

## ABORTION PROVISION: BUILDING ON THE GAINS



By Jennie Bristow,  
Editor, **Abortion Review**

2010 has been an interesting year for abortion provision. Early abortion, in the first trimester of pregnancy, is becoming increasingly acceptable and accessible, as reflected by liberalising laws and practice throughout the world. In Spain, much

discussion has followed the implementation of a new law allowing abortion without restriction in the first 14 weeks. As Stanley Henshaw of the US Guttmacher Institute told the FIAPAC congress in October, abortion is now generally available for, and used by, about 63% of the world's population, and is now a right on request (up to varying gestational limits) for 40% of the world's population.

The legal liberalisation of early abortion has been reflected, in the USA and some European countries, by changes in practice brought about by the 'abortion pill'. Early Medical Abortion (EMA), using the drugs mifepristone and misoprostol, has transformed the provision of abortion under 9 weeks' gestation, with a method that can safely be used outside of clinical settings. A weight of evidence now exists about the safety, efficacy and acceptability of 'home use' of misoprostol, and it has become routine practice in some countries for women to be treated with mifepristone and given the misoprostol when they get home. The prescription of EMA using internet consultations with doctors has been pioneered in some US states, with positive results for improving access to abortion in rural areas; and France has fruitfully piloted involving general practitioners in abortion provision.

While the improvements in access to early abortion are much welcomed, however, there remain some tensions surrounding the provision of abortion later in pregnancy. In a recent essay on the 'late abortion' debate, Ann Furedi, chief executive of BPAS, notes the 'paradox' that 'as early abortion has become more accepted, later procedures have attracted increasing concern'. This concern has also come from those associated with the pro-choice movement, who have 'begun to express doubts openly about whether a woman should be able to choose to end her pregnancy once her fetus begins more closely to resemble a baby'. This presents those working within abortion provision with a challenge: how to promote abortion as early as possible without compromising women's ability to access procedures as late as necessary.

Abortion procedures carried out later in pregnancy are more complex than early procedures, and there are training issues in ensuring that women are able to access a decent 'late' service. A thought-provoking study published in the BJOG in September found that, although surgical termination of pregnancy at 13-20 weeks' gestation is 'at least as safe' as medical induction, and women reported a preference for surgical procedures, 'access to mid-trimester surgical abortion within the NHS is limited' (3). BPAS's medical director Patricia Lohr commented that, although BPAS provides surgical terminations up to 24 weeks, 'we also rely on our NHS colleagues to share management of women with complex medical conditions', and training doctors to be able to provide women with the option of surgical abortion must be a priority.

As Donagh Stenson discusses overleaf, there is now in existence for England and Wales a National Service Specification for abortion services. This indicates some minimum standards and provides best practice guidance for abortion across the NHS, private and independent agency sectors. Ensuring that women have access to, and choice of, procedures is as important for women seeking abortion in later gestations as it is for those who present for early abortion, and it is to be hoped that services in Britain are able to build on the gains of the past 20 years to provide women with the best service possible.

But while service provision issues such as training and best practice are crucial, so is an ongoing engagement with the ethical and political debates surrounding the principle of women's autonomy in making abortion decisions. As Ann Furedi writes, to argue that 'a woman should longer be able to make a moral decision about the future of her pregnancy, because 20 or 18 or 16 weeks are now passed' assaults the principles both of autonomy, and of freedom of conscience. When it comes to late abortion, 'either we support women's right to make an abortion decision or we don't. We can make a judgement that their choice is wrong – but we must tolerate their right to decide. There is no middle ground to straddle.'

**Ann Furedi's essay, 'A moral defence of late abortion', is published in full on Abortion Review Online: [www.abortionreview.org](http://www.abortionreview.org)**

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*Donagh Stenson reviews the National Service Specification  
for Termination of Pregnancy Services  
News and Medical Digest, August - November 2010*

## SERVICE PROVISION UPDATE

**By Donagh Stenson,  
Associate Marketing Director  
BPAS**



This Q&A is based on Stenson's article 'Commissioning abortion and sexual health services', published in *Best Practice & Research Clinical Obstetrics & Gynaecology*, October 2010 (Vol. 24, Issue 5, Pages 555-567).

### **Q) What is the National Service Specification for Termination of Pregnancy Services (NSS)?**

The NSS is a specification that all commissioners use for abortion services in England and Wales, and represents a general agreement on the need to provide holistic care. It indicates that abortion providers should offer a full range of contraceptive counselling and provision - this is significant, as previously contraception was often provided through a different commissioning budget. It also gives a commitment to STI testing and treatment as standard.

The NSS highlights self-referral for abortion as the ideal way to access services, and the opportunities provided by central booking services (CBS). BPAS has been operating CBS for over 20 years, and we have seen the benefits to women, GPs, and commissioners, that come from offering a central point of contact for those wishing to make an appointment for an abortion. CBS speeds up access fits the choice agenda, as it relates to a number of providers and means that women get access to the first, most appropriate appointment irrespective of the provider. Earlier access to treatment is generally accepted as having better outcomes for women and treatment at an earlier gestation is inevitably cheaper for the commissioner.

