BMJ readers donated more than £33 000 to Lifebox last year, which is working to ensure every operating theatre worldwide is equipped with a £160 pulse oximeter. Atul Gawande explains how you can help (*BMJ* 2011;343:d7773) . **Fill in the coupon or donate online at lifebox.org/donations**

BMJ CHRISTMAS APPEAL 2012

Some Christmas presents don't make it past Christmas dinner. Others are lost under the sofa by the time January rolls around. There are very few gifts that you can guarantee will be in constant use one year later—and what's more, that they will be used to save lives.

BMJ readers can claim just that. Last Christmas you put 210 pulse oximeters directly into operating theatres in 10 low resource countries through your generous response to the *BMJ*'s Christmas appeal for the Lifebox Foundation.[1-3]

Every penny you donated—more than £33 000 in a few weeks—was used to send oximeters and education materials to hospitals in need. From Cambodia to Cameroon, Nepal to Nicaragua, Papua New Guinea to the Philippines, your support is making a difference.[4]

In these countries, surgery regularly takes place without any monitoring equipment beyond a manual blood pressure cuff or a finger on the pulse. Essential healthcare interventions that give back life and livelihood are delivered in such dangerous conditions that the operation itself is a regular cause of mortality.

In this kind of austere setting, a pulse oximeter isn't just another piece of monitoring equipment: it's a vital component of safe surgery.

The Lifebox oximeter has an audible tone that drops as a patient's oxygen saturation decreases. In the past year, the changing of the beep has identified internal haemorrhage during emergency caesarean sections while there was still time to act, been the eyes and ears of the surgical team in a suddenly dark operating theatre when

the generator failed again, and alerted an anaesthesia provider to an oesophageal intubation; in short, oximeters have had a direct effect on the safety of surgical care.

The oximeters have transformed the lives of your colleagues too. Take Abayehu Haile, an anaesthesia provider at Limmu Geenet Hospital, Ethiopia. Before she got a pulse oximeter from a *BMJ* reader, she had an impossible dilemma: go into the theatre without the right equipment and risk the patient's life, or refuse to proceed and leave the patient no chance.

"When you come to my profession, pulse oximetry is the heartbeat for my work, for safe surgery," Haile told us. "But I couldn't ever say—'we have no monitor' and refuse to work—I had no choice but to try to save life as best I could.

"Now thanks to you, we are using the oximeter and the World Health Organization Surgical Safety Checklist in our hospital. I would like to thank you again and again for your impressive life saving activity. You are not only supporting patients, you are also helping professionals."

Thank you from all of us at Lifebox too. We were overwhelmed by your generosity and grateful for your ideas and feedback—both in person, when you picked up oximeters to hand deliver on your service trips, and in rapid responses on bmj.com.

In the weeks to come we will share stories from the colleagues worldwide you've supported this year; the training workshops that have been held in Ethiopia, Cameroon, Honduras, and many other countries; and our plans for the future.

There's still a long way to go.

Lack of access to safe surgery in low resource countries is a full blown global health crisis. More than 70 000 operating theatres still don't have a single pulse oximeter.[5] The WHO Surgical Safety Checklist, consistently proved to significantly reduce surgical complications and mortality, is still used in only a few low resource hospitals.[6] Patients are dying needlessly, and providers lack the resources to do more than fight a losing battle.

We hope you will consider donating again to Lifebox, or making your first contribution. Unsafe surgery is a devastating cycle, and we can help to break it. Thank you.

Sarah Kessler, project manager, Lifebox

References are in the version on bmj.com.

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Digital map of where Lifebox oximeters have been distributed: http://bit.ly/UWqzWE.

Follow the campaign at #BMJLifebox

☐ I confirm that I am a UK Income or Capital Gains taxpayer. I have read this statement and want Lifebox Foundation to reclaim tax on the enclosed donation, given on the date shown. I understand that I must pay an amount of Income Tax and/or Capital Gains Tax in the tax year at least equal to the amount that Lifebox Foundation will reclaim on my gift. I understand that the other taxes such as VAT and Council Tax do not qualify. I understand Lifebox Foundation will reclaim 25p on every £1 that I donate.
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Donate online at www.lifebox.org/donations or call 0203 286 0402

Alternatively post this coupon to: *BMJ* Christmas Appeal, 21 Portland Place, London W1B 1PY

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☐ I would like to donate a pulse oximeter (£160) to a facility in need
or ☐ £..... to Lifebox.
I enclose a cheque made payable to Lifebox Foundation

Signature.....

