ANY REPLY OR SUBSEQUENT REFERENCE TO THIS COMMUNICATION SHOULD BE ADDRESSED TO THE PERMANENT SECRETARY AND THE FOLLOWING REFERENCE QUOTED:-

No. _____

MINISTRY OF HEALTH
OCEANA COMPLEX
2 – 4 KING STREET
KINGSTON, JAMAICA

2007 February 19

Honourable Horace Dalley
Minister of Health
Ministry of Health
2-4 King Street
Kingston

Dear Minister:

Thank you very much for meeting with representatives of the Ministry's Advisory Group on Abortion Policy Review, on Wednesday February 14, 2007 at the Knutsford Court Hotel and for allowing us the opportunity to make a verbal report to you and senior members of the Ministry and to obtain some feedback on our work. I found the meeting extremely instructive and regret that it was so long delayed.

In 2006, we were advised by the Ministry that the Government required that matters such as the one that we were reviewing should be presented to the public for consultation before a final decision would be made. The Group therefore, (though not part of our Terms of Reference) prepared the necessary documents to give effect to this requirement. These documents do not form part of our report. They have been submitted to the relevant officers in the Ministry, through whom an application for funding has been made to the Cabinet Office. We have recently been advised that funding for the exercise has been identified, and that the report with its attachments which we are submitting to you today, contain the information necessary to move the process forward.

On the signature page of our report, you will note that two persons have not signed, to date. A letter is attached from the Nursing Council. Also attached is the response to the questionnaire which the clergy member presented to the Group following a meeting which he had with some of his colleagues.

The matter is indeed very controversial and raises a number of extremely important issues. Nevertheless, we have approached our work in the spirit of the specific objectives stated in our Terms of Reference, while not ignoring the larger issues.

We are grateful to the Ministry for the opportunity to serve.

Sincerely,

A Wynante Patterson

A Wynante Patterson (Dr.)
Chairman
Abortion Policy Review Advisory Group
Ministry of Health, Jamaica.

Cc Dr. Grace Allen Young, Permanent Secretary
Dr. Sheila Campbell Forrester, Actg. Chief Medical Officer

MINISTRY OF HEALTH, JAMAICA
ABORTION POLICY REVIEW ADVISORY GROUP
FINAL REPORT

2007 February 19

Hon Horace Dalley
Minister of Health
2-4 King Street
Kingston

Dear Minister:

Further to the interim report submitted to your predecessor, Hon. John Junor in mid December 2005, (attachment 1) we the members of the Advisory Group have pleasure in presenting to you our draft final report.

We have met seven (7) times this year and continued work as instructed in our scope of work.

Our Terms of Reference (attachment 2) provide a background to the issues involved:

- the high prevalence of abortion world-wide including Jamaica
- the high toll in terms of maternal mortality and morbidity in countries where access to abortion is illegal
- the consequent need to develop systems and guidelines to ensure that abortion is safe and accessible for all, including the need for systems and centres to effectively manage abortion complications and provide pre and post abortion counseling, education and family planning services to prevent repeat abortions.

One of the difficulties in countries like Jamaica with restrictive and punitive laws is the difficulty in obtaining accurate statistics as to the prevalence of abortion and its complications because of a tendency to conceal facts and veil intentions which could be considered illegal. As far as we can ascertain the complications of unsafe abortions constitute the eighth leading cause of maternal deaths in Jamaica and the second in the adolescent age group.

Another difficulty in dealing with the public health problem is the controversial nature of abortion. It is impossible entirely to divorce the medical and legal aspects of abortion from the ethical and sociological aspects. These aspects are of the greatest importance and we have thought it to be essential to keep the larger issues in mind when considering our exact terms of reference.

We have obtained information from:

- a review of existing laws globally and specifically within the Caribbean (attachment 3)
- a review of actions taken by the Ministry of Health, Jamaica, to address the issue of illegal and unsafe abortions nationally (attachment 4&5).
- a review of relevant sections of annual reports of the Ministry of Health
- detailed information on abortions derived from records of the Victoria Jubilee Hospital and the Cornwall Regional Hospital
- a review of relevant scientific papers published by researchers working within the local health system
- a review of responses to a ten point questionnaire distributed through members of the Advisory Group
- a report of a Public Opinion Survey and Focus Group Discussions commissioned by the Group to ascertain the views of the Public on the legalization of abortion (attachment 6).

Main Findings

The abortion laws of the Caribbean cover the whole spectrum of the world's abortion laws.

The six stages of the laws on abortion may be listed as follows from the most restrictive to the most liberal; each succeeding stage includes the preceding provisions:

Total prohibition:	where abortion is never lawful
Life only:	where abortion is only permitted to save the woman's life
Physical health:	where abortion is permitted to save the physical health of the mother
Mental health:	where abortion is permitted to avoid the risk to the mothers' mental health
Socio-economic grounds:	where abortion is permitted in consideration of the woman's social and economic condition whether current or foreseeable.
On request:	where abortion is permitted without restriction as to the reason usually for some specified period of gestation.

The laws of the Commonwealth Caribbean are all derived from the 1861 *Offences Against the Person Act*. For several Caribbean countries, the language of the 1861 Act has remained virtually unchanged. That is the case for Jamaica. It is also the case for Antigua, Dominica, St. Kitts and Nevis, and Trinidad and Tobago. In all the others, there have been some changes. Whenever Caribbean legislatures have addressed the issue of law reform, they have consistently expanded the grounds for

lawful abortion. But only Barbados (1983) and Guyana (1995) have moved beyond the restrictive confines of the criminal law and established positive civil law to regulate the service of abortion. (Dr. Fred Nunes: Review of the existing legislation and policies on abortion in Jamaica and the wider Caribbean).

In 1975 the then Minister of Health the Hon. Kenneth McNeil in Ministry Paper No. 1, titled "Abortion: Statement of Policy", (attachment 4) wrote, "the present Laws relating to abortion are contained partly in our Common Law and partly in the Statute Law – The Offences Against the Person Act. The Statute Law position is that it is a criminal offence to procure an unlawful abortion. Indeed sections 65 and 66 of the Offences Against the Person Act lay down a maximum penalty of life imprisonment for the offence. The Statute also provides a maximum penalty of three years' imprisonment for anyone who assists in procuring an unlawful abortion. Despite these severe penalties, the Statute is absolutely silent on the circumstances in which an abortion would be lawful". "The fact that the Statute is silent in this regard is the main reason why our qualified medical practitioners develop inhibitions in this area of work".

No legislative action has proceeded from this Ministry Paper.

There was; however, increasing public health concern about the rising rate of unsafe Abortions and complications especially among adolescents. The Ministry of Health's Annual Report stated that in 1973 and in 1977 almost three quarters (74%) of the young
adult women who were pregnant, had their first pregnancy by the fifth year in school. In terms of unplanned pregnancy, data from the National Family Planning Board's Reproductive Health Survey revealed that 43% of current or most recent pregnancy was mistimed and 18% was unwanted. There was a strong suspicion that many of these women resorted to unsafe abortions. In response to this challenge the Ministry of Health accelerated activity in Family Planning Services and despite the legal framework, established a Fertility Management Unit at the Glen Vincent Health Centre in Cross Roads in 1976. In 1990 and 1991, the Ministry also outlined the criteria for selection of patients for the termination of a pregnancy, (attachment 5), one
of the services provided by trained Obstetricaians/Gynaecologists from the Victoria Jubilee Hospital. However the services of this facility were terminated in mid 1990s, because of inadequacy of finances with which to assign staff to provide the services, as well as to maintain the physical structure of the clinic.

Since 1995, the issue of unsafe abortion has been debated widely and calls for amendments to the current legislation and/or the development of a Medical Termination of Pregnancy Act have been made. However due to the sensitive (political and religious) nature of the issue, respective governments have declined to fast track their policies and the necessary supportive legislation.

