

# Statistical Bulletin

## Abortion Statistics, England and Wales: 2005

This bulletin summarises information from the abortion notification forms returned to the Chief Medical Officers of England and Wales in respect of abortions carried out in England and Wales in 2005.

### KEY FACTS

In 2005, for women resident in England and Wales:

- the total number of abortions was 186,400, compared with 185,700 in 2004, a rise of 0.4%
- the age-standardised abortion rate was 17.8 per 1,000 resident women aged 15-44, the same as in 2004
- the abortion rate was highest, at 32.0 per 1,000, for women in the 20-24 age group
- the under-16 abortion rate was 3.7 and the under-18 rate was 17.8 per 1,000 women, both the same as in 2004.
- 84% of abortions were funded by the NHS; of these, just over half (52%) took place in the independent sector under NHS contract
- 89% of abortions were carried out at under 13 weeks gestation; 67% were at under 10 weeks
- medical abortions accounted for 24% of the total compared with 19% in 2004
- 1,900 abortions (1%) were under ground E, risk that the child would be born handicapped

Non-residents:

- in 2005 there were 7,900 abortions for non-residents carried out in hospitals and clinics in England and Wales (8,800 in 2004)

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## 1. Introduction

1.1 This is the fourth Statistical Bulletin presenting statistics of legally induced abortions in England and Wales and covers those that took place in 2005. The format of the tables presented in this bulletin reflects the recommendations made in the ONS disclosure review (see Section 5 for further information).

1.2 The first bulletin, published by the Department of Health in October 2003, covered abortions in 2002 and was revised to incorporate the final 2002 figures in July 2004 in an Internet-only publication. Statistics for 2003 were first published in August 2004 and more detail was published in July 2005 on the Internet at the same time as statistics for 2004 were published. Statistics for earlier years were published by the Office for National Statistics – *Abortion Statistics*, Series AB nos. 1 to 28.

1.3 The information collected on the abortion notification form (HSA4) was amended during 2002. Details of the changes are in appendix A.

## 2. Data quality

2.1 Incomplete and incorrectly completed forms are returned to practitioners for completion and clarification. In a very

small number of cases (about one-quarter of one percent), the information remains unavailable at the time of publication. Date of birth was missing from 26 records in 2005, gestation information from 223, postcodes from 55 and grounds from 158.

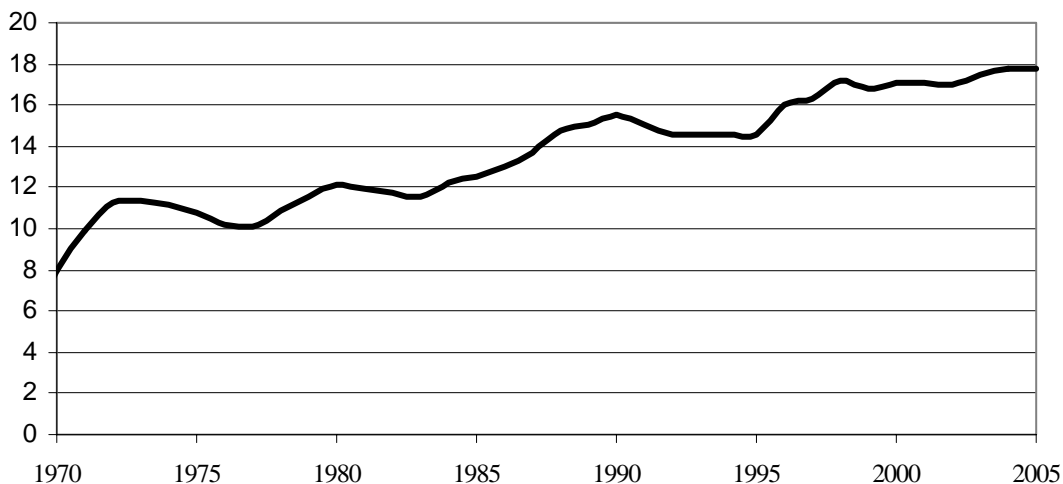
2.2 Records with missing ages were assigned to the 20-24 age group. Missing gestations were imputed as 7, 8, 9 or 10 weeks in equal distribution unless method of abortion or diagnosis suggested otherwise. Missing postcodes were imputed with a random postcode from within the main PCTs of other residents attending the same hospital or clinic. Missing grounds were imputed as ground C (see Section 4.2.1).

