Abortion Review

ISSUE 34 SPRING 2011 ISSN 02627299

# OUR 10-YEAR STRUGGLE TO IMPROVE ABORTION CARE

**By Ann Furedi**
**Chief Executive, bpas**

On Valentine's Day 2011, the Honourable Mr Justice Supperstone, sitting in London's High Court of Justice, 'in the matter of the Abortion Act 1967', found against the British Pregnancy Advisory Service (**bpas**) and for the secretary of state for health. It's a crying shame; **bpas** was trying to solve a problem that has been annoying women, abortion providers, and, paradoxically, health officials for the past decade.

Now the Government is insisting that **bpas**, a charity that makes no profit from its services, must shoulder the cost of the Department of Health's efforts to block evidence-based, sensibly-regulated abortion care. We intend to keep campaigning - and for this, we need your support.

At issue in the **bpas** case was whether the 1967 Abortion Act could be interpreted to enable early medical abortion patients to take the second medication (misoprostol) at home rather than in a clinic. This would have put an end to women making multiple visits to clinics and eliminated the risk of abortion symptoms beginning as they travelled home after taking the tablets. It would have brought early medical abortion in Britain into line with international standards of care, and into line with practice in countries as diverse as the USA, Sweden, France and Vietnam. To this end, we sought a ruling from the High Court that 'treatment' could be interpreted as the *prescription* of misoprostol, rather than its *administration*.

We did not go to Court on a whim. After a decade of negotiations with the Department of Health, in which officials admitted the barriers to improving care were political, **bpas** had little option but to seek legal clarification of a matter so clearly in the public interest. And our action has made a difference. The judge's ruling confirmed that the Secretary of State for Health has the power to approve women's homes as a 'class of place' where certain abortion drugs could be taken.

In short, the judgement gives a green light for ministers to allow home-use, albeit via a different legal route to that which we had suggested.

There is no clinical argument against the change that **bpas** wants to bring about. The Royal College of Obstetricians and Gynaecologists has recently recognised this, issuing guidance confirming that home-administration of the drug in question is backed by evidence and would be fine if it were legal.

**bpas'** proposals to enable home-use of misoprostol also make perfect sense policy-wise. Abortion is now a part of 'public health': almost all abortions are commissioned and funded by the state healthcare system, and policymakers recognise that it is better for women to have abortions earlier in pregnancy than at later gestations. So it is counterintuitive and counterproductive for ministers and officials to oppose them: but for one firm belief, which was expressed clearly in the Supperstone judgement. Paragraph two begins: 'Abortion remains a controversial subject in respect of which there are differing deeply held views.'

Throughout the decade of discussions, officials have repeatedly iterated their fears about how proposals for home-use of abortion drugs will be reported by the press and received by the public. They do not seem to appreciate that times have changed to the point where abortion is accepted and acceptable – especially in the earliest weeks of pregnancy. The media coverage of our court case is an accurate reflection of the general opinion – overwhelmingly balanced and accurate, and implicitly supportive. **bpas** may not have achieved a victory in the court but it certainly achieved a national media discussion of abortion that avoided the usual polarised perspectives.

Given health secretary Andrew Lansley's stated commitment to evidence-based medicine, patient choice and the liberation of clinicians from bureaucracy, one might assume he would wish to employ his powers, so that doctors may provide women legally accessing early abortion with the best possible care. However, a statement from the Department of Health, rushed out on the afternoon of the judgement, is not promising: 'There are no plans to use the provision under Section 1(3a) of the Abortion Act for medical abortion to be carried out in women's homes as an approved class of place'.

The Secretary of State may not have plans to improve abortion services, but we most certainly do. Our ambition is high, but our campaigning fund. Please back **bpas:** visit **www.backbpas.org** and help us legalise the best medical abortion care.

