Abortion Review

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FETAL ANOMALY AND THE DISTORTION OF THE ABORTION DEBATE

By Jennie Bristow,
Editor, *Abortion Review*

The High Court ruled in April that the Department of Health (DH) should publish detailed statistics on the medical reasons why abortions are carried out after 24 weeks' gestation. This is the outcome of a long campaign by the Pro-Life Alliance to override the DH's decision not to publish the medical reasons for abortions when these numbered less than 10. The DH took this decision following the notorious Joanna Jepson campaign of 2003, when two doctors were hounded for performing a post-24 week abortion on a fetus with a cleft lip and palate.

The detailed statistics from 2010, which were finally released in June 2011, show nothing except that the tiny number of abortions that take place for conditions such as cleft palate or club foot. This comes as no surprise. Only 1% of all abortions take place on grounds of fetal anomaly, and less than 0.1% of all abortions take place after 24 weeks.

There is nothing trivial about a woman's decision to terminate a wanted pregnancy following a diagnosis of fetal anomaly; and those women who take that decision do so based on the severity of the condition and their ability to care for a child with a disability. It is an intensely personal decision, not any kind of social statement. The anti-abortion lobby has tried to whip up outrage about the tiny numbers of terminations post-24 weeks, but without much success. The main impact of its vindictive antics will be to increase the pain of women in these circumstances, and to deepen the 'chilling effect' that already surrounds doctors who take it upon themselves to perform the procedures.

The feverish media debate about the statistics on Ground E abortions also clouds the moral and practical debates around the treatment of women undergoing termination of pregnancy for fetal anomaly, or abnormality (TOPFA). In this issue of *Abortion Review*, Jane Fisher, director of the charity Antenatal Results and Choices (ARC), highlights some of the particular considerations involved in treating women undergoing TOPFA. One issue of particular concern to **bpas** is that women have access to a choice of abortion method. Women who have a termination following a diagnosis of fetal anomaly are generally referred to NHS hospitals to have the procedure; but only about one fifth of hospitals provide surgical terminations after 13 weeks' gestation, compared to nearly 88% of specialist providers from the independent sector. (1)

As Jane Fisher explains, women undergoing TOPFA may have a clear preference for the method of medical induction, and/or for having the procedure in an NHS hospital. But some women may not want to experience labour, and may prefer to have a surgical procedure under general anaesthetic. It is the role of abortion providers, in the NHS and the independent sector, to work together to ensure that the care of these women is managed as sensitively as possible.

In an article published in the *Daily Mail* in May (2), Sara Carpenter, already a mother of two children, recounts in harrowing detail her decision to have an abortion following a prenatal diagnosis of spina bifida. 'At 18 weeks pregnant, I was too far gone for a surgical termination and would have to go through a labour and delivery, under the care of midwives at our local hospital,' she writes. Two days after taking mifepristone, she returned for labour to be induced: 'What followed were the worst 16 hours of my life. They passed in a morphine-induced haze, but there was no dulling what was happening. My baby was being forced into the world long before he could survive in it, and it felt unnatural — completely at odds with my instincts as a mother. My body seemed to be doing all it could to hold onto him, and the labour went on and on.'

No woman ever wants to need to have an abortion. No woman carrying a wanted pregnancy wants to have to confront the diagnosis that there is something seriously wrong with the fetus, and from there to terminate the pregnancy. But for women who find themselves having to make this decision, they should at least be able to access the method of treatment that is most acceptable to them. And they should be able to take that decision in a climate that is sympathetic and supportive; not one in which opponents of abortion attempt to trivialise their experience to score political points.

(1) *'Comparing medical versus surgical termination of pregnancy at 13-20 weeks of gestation: a randomised controlled trial'. Kelly T, Suddes J, Howel D, Hewison J, Robson S. BJOG 2010; DOI: 10.1111/j.1471-0528.2010.02712.x*

(2) *'I saw my son's bleak future and knew I had to abort him.' By Sara Carpenter. Daily Mail, 19 May 2011*

Inside this issue:

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CLINICAL UPDATE

Termination of Pregnancy for Fetal Anomaly

Jane Fisher, Director, Antenatal Results and Choices (ARC)

Q) What is meant by termination of pregnancy for fetal anomaly?

Termination of pregnancy for fetal anomaly (sometimes shortened to TOPFA) is used to refer to abortions that are classified under Ground E of the Abortion Act 1967 (as amended in 1990). These are abortions that are carried out when two clinicians are satisfied that: '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'.

