Abortion Review

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'EXTENDING PARENTING BACKWARDS': NEW LIMITATIONS ON WOMEN'S AUTONOMY

In June 2010, the University of Kent will host a two-day seminar, supported by BPAS, on the theme of 'pregnancy and pregnancy planning in the new parenting culture'. The seminar takes as its starting point new developments in modern parenting culture, in which themes of 'intensive parenting' and 'responsible parenthood' have come to shape the direction of social policy. International scholars from a range of disciplines will discuss these themes with an academic, professional and lay audience, focusing on their relationship to women's autonomy and reproductive decision-making.

Policy over recent decades has situated 'parenting' as a key site of political concern. It is not now unusual to see policy measures directed specifically at indicating what foods parents should feed their children, or the extent of their involvement in their child's homework. While many see such developments as contributing positively to a model of responsible parenthood, by giving parents official advice and support in making the best decisions regarding everyday family life, others have warned that putting parenting practices under the spotlight in this way can have some negative consequences in terms of reproductive autonomy.

It has also been argued that, in an era marked by an attachment to 'evidence-based policy', the evidence base for promoting 'one method' of feeding, educating or disciplining children is rather weak; and that children's health and development is the result of a wider range of factors than can be determined simply by the diet their parents feed them, or the amount of time spent reading to them in the evening.

The University of Kent seminar will draw upon this discussion to examine how the imperatives of this new parenting culture have begun to 'extend backwards' into pregnancy and pre-pregnancy. The desire to produce the 'optimal child' has led to an increasingly stark distinction between acceptable and non-acceptable behaviour in pregnant women. Smoking, drinking alcohol, eating certain types of food and taking any kind of medication have become areas of intense concern and anxiety. The fear is that a pregnant woman might harm her fetus by ingesting the wrong kind of substance, and the conclusion often drawn is that she should therefore err on the side of caution by avoiding any 'risky' behaviour during pregnancy, and avoiding becoming pregnant until she has changed her lifestyle in the appropriate ways.

It is known that certain substances and medications can have a negative impact on fetal development, or even cause abnormalities, and it is sensible to take this knowledge into account. Of interest to the conference, however, is the way that even substances or behaviours that have not been proven to cause harm are now tagged as things that the pregnant woman should avoid. One example of this is the 2007 decision, by the Department of Health and the National Institute for Clinical Excellence (NICE), to advise pregnant women and those who may be thinking of becoming pregnant to avoid alcohol completely. This new advice was not based on any new evidence about the harm that alcohol might cause the fetus: there is no evidence that moderate drinking during pregnancy has any effect, and as some important American studies have indicated, the evidence that even heavy drinking harms the fetus is far less clear-cut than is generally presumed.

The justification given for bringing in new official advice about abstaining from alcohol during pregnancy was not based on evidence, but on the presumed need for behavioural change. Encouraging women to change their lifestyle habits (in particular, their drinking behaviour) is now accepted as a necessary precondition for responsible motherhood. This is why the advice extends to women who are merely thinking of becoming pregnant: the effect of alcohol upon the fetus cannot be significant here, as there is no fetus; the issue is one of adopting appropriate maternal attitudes and behaviour.

The effect of these developments upon women's reproductive autonomy is significant. While antenatal care has always exercised a degree of control over women's behaviour, both the expansion of the maternal behaviours seen as problematic and the extension of these concerns to women before they become pregnant, indicates a tendency towards the increasing regulation of women's private choices.

Seminar participants will discuss how the phenomenon of 'extending parenting backwards' can also impact negatively on women's reproductive choices regarding contraception and abortion. A woman's ability to decide, for herself, the circumstances under which she wants to have a child, and to avoid or terminate a pregnancy if those circumstances are not favourable, has been one of the great gains of modern history. But in circumstances where there is a high cultural expectation of the 'perfect pregnant woman' as a necessary precondition for creating the optimal child, and where this expectation is often shared by women before they become pregnant, women might find their personal fertility decisions unduly shaped by wider cultural concerns.

For example, the woman who decides to terminate an unintended pregnancy because she was out drinking with her friends before discovering that she was pregnant, or the woman who worries that her use of hair dye and prescription drugs may have adversely affected the developing fetus, might be seen to be making the responsible choice by having an abortion rather than carrying the pregnancy to term. However, when the actual scientific evidence about a causal link between the woman's behaviour and the fetus is weak, and where her choice to terminate the pregnancy has been informed more by anxiety and pressure about the potential negative consequences of her behaviour than by the question of whether or not she wants to have a baby right now, there is a need to address the extent to which the new parenting culture can affect women's decision-making.

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PREGNANCY AND PREGNANCY PLANNING IN THE NEW PARENTING CULTURE

22-23 June 2010, University of Kent, Canterbury, UK.