Registered charity No. 1143018

UK credit/debit card donations are administered by the BT MyDonate Foundation and will appear as such on your statement

Lifebox would like to send you our quarterly electronic newsletter to keep you up to date on how your donation is making a difference. If you do not wish to hear from us, please tick here ☐

RAVEENDRAN/AFP/GETTY IMAGES

Protests about death of Indian national Savita Halappanavar in Ireland reached New Delhi

Is abortion worldwide becoming more restrictive?

Sophie Arie examines the differences in approach to abortion around the world

bmj blogs
How is the law being changed?
See an interactive map with seven case studies from around the world on bmj.com

Abortion has always been a subject for passionate public debate. But recently the temperature has risen, especially in the United States and Ireland. The Republic of Ireland has seen nationwide protests over the death of Savita Halappanavar, who was refused an abortion during a long and painful miscarriage because the fetus was still alive. After the fetus was finally removed she died of septicaemia and organ failure. The debate has also been reopened in the UK, where health minister Jeremy Hunt recently declared a desire to see the limit in England, Wales, and Scotland drop from 24 weeks to 12 and the prime minister expressed an interest in a more modest reduction.

In recent decades, abortion has become legal in all but five countries if a mother's life is threatened. There has also been a general decline in the numbers of abortions worldwide as contraception has become more widely available. But World Health Organization figures show that the decline has slowed recently. So what's going on? Is there a general shift towards tighter restrictions? Are people being discouraged from using family planning as populations dwindle? And is that forcing more women to take clandestine routes to terminate unwanted pregnancies?

IRELAND Abortion is illegal under most circumstances in both the Republic of Ireland and Northern Ireland: it is allowed only when a mother's life is in danger or her long term health seriously at risk. In Northern Ireland, the process for approving an abortion is very strict: two doctors must agree independently that the mother's health is at risk and the abortion must take place within nine weeks of that decision. The NHS carries out between 30 and 50 abortions a year in Northern Ireland,[1] and last year 1007 women travelled to other UK countries for abortions.[2] In October, Marie Stopes opened the country's first private abortion clinic in Belfast. The organisation says it plans to work within Northern Ireland's legal framework, but anti-abortion groups say it aims to widen access to abortion on mental health grounds.[3]

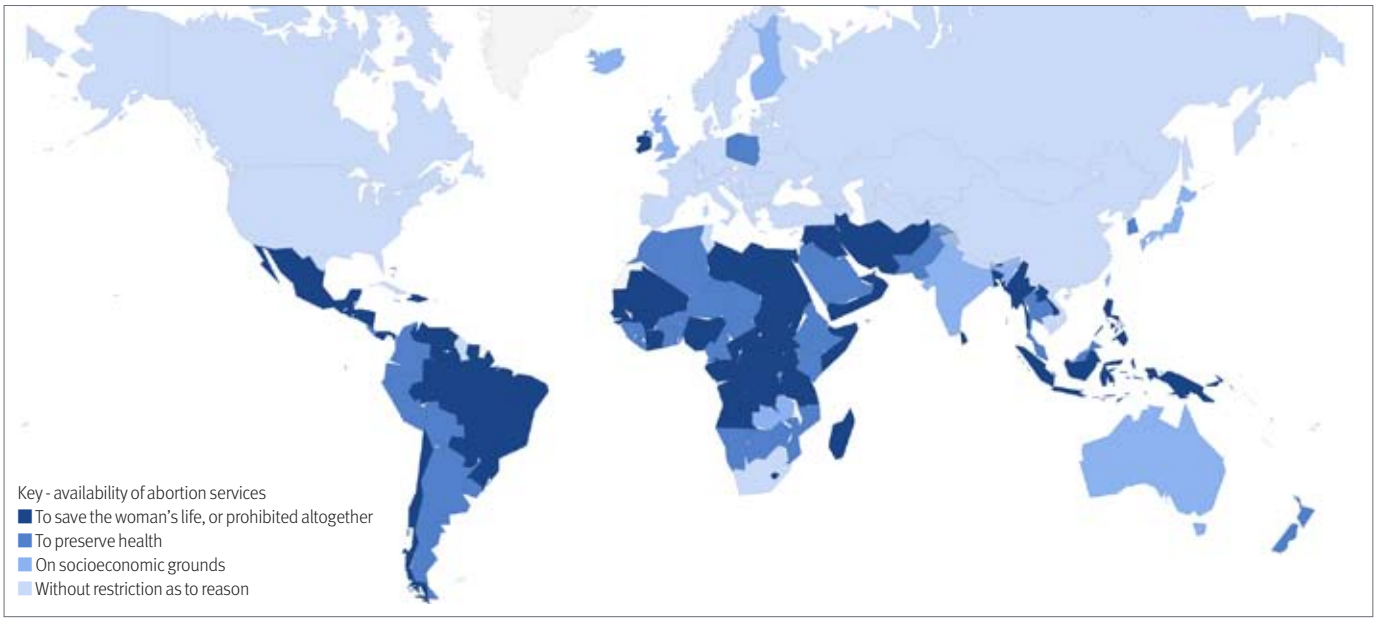
In the Republic of Ireland the circumstances in which a woman's life is deemed to be at risk are not entirely clear, and the recent case of Savita Halappanavar highlighted the fact that even when a woman's life is threatened some doctors or institutions do not consider abortion an option. At least 4149 Irish women made the journey to the UK for abortions in 2011.[2] Ireland is currently revising its guidelines on what constitutes a risk to a woman's health after three women challenged the country's constitution in the European Court of Human Rights.[4] Anti-abortion groups argue that there are always ways to protect a woman's health without carrying out an abortion and fear that the new regulations will be the first step towards widening access to abortion.