In England, Scotland and Wales, terminations under Ground E are legal beyond the 'time limit' of 24 weeks' gestation that applies to most abortions. According to Department of Health statistics, 2,290 abortions were performed under Ground E, in 2010. This represents about just over 1% of the total number of abortions carried out in England and Wales. (1) A total of 147 abortions were carried out over 24 weeks' gestation; less than 0.1% of all abortions.

Abortions in these circumstances are usually referred to as 'terminations' by healthcare professionals and the women involved. This is perhaps an attempt to categorise them as being performed for medical reasons and to differentiate them from the ending of unwanted pregnancies.

Q) At what gestation does TOPFA generally take place?

Although the law allows for TOPFA beyond 24 weeks, the vast majority (over 96%) happen before this. The timing tends to correspond with the scheduling of antenatal screening and diagnostic tests.

There are two types of diagnostic tests: ultrasound scans, and the invasive diagnostic tests for chromosomal and some genetic conditions - chorionic villus sampling (CVS) and amniocentesis. There is an optional universal screening programme for Down's syndrome in England, Scotland and Wales.

In England, most women are offered a first-trimester combined screening test. (2) This is carried out between 11 and 13 weeks' gestation and involves an ultrasound scan and maternal blood test. More common in Scotland and Wales is a maternal blood test performed at around 16 weeks. This test is also provided to those women who book into antenatal care too late for the earlier screening. Even if a woman chooses not to have Down's syndrome screening, she will still have a scan between 10 and 12 weeks to date the pregnancy. Major structural problems can be seen at this early scan.

The provision of earlier screening in England was partly driven by the principle that by having an earlier result, women could access the earlier diagnostic test (CVS) which is carried out between 11 and 14 weeks. This could then allow for earlier reassurance, or if, after the confirmed diagnosis of an anomaly, a woman decides to end the pregnancy, there would be a choice between surgical and medical management of the termination process.

In reality, due to the lack of surgical expertise in NHS settings, most women will be offered a medical termination if they receive a diagnosis beyond 13 weeks. Currently, few are told they may be able to access a surgical procedure through an independent provider.

Women who have a blood test to screen for Down's syndrome between 16 and 20 weeks' gestation and whose result leads to the offer of a diagnostic test will have the option of an amniocentesis. The major scan to check for structural problems in the developing fetus is performed between 18+0 and 20+6 weeks gestation. (3) Problems seen at this scan will usually require further investigations. A proportion of TOPFAs are therefore performed after 20 weeks' gestation. Within the NHS these are always medically managed, with feticide recommended at gestations beyond 21 weeks 6 days.

The small number (147 in 2010) of TOPFAs performed after 24 weeks are usually due to a condition that is detected later in the pregnancy. For example, a woman may present at 28 weeks for a scan to check placental position and a brain abnormality is detected. Or in some cases women may have been monitoring the progression of a condition diagnosed at the mid-pregnancy scan and then find the prognosis deteriorate in the third trimester.

Q) What are the reasons why women would choose a particular method of termination?

There is no research evidence that the method used to end a pregnancy after a prenatal diagnosis will complicate the post-procedure emotional recovery. (4) From ARC's extensive experience in supporting women and couples post TOPFA, the key factor seems to be that they are enabled to have it managed in the way they can best cope with at the time. They will require clear information on their care options and should be given the time they need to decide how to proceed. There will be some instances when a detailed post-mortem is recommended and so medical management will be necessary.

It can be difficult for women to contemplate going through labour and delivery to end a wanted pregnancy, but after the initial shock at the idea, some will decide that this method feels more 'natural' and a more tangible way of managing the loss. There will be an intact fetus and this gives women and their partners the choice to see and hold their baby if this is what they want; but there is no clear evidence to suggest that seeing and holding the baby will lead to less complicated grieving. Other women decide that the surgical option under general anaesthetic will be easier for them to cope with than a medically-managed delivery.

There are no particular clinical skills required by TOPFA.

Q) What are the other considerations in dealing with women presenting for TOPFA?

Most women who present for TOPFA will be grieving the 'healthy baby' they have already lost and distressed that they are ending a wanted pregnancy. Some will be very sensitive to the fact that they may come up against women using abortion services who are in different circumstances with pregnancies that are unwanted. They may feel the need to make it clear to staff that theirs is a wanted pregnancy and that they are only ending it because of the severity of the condition affecting the fetus.