Hopefully the establishment of this Group by the Ministry of Health, with the stated

objective "to reduce maternal mortality (and morbidity) in Jamaica by three quarters by the year 2015 in keeping with the Millennium Development Goal for improving maternal health" signals renewed enthusiasm.

At the Victoria Jubilee Hospital, admissions to Ward 5 which deals exclusively with abortions and their complications, numbered 641 patients between March 1 and August 31st 2005, a period of six months. Seven per cent of those admitted volunteered that they had attempted a termination of pregnancy (TOP). 35% of patients admitted were teenagers, all were single, 75% were unemployment and 27% were engaged in low paying employment, all had inner city addresses. Thirty-eight per cent (38%) admitted to having had a previous TOP, 30% of these had had two or more previous abortions. 45% of the patients said they belonged to Christian denominations. 51% did not respond to the question, 64% of the patients had gestation periods of 12 weeks or less, 62% had induced the abortion medically. 86% of the patients had D&C in hospital for the treatment of incomplete abortions, and four (4) patients had to have major abdominal surgery. 33% of patients had an ultrasound examination and 20% were transfused with blood or blood products. During this period no patient died but morbidity was high. The average length of stay in hospital was 3 days. The longest length of stay was 14 days. 30% of the patients were not billed. Of the 70% who were, none have paid. **These data reveal that many of the women admitted to Ward 5, are young, poor, unemployed and live in economically and socially deprived communities. They are sufficiently well-informed to intervene in their pregnancies early i.e., before 12 weeks, and to choose to access a medically induced method, albeit on the black market. (their drug of choice – Cytotec is not available legally in Jamaica). The management of the complications of abortion incur high hospital costs which in the economic environment of these patients are unrecoverable.**

1. Data from the Cornwall Regional Hospital records between October 01 and December 31, 2005 reveal that 54 patients were admitted with a primary diagnosis of "incomplete abortion". Based on the assumption that cases recorded as being septic or having heavy bleeding had been interfered with under unsafe conditions, 11% can be said to have been so induced. This may well be an under-estimate. **Patients, out of loyalty to the person(s) who have "helped" them do not divulge names, or even admit to any interference because of the possibility of legal punishment both for themselves and for their "helper (s)". The 54 patients under consideration had had a total of 90 deliveries and 63 abortions, giving a very high ratio of abortions to deliveries. In order Caribbean territories this ratio is reported to approach 1:1.** Three of the 54 patients were under 17 years supporting the Reproductive Health's Survey findings of the early initiation of sexual activity. Unlike the patients attending VJH, the majority paid their subsidized fees even if they were un-employed. Like VJH, the hospital costs were high as all patients had D&C and General Anaesthetic and spent a minimum of two days in hospital.

Three maternal deaths have been recorded in the south-east health region during 2005, one each occurring at the Spanish Town Hospital, the Kingston Public Hospital and the University Hospital. (See attachment 7 for details of the impact of unsafe abortions on maternal deaths).

The public Opinion Survey (June 2006) found that the word "abortion" in itself, evokes a spontaneously negative response among many. Specifically when asked whether "women should be legally allowed to access abortions in Jamaica, 53% said "NO". In contrast when asked whether "a pregnant woman should have the legal right to terminate a pregnancy". (TOP) only 38% said "NO". 54% said "under special conditions" and 4.3% said under all conditions". **A total of over 58% of respondents gave a positive response to legalization of TOP.** The "special conditions" emerged as including incest, rape, endangerment of the woman's physical or mental health and/or life. (See Table 1b (1) of Final report of researchers). For other conditions contraception was considered the solution of choice (See final report).

Sixty percent of respondents expressed low support for a punitive Act.

In the focus groups, all participants reported knowing that the practice of abortion, though illegal, is rampant in Jamaica. The majority said they would agree to abortion being legalized within strict guidelines and under specific circumstances.

RECOMMENDATIONS OF THE ABORTION POLICY REVIEW GROUP

Repeal the relevant sections of the Offences Against the Persons Act, and substitute it with a Civil Law, titled "Termination of Pregnancy Act" stating the conditions under which medical termination of pregnancy will be lawful. (See draft Bill for recommended conditions)

Develop, maintain and staff specified centres in each health region for the provision of therapeutic abortions. Such centres should be registered by the Ministry, and monitored according to the Ministry's standards. (See draft Bill for recommendation sites in public facilities).

Doctors private offices may be assessed, registered and monitored for the provision of abortion services for women who are less than 12 weeks pregnant.

Pregnancies up to 12 weeks gestation (calculated from the first day of the last menstrual period) can be performed in registered facilities by an authorized medical practitioner in consultation with the woman. The methods recommended are pharmaceuticals, and menstrual vacuum aspiration.

Pregnancies over 12 weeks gestation are to be performed by, or under the supervision of an Obstetrician/Gynaecologist in the formal setting of a hospital, equipped to effectively manage, utilizing the best current medical practice, any complication that may arise.

Termination of pregnancies over 22 weeks gestation is **not recommended**, except under exceptional circumstances agreed by the woman and two authorized medical practitioners and performed in an appropriate setting authorized by the Ministry.

It is highly recommended that persons involved in the provision of these services receive specific training from a recognized institution

Pre and post abortion counseling, including available options to termination and the use of effective contraception is highly recommended.

Special provisions are recommended for the mentally disabled.

Special provisions are recommended for minors, i.e. persons under age 18 years.

The right to conscientious objection is recognized.

In all matters pertaining to this Policy, confidentiality is paramount.

The establishment of a monitoring and advisory Board is recommended to oversee implementation of the policy.

The Group has drafted an Act including Regulations (attachment 8) which the Hon. Minister may wish to use to give effect to the implementation services and schedules.

Finally, Penalties for unlawful actions under this Act have been suggested.

The Ministry's 'Abortion Policy Review Advisory Group' has to the best of its ability, given the paucity of statistical data on the practice of abortion in Jamaica, worked assiduously to respond to its terms of reference, and is submitting this report in the hope that it will be helpful to the Ministry in meeting the Millennium Development Goals for maternal mortality and in the pursuit of Safe Motherhood outcomes.'

The signatories to the report are on the back page.

Names and signatures of the members of the Advisory Group on Abortion

The names and signatures below following, indicate the acceptance and approval of each member of the Advisory Group of the foregoing documents on this ..... day of ..... 2006: -

Dr. Wynante Patterson (Chair) .....

Dr. Joseph Hall .....

Rev. Phillip Robinson .....

Dr. G. Wesley Bernard .....

Dr. Olivia McDonald .....

Dr. Glenda P. Simms .....

Mrs. Beryl Weir .....

Dr. Karen Lewis-Bell .....

Mrs. Magarette M. Macaulay .....

Dr. Douglas McDonald .....

Dr. Errol Daley .....

Mr. Easton Williams .....

Ms. Sheila Jones .....

NURSING COUNCIL OF JAMAICA
Nurses and Midwives Act, 1964
The Towers-6th Floor, 25 Dominica Drive, Kingston 5
Telephone: (876) 960-0823, 926-6042, 929-5118, 968-2642
Email: nursgcouncilja@mail.infochan.com

ALL COMMUNICATIONS SHOULD BE
ADDRESSED TO THE REGISTRAR

February 20, 2007

The Chairman
Advisory Group on Abortion
C/o Ministry of Health
2-4 King Street
Kingston

Dear Chairman:

Re: Recommendations of the Abortion Policy

The Nursing Council of Jamaica a participant of the Review Group discussed the recommendations at the Council Meeting held on Wednesday February 14, 2007.

The meeting recalled a previous correspondence stating the Council's position which is life only, physical health, mental health and rape.

I have been directed to advise that the Council cannot support the recommendations in its entirety therefore Mrs. Sheila Jones is not authorized to sign on behalf of the Council at this time.