This two-day seminar is organised by Parenting Culture Studies and the Kent Centre for Law Gender and Sexuality, and supported by BPAS and the Economic and Social Research Council.

Speakers and papers include:

- **Professor Kristin Luker**, Elizabeth Josselyn Boalt Professor of Law and Professor of Sociology, University of California: *'Abortion and the politics of motherhood revisited'*
- **Rachel Jones,** Senior Research Associate, Guttmacher Institute, New York: *'Abortion decision making in a culture of "intensive motherhood"'*
- **Danielle Bessett,** Ph.D., Charlotte Ellertson Social Science Postdoctoral Fellow, Ibis Reproductive Health, Cambridge, MA: *'Pregnancy after Abortion: women's experiences of a stigmatised reproductive career'*
- **Evelyn Mahon,** Senior Lecturer in Sociology at the School of Social Work and Social Policy, Trinity College Dublin: *'Is there ever a good time to have a child?'*
- **Elizabeth Mitchell Armstrong,** Associate Professor of Sociology and Public Affairs, Princeton University: *'Do happier pregnancies make healthier babies? Stress and the medicalisation of maternal emotion'*
- **Cynthia Daniels,** Professor of Political Science, Rutgers University: *'Policing pregnancy: The politics of fetal risks'*
- *'What's wrong with advocating alcohol abstinence to pregnant women? Perspectives from the US and Britain'.* **Janet Golden,** Professor of History, Rutgers University; **Pam Lowe**, Lecturer in Sociology, Aston University.
- **Martin Richards,** Emeritus Professor of Family Research, Cambridge University: 'Present practice and future developments in the culture of choice'
- **Julie McCandless,** lecturer in law, Oxford Brookes University: *'What is "supportive parenting"? The new 'Welfare of the Child'.*

See the Parenting Culture Studies website for abstracts and a full programme: http://www.parentingculturestudies.org/seminar-series/seminar5/index.html

Booking:
Tickets £120 two days/£80 one day (employed); £25 (students and unwaged).
Email Sarah Slowe:
s.e.slowe@kent.ac.uk

Further information:
Contact the event organiser, Jan Macvarish:
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CLINICAL UPDATE

HOME MANAGEMENT OF EARLY MEDICAL ABORTION

By Patricia Lohr, Medical Director, BPAS

This Q&A is based on the study 'Women's opinions on the home management of early medical abortion in the UK', by Patricia Lohr and colleagues published in the *Journal of Family Planning and Reproductive Health Care* 2010: 36(1) 21. The full study is available here: **http://www.ingentaconnect.com/search/article?title=Women%27s+opinions&title_type=tka&author=lohr&year_from=1998&year_to=2009&database=1&pageSize=20&index=1**

Q) What is the situation regarding the home management of early medical abortion in the UK?

Under the 1967 Abortion Act, any treatment for abortion has to be carried out in a hospital or a place approved for this purpose by the Secretary of State (1). The Department of Health currently interprets this as meaning that both medications used for early medical abortion (EMA) – mifepristone and misoprostol - must be given in an authorised medical facility.

Practically, this means women must make a separate visit to receive each medication in addition to their consultation and follow-up appointments. Many hospital-based services admit women to the wards after administering misoprostol (2), but most independent abortion providers, like BPAS, discharge women after misoprostol administration to complete the process at home. This service development occurred in response to clients' requests to go home and with the knowledge from studies in other countries that completing an early medical abortion at home was safe and acceptable.

Q) What was the purpose of this study?

There hasn't been much research in the UK on the home management of EMA so we felt it was important to find out women's opinions and experiences of this service. We invited all eligible women undergoing EMA at any BPAS clinic during a two-week period to take part. One week after the administration of misoprostol, we contacted them by telephone and asked them to answer a short structured questionnaire. We also included one open-ended question to give women the opportunity to add other comments.

Q) What did the results find?

We surveyed 162 women and found that most (86%) would rather go home to complete an EMA than remain at the clinic. The majority (96%) found home management very or somewhat acceptable and 96% felt they could have obtained medical help easily if necessary. Most respondents (62%) would prefer home use of misoprostol as opposed to returning to the clinic to obtain and use the medication. The study also found that Asian women, or those with a gestational age of greater than 49 days, were less likely to prefer home management than others in the sample.

Q) What reasons did women give for their preference?

We didn't specifically ask women about the reasons behind their preferences. However, in the open-ended question many women chose to comment on the meaning that being at home had for them. They described it as a good experience, commenting on the benefit of being in 'my own space', and using words such as 'right', 'comfortable', 'relaxed', 'convenient' and 'private'.

Interestingly, 21% of the women who provided qualitative comments remarked on the difficulty of the journey home after misoprostol administration. They described it as inconvenient or noted that they were very concerned about experiencing symptoms before they got home. Some even commented that they began to have bleeding or cramping on the journey home. However, rather than encouraging them to stay in the clinic for the duration of the abortion, these experiences appeared to increase their support for the idea that misoprostol could be used at home. As one woman said: 'I felt so anxious because I really felt that I had to hurry home. I would much rather have been able to do the second medicine in the comfort of my own home'.

