Abortion Review

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IS ABORTION AND CONTRACEPTION POLICY MEETING WOMEN'S NEEDS?

By Jennie Bristow, Editor, *Abortion Review*

Does current policy on abortion and contraception meet the needs of British women? This is the question that will be interrogated at BPAS's forthcoming public conference, to be held at the Royal Society of Medicine in London on Friday 11 May 2012. On one hand, abortion and contraception have come a long way since the 1967 Abortion Act; services are legal, provided, and funded, and control over one's fertility has become an accepted and expected part of life. On the other hand, the extent to which arcane laws and political prejudices prevent the best use of new methods is a source of continuing frustration to service providers, and causes anxiety and inconvenience for women.

Take the development of the 'abortion pill', in the form of the drugs mifepristone and misoprostol. This has transformed provision of early abortion across the world, from an operation requiring a trained surgeon and a hospital bed into a service that can be led by nurses and midwives and administered by women themselves in their own homes. In theory at least, women using this method can have greater control and autonomy over when and where they have an abortion. Throughout the USA and Europe early medical abortion is routinely provided outside of hospital settings, in clinics and GP surgeries, and new research into the use of telemedicine in the USA shows the possibility of even greater flexibility in providing a safe, effective and accessible service.

Yet in Britain, the law is interpreted such that women are denied even the possibility of taking the misprostol, the second drug in the abortion pill, at home, requiring them instead to make multiple trips to clinics and to time taking their medication around the schedules of providers, rather than their own needs. This situation is starkly out of step with clinical guidance, and with practice in other countries. The importance of women's autonomy over childbirth has been recognised over the past few decades, and steps have been taken to 'de-medicalise' childbirth, through promoting midwife-led care and home birth where possible, so why should abortion be so different? Isn't it time we made the most of the skills of nurses and midwives, and took seriously women's desire to have more control over their own bodies?

While provision of abortion in the early stages of pregnancy to healthy women has undoubtedly improved, there is a group of women for whom access is complex and restricted. This includes women seeking an abortion on grounds of fetal anomaly, who might find themselves denied a choice of abortion method or stigmatised over the perceived severity of the anomalies in question, and women with particular health conditions or high BMI. How do we ensure that the abortion and contraception services take account of the needs and circumstances of all individual women?

Another focus of discussion at the 2012 conference will be new developments in Long-Acting Reversible Contraceptives (LARCs), which offer more effective, longer-term prevention of unintended pregnancy. These methods have numerous advantages to women who want to use them; but these methods have disadvantages and side-effects that mean they may not be the 'magic bullet' for reducing abortion rates, or teenage pregnancy, in the way that some policymakers seem to hope. In the meantime, new thinking in the provision of more established forms of hormonal contraception, such as the pill and the 'morning-after pill', seems to have stalled. How do we assess the benefits and downsides of LARCs? What might women in the future expect from contraception?

Underlying all these issues are questions to do with clinical practice, political will, ethical arguments, and medical training. In Britain, as in many other countries where abortion has been legal for more than a generation, there is a gap between women's expectations of a service they can access, and ongoing controversies at a political level. This gap is mirrored in the problems experienced in recruiting and training a new generation of abortion doctors, nurses and midwives, without whom abortion services cannot be run, or improved.

The first in a series of events planned by BPAS on the theme of 'The Future of Fertility', the 'Pills in Practice' conference will bring together clinicians and service providers from the UK, Europe and the USA to discuss improvements in contraception and abortion care, and barriers that remain to the development of a service that is genuinely fit for purpose.

For more information, please see page 5.

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bpas

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CLINICAL UPDATE

Feticide

By Patricia Lohr,
Medical Director, BPAS

Q) What is feticide?

From a medical perspective, this term refers to modalities to induce fetal demise (1). Feticide is most commonly used for selective termination of higher order gestations to twins or singletons. It is also used by some providers before medical and surgical abortion in the second and third trimesters to avoid signs of life at induction or in the belief that it makes the procedure easier and safer. Several methods have been described including intra-cardiac injection of potassium chloride, intra-amniotic injection of digoxin, and transection of the umbilical cord (2). Older methods of medical abortion employed instillation of hyperosmolar solutions such as urea, which also variably induced fetal demise.

Q) When is feticide typically used in the abortion process?

In Britain, the Royal College of Obstetricians and Gynaecologists (RCOG) has made specific recommendations about the use of feticide before medical abortion in cases of fetal abnormality (3). Its recommendations have also been applied to medical abortions for other indications (4). According to the RCOG, because the rare likelihood of a live birth increases from 21+6 weeks of gestation, feticide should be routinely offered after this gestational age to avoid this possibility. The RCOG recommends the use of intra-cardiac potassium chloride to ensure fetal asystole, which can be observed ultrasonographically typically within minutes after injection.