Sincerely yours,

Thelma Deer-Anderson (Mrs.) O.D.
Registrar

ADVISORY GROUP ON ABORTION
C/O MINSTRY OF HEALTH
2 – 4 KING STREET, KINGSTON

2005 November 23

Hon John Junor
Minister of Health
Ministry of Health
2 – 4 King Street
Kingston

Dear Minister:

RE: INTERIM REPORT – ADVISORY GROUP ON ABORTION

The Advisory Group on Abortion has been established and had its first meeting on 2005 September 16. We have had three (3) meetings to date and we are now sending in the first interim report.

SCOPE OF WORK
Review of the existing evidence of abortions and the sequalae in Jamaica
We have so far received a six (6) month review from Dr. Douglas McDonald, Senior Medical Officer, Victoria Jubilee Hospital, which is attached.

The report shows that in the six months under review, forty eight (48) patients admitted to attempting termination of pregnancy. 73% of the 48 patients were unemployed and 27% employed as higglers, store clerks, janitors and bus conductors. Clearly these are lower, socio-economic women. All the women under review were single and unemployed with 82% having an Olympic Way address (Kinston 11).

Review of the existing legislation and policies an abortion in Jamaica as well as the wider Caribbean.
Please see copy of document entitled Task 2: Review of the existing legislation and policies on abortion worldwide. This study was done by Dr. Fred Nunes, Consultant, Abortion Specialist.

With reference to minors, there is a conflict within the law as to the definition of a minor. The Age of Consent is 16 years whereas the age for signing with respect to consent for surgical procedures is 18 years.

Make recommendations for changes to the existing Offences Against the Person Act in support of the draft policy

Please see document attached.

Develop Guidelines for the provision of abortions by the health sector, including on what grounds/basis, in which facility and by whom
Please see policy guidelines for Termination of Pregnancy attached.

Make recommendations for the training of health staff and the equipping of regional centers for the provision of abortion services as well as the referral mechanisms to be employed

We recommend that health staff be trained at the University Hospital of the West Indies as to how to manage mistimed/unwanted pregnancies. Cognizance must be taken of the fact that pharmaceuticals are widely available for self-administered use to procure/initiate an abortion. Abortions should only be done in health facilities private or public as follows:

Under 8 weeks	-	To be done at the community level using Menstrual Vacuum Aspiration (MVA)
8 – 12 weeks	-	To be done at the community level using dilation and curettage (D& C), MVA or drugs
13 – 20 weeks	-	To be done under the supervision of an obstetrician / gynaecologist in an approved hospital setting

We do not recommend abortions later than 20 weeks gestation.

This committee strongly recommends a public education programme. This however will require funding and the Committee is in the process of investigating the possibility of accessing funding from Private Sector Organizations.

A more fulsome report will follow.

Your comments would be greatly appreciated.

Yours sincerely,

Dr. Wynante Patterson
Chairperson
Advisory Group on Abortion

Terms of Reference
Ministry of Health, Jamaica
Abortion Policy Review Advisory Group

Background

The World Health Organization (WHO) reports that each year, over 210 million women globally become pregnant despite available contraceptives and about one-fifth of them resort to abortion. WHO also estimates that 46 million abortions are performed each year. This equates to 35 abortions per 1,000 women aged 15-44 years. Of these 46 million abortions, 27 million are performed legally and 19 million are illegal and unsafe. Unsafe abortion is entirely preventable, yet it remains a significant cause of maternal morbidity and mortality in much of the developing world. Worldwide an estimated 680,000 women die as a consequence of unsafe abortion. Globally unsafe abortions account for 13% of maternal deaths.

Women who resort to unskilled or untrained abortion providers put their health and life at risk due to inadequacy of skills on the part of the provider and use of hazardous techniques and unsanitary facilities. Criminalizing abortion does not reduce its incidence but rather increases mortality and morbidity. Mortality due to abortion is relatively higher in contexts where access to abortion is restricted. This is clearly evidenced by the fact that in Africa where abortions are illegal, 680 women die per 100,000 abortions compared to no more than one death per 100,000 abortions in developed regions.

Where abortion is not against the law, it paves the way for the development of systems and guidelines to ensure that abortion is safe and accessible for all and not just the rich. It enables the adequate training of health workers and the equipping of health facilities to ensure safe abortions. In addition to high quality abortion services there is need for systems and centres for the effective management of abortion complications and post abortion care including pre- and post- abortion counseling, education and family planning services to avoid repeat abortions.

Jamaican Context

Using WHO's estimate of 35 abortions per 1,000 women aged 15-44 years, this indicates that Jamaica probably has some 22,000 abortions annually, all illegal and largely performed by untrained health workers as well as others. Abortions and complications thereof are the eighth leading cause of maternal deaths in Jamaica affecting adolescents primarily.

Under the Offences Against the Person Act (section 72) abortions are illegal in Jamaica under all circumstances. Any woman who seeks to procure an abortion and **any person** who uses drugs, poisons, noxious substances, instruments or other means to induce an abortion, commits an offence. This offence is punishable by life imprisonment with or without hard labour. Section 73 of the same act indicates that it is also an offence to

supply or purchase material intended for abortions. This offence carries a maximum penalty of three years imprisonment with or without hard labour.

Despite the legal framework, due to public health concerns about the increasing rate of unsafe abortions and complications, the Ministry of Health established a Fertility Management Unit at the Glen Vincent Health Centre in Cross Roads. In 1990 and 1991, the Ministry also outlined the criteria for selection of a patient for termination of a pregnancy, one of the services provided by trained Obstetricians/Gynaecologists from the Victoria Jubilee Hospital. However the services at this facility were terminated in the mid 1990s. Since 1995, the issue of unsafe abortions has been debated widely and calls for amendments to the current legislation and/or the development of a Medical Termination of Pregnancy Act made. However due to the sensitive (political and religious) nature of the issue, respective governments have declined to fast track their policies and the necessary supportive legislation.

Overall Objective

To reduce maternal mortality (and morbidity) in Jamaica by three quarters by the year 2015 in keeping with the Millenium Development Goal for improving maternal health.

Specific Objectives

1. To articulate a policy for the provision of safe reproductive health services in Jamaica with special emphasis on safe abortions
2. To draft recommended amendments to the existing Offences Against the Person Act in support of terminations of pregnancy for medical and humanitarian reasons e.g. statutory rape.

Composition of Advisory Group

The Abortion Policy Review Advisory Group should bechaired by a nominee named by the Minister of Health and made up of not more than 12-14 persons inclusive of the following:

- Representative of the Medical Association of Jamaica
- Representative of the Medical Council of Jamaica
- Representative of the Nurses Association or Nursing Council of Jamaica
- Consultant Obstetrician/ Gynaecologist (2)
- Representative of the Ministry of Health (1-2)
- Representative of the legal fraternity
- Representative of the clergy
- Representative of Women's advocacy/ rights groups (1-2)
- Representative of the Population Policy Advisory Committee

The advisory group should be supported by a Secretary to enable accurate and continuous documentation of discussions and final outputs.

Scope of Work

The work of the Abortion Policy Review Advisory Group should include but not necessarily be limited to:

- Review of the existing evidence of abortions and the sequalae in Jamaica
- Review of the existing legislation and policies on abortions in Jamaica as well as the wider Caribbean
- Review of the existing legislation and policies on abortion worldwide e.g. South Africa
- Develop a draft policy on safe abortions for the Ministry of Health's consideration
- Make recommendations for changes to the existing Offences Against the Person Act in support of the draft policy
- Develop guidelines for the provision of abortions by the Ministry of Health, including on what grounds, in which facility and by whom
- Make recommendations for the training of health staff and the equipping of regional centres for the provision of abortion services as well as the referral mechanisms to be employed.

Time Frame

The Abortion Policy Review Advisory Group shall be established for 6-12 months and meet monthly or bi-monthly as often as required to complete the scope of work. It is anticipated that a first report will be available by end of 2005.