2.3 Abortion rates per 1,000 women for 2005 at a national level and at PCT level are calculated using 2004 mid-year population estimates for England, Wales, England & Wales, Primary Care Organisations and Local Health Boards.

2.4 319 forms were received too late to be included in the 2004 publication. The 2004 totals for England and Wales, non-residents and purchaser, and the rates for residents, have been revised to include the extra records. See Tables 1 and 3. No revisions are being made to any other tables for 2004.

**Figure 1 Age-standardised abortion rate per 1,000 population aged 15-44, England and Wales, 1970 to 2005**

Rate



### 3. Overview

3.1 In total there were 194,353 abortions notified as taking place in England and Wales in 2005.

3.2 There were 186,416 abortions to residents of England and Wales in 2005. This represents a rate 17.8 per 1,000 resident women aged 15-44 (age-standardised rate, see Abortion Statistics, Series AB no. 27 page vi). The age-standardised abortion rate peaked at 15.5 in 1990 but remained below 15 until 1995; it then rose to 17.2 in 1998. From 1999 to 2002 the rate remained level at just over 17, the rate then rose again in 2003 and 2004 and in 2005 has remained at 17.8 the same as in 2004 (see *Figure 1* and Table 1).

3.3 In 2005 there were 7,937 abortions to residents of other countries, principally Northern Ireland (15%) and the Irish Republic (70%). This is about 800 fewer than in 2004. The number of abortions to non-residents remained between 9,000 and 10,000 in the period 1995 to 2003. The 2005 total is the lowest in any year since 1969 (see Table 1 and Table 12).

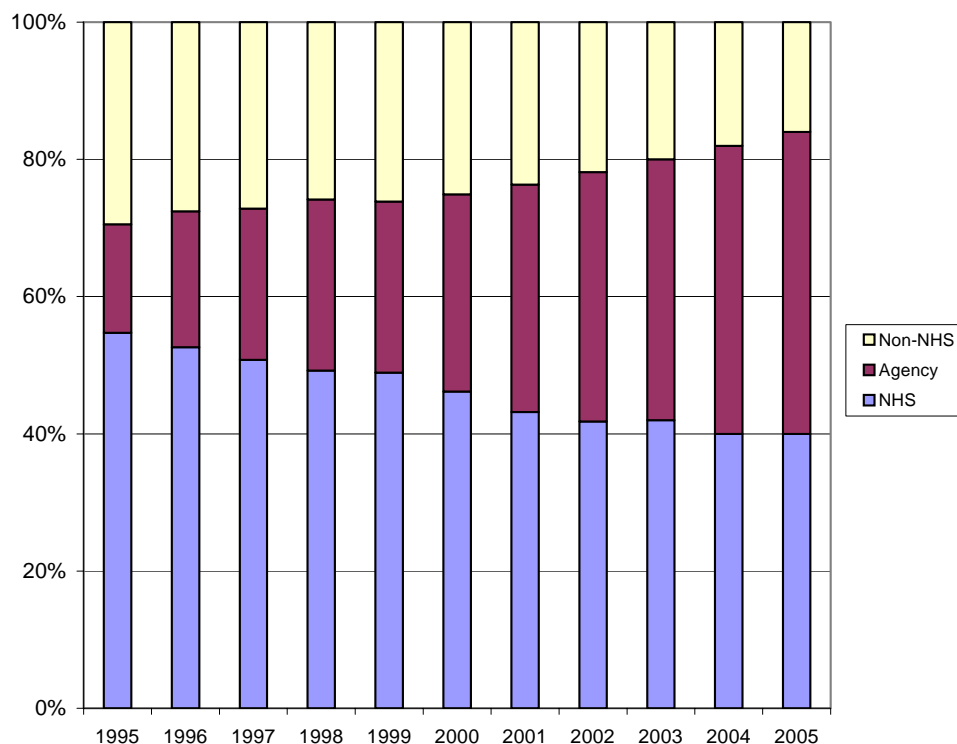
### 4. Analysis and Commentary (England and Wales residents only)

#### 4.1 Location and funding of abortions

4.1.1 Except in an emergency, any treatment for the termination of pregnancy can only be carried out in an NHS hospital or in a place approved for the purpose by the Secretary of State. Through contractual arrangements with Primary Care Organisations (PCOs), some approved independent sector places perform NHS-funded abortions.