The usefulness of feticide before dilatation and evacuation (D&E), the commonest method of surgical abortion in the second trimester, remains a matter of debate. Cervical preparation before D&E usually occurs in the 24-48 hours before surgical evacuation and extra-mural deliveries, although rare, have been reported. Induction of fetal demise in these cases would avoid the potential for a live birth. However, advocates of feticide typically propose that the maceration of the fetus which occurs as a result of demise is beneficial because it leads to an easier, faster and safer surgical evacuation (5).

The only randomised trial comparing feticide to placebo evaluated intra-amniotic digoxin and used procedure duration as a proxy for ease of abortion. With 1mg intra-amniotic digoxin, there was no difference in procedure time (p=0.60) or difficulty as reported by the surgeon (p=0.64) (6). Although the study was not designed to assess clinical outcomes, there were no differences in estimated blood loss, pain scores or complications between the groups. There are no similar studies of potassium chloride or other methods of feticide.

Q) What are the clinical skills required to administer feticide?

Most feticidal procedures are performed by intra-cardiac or intra-amniotic injections. Ultrasound evaluation prior to either allows confirmation of gestational age, evaluation of amniotic fluid level, fetal position, and placental location. Continuous ultrasound guidance is not necessary for intra-amniotic injections as confirmation of location of the needle can be assessed by drawing up a small amount of amniotic fluid into a syringe before injection of the medication. Intra-fetal or intra-cardiac injection, however, requires a greater degree of precision in needle positioning and continuous ultrasound guidance is usually employed. Ultrasound is also useful to confirm fetal asystole following potassium chloride injection.

Q) What are the advantages of using feticide from a clinical point of view?

There is some limited evidence that induced fetal demise before a medical abortion shortens the interval been the onset of the induction and expulsion of the fetus (7). In the setting of placenta praevia, bleeding may be less when feticide has been administered prior to a medical abortion (8). These effects still require testing in the context of larger, randomised trials.

The randomised trial of digoxin before D&E at 20-24 weeks gestation by Jackson et al (6) reported that 92% of participants expressed a strong preference for fetal demise before the abortion. However, of those, 29% believed the injection would make the procedure easier and 19% less painful for the woman having the abortion, neither of which were proven by this study.

Q) And the disadvantages?

Extra-mural delivery of the fetus can occur in the interval between administration of feticide and initiation of a medical or surgical abortion (2). Although signs of life are avoided this is distressing and, in the case of a planned D&E, not the outcome the woman desired. Potential complications include injection site pain, amnionitis, or sepsis. Digoxin is associated with vomiting as a common side effect. One case report of a maternal cardiac arrest has been reported following potassium chloride injection (9).

Q) What would you recommend as best practice in the use of feticide?

There is currently no evidence to support the use of digoxin to facilitate increased safety with dilatation and evacuation. There is, however, evidence that its administration has the potential to cause harm (e.g., infection, vomiting, extra-mural delivery). It has recently been argued that digoxin feticide before D&E should only be provided in the context of a clinical trial aimed at assessing its benefits (10). At BPAS, we routinely perform intra-cardiac potassium chloride injections before D&E at 22+0 weeks and greater. We regularly review complications with all of our procedures and have found that, empirically, this practice is associated with an extremely low rate of complications. However, it is unknown whether it is the feticide or some other aspect of our service delivery which leads to such a strong safety profile. Ideally, this practice should be studied in a randomised trial as well.

At present, the RCOG makes a strong recommendation for the routine offer of feticide before later medical abortions, which is centred around the avoidance of resuscitation that is counter to the objective of terminating a pregnancy. Whether the balance of risks and benefits sways toward fetcide from a clinical perspective remains unclear. In addition, little is known about how patients feel about undergoing this invasive procedure which may, in and of itself, be distressing. Best practice at this stage would be to call for more and better research on the use of feticide.

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(2) Diedrich J, Drey E; Society of Family Planning. Induction of fetal demise before abortion. Contraception. 2010 Jun;81(6):462-73.

(3) RCOG. Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales. London: RCOG, 2010.

(4) RCOG. The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7. London: RCOG, 23 November 2011

(5) Maureen Paul, Steve Lichtenberg, Lynn Borgatta, David A. Grimes, Philip G. Stubblefield, Mitchell D. Creinin, eds. Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care. Chichester, W. Surrey, UK: Wiley-Blackwell, 2009.