Task 2: ***Review of the existing legislation and policies on abortions in Jamaica as well as the wider Caribbean.***

We have collected a virtually complete set of the laws of the Commonwealth Caribbean and the Netherlands Antilles (**attached**). In addition, we have reviewed the literature of the laws of other Caribbean countries, namely, Puerto Rico, Haiti, Cuba, the Dominican Republic, Guadeloupe and Martinique.

Perspective on the Caribbean

The abortion laws of the Caribbean region cover the entire spectrum of the world's abortion laws. This is no doubt testimony to the intense experience of colonialism of the past as well as its persistence. At one end, the Netherlands Antilles reflects a condition of total prohibition of abortion and at the other Guyana represents the most developed form of law and allows abortion on request for the first weeks of pregnancy. This peculiar spread of laws in a small region is most dramatically illustrated in the small island of St Martin where, on the Dutch side of the island, abortion is legally prohibited and on the French side abortion is legally and liberally permitted. This great range is conveniently depicted is a **map** of the region. **1**

With the exception of the Netherlands Antilles, abortion is legal in the Caribbean, but for the most part highly restricted. The statement that abortion is legal is often a surprise to the lay reader. This discomfort can be easily quieted. The statutes of the Commonwealth Caribbean speak consistently of 'unlawful' action – whether in administration, use, supply or procurement. Where the action is undertaken by the appropriate medical persona and done in good faith for the patient's interest abortion is not unlawful. (We discuss the relevant case law below **2.**)

The six stages of the laws of abortion may be listed as follows from the most restrictive to the most liberal; each succeeding stage includes the preceding provisions:

Total prohibition: where abortion is never lawful

Life only: where abortion is permitted only to save the woman's life

Physical health: where abortion is permitted to avoid the risk of physical harm to the woman.

Mental health: where abortion is permitted to avoid the risk of harm to the woman's mental health.

Socio-economic grounds: where abortion is permitted in consideration of the woman's social and economic situation whether current or foreseeable.

On request: where abortion is permitted without restriction as to reason usually for some specified period of gestation.

Historical Context:

The laws of the Commonwealth Caribbean are all derived from the 1861 Offences Against the Person Act. The first English statue on abortion was Lord Ellenborough's Act of 1803, more than 200 years ago. Prior to that abortion was guided by canon law which treated the termination of pregnancy before 'quickening' as a non-issue. Quickening was the point at which the woman could detect movement of the foetus and that was assumed to be the point at which the soul entered the foetus.

For several Commonwealth Caribbean countries the language of the 1861 act has remained virtually unchanged. That is the case for Jamaica. It is also the case for Antigua, Dominica, St. Kitts and Nevis, and Trinidad and Tobago. In all the others there have been some changes.

The laws of the Bahamas, Grenada and St. Lucia employ different constructions but retain the essential language of 'unlawful' and go on to make specific reference to acts done 'in good faith' and 'without negligence' and so offer a degree of protection to the medical practitioner. These acts also mention 'for the purpose of medical or surgical treatment' and so clearly open the platform of abortion in the interest of the woman's health.

The laws of Belize, Bermuda, and St. Vincent retain the language of the parent Act of 1861, but go on to make specific exceptions. In 1980, the law in Belize was revised to add specific legal exceptions for lawful abortion, where two doctors agreed, to protect the life, physical health and mental health of a woman or her children and to avoid the birth of a seriously mentally or physically handicapped child. The physicians making the assessment could consider the woman's 'actual of foreseeable environment.'

Similarly, in 1983, Bermuda introduced the same provisions as modifications to its criminal law. It added specific provisions for lawful abortion for pregnancy resulting from incest and rape. The revisions in Bermuda restricted the service to hospitals and required that abortions were cleared by a hospital Therapeutic Abortion Committee. We should note that the law in Bermuda also permitted a medical practitioner 'or any person assisting him' to lawfully provide the service of abortion. This latter is an important provision since it opens the door to non-physician providers.

In 1988, St Vincent modified its law using language identical to Belize.

Most recently, in 2004, St. Lucia modified its Criminal Code to provide exceptions for legal abortion to protect the woman's physical or mental health 'if the length of the pregnancy does not exceed twelve weeks.' The law also makes specific provision for lawful abortion in cases of rape and incest but requires the woman to provide a police report substantiating her claim. The provisions in St. Lucia import language from the

Medical Termination of Pregnancy Act of Guyana in respect of women's access to termination without their partner's knowledge or consent. St. Lucia also follows the Guyana provisions of mandatory counselling.

Modern Exceptions:

In the Commonwealth Caribbean only Barbados (1983) and Guyana (1995) have moved beyond the restrictive confines of the criminal law and established positive civil law to regulate the service of abortion. The Medical Termination of Pregnancy Act (Barbados, 1983) takes a staged approach allowing a single medical practitioner to form the judgment up to 12 weeks gestation; requiring two for 13-19 weeks; and the concurrence of three medical practitioners for 20 weeks and beyond. The Act makes abortion legal to save the woman's life, to protect her physical and mental health, to avoid the birth of a seriously handicapped child, for socio-economic conditions whether actual or foreseeable and in the event of rape or incest. The woman's written statement is sufficient to satisfy her claim of rape or incest. The requirement in the Barbados MTP is far less onerous on the woman, although it is 20 years older than the similar clause in the St. Lucian law. The law requires the consent of a parent or guardian for a termination of pregnancy for a woman under 16 years old. Terminations of more than 12 weeks duration must be performed in a hospital. For statistical purposes, medical practitioners are required to submit anonymous reports of terminations to the Chief Medical Officer.

The Medical Termination of Pregnancy Act (Guyana, 1995) follows the pattern of the Barbados Act. The Guyana Act goes beyond the Barbados one in that it provides for medical practitioners to provide terminations without requirement of reason ("on request") for up to eight weeks. Between eight and sixteen weeks, the abortion must be provided by 'authorized medical practitioners' in an 'approved institution' and for cause. The range of causes is extensive, covering all the provisions in the Barbados Act and adding contraceptive failure, and if the woman is HIV positive. Terminations between 12 and 16 weeks require the concurrence of two medical practitioners. Beyond 16 weeks, terminations are lawfully permitted only when three medical practitioners agree that the abortion is necessary to save the life of the woman or avoid grave physical or mental injury to the woman or the child. The Guyana MTP Act makes strong provisions for counselling and for the appointment of a board to monitor the administration and operation of the law. We should note that the Guyana Act makes provision for abortions to be provided by an 'authorised medical practitioner and any assistant acting under such authorised medical practitioner's directions.'

The pattern of law reform is unequivocal. Whenever Caribbean legislatures have addressed the issue of abortion law reform, they have consistently expanded the grounds for lawful abortion. There has been no exception to this trend. The challenge has been that some of the well-intentioned provisions have almost certainly constrained access. Among these we might note the mandatory requirement for counselling, a 48-hour delay of service, the restriction of services to hospitals, the need for women claiming rape or incest to provide police reports, the creation of Therapeutic Abortion Committees,

restrictions as to consent of minors, and the restriction of abortion services to medical practitioners.

Health Impact of Legal Abortion:

What can we learn from Barbados and Guyana that decriminalized and liberalized their statutes? First, the fear that the public hospitals would be overwhelmed was unfounded. In Barbados, ten years after the law, the number of admissions for septic abortion had declined by 70% and the admissions for complications of abortion has fallen by 53% **3**. Even more dramatically, within six months of the new law in Guyana, the admissions for complications of abortion fell by 41% **4**.

Common Law:

So much for our review of the statute law. What about the common law? Sadly, in spite of the strong values and sensitivities regarding public policy in this area, the common law is woefully underdeveloped. We have been unable to find any cases in Caribbean jurisprudence that have addressed the ugly social reality and sought to refine or advance the law.

