence and coercion."[9] WHO's director general, Tedros Adhanom Ghebreyesus, characterised Dobbs as a "setback" that will cost lives.[10] Abortion restrictions drive "women and girls toward unsafe abortions resulting in complications, even death" and disproportionately affect the poorest and most marginalised communities.[10] The UN Population Fund stressed that 45% of all abortions globally are unsafe and that more women will die as restrictions by national governments increase.[11] World leaders expressed solidarity with American women whose human rights will be devalued.

Denial of safe abortion and forced continuation of pregnancy constitute both discrimination against women and gender based violence

Since the ruling, 22 states have adopted total or near total abortion bans, some offering no exception for rape, incest, or non-fatal health risks.[12] Many other states could adopt harsh abortion restrictions. Only 19 states explicitly protect abortion rights—five throughout pregnancy and 14 before fetal viability.[12]

The 40 million people who lost the right to abortion will have to travel to states that permit abortions or access abortion medication through the internet or other sources.[13] Many will be unable to access safe, legal abortion, and may resort to unsafe, clandestine abortions without expert medical oversight. Abortion bans will disproportionately affect underserved and marginalised groups, including those who are living in poverty or in rural areas, from ethnic and racial minorities, young, undocumented, and experiencing intimate partner violence.[14]

State abortion bans impose harsh penalties on abortion providers or anyone who "aids or abets" an abortion—including a maximum penalty in Texas of life imprisonment and 10-15 years in 11 other states.[15] Threats of prosecution will undermine health professionals' ability to provide safe care and may even discourage them from treating pregnancy loss, with devastating consequences for public health.

The US, once a world leader in human rights, is now perpetrating violations of those rights. Dobbs poses a major threat to women's rights to health, bodily integrity, and equality.

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EDITORIAL

Global implications of overturning Roe v Wade

US decision must not derail international trend towards liberalisation of abortion law

Given the United States's extensive global influence—including on sexual and reproductive health programmes—how might the recent US Supreme Court decision overturning the federal right to abortion[1] affect the global trend towards expanding access to safe and legal abortion? This important question is considered from different perspectives and for different geographies by three linked articles (doi:10.1136/bmj.o1844, doi:10.1136/bmj.o1908, doi:10.1136/bmj.o1945).[2-4] Although the reverberations of the Supreme Court decision are just beginning to play out, it is crucial to raise awareness of the potential for negative consequences outside the US—and to explore ways of averting such effects.

Negative effects on abortion laws and policies may surface in different ways, as noted by the authors of these articles. Perhaps the most straightforward is the possibility that the US decision derails or slows down the trend towards liberalising abortion laws in countries around the world.[2 3] The positive global trend is compelling: some 50 countries have expanded the legal grounds for abortion this century, whereas only three—including the US—have curtailed legal access to abortion.[5 6] The authors provide examples of how the reversal of Roe *v* Wade may strengthen antiabortion activists in sub-Saharan Africa, the region with the highest level of maternal mortality from unsafe abortion,[7] and in Latin America and the Caribbean, where substantial progress has been made in recent years.[2 3]

Secondly, it could lead to increased efforts to prosecute those who seek or provide abortions that do not align with legal criteria and official guidelines—as was occurring in the UK even before the US decision.[4] Of the 88 countries where abortion is broadly legal, abortion remains in the criminal code of all but two: Canada and South Korea (Mexico and the US are excluded from these counts because abortion laws or criminal codes are determined by states).[6] An increased risk of prosecution is likely to have a chilling effect on abortion provision and exacerbate stigma.

DANIEL CARDENAS/ANADOLU AGENCY/GETTY IMAGES

A third and perhaps less obvious repercussion concerns access to abortion services, especially where the procedure is broadly legal. In Northern Ireland, for instance, the Department of Health has still not commissioned abortion services, even though abortion was decriminalised in 2019.[4] The US decision may lead to restrictions that reduce access to abortion care, such as requiring parental consent, that run counter to the World Health Organization's evidence based guidelines for safe abortion care.[8]

That ruling could also boost movements against broader sexual and reproductive health—for instance, endangering contraceptive services or sexuality education, threatening LGBT+ rights, or preventing the inclusion of selected services in healthcare plans and coverage.[9]

Grounds for optimism

However, other forces exist to help counter these negative global effects. For example, WHO's new guidelines for safe abortion care[8] recommends removing unnecessary policy barriers to safe abortion such as criminalisation, mandatory waiting times, the requirement for consent by partners or family members, and, for the first time, the guidance endorses the use of telemedicine for medication abortion under appropriate conditions.