Women facing TOPFA can feel very vulnerable. Although they know intellectually that they are making the right decision in their situation, emotionally there can be painful conflicting feelings. Some will fear judgement from others for ending a pregnancy because a life-limiting or disabling condition has been diagnosed (this can partly be due to them judging themselves harshly for deciding on termination). Because distress levels can be high, many women will be keen to have their partner with them for support for as much of their time in clinic as possible if this is practicable.

Women presenting for TOPFA will often conceptualise their pregnancy as a 'baby' rather than a fetus and may need reassurance from clinical staff that the procedure will not cause the fetus pain. Some may want to see the screen when having a scan pre-procedure, while others may wish to distance themselves from this pregnancy. There will be women who rapidly want to look ahead to the next pregnancy, which may mean

they wish to opt out of discussions about contraception. It can be useful for women to be given contact details of ARC in case they wish to seek emotional support after the procedure as they can be taken aback by the grief reaction they experience once they return home.

As will all women seeking abortions, the key to the sensitive management of TOPFA is to not make assumptions, take the cue from an individual woman and try as far as possible to accommodate her needs.

For more information about ARC's services go to www.arc-uk.org or call 020 76310280. For more information on TOPFA see the RCOG's 2010 Working Party Report 'Termination of Pregnancy for Fetal Abnormality' http://www.rcog.org.uk/files/rcog-corp/TerminationPregnancyReport18May2010.pdf

References

(1) *Department of Health. Abortion Statistics, England and Wales: 2010. Statistical Bulletin 201111.London: DH 2011*
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127202.pdf

(2) *NHS Screening Programmes: NHS Fetal Anomaly Screening Programme*
http://fetalanomaly.screening.nhs.uk/

(3) *NHS Screening Programmes: NHS Fetal Anomaly Screening Programme*
http://fetalanomaly.screening.nhs.uk/

(4) *Statham H. Prenatal diagnosis of fetal abnormality: the decision to terminate the pregnancy and the psychological consequences. Fetal and Maternal Medicine Review 2002;13:213–47.*

ABORTION NEWS

JUNE 2011

UK: Controversy over pregnancy counselling

Charities that provide abortions could be stripped of their ability also to counsel women, under plans being considered by the government. Pro-choice advocates expressed alarm at the announcement by the Department of Health, which came after the Conservative MP Nadine Dorries, and the Labour MP Frank Field, tabled amendments to the Health and Social Care Bill in March. The amendment's main proposals are:

- That a woman seeking 'information, advice and counselling' about her pregnancy is provided with an 'independent' service. This means either '(i) a private body that does not itself provide for the termination of pregnancies; or (ii) a statutory body'.

- That the National Institute for Clinical Excellence (NICE) must 'make recommendations with regard to the care of women seeking an induced termination of pregnancy', with which abortion providers must comply.

A briefing produced by **bpas** and published on *Abortion Review* addresses some of the principal concerns raised by the Dorries amendments. Ann Furedi, chief executive of **bpas**, said: 'We are extremely concerned to learn that the Department of Health is reviewing care pathways for women considering abortion and looking into a ban on counselling by abortion providers. In recent years, delays for women in need of abortion care have been reduced significantly, and last year nearly 80% of procedures took place within the first 10 weeks of pregnancy. Pregnancy Advisory Bureaux (PABx) run by charities like **bpas** that offer abortion are already licensed and regulated by the Secretary of State, and must conform to a core set of principles regarding information and counselling.

'There is nothing to justify a policy change to this and it is unclear what problem the DH is trying to solve, since there is no evidence that current providers of counselling and support are failing to meet their mandatory requirements. To our knowledge no abortion provider has been asked to change current practice, and there has been no suggestion that a licensed PAB is operating improperly. It is troubling indeed for a Government which continually professes an interest in evidence-based care to be rewriting rules on the basis of politics, not proof.'

In an essay published on *Abortion Review*, the sociologist Dr Ellie Lee, author of *Abortion, Motherhood and Mental Health* and coordinator of Pro-Choice Forum, discusses the long history of pregnancy counselling and abortion provision. The academic literature published to date indicates that:

- Debate about service reorganisation should take into account existing research;
- Care needs to be taken with the definition of purpose when the term 'counselling' is used;
- Confusion between the process of obtaining informed consent and counselling should be avoided;
- Variation in the needs of women needs to be respected and the importance of the process of decision-making in 'private' settings recognised;
- Problems of delaying women who know they want to terminate pregnancy, and allowing ambivalent women time to reach a decision that they feel is right, both need to be given due regard. *28/6/11*

http://www.abortionreview.org/index.php/site/article/993/
http://www.abortionreview.org/index.php/site/article/994/
http://www.abortionreview.org/index.php/site/article/992/

USA: Judge blocks South Dakota's restrictive new law

Governor Dennis Daugaard signed a law on 22 March requiring women to wait three days after meeting with a doctor to have an abortion, the longest waiting period in the USA. The new law also required that the woman have a meeting at an anti-abortion counselling centre before she could have the procedure. On 1 July, a federal judge blocked the law. Planned Parenthood called the ruling a 'decisive victory.' 'This law represents a blatant intrusion by politicians into difficult decisions women and families sometimes need to make,' said Sarah Stoesz, president and chief executive of Planned Parenthood Minnesota, North Dakota, South Dakota.