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(9) Coke GA, et al. Maternal cardiac arrest associated with attempted fetal injection of potassium chloride. Int J Obstet Anesth. 2004;13:287–290

(10) Grimes DA, Stuart GS, Raymond EG. Feticidal digoxin injection before dilation and evacuation abortion Evidence and ethics. Contraception. 2011 May 26. [Epub ahead of print]

ABORTION NEWS

OCTOBER 2011

UK: Tributes to a pioneer of abortion law reform

Madeleine Simms, social rights campaigner and one of the architects of the 1967 Abortion Act, died on 3 October 2011 at the age of 81. Madeleine Simms was author (with Keith Hindell) of *Abortion Law Reformed* and a founding trustee of Birth Control Trust. Writing in *Abortion Review,* Dilys Cossey OBE recalls the work she did with Simms in the Abortion Law Reform Association from 1964-1968:

'In autumn 1963 I had my introduction to three powerful women, when I was interviewed for the job of Secretary of the Abortion Law Reform Association (part-time, £2 per week, working from home) by Vera Houghton, Madeleine Simms and Diane Munday in the Marsham Court flat of Vera's husband, the Labour MP Douglas Houghton.

'Madeleine's quiet, almost ladylike demeanour – a result perhaps of all those years at St Paul's Girls' School - which was what I first observed about her, hid a passionate commitment to women's rights, a strong intellect, formidable writing skills and a mischievous sense of humour. As ALRA's press officer she used every opportunity to write letters to the press – and was sometimes known to use another name both to initiate a correspondence as well as respond to letters under her own name. The newsletter is now a historic record of ALRA's progress over the crucial four years of the campaign.

'The ALRA campaign was a way of life. Madeleine with two young children coped with her responsibilities by concentrating on family matters during the day and worked late into the evening on ALRA affairs. My main memory of Madeleine is her intellectual curiosity and enquiring mind.' *13/10/11*
http://www.abortionreview.org/index.php/sitearticle/1046/

IN BRIEF:

• Event: Sex, feminism and late abortion
BPAS sponsored three provocative debates at the London Battle of Ideas festival: 'How late is too late for abortion?'; 'Coarse sex and cheap lives', and 'What is feminism for?' Jennie Bristow reported on the debates for *Abortion Review*, and Clare Murphy, head of press and public policy, wrote a commentary for the *Independent. 7/11/11, 22/10/11*
http://www.abortionreview.org/index.php/site/article/1060/
http://www.abortionreview.org/index.php/site/article/1057/

• Event: Best Medical Practice with Mifepristone: UK and international perspectives
This interesting meeting at St Thomas's hospital, London, offered perspectives from Mr Kamal Ojha, Dr Christian Fiala, and Dr Raha Shojai, on such issues as home use of the 'abortion pill' in France; the use of mifepristone for cervical priming; and the question of whether there should be a lowest gestational age for Early Medical Abortion. *14/10/11*
http://www.abortionreview.org/index.php/site/article/1047/

SEPTEMBER 2011

UK: Dorries amendment on abortion counselling fails spectacularly

Nadine Dorries, the maverick anti-abortion MP, on 7 September lost her amendment on abortion counselling by 118 votes to 368. The vote followed a highly-charged Commons debate in which Dorries accused Liberal Democrats of blackmailing the prime minister. By the end of the debate Frank Field MP, who co-signed the amendment, called on Ms Dorries not to press ahead with it, and the health minister Anne Milton had issued an unprecedented email to MPs declaring the Department of Health's intention to vote against the amendment, on the grounds that the DH would be organising a consultation on the issue.

Dorries brought her amendment to the government's flagship Health and Social Care Bill, calling for abortion counselling to be provided 'independently': that is, by organisations that do not also provide abortions. If passed, the amendment would have led to a major overhaul of the established abortion service in Britain, where advice and counselling is provided by NHS hospitals and by Pregnancy Advisory Bureaux (PABx) that are licensed and regulated by the DH. Many PABx work alongside clinics that provide abortions; this situation came about because health policymakers considered it to be good practice that women receiving information, advice and counselling before an abortion would have access to medical staff knowledgeable about the clinical aspects of the procedure, and be able to obtain a swift referral for treatment if she decided to have an abortion.

In the weeks running up to the parliamentary debate over the Dorries amendment, there were some furious rows over how abortion advice and counselling is currently provided, as Nadine Dorries made a number of factually inaccurate claims about the service provided by charities such as BPAS: for example, that they operate for profit and thus have a 'vested interest' in encouraging women to have abortions, and that they do not allot sufficient time for women to talk through their situation and make their decision. There was some heated debate over what kind of organisations would be charged with providing information and advice if abortion providers were to be barred from doing so, which focused on concerns that church-led 'crisis pregnancy centres', which seek to dissuade women from abortion, would attempt to move into this role. *Abortion Review* published comprehensive summaries on various aspects of this row, along with a briefing explaining how and why abortion counselling is carried out as it is.