Objections to self-referral have sometimes been made in budgetary terms, but enabling women to refer themselves results in significant savings in GPs' time and often means treatment at an earlier gestation. It is important to see self-referral as part of a suite of referral pathways - some women will always present to their GP for an abortion, and it is important that they are still able to access treatment through that route.

### **Q) How was the NSS developed?**

The Department of Health co-ordinated a stakeholders' meeting in February 2009, which included commissioners, NHS providers and agency providers. It was a real achievement that all parties involved in defining and delivering abortion services were able to play a part in creating the national specification.

However, it has taken a surprisingly long time to get to this point - many of the recommendations are those indicated in the best practice advice published by Birth Control Trust in 1994. Abortion as a service is often left on the shelf by policymakers, because it is a relatively small aspect of healthcare and one that is not very glamorous; and there is an attitude of 'if it ain't broke, don't fix it'. Given that 94% of abortions in England and Wales are now funded by the NHS, and 56% of abortions are provided by independent agencies under NHS contract, the development of a national standard is welcome and we hope this will endure. Britain's abortion service has developed over 40 years and is now at the point where it is well-defined and runs very smoothly.

### **Q) What will the NSS mean for BPAS?**

The NSS recommendations are already employed by BPAS as a standard aspect of its service. In April 2010 BPAS held 119 NHS contracts, and provided nearly half of the 'agency market' for abortions (26% of all abortions in England and Wales). BPAS is at the forefront of best practice in abortion care, and many aspects of our work go beyond the general

standard indicated by the NSS. For example, we employ a Special Services Manager to place women whom we can't treat: for example, those with a high Body Mass Index, or Irish women who are seeking abortion for fetal abnormality.

We recognise that not every provider is set up to provide the level of service that we do as standard, which is why we view the basic recommendations in the NSS as a good place to be, rather than an ideal standard of care. We also recognise that, as independent providers, our technical systems for monitoring are generally better than those in the NHS, and in many respects abortion services are at the cutting edge of commissioning. Other services could learn from this experience.

### **Q) What are the limitations of the NSS?**

Some of the monitoring aspects of the NSS speak to general healthcare priorities, but are not particularly relevant to abortion care. For example, the emphasis on reducing the proportion of DNAs (Do Not Attends) does not work for abortion care, where women need to have the choice about whether to 'opt out' of treatment. Similarly, average waiting times at clinics are not a particularly big issue for women seeking abortion. All the evidence suggests that women seeking abortion have two main outcomes in mind: they want to leave the clinic no longer pregnant, and they want to be given quality care. This is not rocket science, but it is no less important for that.

## **bpas publication**

### **ABORTION IN PRACTICE: A GUIDE FOR GPs**

**This guide makes use of bpas's experience to provide clear information about:**

- Facts and myths about abortion
- Abortion methods at different gestational ages
- Normal and abnormal signs and symptoms post-abortion
- Helping women prevent unplanned pregnancies in the future

**For a free copy of *Abortion In Practice*, contact:  
development@bpas.org**

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[http://www.bpas.org/js/filemanager/files/abortion\\_in\\_practice\\_a\\_guide\\_for\\_gps.pdf](http://www.bpas.org/js/filemanager/files/abortion_in_practice_a_guide_for_gps.pdf)

## ABORTION NEWS

NOVEMBER 2010

### **UK: Do abortion services really make a 'vast amount of money'?**

*A blog on the Liberal Conspiracy website challenges 'a truly risible speech' given to parliament by anti-abortion MP Nadine Dorries during an adjournment debate. The author, Unity, notes Dorries' claim that 'Abortion in this country is an industry from which a small number of organisations and individuals make vast amounts of money', and writes:*

Really? Vast amounts of money? Well let's have a look, shall we.

The British Pregnancy Advisory Service is one of the larger providers of contraception, abortion and related sexual health services in the UK and, happily for our purposes, its also a registered charity (No. 289145), all of which means that its really easy to follow the money and assess the veracity of Dorries' statement.

The organisation operates a national telephone helpline and associated call centre which handles around 290,000 calls a year, within incoming calls charged at local rate. It counsels around 70,000 women a year on their abortion option and, based on information taken from its most recent published accounts, provides and another 39-40,000 consultations a year to women seeking help and advice in relation to contraception, STIs etc.

Of the 70,000 women seeking advice on abortion, 55,000 go on to take up the procedure at one of BPAS's 22 clinics or day care centres, with 93% of patients getting their treatment paid for by the NHS. BPAS currently has service agreements with 96 NHS Primary Care Trusts and 11 Local Health Boards and accounts for around 25-27% the abortions carried out in England and Wales each year.

Taking information from its annual accounts, we find that, for the year 2009/10, BPAS's annual income was £25.042 million of which all but £33k was derived from fees for services. For 2009-10, the standard NHS tariff for abortions ranged from £502 for a medical abortion to £649 for a 'D&E' (surgical dilation and extraction). Had BPAS done nothing else that year but carry out medical abortions for the NHS at its standard tariff then, with 93% (51500) of its clients having their treatment paid for by the state, it would have generated an income of £25.85 million from the NHS.

This would be £840,000 more than its actual income for the year. Far from making 'vast amounts of money' it seems that BPAS actually provides the NHS with a range of cost effective services at less the NHS's own internal tariffs.