Relatively smaller numbers of women gave reasons why they would prefer to stay in the clinic, such as reassurance that the abortion was proceeding as expected, or that they were concerned about things that were unexpected, such as variability in the time to complete the abortion. And a few women also took the opportunity to tell us that they felt that the decision to have home management should be an individual choice, emphasising that the option should be available for everyone, even if some choose not to take it.

Q) How does this study relate to others in the UK?

In many countries, home use of misoprostol is routine, and several studies show that it is safe and highly acceptable (3–7). In the UK, however, the restriction on home use means that information about women's opinions of this practice is limited. One 1992 study in Edinburgh found that only 24% of 180 women who had experienced a medical abortion in a clinical setting would prefer to have the abortion at home. (8) In 2005, Hamoda et al. surveyed 366 women in four hospital-based services in England and Scotland, all of whom remained in this setting after the administration of misoprostol but were asked for their views on the hypothetical situation of having a medical abortion at home. (9) Seventy-one per cent of respondents reported that there was nothing during their stay in hospital that they could not have managed on their own; nonetheless, only 36% would have opted for a home EMA.

Different findings came out of a clinical trial in Aberdeen in 2005, in which 49 women up to 56 days' gestation were treated with 200 mg oral mifepristone in a clinical setting followed by self-administration of 600 µg sublingual misoprostol 36–48 hours later at home. (10) Forty-five participants returned study questionnaires about their experiences and opinions: most (96%) were very satisfied or satisfied with home EMA, and 93% stated they would opt for medical abortion at home if necessary in future. Our finding of a high acceptability of home management of EMA is similar to this study, perhaps because it reflects the opinions of women who have safely and satisfactorily experienced a medical abortion outside of a clinical setting.

Q) What are the practical implications of this study?

The limited amount of information about women's opinions on home management of EMA in the UK, and the differences found by those studies that do exist, means that those designing abortion services need to take care not to assume women's preferences. Some women express a strong preference for managing their abortion at home, and it is important to manage their expectations and provide adequate support services such as a 24-hour telephone advice line. Other women may prefer to stay in the clinic, and giving women this option is reasonable if resources allow it.

However, our study does indicate, in line with research from other countries where home use of misoprostol is routine, that many women find managing their abortion at home highly acceptable, and voice a preference for administering misoprostol at home rather than having to do so in the clinic. My view is that EMA provision in the UK would be improved, and further research into this area permitted, if consideration were given to updating the interpretation of the UK's abortion law to allow home administration of misoprostol.

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ABORTION NEWS

MARCH 2010

USA: Healthcare bill passes with abortion restrictions

The US House of Representatives narrowly voted to pass a landmark healthcare reform bill at the heart of President Barack Obama's agenda. In a last-minute move designed to win the support of a bloc of anti-abortion lawmakers, Mr Obama announced plans to issue an executive order assuring that healthcare reform will not change the restrictions barring federal money for abortion. In doing so, reported Fox News, President Obama 'created a perfect political storm over the issue of abortion': he 'upset both the pro-choice proponents who supported his rise to the White House and the anti-abortion activists vehemently opposed to portions of the health care bill'. *21/3/2010*

http://www.abortionreview.org/index.php/site/article/717/

UK: Fewer restrictions on TV condom ads

Advertising regulators have now agreed to drop the historic ban on condoms being advertised before the 9pm watershed and on Channel 4 before 7.30pm. Condom ads will be allowed at any time, but not around programmes popular with children under the age of 10. It is hoped that the relaxed rules will help reduce teenage pregnancy rates in the UK, the *Guardian* reports. However, a proposal to allow TV and radio ads giving pregnancy advice was attacked by anti-abortion groups, who argued that it will lead to commercials for abortion clinics. This proposal is not included in the new code at this stage.

BPAS chief executive Ann Furedi wrote, in an article in the UK *Independent:* 'Even if condoms are advertised 24/7, there is unlikely to be much impact on the teenage pregnancy rate. Girls who get pregnant usually know about condoms already; so do their boyfriends. Ignorance is not the excuse. Condoms also have a relatively high failure rate – often because people fail to get them out of the packet and on to the necessary part. But they are far better than nothing, and their prime-time advertising should not have been banned until now.' *16/3/10*

http://www.abortionreview.org/index.php/site/article/723/

UK: Sex education reforms shelved

The Secretary of State for Children, Schools and Families has been forced to drop controversial key reforms to sex education in schools, in order to push through legislation before parliament was dissolved for the general election. *7/4/10 and 24/2/10*

http://www.abortionreview.org/index.php/site/article/730/
http://www.abortionreview.org/index.php/site/article/695/