Before the vote on her amendment, Nadine Dorries MP found herself increasingly isolated, and more of her claims were exposed as flawed. In the parliamentary debate, shadow public health minister Diane Abbott said: 'This amendment is the opposite of evidence-based policy making. The proposer of this amendment assumes that thousands of women don't know what they're doing.' Following the vote, BPAS chief executive Ann Furedi said: 'We are pleased to see Nadine Dorries' amendment so overwhelmingly rejected. We look forward to being able to focus our efforts on the issues which pose a genuine problem for women considering ending a pregnancy.'

- Parliament prepares to debate abortion amendments to the Health and Social Care Bill *7/9/11*
  http://www.abortionreview.org/index.php/site/article/1021/
- Health ministers oppose Dorries amendment *4/9/11*
  http://www.abortionreview.org/index.php/site/article/1017/
- Media reports 'Government U-turn' on pregnancy counselling proposals *2/9/11*
  http://www.abortionreview.org/index.php/site/article/1015/
- Political row over pregnancy counselling *31/8/11*
  http://www.abortionreview.org/index.php/site/article/1014/
- Investigation into crisis pregnancy centres *8/8/11*
  http://www.abortionreview.org/index.php/site/article/1009/
- BPAS briefing: Abortion Providers and Pregnancy Advice *29/6/11*
  http://www.abortionreview.org/index.php/site/article/994/

UK: Poll shows backing for a woman's right to choose abortion free from political interference

Fewer than a fifth (17%) of people believe the government has a responsibility to reduce the number of abortions, with 70% believing a woman should have the right to choose free of government interference, an IpsosMORI poll commissioned by BPAS found. Twice as many people (46%) disagreed as agreed (23%) with the suggestion that it should be harder for women to obtain abortions, in the representative sample of nearly 1,000 adults aged 18 and over across Great Britain.

More than half (53%) agreed with the statement: 'A woman should not have to continue with her pregnancy if she wants an abortion'. While this proportion was lower than in 2006 (63%) and 2001 (65%), the number of people disagreeing with this statement (17%) has remained static over the last decade. The fall in definitive agreement appears to be due to an increase in the number of people who state they neither agree nor disagree.

Among those with party political preferences, those who intended to vote Conservative were the most likely to agree with this statement, and the least likely to disagree (59% and 16% respectively). This was followed closely by Labour voters (58% agreed, and 20% disagreed); while of Liberal Democrat voters, 47% agreed, and 26% neither agreed nor disagreed.

When asked which statement most represented their view, more than four times as many people chose 'It is a woman's right to choose whether or not to have an abortion and the government should not interfere' as 'The government has a responsibility to reduce the number of abortions'.

BPAS chief executive Ann Furedi said: 'It is heartening to know the overwhelming majority of people respect a woman's right to make her own decision in her own way when she finds herself in this situation. The decision to have, or not have, a child is personal and private. We welcome findings suggesting that few people wish to see it made more difficult for women to obtain abortions and that there is little appetite for government measures in this area.'

In a commentary on *Abortion Review*, Jennie Bristow discussed the findings in the context of other surveys on abortion and public opinion. *5/9/11*
http://www.abortionreview.org/index.php/site/article/1018/
http://www.abortionreview.org/index.php/site/article/1019/

IN BRIEF:

• UK: Data on abortions for fetal anomaly released
The government published detailed data on the number of post-24 week abortions carried out in England and Wales, after the High Court ordered it to do so following a long-running legal row. The data show there were 147 abortions carried out in 2010 after 24 weeks' gestation. Sixty-six of these were linked to problems in the nervous system, such as spina bifida. Eight terminations were related to musculoskeletal problems, and a total of 29 abortions were for chromosomal problems, including 10 for Down's syndrome and 10 for Edwards' syndrome. *4/7/11*
http://www.abortionreview.org/index.php/site/article/995/

• USA: Woman's Right to Know Act challenged on grounds of free speech and privacy
The American Civil Liberties Union and four other groups sued to challenge a new North Carolina law requiring abortion providers to display and describe ultrasound images of a fetus, the *Los Angeles Times* reports. *29/9/11*
http://www.abortionreview.org/index.php/site/article/1025/

• Event: What does it mean to be pro-choice today?
The Voice for Choice coalition organised a lively public discussion in London about recent political developments in relation to abortion in Britain, with speeches from Evan Harris, Dr Patricia Lohr, and Marge Berer, and chaired by the *Guardian's* Libby Brooks. *22/9/11*
http://www.abortionreview.org/index.php/site/article/1023/

• European ruling may ban women from knowing the sex of their fetus
The *Sunday Telegraph* reports on a draft resolution considered by the Council of Europe in October. *11/9/11, 25/9/11*
http://www.abortionreview.org/index.php/site/article/1024/