There is considerable question in respect of the applicability of the landmark case *R v Bourne* **5**. The context and facts of the case are relevant. The Birkett Commission charged to review the operation of the law of abortion in England was sitting. A young teenager had been raped by several guardsmen. She was taken to Bourne's office by her parents and they all requested an abortion. Mr. Bourne, a physician, examined her and found that she was physically capable of carrying the pregnancy. He nevertheless performed the abortion, believing that if she were obliged to carry the pregnancy, it would make her a "mental wreck". Eager to assist the Commission in appreciating the circumstances under which medical practitioners, acting in good faith perform abortions, he advised the body of his actions. He was prosecuted and charged with the "crime of abortion."

The judge, McNaughton J, pointed out that there was no crime of "abortion" only a crime of "unlawful abortion." The charge sheet was modified. This is of crucial importance in the Caribbean where statues still employs that language. Bourne's defence of acting to protect the woman's mental health was upheld. The case therefore significantly expanded the construct of necessity from that of life to one of health, including mental health.

While no Caribbean case has tested the applicability of Bourne, Rebecca Cook and Bernard Dickens interviewed Attorneys General and concluded that with very few exceptions there was widespread agreement that Bourne would apply in their countries **6**. As we will see below, the Bourne standard is essentially what Minister of Health McNeill codified into practice in Jamaica as long ago as 1975.

So much for the law – statute and common alike. But even more important, what about the law in practice?

The Northern Irish Court of appeal recently took the Ministry of Health to task for not effectively operationalizing the NI abortion law. Northern Ireland's law is essentially the same that applies in most of the Commonwealth Caribbean where Bourne applies. In not issuing guidelines for the effective and fair access to abortion services, the Court explained that the Ministry of Health was in breach of its duties to ensure effective, fair and transparent access. Moreover, the Court explained that the Ministry was in breach of its duties in failing to investigate the actual problems that women face in accessing care **7**.

In others words, where Ministries fail in ensuring effective and timely access to women in need, they are in breach of their duties. If a similar case were to be brought in Jamaica on behalf of women against the Ministry of Health for failure to provide effective, fair and timely access, any Jamaica court would almost certainly find this NI decision very persuasive, given the similarity of the respective laws.

The Practice of Abortion:

We must therefore turn to the law in practice and face the monumental challenge that this issue places before the Advisory Group, the Ministry of Health and Government. Studies in at least four Caribbean countries, Guyana, Barbados Trinidad and Tobago and Antigua, have shown that abortion is widespread **8.** Hospital Admission data reveal that thousands of women are admitted every year for complications of abortion. The fact that these are uniformly poor women speaks to another side of the matter. There is growing evidence that the proportion of medical practitioners providing abortion services has increased significantly over the years **9.** There is further evidence that a large and larger proportion of women can gain easy access to safe abortion services **10**. In other words, as the process of medicalization proceeds, the law is falling into increasing disrepute. Studies have shown that within the Caribbean (Guyana, Barbados, and Antigua) 65-70 percent of women will have had at least one abortion by age 44, and that more than half of those will have had more than one abortion **11**. So abortion is a majority phenomenon for women. The implication for men is also clear: most men create at least one unwanted pregnancy that ends in an abortion. From a political perspective then, abortion is a majority experience of mature adults. That our political system has failed to address this phenomenon is the result of the enormous social stigma associated with abortion and the acute reluctance of our political leadership to face the controversy.

There is another less palatable explanation. The wretched reality is that those who have the voice to change the law have no need to do so; while those who have the need to change the law, have no voice to do so **12.** The law persists because the middle and upper classes live above the law and enjoy access to professional medical services. It is the poor who are harmed in their thousands and who die from time to time. The persistence of the criminal abortion law is testimony to the social divide in our society and to the paucity of political leadership in the face of religious sentiment and opposition.

And more. It is our considered view that the strong punishment-orientation that is such a legacy of our post-slavery society hinders us form moving beyond a criminal law to a civil one. What is ironic is that almost every last one of the colonizers that left us this onerous heritage of laws has moved beyond them. The Netherlands has one of the most liberal abortion laws in the world and the lowest abortion rate in the world; yet the Netherlands Antilles retains the absolutely restrictive law it inherited. The same is true the Commonwealth Caribbean: England changed its law in 1967, moving from prohibition to regulation; but, Barbados and Guyana excepted, the entire region remains trapped in the criminal law, a heritage of our colonial history. And this in spite of a now 30-year old promise of CARICOM Ministers of Health to review the laws of abortion (Nassau, 1975).

Efforts at Law Reform:

It is our considered view that the incremental efforts to create additional exceptions while retaining the criminal law is disingenuous and doomed to failure. So long as the overarching framework remains a criminal one, we will be unable to address the fundamental issue of social stigma without which the behaviour change we seek will remain beyond our reach. We need to come to terms with our preference for control and grow beyond our fear of freedom. We need to trust women as responsible moral agents and give them the freedom to decide.

Our law of abortion is unenforceable. It is ineffective in protecting foetal life and it imperils maternal life. In recent years, a huge change in technology that makes medication abortion cheap, accessible and private also makes our law not only archaic but obsolete. In the interest of justice and fairness, our review of the laws and our recognition of the gap between those laws and the social reality, leads us inexorably to call for action in creating a civil law of abortion.

This is not a new call. In 1975, Minister of Health Kenneth McNeil, a medical practitioner fully informed of the medical complications and impatient of the gross social injustice, promised to submit legislation to make abortion legal. That he was unable to advance such legislation to parliament is an unfortunate tribute to the power of religious institutions that railed against it and against the fairness and justice it would have allowed. Frustrated by that noise, McNeill simply enacted a policy of providing safe abortion services in a public health clinic on Eureka Road in Kingston 13. Fourteen years later, this liberal policy was refined and affirmed in a further memorandum by Dr Deanna Ashley 14. We should note that the religious bodies that made such an uproar at the thought of legal reform were silent at the creation and operation of the Fertility Management Unit.

Footnotes

1. Fred Nunes "Abortion Laws of the Caribbean Basin, 2005" prepared for Aspire (Trinidad and Tobago) based on the global map of the Center for Reproductive Rights and the work of Rebecca J. Cook and Bernard M. Dickens, Abortion Laws in Commonwealth Countries, Geneva: World Health Organization. 1979.

2. See *R v Bourne* [1939] 1 KB 687

3. Yvette Delph, "An Assessment of the Impact of the Medical Termination of Pregnancy Act, 1983 (Barbados) Comparing 1982 and 1992." PAHO, unpublished). See also Pauline Russell-Brown, "Does Liberalization Make a Difference? A study of Pregnancy Termination in Barbados" University of North Carolina, 1994. Russell-Brown's findings are markedly different from Delph's.

4. Fred Nunes and Yvette Delph, "Making abortion law reform work: Slips and steps in Guyana," *Reproductive Health Matters*, No. 9 (May 1997), p. 71

5. Bourne, *op. cit.*

6. Cook, and Dickens, Emerging Issues in Commonwealth Abortion Law, 1982, London: Commonwealth Secretariat, 1983.

7. Family Planning Association of Northern Ireland v Minister of Health Social Services and Public Safety [2004] NICA (08 October 2004)

8. Fred Nunes, "Contraceptive knowledge and practice among women seeking abortions in Guyana, 1996" (unpublished); Fred Nunes and Yvette Delph, "Contraceptive knowledge and practice among women seeking abortions in Barbados, 1996" (unpublished); Fred Nunes, Dane Abbott, Christopher Price and Yvette Delph, Contraceptive knowledge and practice among women seeking abortions in Antigua, 2005 (unpublished).

9. Fred Nunes, Dane Abbott, Christopher Price and Yvette Delph, "Medical Opinion of Abortion Law and Practice in Antigua, 2005 (unpublished).

10. ibid.