The South Dakota law is one of many abortion curbs pushed by conservative lawmakers in dozens of states this year. Other proposals included bans on late abortions and requirements that providers offer women sonograms of their fetuses, Reuters reported. South Dakota has been at the centre of some of the most bitter recent fights over abortion. State lawmakers passed laws in 2006 and 2008 to ban most abortions unless they were necessary to save a woman's life. Voters later overturned both bans. *23/3/11, 30/6/11*
http://www.abortionreview.org/index.php/site/article/946/
http://www.abortionreview.org/index.php/site/article/998/

IN BRIEF:

- **UK: Doctors reject abortion time limit reduction**
  Doctors have rejected calls for the British Medical Association to start campaigning for a cut in the legal time limit for abortion from 24 to 20 weeks. A move to change the BMA's longstanding policy in support of abortions up to the twenty-fourth week of gestation was rejected by about 500 delegates at the union's annual conference in Cardiff by a margin of 61% to 32%, with 7% abstaining. *28/7/11*
  http://www.abortionreview.org/index.php/site/article/991/

- **UK: Christian disciplined in abortion leaflet row**
  The Daily Telegraph reports on the case of a mental health worker who 'felt that the NHS was failing to give patients information about the risks and other options to terminating a pregnancy'. *10/6/11*
  http://www.abortionreview.org/index.php/site/article/988/

- **UK: Concerns over restrictions on NHS-funded fertility treatment**
  More than 70 per cent of NHS trusts and care providers are ignoring official guidance on offering infertile couples three chances at IVF, according to a report by an all-party group of MPs. *7/6/11*
  http://www.abortionreview.org/index.php/site/article/983/

MAY 2011

England and Wales: Abortion statistics 2010

The 2010 national abortion statistics, released in May 2011, show that there were 189,574 abortions in England and Wales in 2010, a very small rise of 0.3% from 2009; and that the age-standardised abortion rate remained 17.5 per 1,000 women. These figures are in line with those of recent years.

Ann Furedi, chief executive of **bpas**, said: 'It is notable that numbers have remained stable despite increasing investment in and promotion of longer-term methods of contraception. This shows how difficult it is for women to prevent unwanted pregnancies. Abortion is not a problem in itself. For many women abortion is a back-up to their contraception. Our challenge is to ensure abortion remains as accessible as possible for those women who need it.'

Some noteworthy aspects of the 2010 statistics are:

- *The continued increase in earlier abortions.* Over three-quarters (76%) of NHS-funded abortions now take place at under 10 weeks' gestation, compared to 74% in 2009 and half (51%) in 2002. Almost two thirds (62%) of abortions at under 8 weeks' gestation are performed by the independent sector under NHS contract.

- *Most later abortions, between 13 and 24 weeks, are provided by the independent sector.* The independent sector is usually able to offer women a choice of either medical (labour induction) or surgical abortion. For women who can only access abortion within NHS settings – either due to local contracts or medical reasons such as a high Body Mass Index (BMI) – choice may be restricted.

- *'Repeat abortion' rates are not surprising.* The phrase 'repeat abortion' implies that women are having serial abortions: this is not the case. The phrase used by the national statistics is 'previous abortion', which is a more accurate and less sensational description. The statistics show that one third of women (34%) who have abortions have had 'one or more' previous abortion. The proportion of women who have had more than one previous abortion is roughly 8 per cent.

- *The role of 'delayed motherhood'.* One reason why women may require more than one abortion, or why the abortion rate seems to be rising among women in their late thirties and early forties, is because they are exposed to unwanted pregnancy for longer than women of previous generations, through deciding to start their families later or not to have children at all. In 2009, the average age of women giving birth was 29 years (28 years at first birth), and 20% of babies born had mothers aged 35 and over. These statistics should remind us again that abortion is not something simply 'done' by young, single women – older women, and those who are already mothers, experience unwanted pregnancy too, and rely on abortion as a solution.