• Event: Testing in the First Trimester - Providing women-centred care
The charity Antenatal Results and Choices held a thought-provoking conference in London on 19 September examining the issues involved in prenatal testing. Issues included the improvements to prenatal screening and sonography brought about by the NHS Fetal Anomaly Screening Programme; scientific advances in non-invasive prenatal diagnosis through testing cell free fetal DNA and Array Comparative Genomic Hybridization techniques; and the emotions and choices that termination of pregnancy for fetal anomaly may involve. Patricia Lohr, Medical Director of BPAS, discussed the role that the independent sector can play in facilitating choice of medical or surgical termination method. *19/9/11*
http://www.abortionreview.org/index.php/site/article/1043/

JULY 2011

UK: Medical students' views on providing abortions

A survey published in the *Journal of Medical Ethics* found that almost half of 733 medical students believe that doctors should be allowed to refuse to perform any procedure to which they object on moral, cultural or religious grounds. 'The survey revealed that almost a third of students would not perform an abortion for a congenitally malformed fetus after 24 weeks, a quarter would not perform an abortion for failed contraception before 24 weeks and a fifth would not perform an abortion on a minor who was the victim of rape,' said researcher Dr Sophie Strickland. 'In light of increasing demand for abortions, these results may have implications for women's access to abortion services in the future,' she added.

The *Guardian* reported that concern about termination services is rising, with fewer doctors willing to perform the procedure, according to the Department of Health. The Royal College of Obstetricians and Gynaecologists has voiced concern about the 'slow but growing problem of trainees opting out of training in the termination of pregnancy and is therefore concerned about the abortion service of the future'.

Patricia Lohr, Medical Director of BPAS, said: 'What's interesting is that even where medical students reported an objection to a procedure, this did not necessarily translate into a refusal to perform it. This small study did not explore the reasons for this, but it may be that while students understand they have a right to object, many recognise the need to put their patients' needs first. This study showed that a majority of students surveyed would not refuse to perform an abortion in a variety of scenarios. Just under 16% stated they would not perform a termination for fetal anomaly under 24 weeks' gestation, implying that the majority would perform the procedure if necessary.

'It's vital we ensure abortion is included in the medical school curriculum, as students may not currently engage much with the reasons why a woman may find herself with an unwanted pregnancy and the distress this can cause. The truth is that abortion is the most commonly performed gynaecological procedure in the country. Regardless of whether a doctor specialises in this area or not, they will during their career come across many women facing an unintended pregnancy and considering abortion.' *18/7/11*
http://www.abortionreview.org/index.php/site/article/1007/

IN BRIEF:

• USA: Panel advises contraception coverage
A leading medical advisory panel has recommended that all insurers be required to cover contraceptives for women free of charge as one of several preventive services under the new health care laws. *19/7/11*
http://www.abortionreview.org/index.php/site/article/1008/

• Russia: New law restricts abortion
President Dmitri A. Medvedev has signed into law the first steps intended to restrict abortion since the collapse of communism. *15/7/11*
http://www.abortionreview.org/index.php/site/article/1002/

• UK: Rally for abortion rights
Pro-choice groups protested in Westminster, London, against recent attempts to restrict abortion provision. *9/7/11*
http://www.abortionreview.org/index.php/site/article/1000/

• Spain: Impact of new law on number of abortions reported
A year after Spain brought in a controversial reform of its abortion laws, statistics show a decline in the number of terminations, putting paid to fears from opponents that rates would rocket, the *Daily Telegraph* reports. *5/7/11*
http://www.abortionreview.org/index.php/site/article/999/

BPAS blog

Anti-Abortion Protests

By Clare Murphy, Director of Press and Public Policy, BPAS

When an activist from a local church recorded a day campaigning against abortion outside our Brighton centre earlier this year, they concluded the most challenging part 'was the girl visiting Wistons with two of her friends. She just found out she was pregnant – 5 months pregnant – and was returning to the clinic for an abortion. The girl didn't want to see anything or engage in conversation... Whilst we were able to persuade her friends to look at our information the mother of this unsuspecting child refused to look at anything we had no matter how innocuous.

'Sometimes it seems in order to go through with killing their unborn children, people must shut down certain normal functions of compassion, logic and reason.'

If ever there were pots and kettles, this writer might well fit the bill – happy to pontificate on their own struggles with a woman considering abortion without a flicker of interest or concern as to how it might feel to be that young woman, on that day, descended upon by a group of people who felt at liberty to tell her what she was doing was wrong - despite not knowing the first thing about her and her own very personal circumstances. Indeed there appear to be a burgeoning number of anti-abortion activists who are running short on either compassion or the ability to differentiate logically between a campaign to alter public opinion on abortion and one that simply seeks to hector and distress individual women as they try to access advice and services.