**Ann Furedi is chief executive of bpas. A longer version of this article is available on *Abortion Review Online*, here: http://www.abortionreview.org/index.php/site/article/927/**

**Inside this issue:**



**Abortion Review, a quarterly update on issues relating to abortion is produced as an educational service by bpas. Editor: Jennie Bristow. Subscription enquiries to the marketing department - Email: abortionreview@bpas.org Published by bpas, 20 Timothys Bridge Road, Stratford Enterprise Park, Stratford-Upon-Avon, Warwickshire CV37 9BF, United Kingdom. www.bpas.org**

## CLINICAL UPDATE

# Very Early Surgical Abortion

**By Patricia A. Lohr, Medical Director, bpas**

***Q) What is meant by very early surgical abortion?***

This typically refers to abortion carried out at gestations under 7 weeks. Early studies showed that the risk of a failed abortion was higher under 7 weeks' gestation especially when a suction cannula with a diameter in millimetres smaller than the gestational age in weeks was used for the procedure. (1) In this study, abortions performed at less than or equal to 6 weeks' gestation had a failure rate of 5.6/1000 compared to 1.9/1000 for those performed at 7 to 12 weeks' gestation. As a result, most providers would not perform a surgical procedure in the earliest weeks of pregnancy, deferring the woman's procedure until after 7 or sometimes 8 weeks' gestation.

***Q) Why has very early surgical abortion not always been used?***

Advisory bodies have been cautious about recommending vacuum aspiration for very early abortions in light of the evidence about method failure. The 2004 guideline of the Royal College of Obstetricians and Gynaecologists (RCOG) stated that, unless a particular rigorous protocol was used, suction termination 'is better deferred until the pregnancy exceeds 7 weeks of gestation'. The availability of medical abortion with mifepristone and misoprostol, which had been studied from the earliest weeks of pregnancy and shown to be highly effective, was also seen as a valid, if not better, alternative.

***Q) What has changed with regard to very early surgical abortions?***

In the past, urine and serum pregnancy tests were not very sensitive, there was limited access to ultrasound, the products of conception were rarely examined, and very early surgical abortions had been shown to have a higher risk of continuing pregnancy. There was also a concern about missing an ectopic pregnancy because the collection of blood in the uterus which can occur with an extra-uterine gestation can have the appearance of a very early gestational sac. So, if a pseudosac was seen on ultrasound and the abortion performed without looking at the aspirate to make sure a gestational sac had been removed, women might be reassured inappropriately following the procedure.

Today, vaginal ultrasound is more readily available and we have a better understanding of the importance of checking the uterine aspirate to make sure a gestational sac is seen. When a gestational sac is not seen, an immediate transvaginal ultrasound can be done to see if the sac was missed and if it was not, serum beta-hCG testing can be performed. The purpose of the serum beta-hCG measurements is to check whether the hormone level is declining rapidly (as one would expect with a successful abortion), going up (as with a continuing pregnancy), or not changing (which may be indicative of an ectopic pregnancy). Importantly, there have been two large case series published (2) that have shown that using a protocol employing these measures leads to a safe, successful abortion almost all of the time and picks up problems, like missed abortions and ectopic pregnancies, very rapidly.

Perhaps most importantly, pregnancy is now detectable by women using home testing kits as early as the third or fourth week of gestation. This has led to an increased demand for early abortion. The increasing availability of early medical abortion has also raised expectations that termination can be accessed very early in pregnancy and has very likely contributed to the increase in abortions performed below 10 weeks' gestation in England and Wales. (3) But for some women, medical abortion may be neither preferable nor advisable, and having a surgical option is important to them. Women find being told to wait for a surgical abortion until they are 'pregnant enough' both stressful and counter-intuitive. The evidence certainly supports women's feelings with regard to safety; the earlier an abortion is performed, the lower the risks. (4)

***Q) What is the protocol for very early surgical abortion?***

In the paper by Creinin and Edwards, careful gestational age dating was performed with vaginal scanning and when a sac wasn't seen in the uterus, a serum beta-hCG level was obtained to make sure it was below the level at which one would expect a sac to be visible on scan. If the level was above this discriminatory zone, the woman would be immediately referred for an ectopic pregnancy work-up. For anyone else, which included some women in which no sac was seen in the uterus, an evacuation was done with a manual vacuum aspirator and a size 7 cannula and the aspirate inspected to ensure the sac was seen. In cases where it was not seen, a vaginal scan was performed straight away and a re-aspiration done if the sac remained in the uterus. If a sac was not seen on scan, serum beta-hCGs were done with referral for an ectopic pregnancy work up if indicated by the levels. With this protocol, they reported a failed abortion rate of 1.3/1000 which was comparable to the rate reported in the Kaunitz study for gestations of 7 to 12 weeks.