11. See papers mentioned at note 7 above.

12. Fred Nunes, *Journal of African Reproductive Health*

13. "Abortion: Statement of Policy." Paper No. 1 signed by Kenneth A. McNeill, Minister of Health and Environmental Control, 15 Jan. 1975. (M.P. No. HH 490/01).

14. Dr. Deanna Ashley "Fertility Management Unit, Glenn Vincent Health Centre," 2nd May, 1989.

MINISTRY PAPER NO. 1

Abortion: Statement of Policy

Honourable Members may be aware of that the question of the law dealing with Abortion has attracted much public debate recently. I have taken cognizance of the debate and its ramifications and now consider it appropriate for me to set out for the information of the House, Government's policy in the matter.

2. The present Laws relating to Abortion are contained partly in our Common Law and partly in the Statute Law – The Offences Against the Person Act.

3. The Statute Law position is that it is a criminal offence for anyone to procure an unlawful abortion. Indeed sections 65 and 66 of the offences Against the Person Act lay down a maximum penalty of life imprisonment for the offence. The Statute also provides a maximum penalty of three years imprisonment for anyone who assists in the procuring of an unlawful abortion. Despite these severe penalties, the statute is absolutely silent on the circumstances in which an abortion would be lawful.

4. The Common Law position is that it is lawful for a registered medical practitioner acting in good faith to take steps to terminate the pregnancy of any woman if having regard to such circumstances as s/he may reasonably consider relevant s/he forms the opinion that the continuation of the pregnancy would be likely to constitute a threat to the life of the woman or inure to the detriment of her mental and physical health.

5. It has been represented to the Government that because this legal position is not embodied in the Statute Law, it creates considerable uncertainty in the minds of medical practitioners. This uncertainty inhibits their willingness to perform operations and this in turn creates hardships for citizens who have lawful grounds for abortion as are contained in the Common Law.

6. The fact that the Statute is silent on the circumstances in which abortion would be lawful is the main reason why our qualified medical practitioners develop inhibitions in this area of work. It is considered that this matter is far too important to be left in a state of uncertainty and an unequivocal law appears to be urgently required.

7. After giving careful consideration to this matter, the Government has now decided to amend the relevant sections of the Offences Against the Person Act so as to:--

(a) make clear when an abortion would be lawful in Jamaica; that is to spell out in Statute Law, or to codify, what in effect is the existing Common Law position;

(b) take steps to make rape, carnal abuse and incest lawful ground for abortion.

8. The fact is that there are circumstances where common decency justifies the termination of pregnancy. For example, in the case of statutory rape, that is, rape of a person below the age of consent, decency and mercy require that the young child should not be obliged to bear a child resulting from the cruel and/or insane desires of a criminal.

9. The purposes of the amendment proposed at paragraph 7(a) above, is merely to incorporate the Common Law position into an Act of Parliament, thereby codifying the Law for the guidance of all and sundry.

10. The Government proposes to introduce legislation into the House to give effect to the proposed amendments as set out in this Paper.

KENNETH A. MCNEILL
Minister of Health & Environmental Control
15th January, 1975

M.P. No. HH490/01

MEMORANDUM

TO: Dr. M. Reid
Senior Medical Officer (H)
KSA Health Department

Dr. H. Carpenter
Medical Officer (H)
KSA

FROM: Dr. D. Ashley
SMO (MCH)

DATE: 2nd May, 1989

SUBJECT: RE: Fertility Management Unit – Glen Vincent H/C

This is to remind all staff about the criteria/guidelines for the operations/services at the Glen Vincent Fertility Management Unit.

Criteria for Selection of a Patient for Termination

1. A pregnant teenager under the age of 17 years. This is considered to be statutory rape as the age of sexual consent has now been raised to 16 years./

2. Any pregnancy that is associated with rape or incest (there must be documented evidence to support this).

3. A case referred by the police, Family Court, Children or Probation services with the supporting documentation to justify termination.

4. Any medical/therapeutic indication e.g. heart disease, sickle cell anaemia, severe hypertension, severe mental illness or mental retardation. Again there must be documentation to support the medical reason given. All medical cases should be referred to a hospital for the procedure as Glen Vincent is not adequately set up to deal with medical emergencies.

5. Failed contraception – the woman must be on a reliable contraceptive method such as the pill, IUD, or depo provera. She must show evidence (i.e. her clinic record) to prove that she is regularly attending one of the Ministry of Health family planning clinics and is on one of the specified methods. Referrals from the private sector cannot be accepted.

6. A woman who comes for a TL and is pregnant can have a combined TL/Termination.

7. A woman who has had more than 2 children can choose to have a tubal ligation. She must receive adequate counselling and sign the specified consent form prior to the procedure being done.

Please note that referrals for termination must be accompanied by satisfactory documentation to show that the case conforms with the guidelines. No woman can have more than 1 termination. Each patient must agree to initiating contraception immediately after termination (preferably an IUD should be inserted prior to discharge).

cc. Dr. O. McDonald
Mrs. B. Chevannes

Final Report of

Public Opinion Survey on The

Legalization of Abortion

Fieldwork conducted: June, 2006

Prepared for: The National Family Planning Board
Contract #: 7/3/06/04

Prepare by: Hope Enterprises Ltd. Kingston, JAMAICA

1.0 INTRODUCTION

1.1 Background:

Despite the illegal nature of abortions in Jamaica, women do seek abortion services for a variety of medical and personal reasons. These women may eventually present with evidence of infection and bleeding in hospitals with some ultimately resulting in death due to complications arising from these unsafe abortions.

To date the Ministry of Health (MOH) has established an Advisory Group on Abortion to carry out a number of tasks. The establishment of this committee is a result of the MOH's concerns for the evident 'backdoor abortions" and attendant maternal mortalities. The Minister of Health in an interview with the Sunday Observer was quoted as saying:

"What we are seeking to do is to review the practice and law in relation to abortion, not for the purpose of allowing abortion, but for the purpose of protecting the health of women who have been seeking illegal abortions in circumstances which endangers their health and their future reproductive capacity."[1]

The established Committee contracted Hope Enterprises Ltd. to conduct a study to investigate issues surrounding abortion. This study sought to explore public attitudes towards abortion particularly as it relates to the establishing of legislation to enable women to access abortions and the circumstances under which this would be most appropriate.

Fieldwork for this survey was conducted island wide during the month of June among 1000 randomly selected Jamaican adults, 15-65 years.

[1] The Sunday Observer; March 12, 2006; Section 1, page 4

1.2 Conclusions:

- Most Jamaicans hold to the view that abortion is wrong. It is considered a sin and just over a half of those surveyed reject the idea of legalizing it (53%). It should be noted however that this view dominates when the word "*abortion*" is used.

  In contrast a more flexible position emerges when the question was phrased as "Should a pregnant woman have the legal right to *terminate* a pregnancy?" In this instance the majority (54%) agreed that *termination* of pregnancies should be allowed *under certain circumstances*. These circumstances emerged as hard reasons or physically traumatic reasons including incest, rape and endangerment of the mother's mental and physical health and/or life. These "conditional supporters" have been observed in other studies conducted in North America where it is described as the existence of a "situationalist majority"[2]. Interestingly this situationalist majority exists even in countries such as the United States of America, where abortion is legal. Specifically, Jelen & Wilcox, 2003 describe this sub-group as:

  "a slight majority of Americans who favor legal abortion under some circumstances, but not others" (Jelen & Wilcox, 2003. page 5)

- It is a third (36%) who agreed that women should be legally allowed to access *abortions* in Jamaica.

- Females, upper and middle income respondents and urban dwellers were significantly more likely to support the view that women should have this legal right under special circumstances. However these are not determining factors as no correlation between support for legal termination and gender, socio-economic group or location was noted.

- Because an abortion is seen as a moral and religious issue, the handling of it must be in keeping with a serious issue therefore:

  - pre counseling was endorsed by 74%

[2] Jelen, Ted & Wilcox, Clyde.2003. *Causes and Consequences of Public Attitudes toward Abortion: A Review and Research Agenda*. www.georgetown.edu faculty wilcoxc Abortion.pdf. Sourced May 2006.