The *Daily Telegraph* reported on the increase in women having abortions in their 40s. A commentary by Jennie Bristow examines the possible reasons for this trend. *24/5/11, 29/5/11*

http://www.abortionreview.org/index.php/site/article/960/
http://www.abortionreview.org/index.php/site/article/990/
http://www.abortionreview.org/index.php/site/article/971/

UK: Storm over sexual health advisory group appointment

The Coalition Government has appointed pro-abstinence charity Life to a new sexual health forum set up to replace the Independent Advisory Group on Sexual Health and HIV, while omitting **bpas**, the *Guardian* reported in May. This is despite **bpas's** long-term position on the previous advisory group and 40-year track record in providing pregnancy counselling nationwide.

The sexual health forum consists of representatives of the British Association for Sexual Health and HIV; the Faculty of Sexual and Reproductive Health at the Royal College of Obstetricians and Gynaecologists; the Association of Directors of Public Health; the British HIV Association; the Terrence Higgins Trust; Brook; the Family Planning Association; the Sex Education Forum and National Children's Bureau; Marie Stopes International; and Life.

The news that **bpas** was to be excluded from the government advisory sexual health forum provoked commentary across the UK media and blogosphere, including appearances by **bpas** chief executive Ann Furedi on the BBC's *Newsnight* and *Woman's Hour*. In a commentary for the *Guardian*, Clare Murphy, **bpas'** Associate Director of Press and Public Policy, argued that the anti-abortion lobby was using new stealth tactics to gain an undue influence on policy.

In an article published on *spiked*, Ann Furedi wrote: 'Much of the concern expressed about Life's invitation to join the Sexual Health Forum has been about the government opening itself up to advice from a group that is opposed to abortion in principle. Personally, I don't share that view. Although most people in Britain believe that abortion is legitimate, some do not and it's fair enough for their views to be sought to inform policy discussions about the rightness or wrongness of abortion.'

However, Furedi continued: 'While Life might have a place on a pregnancy forum, it is hard to extend that concession to a forum advising on sexual health. Life's pregnancy counselling centres do not provide contraceptive services and they do not provide testing for sexually transmitted infections. They could not refer to abortion services, even if they wanted to, because they are not included on the Department of Health's register of Pregnancy Advisory Bureaux. Life's contribution to the discussion on sexual health seems to be limited to telling people not to have sex. It seems a bit like including Jehovah's Witnesses on a panel to discuss how to improve blood transfusion services…' *24/5/11, 6/6/11*
http://www.abortionreview.org/index.php/site/article/972/
http://www.abortionreview.org/index.php/site/article/970/
http://www.abortionreview.org/index.php/site/article/969/

New Abortion Review briefing: *Understanding Abortion Statistics*

This briefing aims to provide journalists, students, and others with an overview of the key themes within the annual abortion statistics.

1) Introduction: About abortion statistics
Where do abortion statistics come from? What the statistics can tell us; What the statistics cannot tell us; Which statistics to treat with particular caution.

2) Number of abortions
How many abortions are there? What is the abortion rate? What is the birth rate? How many women come to Britain from overseas to have an abortion? How many women have 'repeat' abortions? What factors affect the abortion rate?

3) Grounds for abortion
How are the legal grounds applied in practice? How common is termination of pregnancy for fetal anomaly?

4) Age, marital status, previous children, and ethnicity
How does abortion relate to age? Abortion and fertility rates; Marital status, previous children, and ethnicity.

5) Gestation, method and complication rates
'Early' abortion; Later abortion; Methods of abortion; Which method is best? How safe is abortion?

6) Provision, funding and geographical location
Who provides abortions? What are the geographical variations in abortion provision? How is abortion regulated?

Understanding Abortion Statistics can be downloaded from ***Abortion Review*** as a .pdf here:
http://www.abortionreview.org/images/uploads/Abortion_Statistics_May2011.pdf
or read online here:
http://www.abortionreview.org/index.php/site/article/968/.

The 2010 abortion statistics for England and Wales are published by the Department of Health and available here:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127202.pdf

APRIL 2011

UK: Review of evidence on abortion and mental health

The Royal College of Psychiatrists' draft review of the evidence on the mental health effects of induced abortion was published for consultation on 6 April. In finding no causal relationship between abortion and mental health problems, the report confirms the conclusions of other authoritative reviews: most notably, the American Psychological Association's report of 2008.