CHINA China's single child policy means that there are an estimated 13 million abortions annually—making it the country with by far the highest number.[5] The numbers are thought to have been rising since 2003, after a long period of decline, which has been attributed to increased premarital sex, disruptions in access to contraceptive services because of rapid urbanisation, and a lack of condom culture (six million abortions are in women under 25).[6] However, the rapid changes in China have brought growing pressure for a change to the way the one child policy is enforced. Activists monitoring the policy say that instructions have been given to local authorities not to carry out late term forced abortions after one case involving a seven month pregnant woman caused national and international outcry this summer.[7]

INDIA Abortion is legal in India to protect the mother's health, after rape, in insane women and underaged girls, or if the fetus has serious malformations. It is not legal as a way to avoid giving birth to a girl. There are hefty fines for those offering sex tests or abortions for sex selection. But India's 2011 census showed a growing imbalance between the numbers of girls and boys aged 0-6 years, which research suggests is due to an increase in selective abortion of female fetuses.[8] The government has so far failed to change or control the culture that prizes boys over girls and contributes to India having an estimated 11 million abortions per year. India's ministry for women and child development reportedly wants to introduce fines and even prison terms for entire families who force a woman to abort a female fetus. And one state, Uttar Pradesh has introduced baby hatches where people can leave their unwanted baby girls.

RUSSIA Russia was the first country to legalise abortion in all circumstances and has the highest rate of abortion worldwide—54/1000 women aged 15-44 (compared with 24/1000 in China). Over the decades the policy has been changed, and recently it has been restricted by the government of Dmitri Medvedev, which has close ties with the Orthodox church and is facing a low birth rate and shrinking population. In October, parliament voted to limit the period for abortion to 12 weeks of gestation and up to 22 weeks in the case of rape.[9] There is no time limit if there is a risk to the mother's life. Abortion providers are now required to spend 10% of advertising costs on warning of the possible dangers to a woman's health, and it is illegal to describe abortion as safe. The president's wife has taken a leading role in anti-abortion campaigns alongside leaders of the Orthodox church.

UNITED STATES Abortion has always been a subject of heated debate across the US, but in the past decade there has been a frenzied tightening of restrictions in many states that were previously moderate. Overall, according to the Guttmacher



Global availability of abortion, 2011. An interactive version is available at bmj.com Source: United Nations

Institute, there were 92 new provisions restricting abortion in 2011, compared with 34 in 2005.[10] This year there have been at least 39 new restrictions. In 2000, around a third of American women of reproductive age lived in states that were hostile to abortion rights, a third in states that were supportive, and a third in states that stood somewhere in between. By 2011, over half of American women lived in states that were hostile. States found different ways to obstruct women's access to the procedure including insisting women must first receive counselling against it, restricting public or private insurance coverage, and making it difficult for physicians to obtain supplies of mifepristone, the FDA approved treatment for medical abortions. Seven largely rural states banned telemedicine for abortion in 2011, meaning a doctor has to be with the patient when prescribing the treatment.