BPAS is seeing an increase in anti-abortion activity in London and the South-East. The 40 Days for Life protest which ran up to the start of November at one stage saw more than 30 people lined up on the square in front our central London clinic, staring (but apparently there to 'help') while their colleagues by our door harangued clients. At least one woman was escorted into the building by a concerned passer-by. And clearly unconstrained by the title of their protest, on Day 50 activists were still turning up and declaring that they intended to appear every week. At our South London centre, activists man the gates on a regular basis, and have followed women down the drive telling them 'you're killing', while in Brighton women are regularly encircled, questioned, and graphic material pushed into their hands.

We know women are not china dolls who will automatically crack under the pressure of a graphic leaflet, the sight of 30 people watching them as they enter a clinic, or even being followed down a road and called a killer. But why should they have to tolerate this as they access healthcare services to which they are legally entitled? We believe if these activists had any sense of compassion, morality or justice, they would take their protest to the court of public opinion – not linger at gates and doorways to target individual women whose personal circumstances and choices they have no interest in or understanding of.

As one woman wrote to us recently after making her way past activists: 'They are not going to change anyone's mind, they simply magnify the distress felt by the woman a thousandfold. Maybe this is what they want.'
Read Clare Murphy's BPAS blog on the *Abortion Review* website, here:
http://www.abortionreview.org/index.php/site/C39/

Pills in Practice: Is abortion and contraception policy meeting women's needs?

BPAS public conference, 11 May 2012

Discussions include:
- Home abortions: Do we medicalise too much?
- Contraception: LARCs and their limits
- Will the Pill survive a century?
- Prenatal screening, women's decision-making and choice of termination method
- Abortion doctors: Is there a crisis in training and recruitment?
- 'Late' abortions: Towards a woman-centred service

Speakers include:
Beverly Winikoff; Raha Shojai; Kate Greasley; Sam Rowlands James Trussell; Lara Marks; Christian Fiala; Dawn Clark; Joanne Fletcher; Stephen Robson; Jane Fisher; Helen Statham; Ann Furedi; Kaye Wellings; Ellie Lee

Venue: Royal Society of Medicine, London
Time: 9am-5pm

For more information, and to register your interest, please visit:
http://www.futureofabortion.org
or email registration@bpas.org.

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MEDICAL UPDATE

UK: Who presents more than once? Repeat abortion among women in Britain

Nicole Stone and Roger Ingham. Journal of Family Planning and Reproductive Health Care 2011 Oct;37(4):209-15.

The authors note that around one in three sexually active women in Britain will have an abortion during their lifetime and a third of those women will experience more than one. In this study, using data collected during the second National Survey of Sexual Attitudes and Lifestyles, the characteristics of women who have presented for a second or subsequent abortion are compared to those women who have obtained only one.

Results indicate that increased age and parity are key characteristics distinguishing between women who have experienced only one abortion and those women who have had more. Findings also reveal that those who have sought abortion on more than one occasion are more likely (than those who have had one abortion) to be Black, have left school at an earlier age, be living in rented accommodation, report an earlier age at first sexual experience, be less likely to have used a reliable method of contraception at sexual debut and report a greater number of sexual partners.

The authors conclude that it is well recognised that attendance at abortion services presents an important opportunity for the provision of individually tailored information regarding contraception to assist women avoid the need for subsequent procedures. However, differential use of abortion services may also indicate variations in knowledge levels, attitudes to risk, attitudes towards abortion, partner communication, gender power and differential access to services. Further research is required to clarify these potential relationships so that suitable health promotion activities can be developed.
http://www.abortionreview.org/index.php/site/article/1048/

UK: Can we identify women at risk of pregnancy despite using emergency contraception? Data from randomized trials of ulipristal acetate and levonorgestrel

Glasier A, Cameron ST, Blithe D, Scherrer B, Mathe H, Levy D, Gainer E, Ulmann A. Contraception. 2011 Oct;84(4):363-7.

The authors note that emergency contraception (EC) does not always work, and clinicians should be aware of potential risk factors for EC failure. Data from a meta-analysis of two randomised controlled trials comparing the efficacy of ulipristal acetate (UPA) with levonorgestrel were analysed to identify factors associated with EC failure.
The risk of pregnancy was more than threefold greater for obese women compared with women with normal body mass index, whichever EC was taken. However, for obese women, the risk was greater for those taking levonorgestrel than for UPA users. For both ECs, pregnancy risk was related to the cycle day of intercourse. Women who had intercourse the day before estimated day of ovulation had a fourfold increased risk of pregnancy compared with women having sex outside the fertile window. For both methods, women who had unprotected intercourse after using EC were more likely to get pregnant than those who did not.