In addition, the decades long trend towards liberalisation of abortion laws could prove to be impervious to the US court's decision. Many countries that expanded the grounds for legal abortion did so to reduce maternal death and illness and to realise the reproductive rights of all people—justifications that may be strong enough to resist conservative pressures, including those from the US.

Regional coordination of efforts to increase and preserve access to safe abortion may also be a bulwark against events in the US. There is cause for optimism that coordinated mobilisation in Latin American countries, referred to as the "green wave," will lead to further gains in the region and globally.[3] In sub-Saharan Africa, the African Union's Maputo Protocol of 2003 probably contributed to reform in that region.[2] Since the protocol was passed, 21 countries have expanded legal grounds for abortion, seven of which reformed their laws to meet or exceed the protocol's legal criteria for safe abortion.[10]

It will be important to track any negative repercussions of the US Supreme Court ruling in other countries, while working to minimise or prevent those repercussions. Close coordination within and across regions—leveraging WHO's guidelines,[8] as well as the recently published comprehensive definition of sexual and reproductive health and rights and recommended essential package of sexual and reproductive health services[11]—can help sustain the global trend towards improved access to safe and legal abortion and other sexual and reproductive healthcare despite the disturbing situation in the US. Now more than ever, mobilisation of resources is critical to make abortion rights, and sexual and reproductive rights more broadly, a universal reality.

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ABORTION RIGHTS

Lack of abortion rights and access in the UK

Overwhelmingly pro-choice Britons may be horrified by US developments—but significant gaps still remain on this side of the Atlantic, writes **Sarah Graham**

A 2019 right-to-life protest outside an Edinburgh family planning clinic

When the US Supreme Court overturned Roe *v* Wade in June it sent shockwaves across the global reproductive health community and horrified the overwhelmingly pro-choice British population. But campaigners have highlighted that abortion is not a universal right in the UK, either.

What's abortion's current status in the UK?

In England, Scotland, and Wales abortion is still governed by Victorian era criminal law. The 1967 Abortion Act introduced exemptions, permitting abortion under specific circumstances, including a gestational time limit (currently 24 weeks) and the requirement for two doctors to sign off on the procedure.

"There's very little recognition of the fact that, while the 1967 act was ground breaking for its time, it didn't remove the underpinning criminal law from abortion," says Clare Murphy, chief executive of the British Pregnancy Advisory Service (BPAS), an abortion services provider. She explains, "The 1861 Offences Against the Person Act made it a criminal offence for any woman to end her pregnancy and for anyone to assist her with doing so. Today any abortion that takes place outside of the 1967 act still, in principle, carries the penalty of life in prison [for both the woman and the abortion provider]."

Meanwhile in Northern Ireland, abortion was decriminalised in 2019. But although the region now has the most liberal abortion law in the UK, access to abortion is still far from solved. "Abortion was basically illegal in all but the most extreme circumstances until very recently," says Louise McCudden, UK advocacy and public affairs adviser at the charity MSI Reproductive Choices. "The new legal framework came into place in 2020, but access is still a huge problem because the Department of Health in Northern Ireland is still not commissioning the services."

The laws of England, Scotland, and Wales are relatively unusual in punishing pregnant women for having an abortion. Jonathan Lord, co-chair of the Royal College of Obstetricians and Gynaecologists' abortion taskforce and the British Society of Abortion Care Providers, says, "Even in American states where abortion is now banned, women are seen as victims, often in vulnerable situations—not criminals.

"It's typically for quite paternalistic reasons, rooted in the misogynistic assumption that a woman can't actually make a decision for herself, but even the most oppressive of [US] legislation tends to be against the provider, not the women themselves."

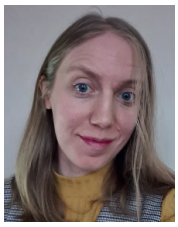
What are the legal implications for patients and clinicians?

From a practical perspective, says Murphy, "Large charitable providers like BPAS and MSI Reproductive Choices have processes and systems in place which mean that meeting the legal obligation of two doctors' signatures can be achieved in a swift and straightforward way so that women don't experience any delays."

