Legal, safe, and rare?

Your July 28 Editorial (p 291)[1] follows the call of Bill Clinton to make abortion "legal, safe, and rare". This is not a clarion call that my journal, which has been in the forefront of publishing on the need for safe, legal abortion, nor the international women's health movement, has ever supported. We campaign for abortion to be safe and legal, but we also recognise and accept that it will continue to be common.

All the evidence shows that even when contraceptive prevalence is as high as it can go (eg, in the Netherlands and Australia, about 70% of women of reproductive age), abortion is less prevalent but not rare. Abortion could only become rare in a world in which contraceptives never failed, women and men having sex together never failed to use them, and sex between them was only ever preplanned and consensual. None of that is realistic, and there seems little point in calling for something that is totally unfeasible.

The implication of "make abortion rare", moreover, is that contraception is good but abortion is "bad". If family planning is valid behaviour, then abortion is as valid when an unwanted pregnancy occurs. I believe Clinton bought into that phraseology because he wanted to appease the anti-abortion movement in the USA. What is *The Lancet*'s reason?

I declare that I have no conflict of interest.

Marge Berer
mberer@rhmjournal.org.uk

Editor, Reproductive Health Matters, London NW5 1TL, UK

1 The Lancet. Making abortion legal, safe, and rare. *Lancet* 2007; **370:** 291.

In your Editorial of July 28,[1] you refer back to the 1994 International Conference on Population and Development in Cairo, Egypt. What a different tack you adopt now compared with July 22, 1995, your Editorial of which date also deconstructed the Cairo conference.[2] Now you join forces with the World Bank in seeking to have family planning raised higher on the political agenda. You even seek inspiration from Bill Clinton, but do not mention that he was a key champion of the barbaric practice of "partial birth abortion".

Back in 1995, your Editorial questioned in a very effective way the one-dimensional manner of defining health in a reproductive context only, thus distorting it beyond recognition. You argued that the UN's determination to "coerce women into adopting fertility control must surely give way to a broader campaign to provide multiple freedoms" (such as freedom from hunger, access to clean water, primary care, housing, etc).

India's first woman president, Pratibha Patil, is arguing for such an approach, announcing in her inaugural speech: "We must banish malnutrition, social evils, infant mortality and female feticide."[3] *The Lancet* published research in 2006, estimating that as many as 10 million female fetuses could have been aborted in India during the past 20 years.[4]

It is a great disappointment to see *The Lancet* drifting towards what it criticised in 1995 as "the new colonialism of the international women's health agenda".

I declare that I have no conflict of interest.

Seamus Grimes
seamus.grimes@nuigalway.ie

Department of Geography, National University of Ireland, Galway, Ireland

1 The Lancet. Making abortion legal, safe, and rare. *Lancet* 2007; **370:** 291.
2 The Lancet. Women in the world. *Lancet* 1995; **346:** 195.
3 Rabinowitz G. First Indian women president sworn in. *The Guardian* (London), July 25, 2007.
4 Jha P, Kumar R, Vasa P, Dhingra N, Thiruchelvam D, Moineddin R. Low male-to-female sex ratio of children born in India: national survey of 1·1 million households. *Lancet* 2006; **367:** 211–18.

Abortion debate in Latin America and beyond

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Jill Replogle's observations on the dispute between Latin American activists, the interference of the Catholic Church in legal changes, and the high numbers of abortions (July 28, p 305)[1] are also pertinent to Argentina.

Abortion is the main cause of maternal mortality in Argentina, accounting for almost a third of maternal deaths.[2] A survey showed that there are between 560 000 and 615 000 induced abortions per year, a figure close to the 700 000 deliveries per year in Argentina. Such figures suggest a mean of two induced abortions per woman of reproductive age.[3]

In Argentina, induced abortion is illegal except in cases in which the mother's life is threatened and in cases of violations on women with mental retardation. Despite this legal concession, women in these exception categories often do not have access to abortion in practice. For example, earlier this year a young mother with severe cancer requiring treatment became pregnant before the cancer treatment started. Her parents requested an abortion in order for her to receive the cancer treatment, but the public hospital authorities refused. The 20-year-old woman gave birth to a premature baby who died, and subsequently died of the cancer herself. The hospital authorities and doctors acted under the Catholic Church's pressure and their own ideology.

In Argentina, women still need protection and must be allowed the right to decide on the basis of their beliefs, not those of doctors or anyone else.

We declare that we have no conflict of interest.