The key point highlighted by the RCPsych's review is that mental health outcomes from induced abortion or childbirth are associated with a woman's mental health before abortion. In other words, if depression follows abortion it is because the woman has a pre-existing mental health condition, not because the abortion itself causes her to be depressed. Furthermore, it states that mental health outcomes are likely to be the same, whether women with unwanted pregnancies opt for an abortion or birth. The review thus recognises that women seeking abortion must be compared, not with women who are not pregnant or who have wanted pregnancies, but with women in a comparable situation with an unwanted pregnancy, which must be carried to term or aborted.

In a commentary, Jennie Bristow writes: 'It is to be hoped that, with this latest review of the evidence about abortion and mental health, the debate about abortion can move beyond this narrow framework. For in reality, women do not have abortions because they are good for their health, or in spite of them being bad for their health. Abortion is a part of the messy reality of life, subject to a whole range of personal, moral, social and relational factors; and the preoccupation with its health effects can skew the debate away from more subtle questions...'
http://www.abortionreview.org/index.php/site/article/951/

UK: Government loses case over late abortion data

The Department of Health lost in April a court battle to keep from publishing some details on statistics for abortions carried out on grounds of fetal anomaly. The government was challenging an Information Tribunal decision, but the High Court has now ruled that data on abortions carried out after 24 weeks' gestation must now be disclosed. The court case follows a long-running campaign by the anti-abortion group ProLife Alliance, coming out of a judicial review brought by the curate Joanna Jepson in 2003. Jepson was interviewed at length by the *Daily Mail* in March. *20/4/11, 21/3/11*
http://www.abortionreview.org/index.php/site/article/955/
http://www.abortionreview.org/index.php/site/article/947/

UK: Developments and obstacles in abortion services

An interesting conference at London's Royal Society of Medicine discussed issues including the provision of Early Medical Abortion in a variety of settings to surgical techniques, the wider issues of conscientious objection, misinformation and staff attitudes that surround the provision of abortion services. Jennie Bristow reports. *15/4/11*
http://www.abortionreview.org/index.php/site/article/956/

IN BRIEF:

- **UK: TV wildlife presenter calls for family size limitation**

Chris Packham, the presenter of Autumnwatch and Springwatch, has called for parents to have fewer children, saying smaller families should be rewarded with tax breaks. 5/4/11
http://www.abortionreview.org/index.php/site/article/948/

- **UK: 'Babies are not the only children worth adopting'**

Writing in the Daily Telegraph, Max Pemberton takes issue with Nadine Dorries MP's 'bizarre claim' that adoption is 'fading out' because of abortion. 25/4/11
http://www.abortionreview.org/index.php/site/article/953/

- **Commentary: 'Beware the anti-abortionists' tiny steps towards reform'**

Writing in the Guardian, Libby Brooks argues that the combination of US-style activism and big society localism poses a real threat to a woman's right to choose. 15/4/11
http://www.abortionreview.org/index.php/site/article/954/

- **UK: 'Attack on abortion is an insult to women'**

In the Herald (Scotland), Anne Johnstone writes: 'Tory MP Nadine Dorries is touchy about being described as pro-life but she sure ain't pro choice'. 31/3/11
http://www.abortionreview.org/index.php/site/article/950/

MARCH 2011

Abortion 'no solution', says Pope

Pope Benedict XVI has urged doctors to protect women from 'misinformation' that an abortion might be an acceptable solution to social or economic difficulties or health problems, reported the *Scottish Catholic Observer*. The Pope reaffirmed the Catholic Church's firm opposition to abortion in a speech to members of the Pontifical Academy for Life, the Vatican's bioethics advisory board, at the end of their General Assembly, which examined 'post-abortion syndrome'.

The Pope said that women are often convinced, sometimes by their own doctors, that abortion is a legitimate choice and in some cases a therapeutic act to prevent their babies from suffering. Saying 'abortion solves nothing,' he called on doctors not to give up their duty to defend the consciences of women from such 'deception'. He appealed to the moral conscience of all those considering an abortion, and argued that all of society should be dedicated to preserving the right to life. He also called for all the women 'who have unfortunately aborted and thereby fallen into a moral and existential drama' to be helped.