4.1.2 Table 3 (i) and *Figure 2* show that in 2005, 40% of abortions were performed in NHS hospitals and 44% in approved independent sector places under NHS contract (NHS Agency), making a total of 84% of abortions funded by the NHS. The remaining 16% were privately funded. The proportion performed under NHS contract has been rising steadily since 1992 while the proportions of NHS hospital and private abortions has been falling.

**Figure 2 Abortions by purchaser, England and Wales, 1995 to 2005**



## 4.2 Statutory grounds for abortion

4.2.1 A legally induced abortion must be certified by two registered medical practitioners as justified under one or more of the following grounds:

- A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated (Abortion Act, 1967 as amended, section 1(1)(c))
- B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman (section 1(1)(b))
- C the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman (section 1(1)(a))
- D the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing children of the family of the pregnant woman (section 1(1)(a))
- E there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped (section 1(1)(d))

or in an emergency, certified by the operating practitioner as immediately necessary:

- F to save the life of the pregnant woman (section 1(4))
- G to prevent grave permanent injury to the physical or mental health of the pregnant woman (section 1(4))

4.2.2 In 2005, the vast majority (96%) of abortions were undertaken under ground C and a further 2% under ground D. Grounds A and B together accounted for about 1% of abortions, and a similar proportion were under ground E. The proportion of ground C abortions has risen steadily since 1995, with a corresponding reduction in grounds B and D cases. (See Table 3 *ii.*) Abortions are rarely performed under grounds F or G.

4.2.3 Chromosomal abnormalities were reported for about a third (39%) of cases under ground E, congenital malformations in about 45%. The most commonly reported anomalies were of the nervous system (24% of all ground E cases) and the musculoskeletal system (6%); Down's syndrome (22% of all ground E cases) was the most commonly reported chromosomal abnormality (Table 9; specific groups are shown only where there are 10 or more cases in total. See Section 5)

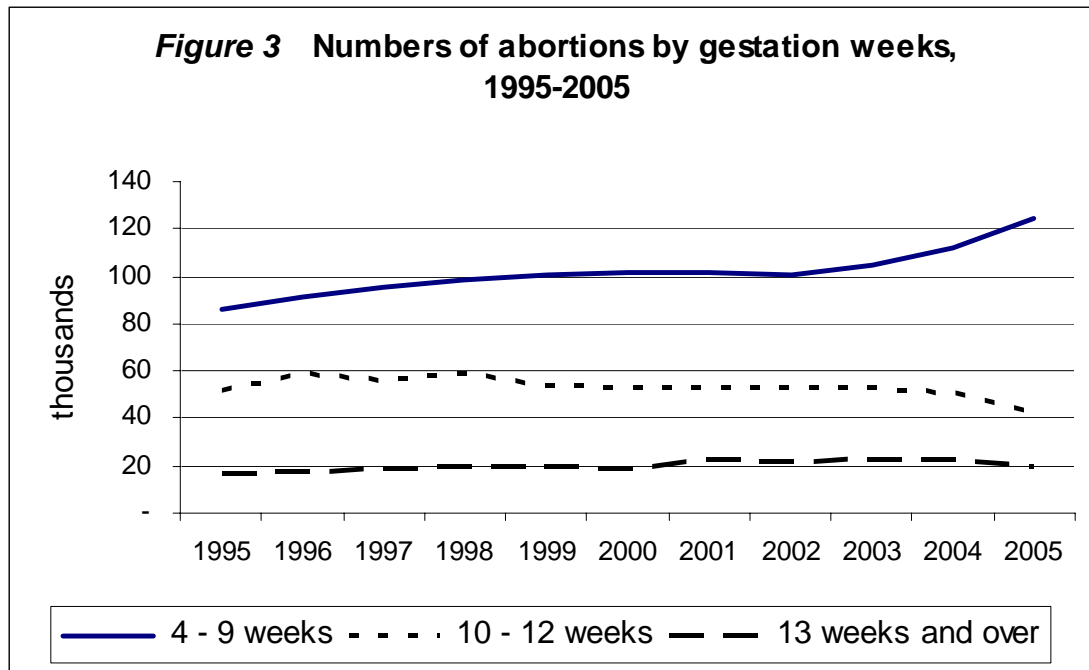
4.2.4 As in 2004, and each year since 1999, fewer than 10 abortions under ground E in 2005 were associated with rubella.