UK: 'Condoms: Lie back and think of England'

A feature by Helen Rumbelow in *The Times* (London) notes that 'Britain donates more than a thousand condoms a minute to the developing world'. *19/3/10*

http://www.abortionreview.org/index.php/site/article/718/

UK: New study shows Pill safety

Research involving 46,000 British women over nearly 40 years has confirmed that the contraceptive Pill is not linked to long-term health risks from cancer or heart disease, according to the report in the *British Medical Journal*. Patricia Lohr, Medical Director of BPAS, said:

'It's always helpful to see large scale longitudinal studies on medications used by millions of women, like the oral contraceptive pill. Although the study could not follow all of the women who were originally enrolled, they were able to track some for almost forty years which is unusual and very helpful. It's reassuring to see that, over time, having used the Pill as a method of birth control is at least as safe as not having used the Pill at all.' *12/3/10*

http://www.abortionreview.org/index.php/site/article/720/

UK: New guidance for pharmacists retains 'conscience clause'

The General Pharmaceutical Council (GPhC) is to take over the regulation of pharmacists, pharmacy technicians and the registration of pharmacy premises from the Royal Pharmaceutical Society later this year. A revised code of conduct will allow staff to opt out of providing items such as emergency contraception and contraception, but they may have to give customers details of alternative shops. *25/3/10*

http://www.abortionreview.org/index.php/site/article/724/

Commentary: Family planning should mean choice, not control

Jennie Bristow reports on the 'morally uncomfortable' questions raised by a recent conference examining the alleged connection between population dynamics, reproductive health and rights, and climate change. *25/3/10*

http://www.abortionreview.org/index.php/site/article/716/

UK: Under-age sex should lead to more prosecutions, says senior Tory

The Conservative party's children's spokesman has said that children who have sex under the age of 16 should face tougher sanctions. Tim Loughton warned there were no apparent consequences for those who had under-age sex, the *Daily Mail* reported. Ann Furedi, chief executive of BPAS, said:

'Let's just say that I don't think jailing young mothers is a sensible way to address teenage pregnancy in Britain. It's widely recognised and accepted that young people are having sex at an earlier age. The notion of criminalising that activity, and in particular criminalising motherhood at any age, is abhorrent.' *18/3/10*

http://www.abortionreview.org/index.php/site/article/719/

USA: Young people's opinions about abortion

A study conducted for NARAL Pro-Choice America has found that, despite some recent surveys suggesting a retrenchment on support for a woman's right to choose, the nation remains majority pro-choice. This research, which focused on people under 30 years of age, also found that younger people are solidly pro-choice, though there is more intensity among anti-choice young people than pro-choice young people. *12/3/10*

http://www.abortionreview.org/index.php/site/article/721/

FEBRUARY 2010

Spain: Senate approves new abortion law

Spain has approved a sweeping new law that allows abortion without restrictions up to 14 weeks and gives 16- and 17-year-olds the right to have abortions without parental consent. Under the previous law, which dates back to 1985, Spanish women could in theory go to jail for getting an abortion outside certain strict limits — up to week 12 in case of rape and week 22 in the case of fetal abnormality. But abortion has been in effect widely available because women can assert mental distress as sole grounds for having an abortion, regardless of how late the pregnancy is.

While the new law has been widely reported as a liberalisation of the law, some reproductive choice advocates have cautioned that, in practice, it may restrict women's access to abortion in later gestations. Before the reforms, although there was no 'right' to abortion, the law allowed abortion without time limit in broadly the same circumstances as the British law up to 24 weeks. This meant that doctors prepared to interpret it liberally could, and did, offer access way beyond the 14 weeks that the new law permits. Women from throughout Europe have been known to travel to Spain to have an abortion that would be denied in their home country.

The new bill provides for greater regulation. It permits abortion up to 22 weeks if two doctors certify there is a serious threat to the health of the mother, or fetal malformation. Beyond 22 weeks, it would be allowed only doctors certify fetal malformation deemed incompatible with life or the fetus

were diagnosed with an extremely serious or incurable disease. *25/2/10*

http://www.abortionreview.org/index.php/site/article/698/
http://www.abortionreview.org/index.php/site/article/712/

UK: New statistics show fall in teenage pregnancy rate

The number of teenage pregnancies in England and Wales has fallen by 4%, according to figures released by the Office for National Statistics (ONS). A total of 41,325 women under 18 fell pregnant in 2008, down 3.9% from 42,988 in 2007. Of these young women 49% had an abortion, compared with 50% in 2007.

The ONS data shows for every 1,000 girls aged between 15 and 17 in England and Wales, there were just over 40 pregnancies. The number of girls aged 13 to 15 getting pregnant fell by 6% in 2008, with 7.8 conceptions per 1,000 girls compared with 8.3 in 2007. Since 2002 the number of teenage girls falling pregnant in England and Wales has been steadily falling, despite a slight rise in 2007.