On the expenditure side, BPAS spent £22.96 million on service provision and further £811k on education and research. As ever, the big ticket items in the expenditure column are the total staff and related costs, including agency and other fees (£14.84 million on the service side and £359k education and research) with actual salary costs for the year weighing in at £10.96 million. Take the organisation's top earners – seven employees who earn in excess of £60k a year – out of the equation and the average (mean) full-time salary at BPAS is around £28k a year gross, rather less than half the amount that Dorries pockets at the House of Commons.

If you're only in it for the money, the slur that Dorries levels at abortion service providers, then there are any number of more lucrative options you could choose to pursue, whether its the traditional consulting rooms on Harley Street or, perhaps, the kind of job that allows you to stick your friends and family on expenses and send the bill to the taxpayer. 8/11/10

<http://www.abortionreview.org/index.php/site/article/879/>

### Pope issues 'game-changing statement' on condoms

Catholic reformers and groups working to combat HIV have welcomed remarks by Pope Benedict XVI that the use of condoms might not always be justified on a case by case basis to prevent the spread of HIV/Aids. The remarks are published in a new book *Light of the World: The Pope, the Church and the Signs of the Times*, based on a series of interview the Pope gave with the German Catholic journalist Peter Seewald.

When asked whether the Catholic Church was not opposed in principle to the use of condoms, the Pope replied: 'She of course does not regard it as a real or moral solution, but, in this or that case, there can be nonetheless, in the intention of reducing the risk of infection, a first step in a movement toward a different way, a more human way, of living sexuality.' Although Pope Benedict reiterated the Church's fundamental opposition to contraception, and repeated his view that condoms were not the answer to curbing HIV, he added that there was much in the area of sexual ethics that needed to be pondered and expressed in new ways.

Clifford Longley, who writes for *The Tablet*, said the 'small concession... could easily become a collapse in the whole edifice of Catholic teaching on contraception'. Jon O'Brien, president of Catholics for Choice, said: 'The pope said that condom use to prevent the transmission of HIV is "a first step in a movement toward a different way, a more humane sexuality." This admission is the Catholic hierarchy's own first step in addressing the realities about sex and sexuality. However, while this is a game-changing

statement, we acknowledge that there is still a long way to go before the Vatican's teachings on condoms meet the needs of Catholics around the world—for contraception as well as for HIV and AIDS prevention. Those of us who have been praying and campaigning about these issues for the past two and half decades are very heartened by this move.' 21/11/10  
<http://www.abortionreview.org/index.php/site/article/881/>

### Event: Debating conscience, control, and choice

BPAS hosted four public debates engaging with key ethical issues: the value of life, conscientious objection, selective reproduction, and population control. A report on the debates, and selected speeches, are published on *Abortion Review Online*. 2/11/10

<http://www.abortionreview.org/index.php/site/article/865/>

### USA: Personal abortion stories make political headlines

A website run by a Minnesota couple that is polling readers on whether the pair should abort the wife's fetus generated over a million votes, and much controversy, before it was revealed as a hoax. And promoting his autobiography, George W Bush claimed that his opposition to abortion was cemented after his mother showed him a dead fetus in a jar after she had suffered a miscarriage. 8/11/10, 23/11/10

<http://www.abortionreview.org/index.php/site/article/882/>

<http://www.abortionreview.org/index.php/site/article/869/>

### USA: 'The big lie about abortion and mental health'

Writing in the *Washington Post* Brenda Major, who chaired the American Psychological Association task force on abortion and mental health, challenged the misleading information behind state laws mandating that women seeking abortions be 'informed' that going ahead with the procedure would expose them to mental health risks, including post-traumatic stress and a greater danger of suicide. 7/11/10

<http://www.abortionreview.org/index.php/site/article/866/>

### IN BRIEF:

- UK: The Royal Society of Medicine on 19 November hosted a lively debate on three controversial issues: elective C-sections, IVF treatment for older mothers, and the desirability of a consultant based obstetrics service in the NHS. Jennie Bristow reports. 23/11/10  
<http://www.abortionreview.org/index.php/site/article/883/>
- USA: A briefing produced by the Guttmacher Institute reveals that US states have created 'a lattice work of abortion law, codifying, regulating and limiting whether, when and under what circumstances a woman may obtain an abortion'. 5/11/10  
<http://www.abortionreview.org/index.php/site/article/867/>
- USA: A briefing produced jointly by the International Consortium for Emergency Contraception and Catholics for Choice details how Catholic bishops continue to oppose access to emergency contraception and lead opposition efforts, going against the beliefs of the majority of their constituents. 8/11/10  
<http://www.abortionreview.org/index.php/site/article/868/>
- Jennie Bristow reports on the key themes emerging from the 2010 annual conference of the Progress Educational Trust, 'Passport to Parenthood - The Evidence and Ethics Behind Cross-Border Reproductive Care'. 10/12/10  
[www.abortionreview.org/index.php/site/article/888/](http://www.abortionreview.org/index.php/site/article/888/)