***Q) Is there a difference between EVA and MVA?***

There is some limited evidence that evacuation using a manual vacuum aspirator causes less destruction to the gestational sac, making it easier to visualise in the aspirate. (5) One large case series has been published which allowed electric vacuum aspiration or manual vacuum aspiration to be used in a similar protocol to that described by Creinin and Edwards reported a higher failure rate. (6) In this study, the failure rate was slightly higher in the EVA group, but in general more failed procedures were reported in this study than in the series by Creinin and Edwards (1.5%, 95% CI 0.9%-2.4%). What is still needed is a randomised trial comparing manual and electric vacuum aspiration to determine which is better.

***Q) What method is used at bpas?***

At **bpas**, we have a protocol that is very similar to the one described by Creinin and Edwards. Evacuation using a manual vacuum aspirator is allowed as soon as a gestational sac is seen on scan and diligent inspection of the aspirate must confirm that a gestational sac was removed. Where a complete evacuation cannot be confirmed, referral is made to an Early Pregnancy Assessment Unit to ensure that the woman does not have an ectopic pregnancy. In the event that she does have an ectopic pregnancy, she is in the right place to be treated promptly.

We have had a positive response to the availability of very early surgical abortion, but there are still challenges to be addressed. These include the need to train surgeons in this technique and ensuring access to serum beta-hCG testing, which means collaborating closely with our colleagues in the NHS or developing that capability at **bpas**. It would also be very valuable to have a randomised controlled trial performed comparing outcomes with early medical abortion using mifepristone and misoprostol and surgical abortion using these methods.

While we feel it is important to offer women a choice of procedures at every gestation, we also recognise that accurate counselling about the relative risks and benefits of any procedure we provide is an essential part of good patient care. The results of a head-to-head trial would help this greatly, but in the end it is for patients to weigh up the profile of any given treatment option and choose what is right for her. Retaining choice in abortion treatments, buttressed by better evidence of a safe method of providing early surgical abortion, has underpinned this service's development at **bpas**.

*(1) Kaunitz AM, Rovira EZ, Grimes DA, Schulz KF. Abortions that fail. Obstetrics and Gynecology. 1985 Oct;66(4):533-7.*
*(2) Creinin MD, Edwards J. Early abortion: surgical and medical options. Current*

*Problems in Obstetrics, Gynecology and Fertility 1997;20:6–32; Paul ME, Mitchell CM, Rogers AJ, Fox MC, Lackie EG. Early surgical abortion: efficacy and safety. American Journal of Obstetrics and Gynecology 2002;187:407–11.*
*(3) Department of Health. Statistical Bulletin 2010/1:Abortion Statistics, England and Wales: 2009. London:Crown, 2010.*
*(4) Bartlett LA. Berg CJ, Shulman HB, Zane SB, Green CA, Whitehead S, Atrash HK. Risk factors for legal induced abortion-related mortality in the United States. Obstetrics and Gynecology 2004;103:729–37.*
*(5) Goldberg AB, Dean G, Kang MS, Youssof S, Darney PD. Manual versus electric vacuum aspiration for early first-trimester abortion: a controlled study of complication rates. Obstetrics and Gynecology 2004 Jan;103(1):101-7.*
*(6) Paul ME, Mitchell CM, Rogers AJ, Fox MC, Lackie EG. Early surgical abortion: efficacy and safety. American Journal of Obstetrics and Gynecology 2002 Aug;187(2):407-11.*



## ABORTION NEWS

**FEBRUARY 2011**

### Late abortion: the new clash in the Choice Wars

The case of Kermit Gossling, the Philadelphia doctor charged with performing illegal late abortions and infanticide, has prompted heated commentary about whether late abortions should be restricted. In an article published on *spiked*, Ann Furedi argues that the case shows exactly why we need a principled defence of abortion - as late as necessary. Furedi writes:

'William Saletan, writing for *Slate* magazine, has turned a scandal of unlawful, incompetent abortion into a grisly show-and-tell, an opportunity to fuel public distaste for later abortion procedures and to demand a ban on the few later abortions that take place legally. Frances Kissling has followed his lead, claiming in the *Washington Post* that public support for abortion in the US has declined because some pro-choice activists' support for late abortion has "eroded the 'pro-choice' brand".