Nevertheless, McCudden adds, "The fact it sits within criminal law makes it easier for the very aggressive, vocal anti-choice minority to chip away at access, stigmatise abortion care, and put barriers in place that don't have any sort of clinical basis."

While it's generally possible to access legal abortion care in the UK, she explains, in a small number of cases—typically in very complicated or desperate circumstances—that may not be possible. In such cases, she says, "The decision [to have an abortion] should be made on a clinical basis, by a doctor, a safeguarding lead if applicable, and the individual who's pregnant. It shouldn't be a matter of criminal law, and clinicians should be able to act in the patient's best interest rather than having to worry about criminalisation."

There's no public interest in pursuing these cases
Clare Murphy



Services in Northern Ireland are still not being commissioned
Louise McCudden

The current UK government is less supportive of abortion rights
Jonathan Lord

PAUL GAPPER/ALAMY

Police investigations into illegal abortions are rare, and prosecutions even more so. However, some recent UK cases have seen women subjected to lengthy and traumatic criminal proceedings under the 1861 Act and the 1929 Infant Life (Preservation) Act. Last month the *Times* reported on two cases involving women facing jail for charges relating to unlawfully taking abortion pills.

There are also implications for patients who have unexplained miscarriages or stillbirths. In 2021 a 15 year old girl was put through a year long investigation—including a "digital strip search" of her phone and laptop—after medical staff raised suspicions about her stillbirth. Another woman was held in police custody for 36 hours after having a stillbirth at 24 weeks, even though this would have been within the legal limit for an abortion.

Murphy says, "There's no public interest in pursuing these cases, and I'm very concerned about the message it sends to women about what might happen to them. What if someone finds herself having a miscarriage or a stillbirth, but she's previously Googled 'abortion' or been to a clinic and then changed her mind? Does that mean she's going to fall under suspicion for ending her own pregnancy?"

This also has a chilling effect on staff, says Lord, such as the CQC's raids on abortion clinics in 2012, ordered by the then health secretary, Andrew Lansley. Lord explains, "They were looking for anomalies in the two doctor signature system, but it turned out to be a colossal expense and did real harm [because of the other inspections that were missed as a result]. It also left staff constantly looking over their shoulder. When you're in that position, you can't act in the best interests of patients because you're worried about being arrested, fired, or referred to the GMC which is incredibly stressful."

The law also acts as a barrier to healthcare professionals pursuing a career in abortion care in the first place, says Victoria Kinkaid, a foundation year 3 doctor and campaign coordinator for the abortion rights group Doctors for Choice UK. "That it needs two doctors to sign off, and doctors face prosecution if that paperwork is not completed correctly, is a source of worry," she says. "It puts colleagues off wanting to be involved in abortion care, and it also means we can't empower nursing or midwifery colleagues to provide it, which is really sad because abortion is essential healthcare."

How does service provision vary?

The lack of services in Northern Ireland means that pregnant patients must still travel to England if they want to access abortion care. "[At MSI Reproductive Choices] we run the booking service, so we know it's an ongoing problem," says McCudden. "We would like that to be moving more quickly but, in fairness to the UK government, they have been quite consistent about saying it's not acceptable and putting pressure on the government in Northern Ireland to sort it out."

Similar challenges also face women seeking second trimester abortions in Scotland, where no health board offers abortion care up to the legal limit of 24 weeks. As a result more than 2000 women have had to travel from Scotland to England for abortion care since 2010.

It puts colleagues off wanting to be involved in abortion care
Victoria Kinkaid

How else is access affected in the UK?

Even for patients seeking abortion within the existing legal framework and in areas where service provision is good, access is not always easy. Over the past decade patients, doctors, and campaigners have expressed concern about the increase of anti-abortion protests outside clinics. Their presence is distressing not only to patients accessing abortion care but also to those seeking healthcare after sexual assault or miscarriage or in other circumstances.

Alice Murray had to walk past protesters outside the Chalmers Sexual Health Centre in Edinburgh when she had an abortion in 2019, then aged 20. "When I found out I was pregnant I knew straight away that wasn't what I wanted, and I felt confident about the choice to have an abortion," she says. "As I came down the road towards the clinic, though, there were six or seven protesters very visible across the road from the entrance. I'd been to Chalmers clinic before to access sexual healthcare and I always felt angry seeing them there, but this time, because I was actually there for an abortion, it felt like I was being personally targeted.