The authors concluded that women who have intercourse around ovulation should ideally be offered a copper intrauterine device. Women with body mass index >25 kg/m(2) should be offered an intrauterine device or UPA. All women should be advised to start effective contraception immediately after EC.
http://www.abortionreview.org/index.php/site/article/1051/

UK: Comparative effectiveness, safety and acceptability of medical abortion at home and in a clinic: a systematic review

Ngo TD, Park MH, Shakur H, Free C. Bulletin of the World Health Organisation. 2011 May 1;89(5):360-70.

The study set out to compare medical abortion practised at home and in clinics in terms of effectiveness, safety and acceptability. A systematic search for randomized controlled trials and prospective cohort studies comparing home-based and clinic-based medical abortion was conducted.

Nine studies met the inclusion criteria (n = 4522 participants). All were prospective cohort studies that used mifepristone and misoprostol to induce abortion. Complete abortion was achieved by 86-97% of the women who underwent home-based abortion (n = 3478) and by 80-99% of those who underwent clinic-based abortion (n = 1044). Pooled analyses from all studies revealed no difference in complete abortion rates between groups. Serious complications from abortion were rare. Pain and vomiting lasted 0.3 days longer among women who took misoprostol at home rather than in clinic. Women who chose home-based medical abortion were more likely to be satisfied, to choose the method again and to recommend it to a friend than women who opted for medical abortion in a clinic.

The authors concluded that home-based abortion is safe under the conditions in place in the included studies. Prospective cohort studies have shown no differences in effectiveness or acceptability between home-based and clinic-based medical abortion across countries.
http://www.abortionreview.org/index.php/site/article/1039/

USA: Alternatives to ultrasound for follow-up after medication abortion: a systematic review

Grossman D, Grindlay K. Contraception. 2011 Jun;83(6):504-10.

The authors note that requiring a follow-up visit with ultrasound evaluation to confirm completion after medication abortion can be a barrier to providing the service. They conducted a systematic search of the PubMed (including MEDLINE), Cochrane Central Register of Controlled Trials and POPLINE databases for studies related to alternative follow-up modalities after first-trimester medication abortion to diagnose ongoing pregnancy or retained gestational sac. The search identified eight articles. The most promising modalities included serum human chorionic gonadotropin measurements, standardized assessment of women's symptoms combined with low-sensitivity urine pregnancy testing and telephone consultation. The authors concluded that alternatives to routine in-person follow-up visits after medication abortion are accurate at diagnosing ongoing pregnancy. Additional research is needed to demonstrate the accuracy, acceptability and feasibility of alternative follow-up modalities in practice, particularly of home-based urine testing combined with self-assessment and/or clinician-assisted assessment.
http://www.abortionreview.org/index.php/site/article/1041/

UK: British gynaecologists' attitudes in 2008 to the provision of legal abortion

Savage W, Francome C. Journal of Obstetrics and Gynaecology. 2011 May;31(4):322-6.

In 2008, the authors investigated the attitudes and practice of British consultant gynaecologists towards induced abortion, and made comparisons with their similar survey in 1989. A random sample of one in six (217) was selected from the register of the Royal College of Obstetricians and Gynaecologists (RCOG). The response to the postal questionnaire was 70% (152).

Satisfaction with the way the 1967 Abortion Act is operating was expressed by 59% (76% in 1989) and an upper limit of 24 weeks was supported by 50% (77% in 1989). Abortion after 20 weeks was approved to protect health by 92%; after rape by 60% and for serious fetal handicap by 87%. A change in the regulations to require the signature of only one doctor (rather than two) to certify the need for abortion was supported by 65%. Only a minority (41%) provided 2nd trimester abortion in person; 61% would separate abortion provision from general gynaecology; 57% suggested there should be separate abortion units for gestations over 13 weeks and 56% felt that fertility control should become be a sub-specialty.

The authors suggest that satisfaction with the Abortion Act 1967 has decreased during the last 20 years. Gynaecologists' attitudes to the indications for second trimester abortion remain wide, with clear implications for women seeking abortion. The service to women would be improved if abortion on request was permitted in the first trimester and after only one medical signature in the second trimester. The authors' view is that the decision to end a pregnancy should be made by the woman and that abortion should be decriminalised.
http://www.abortionreview.org/index.php/site/article/1013/

IN BRIEF:

• UK: Medical abortion and the 'golden rule' of statutory interpretation
Greasley K. Medical Law Review. 2011 Mar;19(2):314-25
• This article reviews the case of *BPAS v the Secretary of State for Health [2011]*, which called for an interpretation of the law that would have allowed the 'abortion pill' to be taken at home.
http://www.abortionreview.org/index.php/site/article/1037/