'I see things somewhat differently. But then, my support for women's ability to make, and exercise, reproductive decisions has never been based on the kind of messaging that experts tell us is best for the pro-choice "brand". There are some messages we cannot massage...'
**http://www.abortionreview.org/index.php/site/article/934/**

### bpas' early medical abortion case gains attention and support

**bpas** on 28 January brought a High Court challenge against the Secretary of State for Health, asking that that the law be interpreted in line with modern science to allow women to complete early medical abortions at home. On 14 February, the High Court rejected the challenge. The case was widely reported throughout the UK media. Commentary includes:

*13 January:* 'Let's make it easier to take the abortion pill.' Ann Furedi writes on *spiked* and in the *Independent*:
**http://www.abortionreview.org/index.php/site/article/905/**

*26 January:* 'Misoprostol and the transformation of the "abortion pill."' Britain was one of the earliest countries to use early medical abortion: and British women are now being penalised for it.
**http://www.abortionreview.org/index.php/site/article/908/**

*14 February:* 'How Britain's abortion law punishes women.' Why are politicians so selective in allowing doctors to make decisions about abortion?
**http://www.abortionreview.org/index.php/site/article/923/**

*17 February:* 'Abortion is quietly shoved off the agenda again'. *Guardian* columnist Zoe Williams writes:

'A third of all women will have had an abortion by the time they are 45, and every year 70,000 of those are EMAs. That is a very large constituency whose needs are being totally ignored because it is considered more important to pamper the free-floating disapproval of anonymous people who think that this a bad business, and that abortions should be as difficult as possible...'
**http://www.abortionreview.org/index.php/site/article/928/**

**bpas'** press statements, and a selection of the media coverage, are available here:

**http://www.abortionreview.org/index.php/site/article/905/**
**http://www.abortionreview.org/index.php/site/article/913/**
**http://www.abortionreview.org/index.php/site/article/924/**

### USA: Politicians vote to strip Planned Parenthood of federal funding

The bill pushed through the US House of Representatives on 26 February calling for Planned Parenthood Federation of America (PPFA) to be stripped of federal funding caused outcry amongst pro-choice supporters.

AFP reported that abortion has 'roared back to center stage', as 'the Republican-controlled House of Representatives shifted its focus from a campaign pledge to create jobs and cut spending to women's issues.' An editorial in the *New York Times*, headlined 'The War on Women', began by stating: 'Republicans in the House of Representatives are mounting an assault on women's health and freedom that would deny millions of women access to affordable contraception and life-saving cancer screenings and cut nutritional support for millions of newborn babies in struggling families. And this is just the beginning.'

In a commentary, Jennie Bristow discusses some of the potential problems facing US reproductive healthcare providers in the current era. *2/3/11 and 18/2/11*
**http://www.abortionreview.org/index.php/site/article/930/**
**http://www.abortionreview.org/index.php/site/article/933/**

### USA: Research finds that most men supportive of abortion decisions

A new analysis of data from the Guttmacher Institute's 2008 survey of women obtaining abortions suggests that most women are able to rely on their partners for support, which previous research has shown improves women's post-abortion well-being. 'Perceptions of Male Knowledge and Support Among U.S. Women Obtaining Abortions', by Rachel K. Jones et al, finds that nearly nine in 10 women who are cohabiting or married report that their partner knew about their abortion (88% and 87%, respectively) and that he was supportive (82% and 87%). By contrast, 72% of divorced and separated women reported that their partner knew and 66% said that he was supportive.

Additionally, women in long-term relationships were more likely than those not in a relationship or in a relationship of less than one year to report both that their partner knew and that he was supportive. Only 12% of women reported that they had not been in a relationship with the man who got them pregnant, but a majority of these women reported that he still knew about the pregnancy and that he was supportive (61% and 64%). *1/2/11*
**http://www.abortionreview.org/index.php/site/article/917/**

### *IN BRIEF:*

- **USA: South Dakota homicide bill postponed**
  A state bill to expand the definition of justifiable homicide to include killing someone in the defence of an 'unborn child' has been indefinitely postponed after an uproar over whether it would put abortion providers at greater risk. *16/2/11*
  **http://www.abortionreview.org/index.php/site/article/929/**

- **Commentary: Anti-abortion lobby reacts to doctors' guidance**
  Draft guidance from the Royal College of Obstetricians and Gynaecologists advises that women should be presented with scientific evidence about the health effects of abortion. Would critics of the guidance prefer that women are lied to?.
  **http://www.abortionreview.org/index.php/site/article/931/**

## JANUARY 2011

### USA: New study of abortion trends

The steady decline in the US abortion rate since 1981 appears to have stalled, new research by the Guttmacher Institute finds. The 2008 rate stood at 19.6 abortions per 1,000 women aged 15–44, significantly below the 1981 peak (29.3 abortions for every 1,000 women). However, the 2008 abortion rate was virtually unchanged from the 2005 rate (19.4 abortions). Likewise, the total number of abortions in 2008 (1.21 million) was essentially unchanged from 2005.