In 2010, Nebraska came up with a new argument for restricting the period in which abortion is permitted. The state ruled to ban abortion after 20 weeks on the basis that the fetus can feel pain at that stage. This theory is not backed up by established science,[11] but seven other states (Alabama, Georgia, Idaho, Indiana, Kansas, Louisiana, and Oklahoma) followed with similar rulings. Arizona restricted abortions beyond 18 weeks in March this year using a similar argument.

CHIP SOMODEVILLA/GETTY IMAGES

Anti-abortion protest, Washington 2011

Critics argue that these laws are unconstitutional because the landmark 1973 Supreme Court ruling in the case of Roe versus Wade held that states could restrict or ban abortion only after fetal viability. It is generally agreed that a fetus could survive outside the womb from 24 weeks at the earliest. Critics also argue that if the concern is for the fetus not to experience pain it would suffice to use anaesthetics.

LATIN AMERICA AND AFRICA In most of Latin America abortion is either totally banned (Nicaragua, El Salvador) or tightly restricted. Across Africa colonial laws make it legal in only a few situations—usually if a woman's life is in danger or in the case of fetal abnormality or rape or incest. Social and religious disapproval also contributes to large numbers of women seeking clandestine abortion, which often leads to complications and deaths. WHO estimates that 5.5 million women in Africa have abortions every year, 99% of which are unsafe, and around 36 000 women die from the procedure.[12] In Ethiopia, for example, unsafe abortions are thought to account for up to half of maternal deaths. Some 95% of abortions in Latin America are also unsafe.[12]

In both regions, a few countries have recently decided to relax their laws and make safe abortion services accessible on the basis that criminalising it causes unnecessary deaths. In Kenya, the constitution was changed in 2010 after years of debate over the need to relax the laws and increase provision of safe abortions. Argentina legalised abortion for raped women in March this year and Uruguay legalised abortion up to 12 weeks in October and is providing government funded abortion services. And since 2009, Ethiopia has piloted an apparently successful programme in which trained health workers in one region provide safe medical abortions with misoprostol.

ARAB WORLD Unlike most Muslim countries, Tunisia legalised abortion in the 1970s. The only conditions are that it must be carried out by a qualified practitioner within the first three months of pregnancy. The country's leaders repressed the population in many ways before the Arab Spring of 2011 but they liberated women by encouraging all sorts of birth control in a bid to control population growth. As a result, the country has the lowest birth rate in the region—2.0 births/1000 women, according to the World Bank's latest figures.[13] It remains to be seen whether the Arab Spring will lead to a relaxing of laws across the Arab world, where abortion is generally available only if a woman's life is in danger. Data are patchy but according to the International Planned Parenthood Federation, in the five years up to 2000, there were 15 million unwanted pregnancies across the Arab world and over seven million abortions in the same period.[14] Clandestine abortions seem to be common, and it is estimated that 5% of maternal deaths are due to unsafe abortions. Because of cultural disapproval, most campaign groups are focusing on promoting better awareness and availability of contraception rather than safe abortions.

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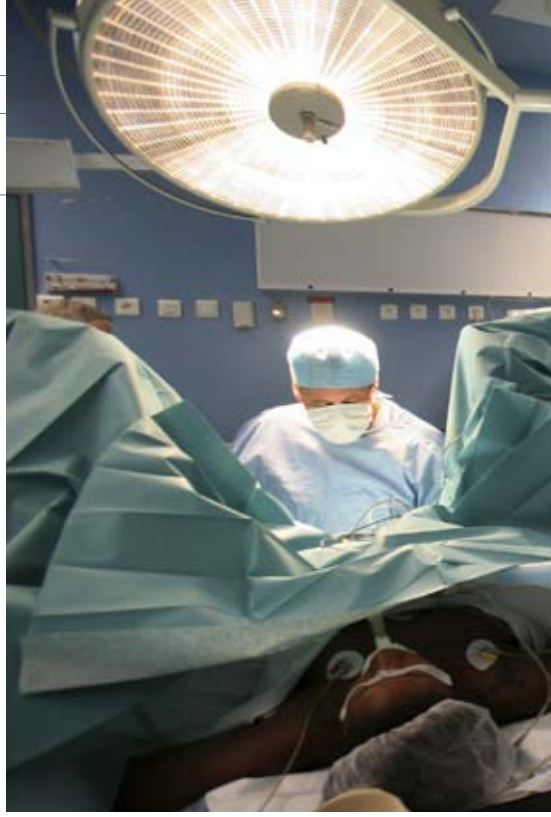