4.2.5 For years 2003, 2004 and 2005, some of the principal medical conditions for abortions performed under Ground E had to be suppressed as the totals for each single year were too small to release (see Section 5). In the three years 2003-2005, there were 11 cases with a principal medical condition of the congenital malformations cleft lip and/or cleft palate (ICD10 Codes Q35-37) and 17 cases recorded as 'other malformations of the digestive system' (ICD10 Codes Q38-45). Other conditions with suppressed data may be published in a 10 year aggregated table.

## 4.3 Gestation period

4.3.1 The vast majority of abortions are performed at under 13 weeks gestation. In 2005, about 67% were at under 10 weeks and a further 23% at 10-12 weeks. The proportion at 13 weeks or more was 11% in 2005. The corresponding

**Figure 3 Numbers of abortions by gestation weeks, 1995-2005**



percentages for 2004 were 60%, 27% and 13% respectively showing a substantial increase in the proportion of abortions that were performed under 10 weeks (Table 3 iii and Figure 3)

4.3.2 Department of Health policy is that women, who are legally entitled to an abortion, should have access to the procedure as soon as possible. Evidence shows that the risk of complications increases the later the gestation. In 2001, the Government set a standard of a maximum waiting time of 3 weeks and since 2002/03 it has invested £7 million to improve early access to abortion services. PCOs' performance in this area is also being measured as part of their NHS performance ratings. The latest data for 2005 show that progress is being made to increase early access: 64% of NHS funded abortions took place at under 10 weeks – compared with 51% in 2002. This represents a 23 % increase in total number of abortions taking place at under 10 weeks between 2002 and 2005 compared with a 6% rise in the total number of abortions over the same period.

4.3.3 Abortions where gestation has exceeded its twenty-fourth week account for less than 0.1% of the total.

There were 137 such abortions in 2005. (Table 5)

4.3.4 For the years 2003, 2004 and 2005, gestations at 26 weeks and over had to be suppressed as the totals for each single year were too small to release (see Section 5). Table A below shows that in the three years 2003-2005, there were a total 207 abortions performed at 26 weeks and over.

**Table A Number of abortions by gestations at 26 weeks and over, 2003-2005**

Gestation weeks	3 year total 2003-2005
26	52
27	21
28	25
29	20
30	11
31	15
32	17
33	12
34	15
35 and over	19

#### 4.4 Age

4.4.1 The abortion rate in 2005 was highest, at 32 per 1,000 residents, for women in the age group 20-24. For single ages, women aged 20 years had the highest rate with 35 per 1,000. There were just over 1,000 abortions to women aged under 15 and about 570 to women aged 45 or over (see Table 4, Table 10b and Figure 4).

4.4.2 The under-16 abortion rate was 3.7 in 2005 and the under-18 rate was 17.8. There were minimal changes in the abortion rates between 2004 and 2005 for all age groups.

4.4.3 For the years 2003, 2004 and 2005, abortions for girls aged under 14 had to be suppressed as the totals for each single year were too small to release (see Section 5). In the three years 2003-2005, there were a total 33 abortions to girls aged under 13 and 409 abortions to girls aged 13. In 2002 there were 15 abortions to girls aged under 13 and 153 abortions to girls aged 13.

4.4.4 A three year under 16 years total and rate by PCO covering years 2003, 2004 and 2005 can be found in Table 10a and 10b respectively. See also Section 5.

#### 4.5 Marital Status

4.5.1 79% of abortions in 2005 were carried out for single women, a proportion that has risen slowly from about two thirds since 1995. (Table 3v)

#### 4.6 Ethnicity

4.6.1 The revised HSA4 forms introduced in 2002 allow for the recording of ethnicity, as self-reported by the women involved; this information was not previously recorded. Ethnicity was recorded on 82% of the forms received for 2005. Of women whose ethnicity was recorded, 74% were reported as White, 13% as Black or Black British and 8% as Asian or Asian British. (Table 3vi)

4.6.2 The percentage of previous abortions (where the woman has had one or more previous abortion in addition to the one recorded for 2005) varies by ethnic group. 28% of Asian women having abortions in 2005 had had a previous abortion compared with 43% of Black women. See Table B.