- an abortion must be a surgical procedure done in a special clinic or hospital by a doctor. This is not so much to ensure the safety of the mother but to underscore the seriousness of the act. Less than 2 in 10 persons were in favour of a tablet.

- The idea of conceiving of or stating a recommended gestation period was difficult for the majority and hence 60% ended up opting for the "latter stages when the mother's health is in danger."

- The majority could not perceive benefits to legalizing abortion but among the 30% who did, the reduction in unwanted children accompanying social burdens was the most important.

- Even as they could not state benefits to legalizing abortion, similarly the majority could not state disadvantages.

While in Jamaica the abortion debate is not polarized into pro life or pro choice issues, the subject is a very emotional and negative one which is compounded by the prevailing religious underpinnings. Latent in all of the emotion however is some flexibility based on the circumstances surrounding the reasons for the desired abortion.

Legalizing abortion will find public favour in special circumstances such as rape or if the mother's health or life is endangered.

1.3 Objectives:

To ascertain the views of the general public as to whether or not legislation should enable women to access abortion and the specific circumstances under which such services should be accessed.

More specifically, the study sought to achieve the following:

- ✓ Ascertain the views of the general public on whether or not legislation should enable women to access abortions
- ✓ Determine the information needed by the public to inform their opinion.
- ✓ Determine the grounds on which the public would agree to pregnancies being terminated on request
- ✓ Determine public opinion on the period of gestation for which abortion service should be made available
- ✓ Determine public opinion on where services should be made available and who should perform such services
- ✓ Determine public opinion on support services which should be in place particularly counseling whether pre, immediate, post and/or continuing
- ✓ Determine public opinion on the preferred method of terminating pregnancy that is whether by self-administered tablet or surgical approach

Research application: Information from this survey is intended to be used to inform the development of the appropriate policy by assisting the Committee in making recommendations for amendments to the existing Offences against the Persons Act, in support of termination of pregnancy in specific circumstances and conditions.

Table 1a (ii)

Response to legalizing "Termination of Pregnancy":

Phrased as: *"A pregnant woman should have the legal right to terminate a pregnancy"*

By Age and Regional Health Authorities

A pregnant woman should have the legal right to terminate a pregnancy	**Not at all**	**Under special circumstances**	**Under all circumstances**	**Unsure**
Total	**38.0**	54.1	4.3	2.8
15-19 years *	44.2	49.7	3.0	3.0
20-49 years	35.1	56.5	5.0	2.6
50-65 years	30.6	59.2	6.1	4.1
SERHA**	35.2	55.8	5.9	2.9
SRHA	38.2	56.2	1.8	3.7
NEHRA	39.0	50.7	2.9	7.4
WRHA	45.8	49.7	4.0	0.6

* p≥0.05 ;**p≥0.005 ; ***p≥0.000

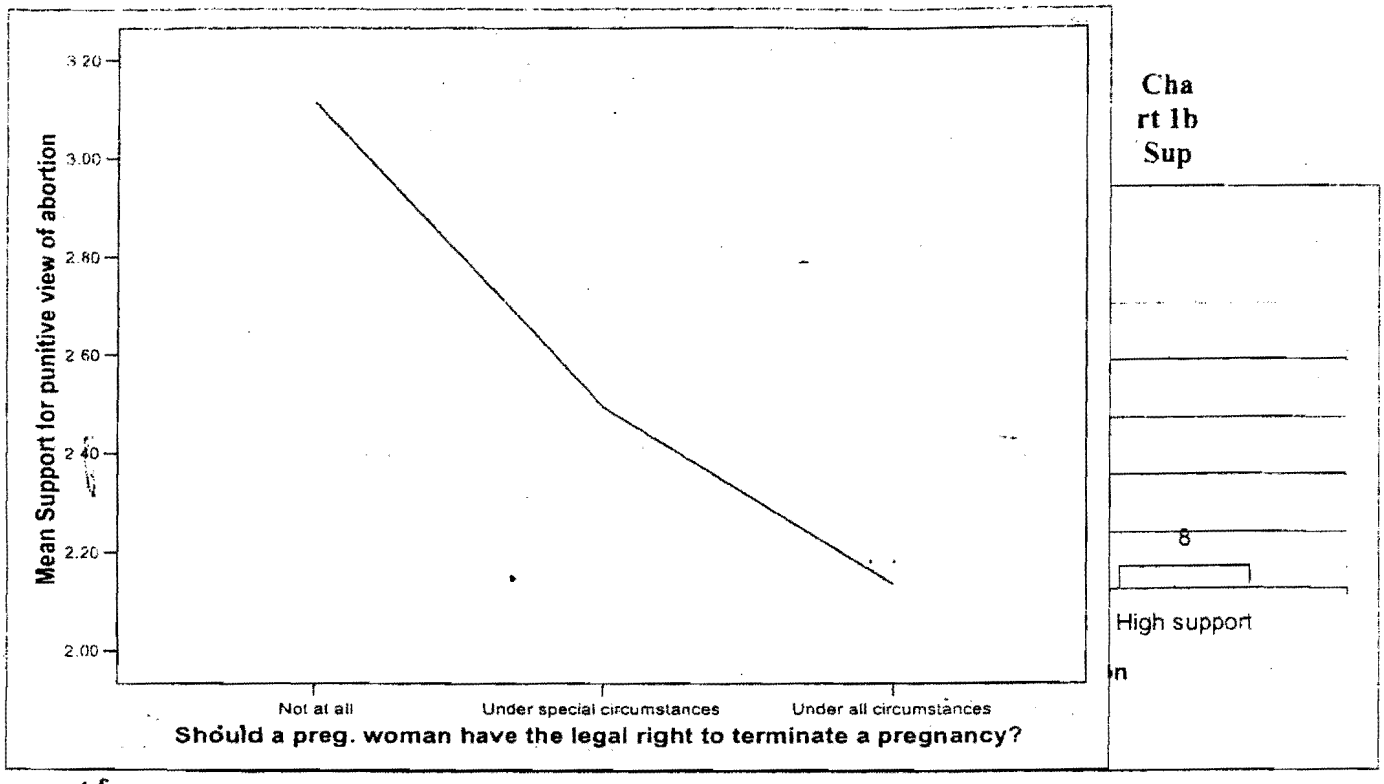
Table 1b (i)

Response to Legalizing "Abortion" in Jamaica:

Phrased as: *"Should women be legally allowed to access abortions in Jamaica?"*

By Gender, Socio-Economic Group and Location

Should women be legally allowed to access abortions in Jamaica	**No**	**Unsure/ undecided**	**Yes**
Total	**53.2**	10.7	36.1
Male	53.8	10.2	35.9
Female	52.7	11.1	36.2
Upper income	34.1	15.9	50.0
Working class	50.7	11.7	37.6
Lower income	62.1	8.0	29.9
Urban	45.4	12.6	42.0
Rural	63.4	8.2	28.4



Punitive View of Abortion (Total sample)

Summary

Abortion is a controversial topic among most of the adult population worldwide, and it is no different here in Jamaica. The focus group discussions produced a variety of responses to this topic. Responses varied across age and gender lines, religious beliefs and levels of sympathy felt towards social and economic problems. Participants who saw abortion as a 'sin' were the most adamantly opposed to the practice. They expressed their 'ideal' view as 'abortion never being allowed unless it meant death to either the mother or child'. Several of the persons in this category felt that rape did not constitute 'a good enough reason' to abort, because the child could be given up for adoption. However, they represented a minority opinion, as most participants felt that rape was 'a justifiable reason' to allow a woman to terminate a pregnancy. Although the word 'murder' was the most commonly associated with the description of abortion, the arguments used in this category were less adamant against abortion. Meaning, all groups made reference to abortion being 'killing the unborn', yet, participants were open to the procedure being allowed under certain circumstances.