"At first, I felt really angry and upset. Then my fight or flight response kicked in, and it was like I went outside my body for a bit—I just kept putting one foot in front of the other. Even though I didn't find getting an abortion traumatic or upsetting in itself, that experience of the protesters was so wrapped up in it, it really affected my ability to process everything."

Besides Jonathan Lord's roles at the Royal College of Obstetricians and Gynaecologists and the British Society of Abortion Care Providers, he is medical director at MSI Reproductive Choices. He says that "over the past few weeks we've had reports of patients arriving in tears." This is understandably upsetting for clinical staff too, who, in addition to dealing with the distress of their patients, face harassment themselves. Staff members at MSI have reported feeling "intimidated" and "uncomfortable," with one saying, "It does affect your mental health after a while. They want to make you feel bad about what you do."

Murray is now a campaign coordinator for Back Off Scotland, a student led campaign founded in 2020 to lobby for "buffer zones," which would ban protests

Experiencing the protesters really affected my ability to process everything
Alice Murray

UK anti-abortion groups have been emboldened by what they see happening in the US

outside abortion clinics in Scotland. Similar campaigns exist in England and have seen such zones introduced at a local level in Ealing, Richmond, and Manchester, but activists in both countries say that national policies are the only effective way to protect all patients accessing abortion care.

This now looks set to happen in Scotland next year, as a bill put forward by Gillian Mackay has received the backing of Nicola Sturgeon's government. In England, however, Sajid Javid rejected cross party calls for buffer zones when home secretary in 2018, saying that they were "not a proportionate response."

Is there a risk to existing UK rights?

The big question is whether the overturning of Roe *v* Wade poses a credible threat to abortion rights here in the UK. "The important thing to keep in mind is that most people in the UK—as many as 90%—are pro-choice, and most of our parliamentarians are pro-choice as well, which is probably why we get support across the political spectrum," says McCudden.

That said, anti-abortion campaign groups, many of which are funded by US organisations, have clearly been emboldened by what they see happening in the US. McCudden adds, "We have seen a rise in anti-choice activity around our clinics. We think some of that might be in response to the repeal of Roe *v* Wade. It's a little early to say if that's the only causal factor, but it is certainly something we're aware of and monitoring, and it does seem to be escalating."

Equally, while there's a pro-choice majority across parliament, Lord notes that the current government is less supportive of abortion rights. This was seen in a failed attempt by ministers to remove the right to telemedical abortion, brought in during the pandemic, which parliament ultimately voted to make permanent. The government also recently came under fire for quietly removing commitments to abortion and reproductive health rights from a global pact on gender equality.

Despite all of this, says Murphy, "If anything, [the repeal of Roe *v* Wade] has galvanised the pro-choice majority and shown that we have to up our game to make sure nothing like that ever happens here."

What change would UK campaigners like to see?

Decriminalisation is the ultimate aim, supported by the Royal College of Obstetricians and Gynaecologists and its Faculty of Sexual and Reproductive Health, as well as organisations such as BPAS, MSI, and Doctors for Choice. This, Lord explains, would mean taking abortion out of criminal law and bringing it solely under general medical regulations, like any other procedure.

Murphy concludes, "I don't necessarily think we need the right to an abortion to be enshrined in law: we just need to get rid of all the laws that inhibit access. But decriminalisation is not enough if you don't have the healthcare services.

"We could decriminalise abortion tomorrow, but we'd still need to keep campaigning to ensure that there is access to services."

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ABORTION RIGHTS

Roe v Wade: How its demise will affect women around the world

The US Supreme Court's decision will have a chilling effect on reproductive healthcare in low and middle income countries, report **Geetanjali Krishna** and **Sally Howard**

In 2018 a reproductive health organisation in Kenya found that anti-abortion advocates had put the address of its reproductive rights helpline on social media. "It was a veiled threat," its programme manager, Mina Mwangi, tells *The BMJ*. "They wanted us to know that they knew how to get us."

On 24 June 2022 the US Supreme Court overturned Roe *v* Wade, the landmark 1973 decision that protected women's liberty to choose to have an abortion without excessive government restriction. Sexual and reproductive health rights organisations across the world, including Mwangi's, feared the effects of the overturning in terms of funding and potential attacks. "We are heightening our security because of how emboldened the opposition are," Mwangi says, adding that she dreads a potential withdrawal of funds from US non-governmental organisations: her organisation receives over 50% of its funding from US donors.