The ONS statistics show there were an estimated 887,800 conceptions among women of all age groups in England and Wales in 2008, a decrease of 0.9% on the 2007 figure of 895,900. Conception rates decreased in all age groups between 2007 and 2008, with the exception of women aged 40 and above, where conceptions remained at 12.6 per 1,000 women. *24/2/10*

http://www.abortionreview.org/index.php/site/article/696/

UK: Tory Party under fire for teen pregnancy statistics error

Pregnancy advice groups and child welfare organisations have criticised the Conservatives over their mistaken assertion that more than half of all girls in deprived areas fall pregnant before the age of 18. The campaigning document, entitled *Labour's Two Nations,* claims: 'In the most deprived areas, 54 per cent are likely to fall pregnant before the age of 18, compared to just 19 per cent in the least deprived areas.'
The proportion of young girls who become pregnant in the UK's ten poorest areas is in fact 5.4 per cent. Ann Furedi, chief executive of BPAS, said: 'The very fact that people can repeatedly get the facts on teenage pregnancy so wrong — ten times wrong — shows that their stereotyped expectations of young people are totally out of sync with reality.' *15/2/10*
http://www.abortionreview.org/index.php/site/article/691/

UK: Tory MPs' abortion opinions

A significant number of Conservative candidates in winnable seats hold strong anti-abortion views, the *Financial Times* reports. According to the FT, this raises the prospect of a fresh drive to cut the time limit from 24 to 20 weeks should David Cameron win this year's general election. *12/2/10*

http://www.abortionreview.org/index.php/site/article/693/

UK: Hospital faces complaint about confidentiality breach

An investigation has begun into claims that a hospital worker broke confidentiality to tell a teenage patient's family about her abortion. The 19-year-old mother-of-two said that her grandmother, a Catholic, was told about it by an administration worker at Prince Charles hospital in Merthyr. Cwm Taf NHS Trust said it was 'engaged' with the woman as part of the complaints procedure. *1/2/10*

http://www.abortionreview.org/index.php/site/article/699/

USA: Anti-abortion campaign targets black community

The UK *Independent* reports on a controversial poster campaign in Georgia. The message on dozens of billboards across Atlanta is that black children are an 'endangered species'. The ads, featuring a young black child, are an effort by the anti-abortion movement to use race to rally support within the black community. The effort is sponsored by Georgia Right to Life, which also is pushing legislation that aims to ban 'abortions based on race'. *15/2/10*

http://www.abortionreview.org/index.php/site/article/697/

UK: New research on intimate violence makes headlines

A government advertising campaign is being launched to raise awareness of domestic violence in teenage relationships. The adverts will target boys and girls aged 13 to 18, urging them not to use violence against their girlfriends, BBC News Online reports. The campaign follows research by the NSPCC, which suggested that a quarter of girls aged 13 to 17 had experienced physical violence from a boyfriend and a third had been pressured into sexual acts they did not want. *15/2/10*
http://www.abortionreview.org/index.php/site/article/692/

UK: 'Climate change - Calling planet birth'

The UK *Guardian* published a lengthy article by Oliver Burkeman arguing that 'family size has become the great unmentionable of the campaign for more environmentally friendly lifestyles'. He writes: 'For all the confusion and sensitivities that surround the subject, though, the basic facts are clear. If you live in Britain or the US in 2010, there is nothing you can do to reduce your impact on the environment that even comes close to the effects of having one fewer child...' *13/2/10*

http://www.abortionreview.org/index.php/site/article/686/

JANUARY 2010

USA: Dr George Tiller's killer guilty of murder

A man who said he killed the Kansas abortion doctor to save the lives of unborn babies has been found guilty of first-degree murder. Scott Roeder had pleaded not guilty to murder, arguing that he committed manslaughter to prevent a greater harm. The jurors took only 37 minutes to find him guilty. *29/1/10*

http://www.abortionreview.org/index.php/site/article/681/
http://www.abortionreview.org/index.php/site/article/671/

USA: New rise in teenage pregnancy rate

After more than a decade of declining teenage pregnancy, the rate among girls ages 15 to 19 increased 3 percent from 2005 to 2006, the Guttmacher Institute has found. This development is likely to intensify the debate over federal financing for abstinence-only sex education, the *New York Times* reports. According to the Guttmacher analysis, the teenage pregnancy rate declined 41 percent from its peak, in 1990, when there were 116.9 pregnancies per 1,000 women aged 15 to 19, and 2005, when there were only 69.5 per 1,000. In 2006, the rate rose to 71.5 pregnancies for 1,000 women. Teenage birth and abortion rates also declined in that period, with births dropping 35 percent from 1991 to 2005 and teenage abortion declining 56 percent between its peak, in 1988, and 2005. *26/1/10*
http://www.abortionreview.org/index.php/site/article/678/