The Pontifical Academy for Life, the Vatican department dedicated to studying issues related to bioethics and the protection of life, met in Rome with experts from different cultures and religions to talk about 'post-abortion trauma', the *Scottish Catholic Observer* reported. The academy invited Teresa Burke, president of Project Rachel's Vineyard Ministries in the United States, and Justo Aznar, from the Institute of Life Sciences in Valencia, Spain, to discuss the impact an abortion has the psychology of women. The academy was instituted by Pope John Paul II in 1994. It includes more than 70 members, representing the different branches of biomedical sciences related to the 'promotion of life'.
http://www.abortionreview.org/index.php/site/article/944/

UK: Media fears about women buying abortion drugs online

Two national newspapers in March reported concerns about the possibility of 'new backstreet abortions' provoked by the availability of misoprostol over the internet. Noting that at **bpas** clinics, women will also be given information about what is normal after the abortion and have a follow-up consultation to check that the procedure has worked, the *Mirror* article also discusses **bpas's** 2011 High Court challenge to the Secretary of State for Health on the administration of Early Medical Abortion drugs. The newspaper highlights the unnecessary number of visits that women must make to clinics as possible reasons why women might be tempted to buy the drugs online.

Patricia Lohr, medical director of **bpas**, told the *Mirror*: 'One of the biggest risks with buying drugs over the internet is that in most cases they're uncontrolled and unregulated so there's no way of telling that they are what they say they are. This means they could be ineffective or even harmful.

'When you go through the proper channels, you'll be asked about your medical history. Not everyone is suitable for an abortion pill – for instance it shouldn't be prescribed for women on certain medications or with particular conditions. It's also vital to know exactly how far along in the pregnancy you are as this determines how the pill should be taken and whether or not it will be effective.' *5/3/11, 8/3/11*
http://www.abortionreview.org/index.php/site/article/940/

IN BRIEF

- **USA: Nebraska's late abortion ban forces mother to give birth to dying baby**

The state's new 'fetal pain' law meant that Danielle Deaver had to wait to give birth to a baby that she and her doctors knew would die minutes later, reports NebraskaStatePaper.com. *7/3/11*
http://www.abortionreview.org/index.php/site/article/939/

MEDICAL UPDATE

USA: Later abortions and mental health: psychological experiences of women having later abortions - a critical review of research

Steinberg JR. Women's Health Issues. 2011 May-Jun;21(3 Suppl):S44-8.

The author notes that some abortion policies in the US are based on the notion that abortion harms women's mental health. The American Psychological Association (APA) Task Force on Abortion and Mental Health concluded that first-trimester abortions do not harm women's mental health. However, the APA task force does not make conclusions regarding later abortions (second trimester or beyond) and mental health. This paper critically evaluates studies on later abortion and mental health in order to inform both policy and practice.

Using guidelines outlined by Steinberg and Russo (2009), post-1989 quantitative studies on later abortion and mental health were evaluated on the following qualities: 1) composition of comparison groups, 2) how prior mental health was assessed, and 3) whether common risk factors were controlled for in analyses if a significant relationship between abortion and mental health was found. Studies were evaluated with respect to the claim that later abortions harm women's mental health.

Eleven quantitative studies that compared the mental health of women having later abortions (for reasons of fetal anomaly) with other groups were evaluated. Findings differed depending on the comparison group. No studies considered the role of pre-pregnancy mental health, and one study considered whether factors common among women having later abortions and mental health problems drove the association between later abortion and mental health.

The author concludes that policies based on the notion that later abortions (because of fetal anomaly) harm women's mental health are unwarranted. Because research suggests that most women who have later abortions do so for reasons other than fetal anomaly, future investigations should examine women's psychological experiences around later abortions.
http://www.abortionreview.org/index.php/site/article/977/

UK: Teenage pregnancies that end in abortion: what can they tell us about contraceptive risk-taking?

Hoggart L, Phillips J. Journal of Family Planning and Reproductive Health Care. 2011 Apr;37(2):97-102.

A wide range of interviews were conducted with young women, and professionals, in 10 London primary care trusts. The analysis adds to a substantial body of qualitative research that points to the complexity of sexual decision-making for young women. Contraceptive risk-taking was evident as some young women spoke of the difficulties they experienced with user-dependent methods (primarily the condom and the pill) in often unplanned, sexual encounters. They were also generally poorly informed about different contraceptive methods. Misunderstandings about fertility also emerged as an important issue that can lead young women to draw the wrong conclusions if they do not become pregnant following unprotected sex.

The authors concluded that young people need improved access to, and informed understanding of, the full range of contraceptive methods

available to them. In addition, efforts should be made to enable young women to have a better understanding of their own likely fertility.
http://www.abortionreview.org/index.php/site/article/984/

WHO: Can midlevel health-care providers administer early medical abortion as safely and effectively as doctors? A randomised controlled equivalence trial in Nepal

Warriner IK, Wang D, Huong NT, Thapa K, Tamang A, Shah I, Baird DT, Meirik O. Lancet. 2011 Apr 2;377(9772):1155-61.