Her fears are well founded. Regressive US policy moves on abortion have historically had a profound ripple effect around the world, particularly in countries where sexual and reproductive healthcare is partly or fully funded by overseas donors.

In the decades since Roe *v* Wade 55 countries, including Spain, Ireland, Argentina, Kenya, Romania, Nepal, and South Korea, have brought in legislation and policies that have improved access to abortion. Liberia, Sierra Leone, and the Democratic Republic of Congo are in the process of legally expanding access, as are several Latin American countries in a "green wave" of liberalisation led by Mexico (see p269).

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa—the first treaty to recognise abortion (under certain conditions) as women's human right—has expanded availability in the 15 member nations of the African Union. In sub-Saharan Africa, which has the world's highest number of abortion related deaths, Roe *v* Wade has been an oft invoked precedent for advocates of more liberal abortion laws. During the same period only four nations, most recently the US, have imposed further curbs.

WHO estimates at least 7.9% of maternal deaths are due to unsafe abortion

SIMON MAINA/AFP /GETTY

A pro choice demonstration in Nairobi in 2019 in the run up to a vote on a bill that would have widened access to safe medical abortion. It was defeated in parliament

Gains at risk of reversal

"We've seen amazing progress," says Sarah Shaw, head of advocacy at Marie Stopes International, a non-governmental organisation that provides contraception and safe abortion services in 37 countries. "Malawi and Sierra Leone are in advanced stages of discussions around law reform for abortion, as are many countries in Latin America, which could lead, remarkably, to the spectre of women from US states crossing the border for safe abortions in Mexico."

Kenneth Juma, of the African Population and Health Research Center in Kenya, points to the sexual and reproductive health bill currently at the East African Legislative Assembly, the legislative arm of the seven country East African Community, and to liberalising legislation in Liberia as causes for hope. But he fears what the US decision might bring. "I was in Liberia last week, where lawmakers are preparing a bill to expand access to abortion, and [the US Supreme Court decision] has come at the very worst time as it has awoken anti-abortion rights activists and given them a seat at the table," says Juma, who has researched access to safe abortion in Kenya, Nepal, and Madagascar.

Shaw fears that Sierra Leone's safe motherhood and reproductive health bill, which expands access to abortion in a country where terminations are permitted only when a mother's life is at risk, will also "run into trouble." The country has one of the world's highest rates of maternal mortality and unsafe abortion, and the bill, though approved by cabinet ministers on 7 July, has not yet been enacted. "The US ruling sends [lawmakers] the message that it's completely acceptable to disregard the reproductive healthcare needs of half of your population," says Shaw.

"There is great concern that the dismantling of Roe may catalyse efforts towards similar retrogression in other countries," Payal Shah, director of Physicians for Human Rights' programme on sexual violence in conflict zones, tells *The BMJ*.

Sub-Saharan Africa has the world's highest number of abortion related deaths

THE GLOBAL GAG RULE

In tandem with this year's US Supreme Court ruling on Roe *v* Wade comes the threat of the future return to play of the political football known as the "global gag rule." Under this US aid policy, first enacted by Ronald Reagan in 1984, organisations outside the US that receive US government funding cannot provide, refer for, or promote abortion as a method of family planning. But the rule has see-sawed as successive Democratic and Republican presidents enact or revoke the policy as soon as they take office. Most recently, Joe Biden set it aside when he became president in November 2021.

However, the effect of Donald Trump's unprecedented 2019 strengthening of the rule is still felt. This change cut funding not only to foreign non-governmental organisations directly involved in abortion services or abortion rights advocacy but also those that fund or support other groups that provide or discuss abortion.

The Trump presidency saw many reproductive healthcare services in Kenya shuttered, including Family Health Options, one of the largest reproductive health organisations, says Kenneth Juma of the African Population and Health Research Center. "Suddenly, providers could not fund staff salaries overnight," he tells *The BMJ*. "There was huge disruption to reproductive healthcare service delivery models, which were 50% NGO-funded, as well as a fragmentation of the HIV care platforms through which much reproductive healthcare is organised." This capacity, he adds, has not recovered.