Clinical Review: Female genital mutilation (*BMJ* 2012;344:e1361)
YouTube: Sue Lloyd-Roberts reports on the hidden world of female genital mutilation and the lack of convictions in the UK (http://bit.ly/WGCmnP)

UK'S SHAMEFUL RECORD ON FEMALE GENITAL MUTILATION

The Crown Prosecution Service has announced plans to crack down on female genital mutilation. But **Sue Lloyd-Roberts** asks why we are lagging behind our European neighbours

Ayanna, a 23 year old mother now living on the 15th floor of a Glasgow tower block, fled Gambia a year ago and applied for asylum in the UK to escape an abusive husband and prevent her 6 month old baby girl from being genitally mutilated. "My husband would have insisted," she explains. "All the women in my community have been cut."

She says she feels safe in Scotland but tries to avoid contact with the African community. "They'll tell me that my daughter should be cut. It's being done here," she says, pointing through the window at the other tower blocks which make up the Red Road housing estate. "The older women do it—the grandmothers," she explains. "They use scissors, razor blades, or sharp knives. I know that just last week one 3 year old and a 2 week old baby were cut."

A group of Somali schoolgirls in Bristol tell me of "cutting parties." "They tell you that something exciting is going to happen at the party, something that will make us adults. Parents organise the party because it is cheaper that way," explains 18 year old Mouna. Who does the cutting? "They get an older woman, or the local Imam. Someone with experience who knows how to do it."

The cutting normally involves what the World Health Organization categorises as type 3 mutilation, says Comfort Momoh, a midwife at St Thomas' Hospital in London who is widely regarded as the UK expert on the subject. "The clitoris is removed, [and] the vaginal area is sewn up, leaving only a small hole through which the woman can urinate and menstruate. Sexual intercourse is very painful." That could be putting it mildly. Ayanna told me that, for her, sexual intercourse is more painful than childbirth.

"The clitoris is removed, [and] the vaginal area is sewn up, leaving only a small hole through which the woman can urinate and menstruate"

Midwife Comfort Momoh is a UK expert in the effects of female genital mutilation

Why is it still happening in the UK despite the fact that the practice was banned in 1985? A report compiled by the female genital mutilation (FGM) campaigning group, Forward, together with the London School of Hygiene and Tropical Medicine claims that some 20 000 young girls are at risk each year.[1] Momoh says that there are now 17 specialised units in NHS hospitals in England set up to cope with the number of immigrant women who arrive at hospital, often in an advanced state of labour, who have to be defibulated to allow for childbirth. There is little doubt that this ghastly, criminal practice is taking place routinely in the UK and yet no one has ever been prosecuted for it.

Tougher approach

In France, where female genital mutilation was outlawed at about the same time as in the UK, there have been more than 40 high profile trials. Over 100 parents and two practitioners have been convicted and served prison sentences. "In England, you don't want to hurt the feelings of immigrants or of people of foreign origin," says the campaigning lawyer Linda Weil-Curial. "But, what is more important—these people's feelings or the suffering of their children?"

Weil-Curial is contemptuous of the British attitude. "In France we believe that society must look after the child. In the UK, I have never heard that anyone has had the guts to report that a little girl has been cut. Why? That is the wonder."

Linda introduced me to one of France's most infamous practitioners of FGM, Hawa Greou, who is originally from Mali. Now in her 70s, she was jailed for eight years in 1999 for mutilating 48 girls. She was reported when neighbours complained to police about the repeated screams of anguish that were heard coming from her apartment. The police charged Greou and, at the subsequent trial, Weil-Curial represented the children. She and Greou, now out of jail, have become good friends and campaign together against FGM. "The lawyers did what they had to do," says Greou today, "they had to send me to prison. They did their job."

The trial was played out on French television night after night and sent a clear message to the immigrant communities of France. But the campaign against FGM is also being fought in clinics and schools throughout the country. All French

BSIP/UIG/GETTY IMAGES

Surgeon Pierre Foldes (right) works pro bono in cases of reconstructive surgery in France (above)

mothers are expected to attend mother and child clinics for regular check-ups until a child is 6 years old. Doctors and nurses have no inhibitions about examining the genitalia of little girls.

Such an examination would be considered an abuse of human rights in the UK, I explain to a doctor at one of the clinics on the outskirts of Paris, Malika Ameliou. "Why?" she asks, genuinely surprised at my remark. "We are here to protect all little girls, and the examinations are carried out on all ethnic groups. No one complains because it is in the interests of the child."