The new study further found an increase in the use of early medical (or 'medication') abortion, which uses a combination of two drugs in lieu of surgery. The number of such procedures performed in nonhospital facilities rose from 161,000 to 199,000 between 2005 and 2008, and the proportion of all nonhospital abortions that were early medication procedures increased from 14% to 17%. Early medical abortion has become an integral part of abortion care; 59% of all known abortion providers in the USA now offer this service.

According to the new study, the number of abortion providers changed little - from 1,787 to 1,793 - between 2005 and 2008. As before, 87% of US counties had no abortion provider, and 35% of women of reproductive age lived in those counties. The report also found a 'disturbing' increase in the proportion of large non-hospital providers (those offering 400 abortions or more) reporting anti-abortion harassment—from 82% in 2000 to 89% in 2008. Harassment was particularly common among providers of all sizes in the Midwest and South. Picketing was the most common form of harassment (reported by 55% of providers), followed by picketing combined with blocking patient access to facilities (21%).
**http://www.abortionreview.org/index.php/site/article/904/**

### UK: Small proportion of contraceptive implant failure makes headlines

The news that 584 women over 11 years have become pregnant while using Implanon sparked some consternation in the British media. The Medicines and Healthcare Regulatory Agency had also received 1,607 reports of adverse reactions to the implant. According to the Department of Health around 1.4 million women have used Implanon since it was first licenced in 1999.

Nine of the 584 women who reported an unwanted pregnancy used the terms "device failure", "device dislocation", "device ineffective" and "device difficult to use" to describe their experience. Others reported scarring and problems with removing the 40mm long implant. Late last year Implanon was replaced with a device called Nexplanon, which is designed to be inserted more easily.

Ann Furedi, chief executive of **bpas**, said: 'Implants are an excellent and usually extremely reliable method of birth control. But all contraceptives have a failure rate, and although with implants this is tiny, women do need to be aware.' *5/1/11*
**http://www.abortionreview.org/index.php/site/article/901/**

### UK: IVF risks in the headlines

An editorial in the *British Medical Journal* claims that about the same number of women die from IVF every year as they do from abortion. Seven women died as a direct result of IVF between 2003 and 2005, but two died as a result of having abortions in 2007, write Dr Susan Bewley and colleagues. That is despite there being only a quarter the number of IVF cycles as abortions.

The authors say that IVF deaths are 'rare but relevant', particularly with growing numbers of older women resorting to the method. 'More stringent attention to stimulation regimens, pre-conceptual care, and pregnancy management is needed so that maternal death and severe morbidity do not worsen further,' they conclude. Also in January, the Human Fertilisation and Embryology Authority (HFEA) stated that clinics should warn patients about the increased risk of birth defects for children conceived using fertility treatment. *27/1/11* and *1/1/11*
**http://www.abortionreview.org/index.php/site/article/914/**

### UK: Warnings issued over later motherhood

As more women give birth over the age of 35, public health messages about contraception need to be put into perspective with information on age-related reproductive risk, according to a review in *The Obstetrician & Gynaecologist*. At the age of 25, 5% of women take longer than a year to conceive and this rises to 30% in women aged 35; older women are also at greater risk of miscarriage and other pregnancy complications. Jason Waugh, the journal's Editor–in-Chief, said: 'There are a number of reasons why women are leaving it later to start a family, for example, career concerns, financial reasons and finding a suitable partner. However, women should be given more information on the unpredictability of pregnancy and the problems that can occur in older mothers.'
**http://www.abortionreview.org/index.php/site/article/915/**

## DECEMBER 2010

### European Court rules on *A, B, and C v. Ireland*

The European Court of Human Rights in December ruled that Irish abortion laws violated the rights of one of three women who sought terminations in Britain. The woman, who was in remission for a rare form of cancer, feared it might return as a result of her pregnancy. While abortion in the Republic is technically allowed if a woman's life is at risk, the court

said that was not made possible for the woman involved. But it ruled two other women in the case had not had their rights breached.