BAZ RATNER/REUTERS/ALAMY

A Family Health Options clinic in the Kibera area of Nairobi in 2017

Health impacts of unsafe abortion

Evidence is clear that restricting abortion does not reduce its incidence but instead makes it less safe. Women and girls who are denied access to safe abortion are forced to use unsafe methods and providers; it is estimated that nearly 25 million unsafe abortions take place each year. The World Health Organization estimates that at least 7.9% of maternal deaths are due to unsafe abortion, with a greater proportion occurring in Latin America, the Caribbean, and sub-Saharan Africa. The complications of unsafe abortions include infection, haemorrhaging, and injury to internal organs.

"Our staff witness at first hand the maternal death and suffering that result from unwanted pregnancies and unsafe abortions," says Maura Daly, a sexual and reproductive health adviser at Médecins Sans Frontières. In 2019 MSF treated more than 25 000 women and girls with abortion related complications, many of which resulted from unsafe attempts to end a pregnancy.

Daly lists various factors that come into play, including access to abortion drugs, outdated or harmful information on abortion, and the restrictiveness of the country's legal framework.

Aisha Awan is a GP in Salford who has seen the effects of unsafe abortion at first hand in her voluntary work at a community clinic in Tanzania, where abortion is highly restricted and maternal morbidity and mortality remain high. "Women were at the mercy of cheaper untrained providers, where in some instances 'instruments' such as twigs to cleaning products were employed," says Awan. "They were therefore plagued by chronic pain and in some cases torn or highly damaged cervixes [for years after the abortion], leaving them at risk of miscarriages or future preterm births."

Poor and marginalised people bear the heaviest burden from restrictive laws, Juma adds. "Poor people die in greater numbers due to unsafe abortions, are forced to have more children than they can afford, and are at greater risk of poverty due to being forced to carry an unwanted child to term," he says.

Antonia Mulvey of Legal Action Worldwide, which provides legal aid to victims and survivors of human rights violations and abuses, says that any further restriction of abortion provision would be "catastrophic" for victims of sexual violence in conflict. "Where medical services are available to survivors, they often do not include emergency contraception, meaning that access to free and safe abortions is life saving," she says.

Encouraging the incorrigible

Reproductive rights activists say the US about-turn is also giving encouragement to some anti-abortion factions in poor countries that are funded by US far right groups and that conduct ugly pressure campaigns through social media and misinformation.

"When Trump strengthened the global gag rule (box, p267) we saw rising social media attacks against MPs who support sexual and reproductive health in Kenya," says Shaw. "It has also been reported in Nigeria that we [Marie Stopes International] are part of a neocolonial effort to control the population of Nigeria through abortion."

In Kenya, CitizenGO, a community group that uses social media to "defend and promote life, family, and liberty" was partly responsible for the sinking of the 2020 Reproductive Healthcare Bill that sought to expand access to safe medical abortion and other reproductive health services. Its tweets labelled the bill as an "abortion bill," despite several researchers and rights observers arguing that the bill was in keeping with the rules of Kenya's existing constitution. The non-profit internet software company the Mozilla Foundation found that about 15 people, mostly Kenyan, were being paid $10 to $15 per campaign to manipulate the online conversation about abortion.

"In the months to come we will see more and more from these actors," says Phonsina Archane, programme adviser at the Safe Abortion Action Fund in Kenya.

Women can be left plagued by chronic pain
Aisha Awan

For victims of sexual violence in conflict further limits would be catastrophic
Antonia Mulvey

Poor people die in greater numbers due to unsafe abortions
Kenneth Juma

The road ahead

Some non-governmental organisations retain hope that the US's reversal of Roe *v* Wade will instead galvanise progressive groups and lawmakers to take positive action to protect abortion rights from further attack.

Marie Stopes International is increasingly focusing on advocacy to protect gains in abortion service provision from being affected by US policy fluctuations, Shaw tells *The BMJ*. When in 2019 an abortion provider in Kenya was falsely accused of providing abortions outside the national legal framework, Marie Stopes and local organisations successfully countered this misinformation through petitions and coordinated opinion pieces in the media, she says. Shaw also welcomes the arrival of national legal guidelines such as Nigeria's Legal Framework on Abortion, which clearly states what reproductive healthcare providers can and can't offer to patients to protect such providers from legal consequences.