Ireland: New calls for change in abortion law

The Human Rights Watch organisation has called on the Irish government to decriminalise abortion, and a new survey suggests that two-thirds of 18-34 year olds believe abortion should be legal. *28/1/10 and 21/1/10*

http://www.abortionreview.org/index.php/site/article/680/

USA: Renowned clinical psychologist dies

Henry P. David, whose research on the psychological effects of abortion was hugely influential, died on 31 December 2009 at the age of 86.

http://www.abortionreview.org/index.php/site/article/670/

USA: Thinking ethically about emergency contraception

An excellent article in the Journal of the Catholic Health Association of the United States by Ron Hamel, PhD, examines the controversy over the use of emergency contraception in Catholic hospitals for victims of sexual assault. Hamel concludes: 'Given what is currently known

about Plan B from scientific research, Catholic hospitals can respond with sensitivity, compassion and assistance to women who have been raped and are in need of care, while being confident that they are also remaining true to Catholicism's fundamental commitment to respect for human life'.

http://www.abortionreview.org/index.php/site/article/675/

USA: 'The last abortionist'

In a feature published in the UK *Observer*, John H Richardson meets Warren Hern, provider of late abortions in the USA. *24/1/10*

http://www.abortionreview.org/index.php/site/article/679/

MEDICAL UPDATE

MARCH

USA: Advance provision of emergency contraception for pregnancy prevention

Polis CB, Grimes DA, Schaffer K, Blanchard K, Glasier A, Harper C. Cochrane Database of Systematic Reviews 2007, Issue 2. Art. No.: CD005497.

A Cochrane Review summarised randomised controlled trials evaluating advance provision of emergency contraception to explore effects on pregnancy rates, sexually transmitted infections, and sexual and contraceptive behaviours. The authors found that advance provision did not decrease pregnancy rates, despite reported increased use and faster use. They also found that advance provision did not lead to increased rates of sexually transmitted infections, increased frequency of unprotected intercourse, or changes in contraceptive methods. Women who received emergency contraception in advance were equally likely to use condoms as other women.

The authors concluded that women should have easy access to emergency contraception, because it can decrease the chance of pregnancy. However, the interventions tested thus far have not reduced overall pregnancy rates in the populations studied.

http://www.abortionreview.org/index.php/site/article/715/

UK: Mortality among contraceptive pill users: cohort evidence from Royal College of General Practitioners' Oral Contraception Study

Hannaford PC, Iversen L, Macfarlane TV, Elliott AM, Angus V, Lee AJ. BMJ 2010;340:c927

This was a prospective cohort study started in 1968 with mortality data supplied by participating general practitioners, National Health Service central registries, or both. The setting was 1400 general practices throughout the UK; participants were 46 112 women observed for up to 39 years, resulting in 378 006 woman years of observation among never users of oral contraception and 819 175 among ever users.

The authors concluded that oral contraception was not associated with an increased long term risk of death in this large UK cohort; indeed, a net benefit was apparent. The balance of risks and benefits, however, may vary globally, depending on patterns of oral contraception usage and background risk of disease.

http://www.abortionreview.org/index.php/site/article/720/

FEBRUARY

USA: Alternatives to a routine follow-up visit for early medical abortion

Clark W, Bracken H, Tanenhaus J, Schweikert S, Lichtenberg ES, Winikoff B. Obstetrics and Gynecology 2010 Feb;115(2 Pt 1):264-72.

The study set out to evaluate the ability of women and their providers to assess abortion outcome without the routine use of ultrasonography. The authors concluded that relying on women's observations, a low-sensitivity pregnancy test, and clinical examination, women and their providers can accurately assess whether follow-up care is required after medical abortion without routine ultrasonography.

http://www.abortionreview.org/index.php/site/article/700/

UK: 20-year survival of children born with congenital anomalies: a population-based study

Tennant PW, Pearce MS, Bythell M, Rankin J. Lancet. 2010 Feb 20;375(9715):649-56.

The authors estimated survival up to 20 years of age for a range of congenital anomaly groups and subtypes. 20-year survival was 85.5% in individuals born with at least one congenital anomaly, 89.5% for cardiovascular system anomalies, 79.1% for chromosomal anomalies, 93.2% for urinary system anomalies, 83.2% for digestive system anomalies, 97.6% for orofacial clefts, and 66.2% for nervous system anomalies. Survival varied between subtypes within the same congenital anomaly group.