The court said that the government in Dublin had breached the third woman's right to respect for her private life by its 'failure to implement the existing constitutional right to a lawful abortion in Ireland'. It ruled that 'neither the medical consultation nor litigation options, relied on by the Irish government, constituted effective and accessible procedures which allowed the third applicant to establish her right to a lawful abortion in Ireland'. Irish Prime Minister Brian Cowen said politicians now needed to consider the implications of the ruling.

**bpas** provided an expert submission to the court on the needs of Irish women travelling for abortion care in the UK and the problems caused by treatment delays imposed by legal restrictions. **bpas's** chief executive Ann Furedi said:

'Although this ruling will help a tiny number of women with life-threatening conditions it does little to change matters for the many women from Ireland with crisis pregnancies who must travel to access a fundamental service routinely available throughout Europe but which they are denied. Contraception fails in Ireland as it does in England, and women have abortions – but they do so here, while their political leaders look away.

'We hope this case has gone some way in highlighting the plight of thousands of women from Ireland every year, who simply want to be able to make meaningful responsible decisions about their lives, their families, and their futures. The lack of clarity as to when abortion may be lawful in Ireland puts women and doctors in an impossible situation, and the sooner this can be remedied the better.' *16/12/10*
**http://www.abortionreview.org/index.php/site/article/887/**

### UK: National statistics on fertility trends

The size of the average family seems to be getting smaller, according to the Office for National Statistics (ONS). Researchers looked at women born in England and Wales in 1964 and compared them with their mother's generation, represented by women born in 1937. By 2009, they had on average 1.9 children, while at a similar stage in their lives their mothers had on average 2.4 children. Twenty per cent of women born in 1964 are childless, compared to 12% of women born in 1937.

The most common family size for both groups is two children, but larger families are becoming rarer. Only one in 10 women from 1964 had a family of four or more, compared to twice that number for their mothers' generation. The Total Fertility Rate (TFR) for 2009 shows an average of 1.96 children per woman in England and Wales - a fall for the first time in 8 years - although the 2008 figure was at its highest rate for 35 years. *9/12/10*
**http://www.abortionreview.org/index.php/site/article/885/**

## MEDICAL UPDATE

### UK: New RCOG guidance highlights advances in abortion care

Britain's Royal Society of Obstetricians and Gynaecologists (RCOG) on 22 January published, for consultation, its draft evidence-based clinical guideline, The Care of Women Requesting Induced Abortion. This will replace the guidance produced in 2000, and last updated in 2004. It is a thorough and comprehensive document, running to 86 pages, providing important summaries of scientific evidence and recommendations based on best practice.

Some key points are summarised on *Abortion Review*:

- The extent and practice of abortion
- The relationship between law and clinical practice
- Early medical abortion (up to 63 days' gestation)
- Later medical abortion
- Surgical abortion
- Complications and sequelae
- Anaesthesia and analgesia
- Scanning and follow-up
- Contraception after abortion
- Choice and referral
- Training issues
- Consent, confidentiality and conscientious objection

**http://www.abortionreview.org/index.php/site/article/909/**

### USA: Alternatives to routine ultrasound for eligibility assessment prior to early termination of pregnancy with mifepristone-misoprostol

*Bracken H, Clark W, Lichtenberg ES, Schweikert SM, Tanenhaus J, Barajas A, Alpert L, Winikoff B. BJOG. 2011 Jan;118(1):17-23.*

The study set out to test the feasibility and efficacy of an approach that foregoes the routine use of ultrasound for the determination of eligibility for medical termination of pregnancy. Women provided estimates of the date of their last menstrual period and underwent pelvic bimanual and ultrasound examinations. The researchers compared estimates of gestational age using these three methods. The main outcome measure was the proportion of women of ≤9 weeks' gestation by woman or provider estimate, but >9 weeks' gestation by ultrasound.