Juma thinks resilience will come only when nations significantly reduce their reliance on outside aid. He would like to see Kenya's rights advocates being "proactive rather than reactive" and making the data on abortion clear: "that restrictions increase abortions, unsafe abortions, and mortalities." He would also like to see the United Nations Refugee Agency (UNHCR) institute a slush fund to enable it to step in and supply supplies and equipment, such as the chemical abortion drugs mifepristone and misoprostol, anaesthetics, and speculums and tenaculums. This would mitigate the effects when non-governmental organisations are forced to withdraw assistance because of external government policies.

Societies need to start treating abortion as a medical issue rather than a political one, says MSF's Daly. "The heavy burden on people seeking abortion, and their communities, is lost in all the political justifications for not providing this care rather than seeing it for what it is: a medical decision," she says.

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Mexican campaigners celebrate with an "Abortion in Coahuila is no longer a crime" banner after the ruling that declared that the criminalisation of abortion was unconstitutional in 2021

DANIEL BECERRIL/REUTERS/ALAMY

ABORTION RIGHTS

How South America became a global role model for abortion rights

After decades of repression, the continent's countries are reversing the trend and could soon produce the world's strongest constitutional guarantee of the right to abortion. **Luke Taylor** reports

Just five years ago, Latin American countries where abortion was not a criminal offence were the exception. As late as 2020, 97% of Latin American women of reproductive age lived in countries where access to the procedure was severely restricted by law. Few places bucked the conservative trend: only Cuba, Uruguay, and Mexico City permitted women to end their pregnancy without restriction in the first 12 weeks.

Women's rights groups looked to the US—where the constitutional right to abortion had been guaranteed since 1973—for inspiration on what freedoms could be achieved and how to realise them. The overturning of Roe *v* Wade changed all of that. The US Supreme Court's decision has taken away access to safe, legal abortion in the most influential nation in the Americas.

Perhaps, say abortion rights experts, the US must now look south for guidance on how to get back on track. In the past three years, astute legal pushes and coordinated social mobilisation—known as the "green wave," owing to the T shirts, bandanas, and handkerchiefs worn by supporters—have resulted in the decriminalisation of abortion in three of Latin America's four most populous nations: Argentina, Colombia, and Mexico. Now, the Latin American nations where abortion is illegal are outliers.

Cristina Rosero, senior legal adviser for Latin America and the Caribbean at the New York based Center for Reproductive Rights, says, "These changes are not only important because they create a different perspective on the way abortion is regulated, but also because these three countries are taken as a reference for the region.

"If we keep going this way, improving the protection of abortion rights, Latin America could definitely become a global reference regarding this issue."

Green wave

In 2015 Latin America was recording the world's highest number of maternal deaths per capita from unsafe abortion procedures, as strict laws left many women with only clandestine alternatives. Around 95% of the 4.4 million abortions performed in 2008 were unsafe, said a 2012 report from the US based Guttmacher Institute.

That's now changing. The right to abortion has spread rapidly throughout the continent since Argentina's senate voted in December 2020 to legalise terminations in the first 14 weeks of pregnancy. The Buenos Aires ruling sparked a regional conversation and set off a domino effect of nations rolling back restrictions on abortion that have been credited to cross border cooperation among

The Latin American nations where abortion is illegal are now outliers

women's rights groups. (Argentina was the first, and so far the only, South American country to legalise abortion through congress, after the law was first proposed by the current president, Alberto Fernández. All other countries' changes have been through court hearings.)

Mexico followed Argentina in September 2021. Its Supreme Court ruled criminalisation of abortion unconstitutional—although restrictions do remain in some states. Previously, most states permitted abortion only in certain cases, such as the result of rape or when a pregnancy endangered the mother's life.

Colombia, a predominantly Catholic nation, was the latest to make progressive moves, this February. Its Supreme Court voted 5-4 in favour of decriminalising the procedure. Previously, women in Colombia could be punished with 16-54 months in prison for terminating a pregnancy unless it risked the health of the mother, the fetus had life threatening health problems, or it was conceived by rape. The landmark ruling means that those stipulations are now required only after the fetus is 24 weeks old.

It's a remarkable turnaround: at least 350 women were convicted or sanctioned

for abortions in Colombia from 2006 to mid-2019, says Causa Justa, the coalition of women's rights groups that led the legal case presented to the Supreme Court. Moreover, in 2016 around 2000 Latin American women were dying each year from unsafe abortions—12% of all maternal deaths—and one million women required hospital treatment as a result.