The proportion of terminations for fetal anomaly increased throughout the study period (from 12.4 in 1985 to 18.3% in 2003). The authors concluded that estimates of survival for congenital anomaly groups and subtypes will be valuable for families and health professionals when a congenital anomaly is detected, and will assist in planning for the future care needs of affected individuals.

http://www.abortionreview.org/index.php/site/article/701/

USA: The Back Alley Revisited: Sepsis after attempted self-induced abortion

IPPF Abortion Abstract 212

Kelly Culwell, MD, MPH, provides a useful discussion about the practice of self-induced abortion in parts of the developed world where abortion is legal and generally available. This is prompted by a case report by Saultes et al in the *Western Journal of Emergency Medicine. 2009 November; 10(4): 278–280.*

http://www.abortionreview.org/index.php/site/article/690/

Abortion jabberwocky: the need for better terminology

Grimes DA, Stuart G. Contraception. 2010 Feb;81(2):93-6. Epub 2009 Oct 20.

Grimes and Stuart note that 'the contentious issue of abortion is riddled with jabberwocky…terminology that is contradictory, obsolete, ambiguous and misleading'. In this commentary, they highlight a number of examples of 'archaic or suboptimal abortion terminology', and suggest some preferred terms.

http://www.abortionreview.org/index.php/site/article/673/

JANUARY

UK: Ulipristal acetate versus levonorgestrel for emergency contraception: a randomised non-inferiority trial and meta-analysis

Glasier AF, Cameron ST, Fine PM, Logan SJ, Casale W, Van Horn J, Sogor L, Blithe DL, Scherrer B, Mathe H, Jaspart A, Ulmann A, Gainer E. Lancet. 2010 Feb 13;375(9714):555-62.

The authors compared the efficacy and safety of ulipristal acetate with levonorgestrel for emergency contraception. Women with regular menstrual cycles who presented to a participating family planning clinic requesting emergency contraception within 5 days of unprotected sexual intercourse were eligible for enrolment in this randomised, multicentre, non-inferiority trial. The primary endpoint was pregnancy rate in women who received emergency contraception within 72 h of unprotected sexual intercourse, with a non-inferiority margin of 1% point difference between groups (limit of 1·6 for odds ratio). In the meta-analysis (0—72 h), there were 22 (1·4%) pregnancies in 1617 women in the ulipristal acetate group and 35 (2·2%) in 1625 women in the levonorgestrel group. The authors concluded that ulipristal acetate provides women and health-care providers with an effective alternative for emergency contraception that can be used up to 5 days after unprotected sexual intercourse.

http://www.abortionreview.org/index.php/site/article/683/

USA: Mifepristone: ten years later

Schaff EA. Contraception. 2010 Jan;81(1):1-7.

Despite the controversies, millions of women around the world have used mifepristone for medical abortion. This review describes how researchers addressed the numerous barriers of a mifepristone abortion (i.e., gestational age limitation, lengthy process, high costs, complex regimen, failures, side effects and complications) and continue to improve upon the limited numbers and types of clinicians offering mifepristone.

http://www.abortionreview.org/index.php/site/article/706/

USA: Setting priorities for safe motherhood interventions in resource-scarce settings

Prata N, Sreenivas A, Greig F, Walsh J, Potts M. Health Policy. 2010 Jan;94(1):1-13.

Three models were constructed based on 34 sub-Saharan African countries to assess the relative cost-effectiveness of available safe motherhood interventions. The most cost-effective interventions were family planning and safe abortion, antenatal care including misoprostol distribution for postpartum haemorrhage prevention at home deliveries, followed by sepsis treatment and facility-based postpartum haemorrhage management. The authors concluded that the combination of interventions that avert the greatest number of maternal deaths should be prioritised and expanded to cover the greatest number of women at risk.

http://www.abortionreview.org/index.php/site/article/708/

USA: A randomised pilot study on the effectiveness and side-effect profiles of two doses of digoxin as fetocide when administered intraamniotically or intrafetally prior to second trimester surgical abortion

Nucatola D, Roth N, Gatter M. Contraception. 2010 Jan;81(1):67-74.

The authors conducted a pilot study to determine the incidence of side effects after intraamniotic or intrafetal injection of digoxin and whether effectiveness can be improved with variations in dose and technique. They concluded that IA or IF injection of digoxin is safe and effective for inducing fetal death prior to second-trimester surgical abortion. Doses greater than 1.0 mg may not be necessary.

http://www.abortionreview.org/index.php/site/article/704/

Egypt: Vaginal misoprostol for second-trimester pregnancy termination after one previous caesarean delivery

Naguib AH, Morsi HM, Borg TF, Fayed ST, Hemeda HM. International Journal of Gynaecology and Obstetrics. 2010 Jan;108(1):48-51.