• Sweden: Comprehensive counselling about combined hormonal contraceptives changes the choice of contraceptive methods: results of the CHOICE program
Gemzell-Danielsson K, Thunell L, Lindeberg M, Tydén T, Marintcheva-Petrova M, Oddens BJ. Acta Obstetricia et Gynecologica Scandinavica. 2011 Aug;90(8):869-77.
This cross-sectional multicentre study, set in 70 Swedish family planning clinics, aimed to study the influence of counselling on women's contraceptive decisions.
http://www.abortionreview.org/index.php/site/article/1053/

• USA: Effectiveness and acceptability of medical abortion provided through telemedicine
Grossman D, Grindlay K, Buchacker T, Lane K, Blanchard K. Obstetrics and Gynecology. 2011 Aug;118(2 Pt 1):296-303.
This study aimed to estimate the effectiveness and acceptability of telemedicine provision of early medical abortion compared with provision with a face-to-face physician visit at a Planned Parenthood affiliate in Iowa. The authors concluded that provision of medical abortion through telemedicine is effective and acceptability is high among women who choose this model.
http://www.abortionreview.org/index.php/site/article/1032/

• France: Medical vs. surgical abortion: the importance of women's choice
Caroline Moreau, James Trussell, Julie Desfreres, Nathalie Bajos. Contraception 2011 Sep;84(3):224-9.
Using a large national sample of women undergoing an abortion in France, the authors explore the factors associated with medical or surgical abortion, drawing particular attention to the influence of women's preferences in the decision-making process.
http://www.abortionreview.org/index.php/site/article/1044/

• USA: Fetal pain, abortion, viability, and the Constitution
Cohen IG, Sayeed S. Journal of Law and Medical Ethics. 2011 Summer;39(2):235-42
The authors note that in early 2010, the Nebraska state legislature passed a new abortion restricting law asserting a new, compelling state interest in preventing fetal pain. In this article, they review existing constitutional abortion doctrine and note difficulties presented by persistent legal attention to a socially derived viability construct. They then offer a substantive biological, ethical, and legal critique of the new fetal pain rationale.
http://www.abortionreview.org/index.php/site/article/1036/

• USA: Immediate versus delayed IUD insertion after uterine aspiration
Bednarek PH, Creinin MD, Reeves MF, Cwiak C, Espey E, Jensen JT; Post-Aspiration IUD Randomization (PAIR) Study Trial Group. New England Journal of Medicine. 2011 Jun 9;364(23):2208-17.
The authors note that intrauterine devices (IUDs) provide highly effective, reversible, long-term contraception that is appropriate for many women after first-trimester uterine aspiration. However, the effects of immediate versus delayed IUD insertion after uterine aspiration on rates of complications and IUD use are uncertain.
http://www.abortionreview.org/index.php/site/article/1004/

• USA: Intrauterine device insertion after medical abortion
Betstadt SJ, Turok DK, Kapp N, Feng KT, Borgatta L. Contraception. 2011 Jun;83(6):517-21
In this prospective, observational clinical study, the authors concluded that intrauterine devices inserted at the time of completed, confirmed first-trimester medical abortion have low rates of expulsion.
http://www.abortionreview.org/index.php/site/article/1035/

• USA: Cervical preparation for surgical abortion between 12 and 18 weeks of gestation using vaginal misoprostol and Dilapan-S
Wilson LC, Meyn LA, Creinin MD. Contraception. 2011 Jun;83(6):511-6.
This study investigated the safety and efficacy of using misoprostol and Dilapan-S™ hygroscopic cervical dilators to prepare the cervix for surgical abortion from 12 to 18 weeks of gestation in an outpatient office setting.
http://www.abortionreview.org/index.php/site/article/1042/

• USA: Changes in abortion rates between 2000 and 2008 and lifetime incidence of abortion
Jones RK, Kavanaugh ML. Obstetrics and Gynecology. 2011 Jun;117(6): 1358-66.
The results found that the abortion rate declined 8.0% between 2000 and 2008, from 21.3 abortions per 1,000 women aged 15-44 to 19.6 per 1,000. Decreases in abortion were experienced by most subgroups of women. One notable exception was poor women; this group accounted for 42.4% of abortions in 2008, and their abortion rate increased 17.5% between 2000 and 2008 from 44.4 to 52.2 abortions per 1,000. The authors concluded that abortion is becoming increasingly concentrated among poor women, and restrictions on abortion disproportionately affect this population.
http://www.abortionreview.org/index.php/site/article/1034/

• Netherlands: Women's views on the moral status of nature in the context of prenatal screening decisions
García E, Timmermans DRM, van Leeuwen, E. Journal of Medical Ethics 2011;37:461-465
Researchers explored the meaning of appeals to nature among pregnant women to whom a prenatal screening test was offered and the impact of these appeals on their choices regarding the acceptance of screening.
http://www.abortionreview.org/index.php/site/article/1006/

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