## OCTOBER 2010

**Abortion: Why doctors should have the 'right to refuse'**

Rising numbers of doctors refusing to be involved in abortions has prompted a debate about conscientious objection in healthcare. Ann Furedi, chief executive of BPAS, wrote on the *Independent's Eagle Eye* blog on 7 October:

The issue of conscientious objection within healthcare has come to the fore, as Members of the Parliamentary Assembly of the Council of Europe are set to vote on a resolution calling for the removal of the right of doctors to opt out of referring women for abortions. Proposing the motion, Christine McCafferty of the UK Socialist Group is concerned that 'the unregulated use of conscientious objection disproportionately affects women', and argues: 'There is a need to balance the right of conscientious objection of an individual not to perform a certain medical procedure with the responsibility of the profession and the right of each patient to access lawful medical care in a timely manner'. The resolution also calls for a register of doctors who object to abortion.

The issue of 'conscientious objection' is a difficult balance of the right of doctors to withdraw from an act they think is wrong, and the right of individuals to receive legal health care. Those of us who champion reproductive choice are keenly aware of the problems that conscientious objection can cause for women – particularly in countries where few doctors agree with abortion. Even in Britain, where abortion is widely available, many women facing an unwanted pregnancy are reluctant to involve their GP because they fear their doctor may judge them or even object.

But maintaining this difficult balance is preferable, both on moral and practical grounds, to a system that would force doctors to act against their consciences. At BPAS, we think it is better that doctors with a moral objection to abortion do have the opportunity to opt out of services, providing they make this clear to patients and inform them about others who will help. Women seeking abortion deserve better than treatment from doctors who think they are sinning.

Where there are problems with accessing abortion services, these can be resolved by changing the ways services are organised, rather than by forcing doctors to perform or refer for procedures to which they fundamentally object. For example, systems that allow women to refer themselves directly to an abortion provider circumvent delays that conscientious objection may cause, save precious GP time and help women to get sympathetic care. Such practical measures would avoid the illiberal implications of putting doctors on a 'refusal register', and be of more practical use to women, for whom access to abortion should be as straightforward as possible. 7/10/10 <http://www.abortionreview.org/index.php/site/article/857/>

**UK: TV row over morality of abortion and euthanasia**

Broadcaster and agony aunt Virginia Ironside caused a stir on the BBC's Sunday Morning Live show by saying: 'If a baby's going to be born severely disabled or totally unwanted, surely an abortion is the act of a loving mother.' The writer added: 'Abortion can often be seen as something wicked and irresponsible, but in fact it can be a moral and unselfish act... Sometimes the decision of a good mother is not to have the child.'

Writing in the *Guardian*, columnist Zoe Williams argued that 'Ironside has done something crucial: somebody has to assert the moral dimension of being pro-choice, that it's not all convenience and heartlessness'. She continued:

'The self-proclaimed moral superiority of the anti-abortionists is predicated on the idea of a human life springing into being at the moment sperm meets egg. But if you don't believe that, then the argument has no moral weight at all... In tandem, somebody has to say that being pro-abortion isn't the same as being prejudiced against disabled people, any more than being anti-abortion is the same as doing anything beneficial for disabled people. There is a furious lobby that attaches a eugenicist tag to anybody who is pro-choice or euthanasia, but it silences its opponents in an underhand way by accusing them of hostility towards the disabled.'

'Of course Ironside is not waging a war against the disabled: she simply said "life isn't a gift per se". There are plenty of circumstances that make it more burdensome than joyful. The fact that Ironside ruffled any feathers at all illustrates how important it is not to take this as tacit, but to say it out loud'. 4/10/10; 5/10/10

<http://www.abortionreview.org/index.php/site/article/838/>

**Event: 'Achieving Excellence in Abortion Care'**

The conference of the International Federation of Abortion and Contraception Associates (FIAPAC) in Seville hosted a full and varied programme, with plenary sessions on global trends and practice in abortion and contraception; late abortion; medical abortion; and legal aspects of the international abortion debate. Jennie Bristow reports. 25/10/10

<http://www.abortionreview.org/index.php/site/article/861/>

**Population control debate continues**

GPs and TV wildlife show presenters have called for the need for British couples to limit the size of their families, while commentators criticise explicit and subtle methods of population control. In September, the BBC reported that 30 years after the introduction of China's one-child policy, the government is being urged to rethink its population controls. The September 2010 issue of the Catholics for Choice magazine *Conscience* is dedicated to exploring the questions raised by population growth. 20/10/10, 25/9/10, and 14/9/10

<http://www.abortionreview.org/index.php/site/article/859/>

<http://www.abortionreview.org/index.php/site/article/854/>

<http://www.abortionreview.org/index.php/site/article/836/>

**Australia: Large rise in use of the abortion pill**

Therapeutic Goods Administration data shows use of mifepristone increased greatly in the second half of 2009 after a national chain of day clinics was licensed to use it. More than 3000 RU486 abortions have been performed in Australia since a ban on its importation was lifted four years ago, after conscience votes by MPs and senators, *The Australian* reports. 2/10/10