There seemed to be a correlation between persons sympathy for the reasons associated with a woman's unwanted pregnancy, and her right to an abortion. The higher the level of sympathy, the more leniency to allowing abortion. Overall, the group of older females, followed closely, by the group of younger males expressed the least sympathy for the woman, and the most opposition to terminating a pregnancy. Meanwhile, the group of older males, followed closely, by the group of younger females expressed the most sympathy, and the least opposition to terminating a pregnancy. Although participants view the high rate of unwanted pregnancy, and high birth rates as very important issues in Jamaica, they do not think that abortion ought to be the solution to these problems.

In general, all groups reported knowing that the practice of abortion, though illegal, is rampant in Jamaica. The majority of participants said they would **agree** to abortion being legalized *within strict guidelines and under specific circumstances.* The greatest expressed concern regarding legalization is the perception that it would lead to increased 'promiscuous sexual behavior' throughout society. The consensus circumstances were **health risk to mother, health risk to child (severe deformity, or handicap) and rape**. Groups were also adamant that services should *only be available* in specific locations, which are, **hospitals and some private doctors**. Clinics were not thought to be good locations to perform abortions. They felt that the services should be available to all women, and up the three months of pregnancy. They felt qualified medical practitioners should be the only ones to carry out the procedure, and did not feel the self-administered method should be allowed unless directed by a doctor. Groups expressed concern that some women (and doctors) would try to 'beat the system', and so public transparency guidelines need to be in place. Participants unanimously saw the need for there to be trong support counseling services available, both before and after, having an abortion.

Abortions Ward 5 1/3 to 31/8/05

- No of Admissions 641
- Incomplete Abortions 261
- Complete Abortions 6
- Inevitable Abortions 18
- Threatened Abortions 33
- Missed Abortions 10

- 48 patients admitted to attempting TOP

Age of Patient

- < 15 yo 0
- 15 - 17 yo 13.5%
- 18 –19 yo 21.6%
- 20 - 24 yo 18.9%
- 25 - 29 yo 18.9%
- 39 - 34 yo 16.2%
- 35 - 39 yo 16.2%
- 40 or > ..... 2.7 %

Union Status

- All the patients under review were single.

Occupation

- 73 % ——— unemployed
- 27 % ——— employed
  higgler — 8.1 %
  store clerk — 8.1 %
  janitor, bus conductor

Address by Postal Code

- Kingston 2,3,4,
  Kingston 11 * 82 %
  Kingston 13,14,16
  Kingston 19,20
- Waterford, Bull Bay 18 %
  Sp. Town Clarendon

Previous Abortion

- 38 % ..... gave a positive history
  30 % of these had two
  or more previous abortions

62 % ..... Not stated or denied
previous abortion

Religion

- Not stated ..... 51.3 %
- Church of God ..... 27.0 %
- S.D.A. ..... 8.1 %
- Christian ..... 8.1 %
- Other ..... 5.5 %

No. of Children

0	.....	33.3 %
1	.....	11.1 %
2	.....	13.9 %
3	.....	13.9 %
4	.....	13.9 %
5 or >	.....	13.9 %

Gestn. Age at time of Abortion

- Under 8 weeks ..... 27.0 %
- 9 – 12 weeks ..... 37.8 %
- 13 – 17 weeks ..... 8.1 %
- 18 – 20 weeks ..... 8.1 %
- > 20 weeks ..... 2.7 %
- Not stated ..... 16.3 %

Method of Abortion

- Cytotec ..... 62.0 %
- Instrumentation ..... 19.0 %
- Not stated ..... 19.0 %

Diagnosis on Admission

- Incomplete Abortion ..... 73.0 %
- Incomplete Septic Abortion ..... 16.2 %
- Inevitable Abortion ..... 8.1 %
- Live Intra Ut. Pregnancy ..... 2.7 %

Operation Performed

- D & C ..... 86.5 %
- Hysterotomy ..... 1 patient
- Sub total hyste. Bowel resection & colostomy ..... 1 patient
- Laparotomy, drainage of tubo ovarian abscess & salpingo/ oophorectomy ..... 1 patient
- Lap. Extra uterine pregnancy ... 1 patient

Ultrasound

- 33% of Patients had an U/S Examination.
- 1 Patient had lower limb Doppler to rule out DVT.

Blood Transfusion

- 20 % of Patients were transfused with
  - Whole blood
  - Packed Cells
  - FFP

Length of Stay

The average length of stay in hospital was three (3) days.

The longest length of stay was fourteen (14) days.

Hospital Costs

- 30 % of patients were not billed
- 70 % of patients were billed
- None of the patients have paid

Unsafe Abortions

- High Mortality
- High Morbidity
- High Hospital costs

TO IGNORE UNSAFE ABORTIONS IS TO PRETEND THAT IT ISN'T HAPPENNING.

Three (3) cases of Maternal Deaths resulting from unsafe abortions.

AA	.....	Spanish Town Hospital
AB	.....	Victoria Jubilee Hospital
AC	.....	University Hospital

Three (3) Cases of Maternal Deaths Resulting From Unsafe Abortion

AA

27 year old P3+ 0 unemployed lady whose last menstrual period was on February 20, 2005.

She was admitted to the ward from casualty with a 2/7 history of bleeding per vaginam and vomiting and a 1/7 history of abdominal pains.

On examination she was ill looking. Pale +++ dehydrated. Her fundal height was 24/40, tender ++. Vaginal examination showed a soft cervix, which admitted 1 finger, and there was blood stained fetid liquor. She was resuscitated and IV antibiotics commenced.

An ultrasound examination showed an empty uterus with fluid in the abdominal cavity. Her condition remained unstable and low BP persisted.

A laparotomy was done. There was 1.8litres of gassy haemoperitoneum. The uterus was 18/40, necrotic and gangrenous, with an 8cm transverse fundal rupture, a 10cm lateral rupture on the right side extending into the uterine vessels. Fetal parts were in the peritoneal cavity. A subtotal hysterectomy was done.

This patient died during the operation.

Presentation to death interval - 18 hours.

AB

14 year old primipara from Rural St. Andrew.

Her last menstrual period was not known. She was admitted to the ward from casualty on June 4, 2005 at 1:15 p.m.

The history from the girl and her mother was that of the girl falling and hurting her back. She was taken to a centre for care. The girl later gave a history of having had an abortion done followed by heavy bleeding ++.

On admission to VJH the patient was cold, clammy, her pulse was thready. There was massive bleeding per vaginam and a vaginal pack was in situ. IV gelofusine and blood transfusion was commenced. She deteriorated rapidly and was pronounced dead 4 hours after admission.

An autopsy was performed.

At autopsy the uterus contained a male foetus of 20-21 weeks gestation. The foetus showed an ovoid laceration of the lower back with extensive haemorrhage into the surrounding soft tissue.

Death was due to massive bleeding from a cervical laceration.

Presentation to death interval – 4 hours.

AC

23 year old p2+0 lady. She was unaware of the dates of her LMP. She was admitted to the ward from casualty with a one week history of abdominal pains and bleeding per vaginam. She admitted to having a TOP two weeks prior to presenting.

On examination she was pale ++, febrile, tachycardic and hypotensive. The uterus was enlarged to 18/40 size and was tender. Foetal parts were felt through the cervical os and there was a foul smelling discharge.

A diagnosis of septic incomplete abortion was made. She was resuscitated and an ultrasound examination, revealed ? retained products of conception. A D&C was done under general anaesthesia, but she continued to bleed heavily per vaginam.

A Laparotomy was done and the findings were:

1. A large tear in the posterior aspect of the broad ligament.
2. A large haematoma on the right posterior wall of the uterus.

TAH & BSO was done. She subsequently developed a pelvic abscess and had repeat Laparotomy.

She died three weeks later.