The results found that the reliance on women's report of their last menstrual period together with physical examination to determine their eligibility for termination of pregnancy with mifepristone-misoprostol would result in few women (63/4008 or 1.6%) accepted for treatment outside the current limits of standard mifepristone-misoprostol regimens used for early termination of pregnancy (i.e. ≤63 days' gestation on ultrasound). The authors concluded that last menstrual period and physical examination alone, without the routine use of ultrasound, are highly effective for the determination of women's eligibility for early termination of pregnancy with mifepristone-misoprostol.
**http://www.abortionreview.org/index.php/site/article/925/**

### Netherlands: Medical methods for mid-trimester termination of pregnancy

*Wildschut H, Both MI, Medema S, Thomee E, Wildhagen MF, Kapp N. Cochrane Database of Systematic Reviews. 2011 Jan 19;1:CD005216.*

The authors note that with the improvement of ultrasound technology, the likelihood of detection of major fetal structural anomalies in mid-pregnancy has increased considerably. Upon the detection of serious anomalies, women typically are offered the option of pregnancy termination. Additionally, there are still many reasons other than fetal anomalies why women seek abortion in the mid-trimester. The study set out to compare different methods of second trimester medical termination of pregnancy for their efficacy and side-effects.

The authors concluded that medical abortion in the second trimester using the combination of mifepristone and misoprostol appeared to have the highest efficacy and shortest abortion time interval. Where mifepristone is not available, misoprostol alone is a reasonable alternative. The optimal route for administering misoprostol is vaginally, preferably using tablets at 3-hourly intervals. Apart from pain, the side-effects of vaginal misoprostol are usually mild and self limiting. Conclusions from this review are limited by the gestational age ranges and variable medical regimens, including dosing, administrative routes and intervals of medication, of the included trials.
**http://www.abortionreview.org/index.php/site/article/935/**

### Denmark: Induced first-trimester abortion and risk of mental disorder

*Munk-Olsen T, Munk Laursen T, Pedersen CB, Lidegaard Ø, Mortensen PB. New England Journal of Medicine 2011; 364:332-339. 27 January 2011.*

The authors note that concern has been expressed about potential harm to women's mental health in association with having an induced abortion, but it remains unclear whether induced abortion is associated with an increased risk of subsequent psychiatric problems. They conducted a population-based cohort study that involved linking information from the Danish Civil

Registration system to the Danish Psychiatric Central Register and the Danish National Register of Patients. The information consisted of data for girls and women with no record of mental disorders during the 1995–2007 period who had a first-trimester induced abortion or a first childbirth during that period. The authors estimated the rates of first-time psychiatric contact (an inpatient admission or outpatient visit) for any type of mental disorder within the 12 months after the abortion or childbirth as compared with the 9-month period preceding the event.

The incidence rates of first psychiatric contact per 1000 person-years among girls and women who had a first abortion were 14.6 before abortion and 15.2 after abortion. The corresponding rates among girls and women who had a first childbirth were 3.9 before delivery and 6.7 post partum. The relative risk of a psychiatric contact did not differ significantly after abortion as compared with before abortion but did increase after childbirth as compared with before childbirth. The authors concluded that the finding that the incidence rate of psychiatric contact was similar before and after a first-trimester abortion does not support the hypothesis that there is an increased risk of mental disorders after a first-trimester induced abortion.
**http://www.abortionreview.org/index.php/site/article/916/**

## USA: How commonly do abortion patients report attempts to self-induce?

*Jones RK. American Journal of Obstetrics and Gynecology. 2011 Jan;204(1):23.e1-4.*

This study measures the extent to which women who access clinical abortion services in the United States report having ever used misoprostol or other substances to self-induce. A random sample of 107 US abortion providers was asked to distribute questionnaires to abortion patients. Information was gathered from 9493 patients at 95 facilities, and weights were constructed to make the data nationally representative of all US abortion patients.

Only 1.2% of women obtaining abortions report having ever used misoprostol on their own to 'bring back' their period or end a pregnancy. A similarly small proportion of women, 1.4%, reported using other substances, such as vitamin C or herbs, to attempt to end a pregnancy. The author concluded that media reports of self-induced abortions using misoprostol may be exaggerated, but further research is needed to estimate the incidence of self-induced abortion among women who do not access clinical abortion services.
**http://www.abortionreview.org/index.php/site/article/926/**

## Norway: Induced abortion: a means of postponing childbirth?

*Vlietman M, Sarfraz AA, Eskild A. Acta Obstetricia et Gynecologica Scandinavica. 2010 Dec;89(12):1564-70.*

The authors note that the maternal age at child birth is increasing, and that if induced abortion is an important means of postponing childbirth in a population, it is to be expected that in young women the rate of conceived pregnancies is stable over time, but the induced abortion rate is increasing. They studied birth rates, induced abortion rates and the sum of these rates by maternal age during four decades.