Most mutilations are carried out under the age of 6. Nonetheless, Ameliou says that examinations continue on all girls of school age, when they are more deliberately targeted. "After 6 years old, we liaise with school health inspectors, who visit schools regularly so that they can check on girls and families considered most at risk. If we find a girl has been mutilated, we offer her medical and psychological support and also surgery, if she wants it."

The French system is not just punitive against the offenders. Since 2004, hundreds of young women have been offered reconstructive surgery, paid for by the state and thanks to a pioneering urological surgeon at St Germain Poissy Hospital outside Paris, Pierre Foldes, who works pro bono on these cases. He has operated on nearly 3000 young women, and in most cases, he says, the procedure "has reduced local pain and restored clitoral pleasure."

During my investigations I heard of one doctor in Scotland who sewed a woman back up after childbirth because her husband told him that it was "our culture"

Turning a blind eye

So why can't we be more like the French? When I asked the Department of Health press office whether there were any plans for offering reconstructive surgery in the UK, I was told there were none, apart from the defibulation necessary to ease sexual intercourse and childbirth. During my investigations I heard of one doctor in Scotland who sewed a woman back up after childbirth because her husband told him that it was "our culture."

I was unable to corroborate this story because so few people in official positions are prepared to talk. In Scotland, where mass immigration is relatively new, health workers told me off the record that they are struggling to cope. The Scottish NHS told me I could not interview doctors and midwives about FGM. When I asked Social Services whether their employees look out for baby girls born to mothers from communities that practise FGM, I was told there "were no social workers available with sufficient experience of FGM" who could answer my question.

Commander Simon Foy, the child abuse specialist at Scotland Yard, perhaps best sums up the British head in the sand attitude. When asked why there had been so few prosecutions, he replied, "I am not necessarily sure that the availability of a stronger sense of prosecution will change it for the better" and went on to explain how hard it is to investigate cases. When asked whether inspections might help, he replied, "Inspection almost at times is considered to be a form of abuse in itself. We should not encourage behaviour if that behaviour is in itself child abuse."

I suspect that his view that inspections would be child abuse is widely held in the UK. But it is a scandal that so little has been done since we were alerted to the prevalence of FGM in the UK almost 30 years ago.

The Dutch, ever pragmatic and sensible in these matters, have come up with a good compromise, although it addresses only part of the problem. Many girls from European countries are cut while on long summer holidays in the countries of their parents' origin. After consulting local immigrant groups, the Dutch government has produced a health passport, which is printed in every language relevant to Dutch immigrants. It contains a warning that if a child is cut while away, her parents will be arrested on their return to the Netherlands.

Zarah Naleie of the Federation of Somali Associations in the Netherlands, who was part of the Dutch government consultation process, says these passports have reduced the number of mutilations. She explains that families in Somalia are reliant on remittances sent back by family members living in the Netherlands and Britain. "It helps," she says, "if a woman can go back home and say "if you mutilate my daughter, I'll go to prison and I'll no longer be able to help you financially."

This idea was apparently under consideration at the UK Home Office but nothing has yet materialised. Naleie claims that thousands of Somalis have left the Netherlands to settle in the UK in recent years because "there are fewer controls there and less awareness about FGM. FGM is being carried out underground in the UK. People from many countries in Europe go to the UK for this purpose."

So what are we in the UK doing? The Crown Prosecution Service has recently published action plans, I like to think partly because BBC2's *Newsnight* commissioned a number of reports on FGM and devoted an entire programme to the subject in July. The director of public prosecutions, Keir Starmer, says that he is "determined to start getting these offenders to court." In his list of "action plans," he calls for the involvement of health workers in the following ways:

- Explore what the reporting duties are for medical professionals, social care professionals, and teachers in referring possible FGM cases to the police
- Consider whether existing reporting mechanisms need strengthening
- Consider position of medical professionals to enable reporting without risk of criminalisation.

We shall see whether, as Weil-Curial would put it, we have "the guts" to implement the plans. Meanwhile, the latest figures published by Forward on the incidence of FGM in the UK suggest that, with the recent increase in the Somali population, the number of mutilations is increasing or, as one campaigner points out, two children in the UK could be being mutilated every hour.

Names have been changed to protect anonymity.

Sue Lloyd-Roberts, special correspondent, BBC, London **sue.lloyd-roberts@bbc.co.uk**

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1 Forward. A statistical study to estimate the prevalence of female genital mutilation in England and Wales. 2007. www.forwarduk.org.uk/key-issues/fgm/research.

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