<http://www.abortionreview.org/index.php/site/article/856/>

**IN BRIEF:**

- Australia: A District Court jury in far north Queensland has found a Cairns couple not guilty of procuring an illegal 'home' abortion. 14/10/10 <http://www.abortionreview.org/index.php/site/article/873/>
- Ireland: Writing on RH Reality Check, Stephanie Lord interrogates the figures on Irish women travelling for abortion. 26/11/10 <http://www.abortionreview.org/index.php/site/article/872/>
- Northern Ireland: Pro-choice campaigners at the first all-Ireland conference on abortion and clinical practice, jointly organised by FPA and IFPA, called for the restrictive abortion laws to be modernised. 9/10/10 <http://www.abortionreview.org/index.php/site/article/858/>
- UK: The Texas-based religious group '40 days for life' has been protesting outside an abortion clinic in central London, prompting concern about 'US-style' protests coming to Britain. 26/10/10 <http://www.abortionreview.org/index.php/site/article/870/>
- UK: British scientist Robert Edwards, who devised IVF fertility treatment, has been awarded the 2010 Nobel prize for medicine. Infertility affects 10% of all couples worldwide, and nearly four million babies have been born following IVF, BBC Online reports. 4/10/10 <http://www.abortionreview.org/index.php/site/article/839/>



## SEPTEMBER 2010

### USA: Ten years of mifepristone

Initially known as RU-486, the 'abortion pill' was introduced in France in 1988, and anti-abortion activists fought doggedly over 12 years to keep it out of the USA, AP reported. The Food and Drug Administration (FDA) finally gave its approval on 28 September 2000, and nearly 1.4 million American women have used the pill since then. The pill marketed as Mifeprex now accounts for about one-quarter of US abortions performed in the first nine weeks of pregnancy and about 15 percent of all US abortions. In 2008, about 184,000 American women used the pill - up from 55,000 in 2001, even though the overall number of US abortions wasn't rising.

Dr David Grimes, a North Carolina obstetrician/gynaecologist who formerly headed the abortion surveillance branch at the Centers for Disease Control and Prevention, said the pill's impact has been overwhelmingly positive. 'I just don't see any downsides,' he said. 'For those women who don't like the invasiveness of surgery, it gives them a very important option.' He noted the option enables a woman to undergo an abortion in the privacy of her home after getting the pill from her doctor. Some of the pill's opponents 'said this would make it too easy for women,' Grimes said. 'That implies that the procedure should be punitive. I don't buy that.'

AP also reported on initiatives using telemedicine to make mifepristone more available. A pioneering telemedicine programme in Iowa has provided the pill to about 1,900 women - with a doctor able to consult with a faraway patient in a video teleconference, then unlock a container by remote control to release the pill. Abortion providers in other states are pondering whether similar programmes would enable them to serve more women, especially in rural areas. 28/9/10

<http://www.abortionreview.org/index.php/site/article/855/>

### UK: Pope Benedict XVI's visit to England and Scotland provoked debate about human rights and religious freedom.

More than 50 public figures signed a letter in the *Guardian* newspaper, opposing the state visit because of the Pope's responsibility for 'opposing the distribution of condoms and so increasing large families in poor countries and the spread of Aids; promoting segregated education; denying abortion to even the most vulnerable women; opposing equal rights for lesbians, gay, bisexual and transgender people; failing to address the many cases of abuse of children within its own organisation'. They also rejected 'the masquerading of the Holy See as a state and the pope as a head of state as merely a convenient fiction to amplify the international influence of the Vatican.'

Others argued that 'secularists really should take the opportunity to remind themselves of the Enlightenment values they claim to stand for - such as tolerance, freedom of thought and conscience and a human being as a rational subject - rather than focusing on what they hate about the Church and, by extension, Catholics.'

A survey published in *The Scotsman* ahead of the Pope's visit found that most British Roman Catholics disagree with their Church's position on issues including contraception, abortion and homosexuality. And an ice cream company banned from using an advert displaying a pregnant nun has vowed to position similar posters in London in time for the Pope's visit. 16/9/10, 15/9/10, 13/9/10

<http://www.abortionreview.org/index.php/site/article/831/>

<http://www.abortionreview.org/index.php/site/article/832/>

<http://www.abortionreview.org/index.php/site/article/833/>

## AUGUST 2010

### Poland: 'Abortion tourism' reflects restrictive law

Leading Polish activists held a civil hearing at the Polish parliament on 26 August on the rising number of Polish women who are travelling abroad to obtain access to abortion. The doctors said women sought abortions abroad because they were illegal at home and often performed in poor

conditions, and they fear social ostracism. An illegal abortion in Poland costs 2,000-4,000 zlotys (\$640-\$1,270), compared to 400-600 euros (\$510-\$760) in Germany, 280 euros in the Netherlands and 450-2,000 pounds (\$700-\$3,120) in Britain, they said.

The British media has previously reported 'abortion tourism' from Poland in scandalised terms, claiming that women are frequently travelling to the UK to get abortions free on the National Health Service. Ann Furedi, chief executive of BPAS, said:

'In 2009 just 20 Polish women were included in the official statistics for the number of women from overseas who had abortions in Britain. However, this does not include the many Polish women who are able to claim free NHS care because they are registered to work or studying, are resident in Britain. Arrangements now exist for reciprocal health care between European countries.