Colombia's ruling is a game changer: most women gained better access to legal and safe abortion almost immediately, says Rosero. But the change is still under way, as women's rights groups in Bogotá say some providers are still resisting for ideological reasons and use excuses such as a lack of permits or training to avoid offering abortion services.

Still, women can now visit a healthcare provider and request the free termination of their pregnancy without having to provide any reason or proof. Rosero says, "Healthcare providers have less possibilities to create barriers now, because before you had to comply with requirements such as providing a medical certificate or presenting a case before the authorities in the case of rape. Now, you don't have to present anything."

It's too early to obtain government statistics on the number of legal abortions being performed since decriminalisation, but clinics are generally performing twice as many procedures, says Laura Gil, Colombian gynaecologist and director of Grupo Médico por el Derecho a Decidir, a group of doctors advocating for women's sexual and reproductive rights.

It's not the case that more women are having abortions, says Gil. Rather, they are now having them safely in regulated clinics, undeterred by the fear that their reasons for having an abortion are not strong enough. And it's the least privileged who tend to face the highest barriers to abortion access because of a poor understanding of the system or a lack of healthcare access, particularly in rural regions.

Riding the wave

While most of the region is opening up access to abortion, progress isn't uniform. Brazil, Latin America's most populous nation, is yet to follow its neighbours. Abortion is permitted there only to save a pregnant woman's life or when the pregnancy is the result of rape or incest. In a statement released shortly after the US struck down Roe *v* Wade, Brazil's government said that it would continue "promoting the right to life, from conception to natural death."

A spate of abortion related deaths and jailing of women in El Salvador, where abortion remains illegal and highly prosecuted, has shocked human rights groups. And in 2021 Honduras's president modified the country's constitution to make it harder to decriminalise abortion.

All eyes are now on Chile, where the most momentous of U turns could be possible. For decades abortion in Chile has been prohibited under all circumstances—the legacy of a 1989 law from the dictator Augusto Pinochet. Things started to change in 2017 when the outright ban was lifted and abortion legalised when the woman's life was in danger, a fetus was unviable, or rape had caused the pregnancy. In 2021, however, politicians voted down full decriminalisation. Over the past five years 366 Chileans have been prosecuted for autonomous abortions, including 39 girls.

An opportunity for permanent change lies just around the corner, however. On 4 September the country will vote on a new constitution drafted by the half female assembly. As well as creating a national health service, the proposal includes the right for everyone to "make free, autonomous and informed decisions about their own body, sexuality, reproduction, pleasure and contraception."

Sidestepping the country's conservative politicians could mean Chile emerges from

A 2021 march in Santiago, Chile, to mark the global day of action for access to legal, safe, and free abortion

SOPA IMAGES / ALAMY

A pro choice rally in Buenos Aires in 2020

CAROLINA JARAMILLO CASTRO / ALAMY

the shadow of its brutal military dictatorship as a global leader in abortion rights and the first country to enshrine abortion as a fundamental right, says Rosero.

Land of the free

But the benefit of the "green wave" extends far beyond abortion, says Rosero. "It's also creating the possibility to have more protections for reproductive rights in a broader way," she says.

In the case of Colombia, the court ordered that women should be able to avoid any type of unwanted pregnancy and thus needed better tools to make good decisions on pregnancy, including access to contraception, sexual education, and healthcare. Improving access is likely in turn to boost access to healthcare across the board, Rosero adds.

Mexico's decriminalisation of termination has brought such benefits, says Amelia Ojeda Sosa, legal coordinator of the Psychological, Sexological and Educational Care Unit for Personal Growth based in Merida, Yucatan. Now access to abortion is greater at home, support groups are increasingly turning their attention elsewhere.

Mexican *acompañantes*, or companions, have long supported women in Central America, where abortion is generally prohibited. They send medicines, guide them through the process, and offer emotional support. Now that US states such as Texas have enforced strict restrictions these companions are helping American women, too. Support groups in Mexico are posting drugs that induce an abortion, such as mifepristone or misoprostol, or carrying them over the border. For Latin American women who live in the US, collectives are helping them cross the border to find treatment.

"We have always looked to the US as a world power, a developed country, a country of freedom," says Ojeda Sosa. "But if women there have their rights restricted, we are all prepared to support them so that they continue to have access to self-managed abortion."

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