**Figure 4 Abortion rate per 1,000 population by single year of age, England and Wales, 2005**

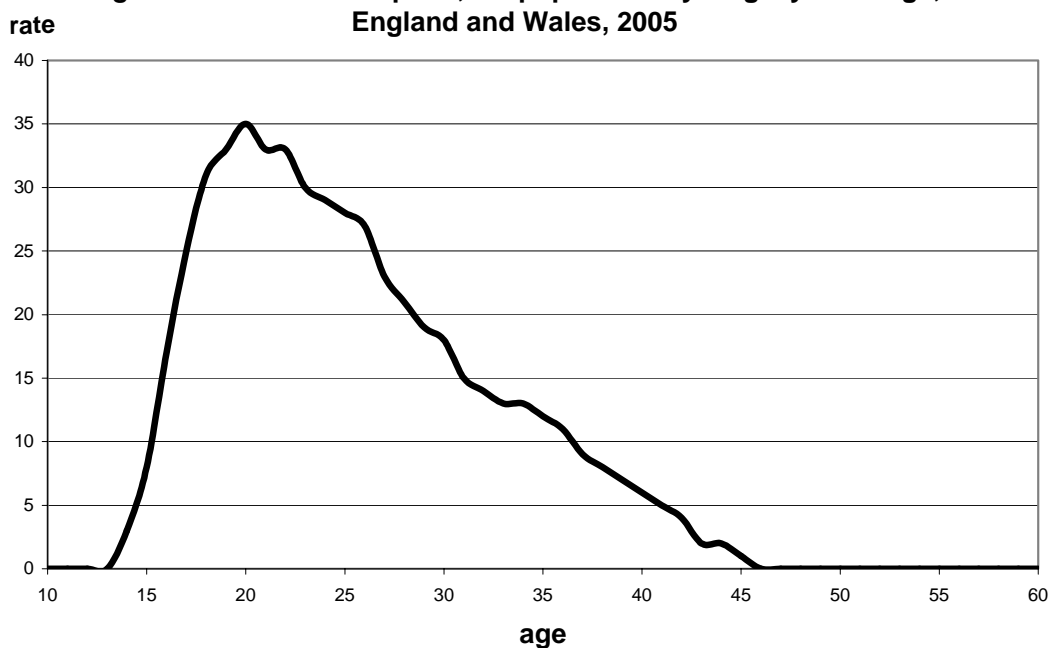


Table B

Percentage of previous abortions  
by ethnic group, 2005

Asian or Asian British	28%
Black or Black British	43%
Chinese or Other ethnic group	32%
Mixed	38%
White	31%

#### 4.7 Previous abortions

4.7.1 As in 2003 and 2004, 32% of women undergoing abortions in 2005 had one or more previous abortions. The proportion has risen from about 28% since 1995. (Table 3ix and Table 11)

4.7.2 In 2005, 24% of women aged under 25 having an abortion, had had a previous abortion. (Table 11) Repeat unintended pregnancy and subsequent abortion is a complex issue associated with increased age as it allows longer time for exposure to pregnancy risks.

#### 4.8 Previous obstetric history

4.8.1 In 2005, about 47% of women undergoing abortions had one or more previous pregnancies that resulted in a live or stillbirth, a proportion virtually unchanged over the last 10 years. About 14% of women had a previous pregnancy resulting in a miscarriage or ectopic pregnancy. (Tables 3vii & viii)

#### 4.9 Method of Abortion

4.9.1 Different methods may be used to terminate a pregnancy, depending on the duration of gestation and other circumstances relating to the individual woman. There is one principal medical method, involving the use of the abortifacient drug Mifegyne (mifepristone, also known as RU486). The main surgical methods are vacuum aspiration, recommended at up to 15 weeks gestation, and dilatation and evacuation (D&E) recommended where gestation is greater

than 15 weeks. D&E may be used in combination with vacuum aspiration; such cases are recorded in the statistics as D&E. For abortions at 22 weeks or beyond, feticide is recommended prior to the evacuation of the uterus.