'Privately paid for abortions in Britain are relatively expensive; but Polish women are smart and who can blame them if they travel to get the care they need. No one knows exactly how many Polish women have abortions in Britain - it may be thousands. At BPAS we treat, without prejudice, anyone who wants our care and is lawfully able to receive it.' 27/8/10  
<http://www.abortionreview.org/index.php/site/article/824/>

### UK: Judge condemns forced contraception plan

A council's plan to force contraception upon a woman with a low IQ was 'essentially a horrendous prospect' that has 'shades of social engineering', Mr Justice Bodey said. He said the local authority's plan, to stop the 29-year-old woman having more children, 'would raise profound questions about State intervention in private and family life'. 20/8/10

<http://www.abortionreview.org/index.php/site/article/809/>

### IN BRIEF:

- USA: The 'Ella' emergency contraceptive pill, which can prevent unwanted pregnancy up to five days after unprotected sex, has gained final approval from the Food and Drug Administration. 14/8/10  
<http://www.abortionreview.org/index.php/site/article/805/>
- UK: The pharmacy chain Boots has launched a website enabling customers to purchase certain treatments online, including emergency contraception. 13/8/10  
<http://www.abortionreview.org/index.php/site/article/806/>
- UK: Complaints about the first UK television advertisement by an abortion advisory organisation, Marie Stopes International, have been rejected by the Advertising Standards Authority. 4/8/10  
<http://www.abortionreview.org/index.php/site/article/798/>
- USA: A battle has broken out over abortion coverage in student insurance plans at the University of North Carolina. 18/8/10  
<http://www.abortionreview.org/index.php/site/article/814/>
- UK: The Government is to 'put family planning at the heart of its approach to women's health in the developing world' in an attempt to reduce the persistently high number of women who die in pregnancy and childbirth, the Secretary of State for International Development has announced. 27/7/10  
<http://www.abortionreview.org/index.php/site/article/807/>
- Argentina: A report by the New York-based organisation Human Rights Watch claims that 40 percent of Argentine pregnancies end in abortion, most of which are carried out clandestinely and are the leading cause of maternal mortality. 10/8/10  
<http://www.abortionreview.org/index.php/site/article/800/>
- Ireland: An article published by Reuters suggests that the economic recession is encouraging more women to seek abortions, although it notes that 'statistical evidence is hard to find'. 11/8/10  
<http://www.abortionreview.org/index.php/site/article/812/>

- UK: The Human Fertilisation and Embryology Authority is considering increasing compensation for egg and sperm donors. 23/8/10  
<http://www.abortionreview.org/index.php/site/article/822/>
- UK: According to the Daily Mail, a 'major study' has found that 'binge drinking "ladettes" are 40 per cent likelier to have an abortion'. In fact the study, published in the Journal of Public Health, found no association between heavy drinking and using emergency contraception or accessing abortion, although they did find that 'non-use of reliable contraception at first intercourse was reported more often by respondents who gave being drunk as their main reason for sex.' 20/8/10  
<http://www.abortionreview.org/index.php/site/article/810/>

## MEDICAL UPDATE

### UK: 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;117:1512–1520. 22 September 2010

Researchers undertook a randomised controlled trial of women accepted for termination of pregnancy (TOP) at 13-20 weeks looking at the psychological impact, acceptability and clinical effectiveness of medical versus surgical termination. The results showed that in general women preferred STOP and found it less painful. Women who had MTOP experienced more pain on the day of the procedure (43% versus 23%) and more bleeding (37% versus 4%). All 26 women in the STOP group who were followed up would opt to have the same procedure again but only half (53%, 16/30) in the MTOP group. None of the women in the STOP group said the procedure was worse than expected, compared with half (53%, 16/30) in the MTOP group.

The paper also found that, despite the available evidence that 'STOP in experienced hands is at least as safe as MTOP, and the evidence presented here that many women prefer STOP, access to midtrimester surgical abortion within the NHS remains limited'. Although most (71%) NHS hospitals provide facilities for abortion after 13 weeks of gestation, the majority (79%) only provide MTOP. In contrast, whereas only 11% of abortion providers are from the private sector, 88% offer STOP.

Patricia Lohr, Medical Director of BPAS, said: 'We welcome this important study. Even though it's a small study, it's the largest one randomising women to modern methods of abortion after 13 weeks gestation to date. While this study did not look specifically for differences in safety, both methods had a low complication rate. And clearly choice between methods matters to women, especially having a surgical option.'

'BPAS has been safely providing surgical abortions to 24 weeks for many years and our service reflects those of this study, most of our clients choose this option. While the independent sector clearly provides an important service for women seeking abortions, we also rely on our NHS colleagues to share management of women with complex medical conditions. At present, very few NHS services offer surgical abortion as an option and only one NHS service in the entire UK can perform abortions surgically to 24 weeks. Training must be made a priority of women's ability to make decisions about their healthcare is to be optimal.'  
<http://www.abortionreview.org/index.php/site/article/842/>

### USA: Do depression and low self-esteem follow abortion among adolescents? Evidence from a national study

Jocelyn T. Warren, S. Marie Harvey and Jillian T. Henderson. *Perspectives on Sexual and Reproductive Health*, 2010, 42(4):230–235, doi: 10.1363/4223010, 30 September 2010

Data from the National Longitudinal Study of Adolescent Health were used to examine whether abortion in adolescence was associated with subsequent depression and low self-esteem. In all, 289 female respondents reported at least one pregnancy between Wave 1 (1994–1995) and Wave 2 (1996) of the survey. Of these, 69 reported an induced abortion. Population-averaged lagged logistic regression models were used to assess associations between abortion and depression and low self-esteem within a year of the pregnancy and approximately five years later, at Wave 3 (2001–2002).