*Mabel Bianco, José M Belizán, *Fernando Althabe*
althabef@gmail.com

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Fundación para Estudio e Investigación de la Mujer, Buenos Aires, Argentina (MB); and Institute for Clinical Effectiveness and Health Policy, Buenos Aires, Argentina (JMB, FA)

1 Replogle J. Abortion debate heats up in Latin America. *Lancet* 2007; **370:** 305–06.
2 Direccion de Estadisticas e Información de salud. Sistema Estadístico de Salud. Estadisticas Vitales. Informacion básica 2005. http://www.deis.gov.ar/ (accessed Aug 9, 2007).
3 Pantelides EP, Mario S. Módulo de estimación de la magnitud del aborto inducido. Morbilidad materna severa en la Argentina. Prevención y calidad de la atención para reducir la incidencia y las consecuencias adversas del aborto. CEDES/RE 2006/2. http://www.cedes.org/areas/salud-es/index.html (accessed Aug 10, 2007).

Jill Replogle discusses contradicting developments surrounding the abortion law in Latin America.[1] Similar conflicts are known from Europe and the USA.[2,3] In European countries such as Germany in the early 1990s, the abortion law was subject to professional wrangling. Doctors' expertise and professional ethics were marginalised by repeated changes in law and jurisdiction. After furious debates, the liberal solution was adopted that every woman is entitled to have a termination within the first 12 weeks after conception, provided she has attended an independent counselling session at least 3 days before the procedure.[4]

The initial worry that the liberal law might result in a higher abortion rate has not become reality. In fact, the opposite is true: according to the Federal Statistical Office, the termination rate has fallen from 8·7 terminations per 1000 women of childbearing age (145 267 cases) in 1990 to 7·2 terminations per 1000 (119 710 cases) in 2006.[5] Advice and help thus seem more effective than repression.

We declare that we have no conflict of interest.

Helmut Hausner, Göran Hajak, Hermann Spießl
helmut.hausner@medbo.de

University of Regensburg, 93053 Regensburg, Germany

1 Replogle J. Abortion debate heats up in Latin America. *Lancet* 2007; **370:** 305–06.
2 Annas GJ. The Supreme Court and abortion rights. *N Engl J Med* 2007; **356:** 2201–07.
3 Rogers A. Europe: abortion rights. *Lancet* 1993; **341:** 1271–72.
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New indicator of quality of emergency obstetric and newborn care

The current UN emergency obstetric care process indicators[1] do not address the quality of care from the perspective of the fetus or the neonate. We know that most interventions to ensure maternal survival in case of obstetric complications also have a beneficial effect on the neonate, and we would like to monitor progress in that direction.[2] A new indicator with a different perspective—the intrapartum case fatality rate—has been proposed and will be included in the revised WHO guidelines on monitoring the availability and use of obstetric services.[3] I would like to bring this new indicator to the attention of those concerned with improving the quality of obstetric services, and to point out some difficulties that might arise in practice.

The intrapartum case fatality rate is defined as the proportion of deliveries that result in late stillbirths and early neonatal deaths (deaths during the first 24 h) in a given obstetric facility. In practice, three main difficulties affect the collection of the data.

First, the identification, reporting, and recording of very early neonatal deaths can be difficult. In some areas, the practice might be that women only stay in the facility for an average of 6 h or 12 h after birth, so it might be better to restrict the definition of early neonatal deaths to those occurring within the first 6 h (or 12 h).

Second, so as to measure the quality of obstetric care and not the risks attached to a very small size at birth (caused by prematurity or intrauterine growth retardation) it would be preferable to restrict the data to babies whose birthweight exceeds 2500 g (or 2000 g in areas where most babies are small).

Third, identification of late stillbirths involves examination of the individual admission records for the presence of audible fetal heartbeats at the onset of labour. A more feasible alternative would be the examination of stillborn fetuses for indications of freshness, by absence of signs of maceration.

Many programme managers and advisers have expressed interest in using this new indicator in facilities with large numbers of births, either starting data collection from scratch, or using the data available in existing monitoring systems. This letter aims to increase awareness and stimulate collaboration among those interested in testing the new indicator, those willing to share experience, and those having access to data of reasonable quality and quantity. It will also be useful to set up standard values; to exchange lessons learnt, caveats, and results; and to compare data across settings and over time, specially before and after implementation of interventions to improve obstetric care.

I declare that I have no conflict of interest.

Vincent Fauveau
fauveau@unfpa.org

United Nations Population Fund, Geneva 1219, Switzerland

1 UNICEF, WHO, UNFPA. Guidelines for monitoring the availability and use of obstetric services. New York: UNICEF, 1997.
2 Lawn J, Shibuya K, Stein C. No cry at birth: global estimates of intrapartum stillbirths and intrapartum-related neonatal deaths. *Bull World Health Organ* 2005; **83:** 409–17.
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