The study set out to determine the safety and efficacy of using misoprostol vaginally for second-trimester abortion in women with a single previous caesarean delivery.
This prospective observational study was carried out at a university hospital in Egypt with 50 pregnant women with 1 previous caesarean delivery; a gestation of at least 16 weeks but less than 20 weeks (group 1) or 20 or more weeks (group 2); and a need to terminate the pregnancy. The authors concluded that inducing abortion with lower misoprostol doses appear to be safe and effective throughout the second trimester in women with a single previous caesarean delivery. Larger randomised trials are needed to validate these results.

http://www.abortionreview.org/index.php/site/article/707/

China: Timing and indication for curettage after medical abortion in early pregnant women with prior uterine incision

Wang G, Li D, Manconi F, Dong B, Zhang Y, Sun B. Contraception. 2010 Jan;81(1):62-6.

The authors concluded that the combination of mifepristone and misoprostol was found to be a safe and effective method to terminate early pregnancy in women with a previous caesarean delivery. If a woman with a prior uterine incision experienced vaginal bleeding intervals >or=21 days and/or had a bilayer endometrial thickness >or=15 mm and/or serum beta-hCG >or=500 IU/L after a medical abortion, then she should undergo curettage.

http://www.abortionreview.org/index.php/site/article/705/

DECEMBER

USA: Abortion and mental health: Evaluating the evidence.

Major B, Appelbaum M, Beckman L, Dutton MA, Russo NF, West C. American Psychologist. Vol 64(9), Dec 2009, 863-890

This article evaluates empirical research addressing the relationship between induced abortion and women's mental health. The authors found that major methodological problems pervaded most of the research reviewed. The most rigorous studies indicated that within the United States, the relative risk of mental health problems among adult women who have a single, legal, first-trimester abortion of an unwanted pregnancy is no greater than the risk among women who deliver an unwanted pregnancy. Evidence did not support the claim that observed associations between abortion and mental health problems are caused by abortion per se as opposed to other pre-existing and co-occurring risk factors. Most adult women who terminate a pregnancy do not experience mental health problems. Some women do, however. It is important that women's varied experiences of abortion be recognised, validated, and understood.

http://www.abortionreview.org/index.php/site/article/674/

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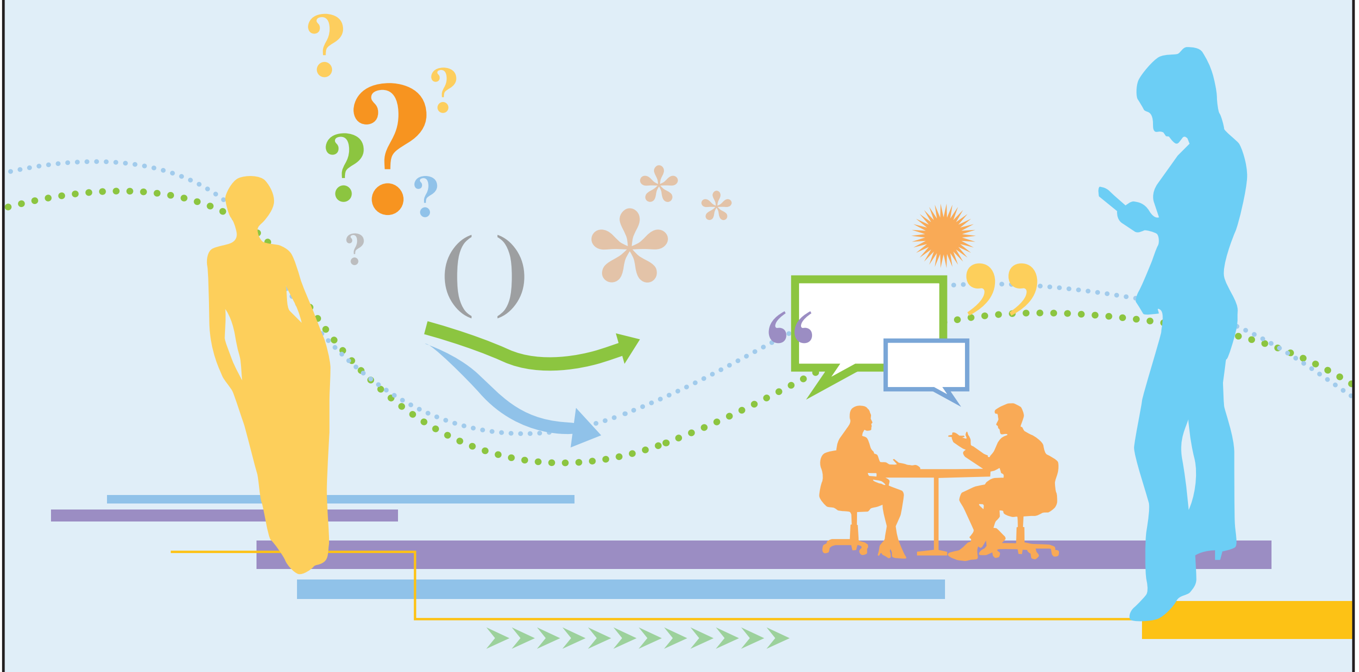

We are here if you feel you need to talk to someone after your abortion.

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