The results found that abortion was not associated with depression or low self-esteem at either time point. Socioeconomic and demographic characteristics did not substantially modify the relationships between abortion and the outcomes. The authors concluded that adolescents who have an abortion do not appear to be at elevated risk for depression or low self-esteem in the short term or up to five years after the abortion.  
<http://www.abortionreview.org/index.php/site/article/853/>

### USA: Surgical procedures for evacuating incomplete miscarriage

Tunçalp O, Gülmözoglu AM, Souza JP. *Cochrane Database of Systematic Reviews*. 2010 Sep 8;(9):CD001993.

The study's objective was to compare the safety and effectiveness of surgical uterine evacuation methods for management of incomplete miscarriage. The authors concluded that although the review indicates that vacuum aspiration is safe, quick to perform, and less painful than sharp curettage, and should be recommended for use in the management of incomplete miscarriage, the results are based on data from only one study. Analgesia and sedation should be provided as necessary for the procedure.  
<http://www.abortionreview.org/index.php/site/article/875/>

### France: The future of women's contraception: stakes and modalities

Hugon-Rodin J, Chabbert-Buffet N, Bouchard P. *Annals of the New York Academy of Sciences*. 2010 Sep;1205(1):230-9

The authors write that the current goals of contraception remain to achieve effective, accessible, reversible, and well-tolerated birth control for everyone. Despite progress, these goals have not been reached. To achieve these goals, it is mandatory to create new hormonal combinations and to discover new contraceptive targets.

Recent innovations associate the development of new progestogens, selective progesterone receptor modulators, and the creation of new contraceptive combinations. Other innovations involve the use of natural oestrogens but also optimizing existing treatment regimens and doses, as well as the development of new methods of emergency contraception. Finally, a major step will be to invent an efficient contraceptive that carries the lowest possible risk associated with methods protecting against sexually transmitted diseases.

In the future, in relation to progress in the fields of genomics, proteomics, and immunology, new methods of contraception will be developed. These methods will be more targeted and will eventually be nonhormonal and independent of sexual activity.

<http://www.abortionreview.org/index.php/site/article/843/>

### USA: Cervical preparation for second trimester dilation and evacuation

Newmann SJ, Dalve-Endres A, Diedrich JT, Steinauer JE, Meckstroth K, Drey EA. *Cochrane Database of Systematic Reviews*. 2010 Aug 4;8:CD007310.

The authors note that abortion during the second trimester of pregnancy accounts for 10-15% of abortions performed worldwide. Dilation and evacuation (D&E) is the preferred method of second-trimester abortion in most parts of the developed world. Cervical preparation is recommended for dilation and curettage (D&C) after 12 weeks gestation and is standard practice for D&E beyond 14 weeks gestation. Prostaglandins, osmotic dilators, and Foley balloon catheters have been used and studied as cervical preparation prior to second-trimester D&E.

However, no consensus exists as to which cervical preparation method is superior with regards to safety, procedure time, need for additional dilation, ability to perform the procedure, or patient and provider acceptability. Despite the fact that the advent of osmotic dilation has improved the safety of the D&E procedure during the second trimester, it is unclear whether a certain type of osmotic dilator is superior to another or whether osmotic dilation with adjuvant prostaglandin is superior to osmotic dilation alone or to prostaglandins alone.

This review evaluates cervical preparation methods for second-trimester surgical abortion with respect to differences in procedure time, dilation achieved, need for additional dilation, complications, ability to complete the procedure, patient pain scores, and patient and provider acceptability and satisfaction.

The authors searched for trials of cervical preparation prior to second-trimester D&E. They included all randomized controlled trials that compared osmotic, mechanical, antiprogesterone, prostaglandin, or other medical agents of cervical preparation for second-trimester surgical abortion from 14-24 weeks of gestation. Data were abstracted by two authors and data entry was verified by a third author. Mean difference and Peto Odds Ratio were calculated.

Osmotic dilators were found to be superior to prostaglandins with respect to cervical dilation throughout the second trimester and with respect to procedure time within the early second trimester. Addition of prostaglandins to osmotic dilators was not found to increase cervical dilation, except after 19 weeks gestation, however, no impact was seen on procedure time. Addition of mifepristone to misoprostol was found to improve cervical dilation, yet increase procedure time and frequency of pre-procedural expulsions. Two-day cervical preparation was found to produce greater cervical preparation than one-day, but had no impact on procedure time. Serious complication rates or ability to complete the procedure did not differ significantly between any of the preparation methods reviewed.