4.9.2 Medical abortions accounted for about 24% of the total in 2005. The proportion of medical abortions has doubled in the last five years. There has been a continuing upward trend in medical abortions since 1991 when Mifegyne was licensed for use in the UK. (Table 3iv and Table 5)

4.9.3 Vacuum aspiration was used in for 71% of abortions in 2005 and Dilatation and Evacuation (D&E) alone in about 5%. (Table 3iv)

4.9.4 Less than 1% of abortions in 2005 were reported as involving feticide. Recording of feticide was introduced in 2002. See Table 7.

#### 4.10 Length of Stay

4.10.1 In 2005 around 700 (0.4%) women were reported as having a duration of stay of one or more nights. Half of these stays were for abortions performed at later gestations – 20 weeks and over. See Table C below.

Table C

Percentage of abortions requiring a  
duration of stay of one or more nights,  
by gestation, 2005

Gestation weeks	(100%)
under 10	20%
10 -12	18%
13-19	12%
20 and over	50%

#### 4.11 Complications

4.11.1 Complications were reported in about 300 cases in 2005, a rate of about 2 in every thousand abortions slightly lower than in 2003 and 2004. (Table 8)

#### **4.12 Selective Terminations.**

4.12.1 In 2005 there were 76 abortions which were selective terminations. In 38 cases, 2 fetuses were reduced to 1 fetus and in 24 cases 3 fetuses were reduced to 2 fetuses.

#### **4.13 Chlamydia Screening**

4.13.1 Screening for chlamydia is a key component of the Department of Health's Sexual Health and HIV Strategy. Analysis of returned data for 2005 shows that 70% of women aged under 25 having abortions in 2005 were offered chlamydia screening.

#### **4.14 Place of residence**

4.14.1 Following the abolition of the English Health Authorities in April 2002, the place of residence details provided on the HSA4 form are allocated for analysis to Primary Care Organisations. For Wales, place of residence is allocated to their equivalents, Local Health Boards.

4.14.2 There will be boundary changes for PCTs from 1st October 2006 and the number of PCTs will be reduced from 303 to 152. Further information can be found at the following website

[http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT\\_ID=4121228&chk=Mwth7Y](http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4121228&chk=Mwth7Y)

### **5. Recommendations from the National Statistics Disclosure Review**

In using and releasing health statistics there is a risk, generally with small numbers, of identifying individuals. To address this, the Department of Health asked the National Statistician to provide it with guidelines for interpreting the National Statistics Code of Practice and associated protocols in the handling of health statistics across the health community, in a way that balances data confidentiality risks with the public interest in the use of the figures. The Office for National Statistics (ONS) published a report on disclosure guidance

for abortion statistics in July 2005 and a further report giving guidance for all health statistics will be published later in 2006. The report for abortions statistics can be found on the ONS website at

<http://www.statistics.gov.uk/statbase/Product.asp?vlnk=11988>

The key recommendations can be found in Appendix B.

The 2005 Abortion Statistics bulletin applies the conclusions of the ONS disclosure review and guidance for abortion statistics. The guidance provides details on how to identify cells within tabulated statistics where the risks of a breach of confidentiality are unacceptable ("unsafe cells"). It then describes methods for reducing these risks.

For the bulletin, the risks identified have been reduced largely by redesigning tables. However, where table redesign proved to be impossible then suppression was applied to cells with fewer than 5 cases at National level or fewer than 10 cases at sub-national level and for highly sensitive variables such as gestation weeks by medical grounds. The same principles were also applied to tables showing rates and percentages.

In line with the commitment made in the 2004 abortions bulletin, this publication also includes 3 year aggregate figures for 2003-2005 for some of the areas whose data are suppressed each year due to small numbers.

Three year aggregate figures are presented in:

- paragraph 4.3.4 for gestation weeks
- paragraph 4.4.3 for ages 13 and under 13 years
- paragraph 4.2.5 for Ground E conditions

- Tables 10a and 10b for age and age rates by PCT for women aged under 16.

Further 3 year aggregate tables are planned for publication in 2009 for the years 2006-2008.

### **EDITORIAL NOTES**

Percentages are subject to rounding and totals may not agree with the sum of the component figures shown. Rates are also rounded.