The authors assessed whether early first-trimester medical abortion provided by midlevel providers (government-trained, certified nurses and auxiliary nurse midwives) was as safe and effective as that provided by doctors in Nepal. They concluded that the provision of medical abortion up to 9 weeks' gestation by midlevel providers and doctors was similar in safety and effectiveness. Where permitted by law, appropriately trained midlevel health-care providers can provide safe, low-technology medical abortion services for women independently from doctors.
http://www.abortionreview.org/index.php/site/article/982/

Finland: Attendance at post-abortal follow-up visits is low - can the risks of non-attendance be identified?

Pohjoranta E, Suhonen S, Heikinheimo O. Acta Obstetricia et Gynecologica Scandinavica. 2011 May;90(5):543-6. doi: 10.1111/j.1600-0412.2011.01099.x. Epub 2011 Mar 29.

The authors note that post-abortal follow-up visits are recommended following induced abortion. To assess the rates of attendance and the factors affecting it, they performed a retrospective study of 500 women who had an induced abortion up to 20 weeks of gestation. Altogether, 285 (57%) women attended for the follow-up visit as scheduled. In univariable analysis a history of drug abuse was associated with non-attendance. Women who underwent medical abortion either at the hospital or partly at home, and those with a history of human papilloma virus manifestation, were more likely to attend the follow-up visit. The effects of medical abortion and a history of human papilloma virus manifestation persisted in multivariable analysis.

The authors conclude that attendance at post-abortal follow-up visits is low, with only a few clinically significant risk factors predicting non-attendance.
http://www.abortionreview.org/index.php/site/article/985/

IN BRIEF

- **USA: Associations between perceived partner support and relationship dynamics with timing of pregnancy termination**
  Kapadia F, Finer LB, Klukas E. Women's Health Issues. 2011 May-Jun;21 (3 Suppl):S8-13.
  Findings from this study suggest that factors influencing a woman's decision to terminate a pregnancy are not limited to her own professional or personal goals, but also include the social and relationship context within which the pregnancy occurs.
  http://www.abortionreview.org/index.php/site/article/973/

- **USA: Abortion stigma: a reconceptualization of constituents, causes, and consequences**
  Norris A, Bessett D, Steinberg JR, Kavanaugh ML, De Zordo S, Becker D. Women's Health Issues. 2011 May-Jun;21(3 Suppl):S49-54.
  The authors draw from the social science literature to describe three groups whom they posit are affected by abortion stigma: women who have had abortions, individuals who work in facilities that provide abortion, and supporters of women who have had abortions.
  http://www.abortionreview.org/index.php/site/article/976/

- **USA: Conducting collaborative abortion research in international settings**
  Gipson JD, Becker D, Mishtal JZ, Norris AH. Women's Health Issues. 2011 May-Jun;21(3 Suppl):S58-62.
  This paper draws on the authors' collaborative research experiences conducting abortion-related studies using clinic- and community-based samples in five diverse settings.
  http://www.abortionreview.org/index.php/site/article/974/

- **USA: Perceived and insurance-related barriers to the provision of contraceptive services in US abortion care settings**
  Kavanaugh ML, Jones RK, Finer LB. Women's Health Issues. 2011 May Jun;21(3 Suppl):S26-31.
  This analysis examines a range of factors that may act as barriers to integrating contraceptive and abortion services and documents abortion providers' perspectives on their role in their patients' contraceptive care.
  http://www.abortionreview.org/index.php/site/article/980/

- **USA: Physicians and abortion: provision, political participation and conflicts on the ground - the cases of Brazil and Poland**
  De Zordo S, Mishtal J. Women's Health Issues. 2011 May-Jun;21(3 Suppl) S32-6.
  This article argues that gynaecologists' perspectives and practices not only reflect or heed religious precepts on reproductive rights, but are also deeply influenced by inadequate medical training and by the fear of being prosecuted or stigmatised.
  http://www.abortionreview.org/index.php/site/article/978/

- **USA: Genetic testing likelihood: the impact of abortion views and quality of life information on women's decisions**
  Wilson JL, Ferguson GM, Thorn JM. Journal of Genetic Counseling. 2011 Apr;20(2):143-56. Epub 2010 Nov 6.
  The authors examined the contribution of multiple factors to predicting genetic testing likelihood for cystic fibrosis.
  http://www.abortionreview.org/index.php/site/article/987/

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