The authors concluded that cervical preparation with osmotic dilators and/or misoprostol before second-trimester D&E is safe and effective. Osmotic dilators appear to provide superior cervical dilation when compared to prostaglandins alone or when combined with prostaglandins, however this difference in cervical dilation does not appear to result in differences in procedure time or complication rates. There does not appear to be clear clinical benefit from two days of cervical preparation compared to one-day prior to second-trimester D&E below 19 weeks gestational duration.

Mifepristone plus misoprostol was associated with high rates of pre-procedural expulsions and does not appear to be a useful method of cervical preparation before second-trimester dilation and evacuation. Same-day procedures appear to be a safe and reasonable option in the early second trimester, however, more research is needed to assess the effectiveness and safety of same-day procedures in the later second trimester.

<http://www.abortionreview.org/index.php/site/article/849/>

## IN BRIEF

### USA: Unplanned pregnancy in women with anorexia nervosa

*Bulik CM, Hoffman ER, Von Halle A, Torgersen L, Stoltenberg C, Reichborn-Kjennerud T. Obstetrics and Gynecology. 2010 Nov;116(5):1136-40.*

The authors concluded that the higher rate of unplanned pregnancy and abortion in women with anorexia nervosa is of clinical concern because absent or irregular menstruation may be misinterpreted as decreasing risk of pregnancy.

<http://www.abortionreview.org/index.php/site/article/874/>

### USA: Reproductive outcomes in subsequent pregnancies after a pregnancy complicated by open maternal-fetal surgery (1996-2007)

*Wilson RD, Lemerand K, Johnson MP, Flake AW, Bebbington M, Hedrick HL, Adzick NS. American Journal of Obstetrics and Gynecology. 2010 Sep;203(3):209.e1-6.*

The authors concluded that the reproductive outcomes of uterine dehiscence (14%) and rupture (14%) in a subsequent pregnancy continue

to be a major counselling issue for open maternal-fetal surgery (OMFS). Fertility and gynaecologic factors do not appear to be increased for women undergoing OMFS.

<http://www.abortionreview.org/index.php/site/article/877/>

### USA: The effect of Medicaid eligibility expansions on fertility

*Zavodny M, Bitler MP. Social Science and Medicine. 2010 Sep;71(5):918-24. Epub 2010 Jun 17.*

The authors note that in the United States, pregnant women and children's eligibility for Medicaid was expanded dramatically during the 1980s and early 1990s. The authors find little evidence that the Medicaid expansions led to changes in birth rates or abortion rates. However, some results do suggest that the Medicaid expansions boosted the birth rate among white women who have not completed high school. They find that restrictions on Medicaid funding of abortions decrease abortion rates and increase birth rates. The results thus do not provide definitive evidence that expansions in public health insurance eligibility have sizable effects on women's fertility.

<http://www.abortionreview.org/index.php/site/article/850/>

### USA: Retained viable single intrauterine pregnancy after vacuum aspiration for a dichorionic-diamniotic twin pregnancy.

*Asemota OA, Podolsky ML. Obstetrics and Gynecology. 2010 Aug;116 Suppl 2:494-6.*

The authors report a case of a retained single intrauterine pregnancy after an elective vacuum aspiration of a dichorionic-diamniotic twin gestation.

<http://www.abortionreview.org/index.php/site/article/848/>

### Finland: Young age and termination of pregnancy during the second trimester are risk factors for repeat second-trimester abortion

*Mentula MJ, Niinimäki M, Suhonen S, Hemminki E, Gissler M, Heikinheimo O. American Journal of Obstetrics and Gynecology. 2010 Aug;203(2):107.e1-7. Epub 2010 May 1*

The authors concluded that second-trimester TOP and young age are risk factors for repeat second-trimester TOP.

<http://www.abortionreview.org/index.php/site/article/852/>

### Australia: Views and practices of induced abortion among Australian Fellows and specialist trainees of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

*de Costa CM, Russell DB, Carrette M. Medical Journal of Australia. 2010 Jul 5;193(1):13-6.*

The authors concluded that there was broad support among responding specialist obstetricians and gynaecologists and trainees for the availability of induced abortion in Australia. This study highlights the difficulties of accurately reporting a wide range of views on a contentious issue.

<http://www.abortionreview.org/index.php/site/article/847/>

### Australia: Early medical abortion: legal and medical developments.

*Petersen KA. Medical Journal of Australia. 2010 Jul 5;193(1):26-9.*

The authors argue that the decriminalisation of abortion in all Australian jurisdictions would protect medical practitioners from criminal liability, promote the health interests of Australian women, and discourage the illegal importation of abortifacients that are being used without quality controls or medical supervision. The Victorian Abortion Law Reform Act 2008 is one legislative model for this.

<http://www.abortionreview.org/index.php/site/article/846/>

### Australia: Declining prevalence of cystic fibrosis since the introduction of newborn screening

*Massie J, Curnow L, Gaffney L, Carlin J, Francis I. Archives of Disease in Childhood. 2010 Jul;95(7):531-3.*

The authors observed a modest reduction in the live-birth prevalence of CF since the introduction of newborn screening. This is principally due to at-risk couples detected by newborn screening electing to use prenatal testing on subsequent pregnancies.

<http://www.abortionreview.org/index.php/site/article/845/>

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