The following symbols are used in the tables:

- . = not applicable
- .. = suppressed values

Enquiries about the data or requests for further information should be addressed to:

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This bulletin for 2005, and previous bulletins for 2002-2004 can be found on the Department of Health website:

[www.dh.gov.uk/publichealthstatistics](http://www.dh.gov.uk/publichealthstatistics)

Data for 1991 to 1999 can be found on the Office for National Statistics website.

<http://www.statistics.gov.uk/statbase/product.asp?vlnk=68>

July 2006

## Appendix A

Changes introduced with the new abortion notification form, following a consultation exercise undertaken in 2000, are shown in the table below. A blank entry in the right hand column indicates an item that remains unchanged.

Notification form 1991-2002	Notification form 2002 onwards – changes to items
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Name and address of operating practitioner and certifying practitioner(s)	
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### Patient details

Name	Revised: Hospital/clinic number or name
Address	Revised: Postcode or complete address
Date of birth	
Marital status	<i>Single</i> expanded further with sub-category “ <i>single not stated</i> ” added in 2003
Parity (previous live births, stillbirths, spontaneous miscarriages, legal terminations)	<i>previous live births, stillbirths</i> replaced by previous pregnancies resulting in live birth(s) or stillbirth(s); ectopic pregnancies included with miscarriages
	New item: ethnicity, using 2001 Census categories

### Treatment details

Name and address of place of termination	
Whether patient was an NHS case terminated in an approved place under an agency agreement	Revised: whether NHS or privately funded
Gestation period and method of estimation	Revised: method of estimation no longer collected
Statutory grounds for terminating pregnancy	
Medical condition of woman or diagnosis or suspected medical condition of fetus	
Date of admission to place of termination	
Date of termination	
Date of discharge from place of termination	
Method of termination	Feticide now separately identified
Whether selective termination of a multiple pregnancy	
Whether sterilisation performed	No longer collected
Complications prior to notification	Changed: complications prior to discharge
In case of death, date and cause	
	New item: whether chlamydia screening offered

## ***Appendix B***

### **Key recommendations from the National Statistics Disclosure Review**

Recommendation 1: Within a release of abortion statistics unsafe cells are defined as being counts of abortions that are:

- zero unless no other value is logically possible
- less than 5 for Government Office Region in England, the country of Wales or any larger geography
- less than 10 for any geography below the Government Office Region in England or the country of Wales
- less than 10 for highly sensitive variables
- associated with either 1 or 2 practitioners
- associated with either 1 or 2 hospitals

The variables that are considered highly sensitive are:

- Young ages (<15)
- Late gestation (over 24 weeks)
- Procedure by gestation
- Medical conditions

Recommendation 2: Simple calculations such as rates or percentages do not necessarily make an unsafe cell safe and should not be used to protect data unless it can be demonstrated that one cannot work back to the original count. In order to keep statistical disclosure control rules clear and consistent for abortion statistics rates or percentages should only be calculated from safe cells.

Recommendation 3: In order to ensure that unsafe cells in the abortion statistics are disguised table design should be used as a preliminary protection method. Redesign should be implemented taking into account the information required by the main users of the data.

Recommendation 4: Statistics should only be constructed using area of residence rather than place of termination thus reducing the risk of disclosure from counts of events that are associated with 1 or 2 practitioners/hospitals.

Recommendation 5: If unsafe cells exist in tables after redesign these should be removed using suppression methods (primary and secondary).

Recommendation 6: In order to avoid resource intensive analysis of disclosure by differencing the abortions data should not in general be published on geographies that are non-coterminous with SHA/region/PCO/LHB or for non-standard variable categories.

Recommendation 7: In order to release more detail some data should be published aggregated over a number of years. To keep the methods for disclosure control clear, consistent and easy to implement the recommendation is made that rolling aggregates are not produced but years are aggregated independently.

Recommendation 8: The guidelines should be implemented for all published outputs of abortion data e.g. in cases where the data published can be used to make direct inferences about abortions. The guidelines should be implemented as soon as possible. The DH and ONS should work together in order to implement these guidelines for the annual bulletin release for 2003 and 2004.

Recommendation 9: Users should be made aware of what constitutes an unsafe cell within the abortion statistics. The user should also be told that the method used to protect the table is predominantly table redesign used to minimise the number of unsafe cells that require suppression. The impact on the quality of the data will be that in some cases less detail will be displayed and suppressions will mean that some information is removed from the table.