The results found that the induced abortion rates have been relatively stable within age groups, except for a decrease in women 15-19 years (from 24.2 in 1979 to 17.0 in 2007) and an increase in women 20-24 years (from 23.2 to 29.5). The birth rates however, have decreased dramatically in women 20-24 years old (from 113.6 to 60.5). Hence, the sum rate of births and induced abortions in women 20-24 years old has decreased from 136.8 to 90.0. In women 30 years old or older, the birth rates have increased. The authors concluded that the induced abortion rate has been relatively stable in all age groups over time, suggesting a limited influence of induced abortions on the postponement of childbearing.
**http://www.abortionreview.org/index.php/site/article/895/**

## *IN BRIEF:*

- **Finland: Clinical efficacy of mifepristone and misoprostol in second trimester pregnancy termination**
  *Joensuu-Manninen H, Kuvaja P, Talvensaari-Mattila A. Acta Obstetricia et Gynecologica Scandinavica. 2010 Dec;89(12):1552-6.*
  The authors concluded that multiparous women and women with early gestation complete medical termination faster. Multiparity and shorter gestation time are also associated with lesser need for opiate analgesia, compared to nulliparous women or longer gestation time (≥17 weeks).
  **http://www.abortionreview.org/index.php/site/article/893/**

- **Non-invasive prenatal assessment of trisomy 21 by multiplexed maternal plasma DNA sequencing: large scale validity study**
  *Rossa W K Chiu et al. BMJ 2011; 342:c7401.*
  The authors concluded that multiplexed maternal plasma DNA sequencing analysis could be used to rule out fetal trisomy 21 among high risk pregnancies. If referrals for amniocentesis or chorionic villus sampling were based on the sequencing test results, about 98% of the invasive diagnostic procedures could be avoided.
  **http://www.abortionreview.org/index.php/site/article/907/**

- **France: Evaluation of a urinary test as a diagnostic tool of a nonprogressive pregnancy**
  *Mazouz S, Lee JK, Fernandez H. Fertility and Sterility. 2011 Feb;95(2):783-6.*
  The authors concluded that abnormal pregnancy, such as an ectopic or a miscarriage, can be rapidly detected with the one-step test for intact hCG and free β-hCG isoforms. If ultrasound cannot confirm the localisation and/or evolution of a pregnancy, using this test reduces medical supervision and repeated quantification of hCG.
  **http://www.abortionreview.org/index.php/site/article/936/**

- **Denmark: Legal termination of a pregnancy resulting from transplanted cryopreserved ovarian tissue**
  *Greve T, Ernst E, Markholt S, Schmidt KT, Andersen CY. Acta Obstetricia et Gynecologica Scandinavica. 2010 Dec;89(12):1589-91. Epub 2010 Nov 5.*
  The authors note that currently, 12 healthy children have been born worldwide as a result of transplanting frozen/thawed ovarian tissue. Of these children 3 are Danish and a number of other Danish women are currently attempting to become pregnant. The authors note that one of these women conceived naturally and had a normal intrauterine pregnancy following transplantation of cryopreserved ovarian tissue. However, the woman decided to terminate the pregnancy within the legal time frame. This pregnancy imposes cryopreservation of ovarian tissue for fertility preservation as a valid method and illustrates that personal life circumstances may rapidly change.
  **http://www.abortionreview.org/index.php/site/article/894/**

- **USA: Spontaneous reduction before 12 weeks' gestation and selective reduction similarly extend time to delivery in in vitro fertilisation of trichorionic-triamniotic triplets**
  *Skiadas CC, Missmer SA, Benson CB, Acker D, Racowsky C. Fertility and Sterility. 2011 Feb;95(2):596-9.*
  The authors concluded that selective reduction of one fetus was used in 56.9% of patients in this population. Early spontaneous reduction (<12 weeks) and selective reduction to twins each conferred similar benefits by extending time to delivery and increasing the likelihood of delivery at or after 34 weeks' gestation.
  **http://www.abortionreview.org/index.php/site/article/937/**

## Commentary: Abortion is not a mental health problem

**By Jennie Bristow, editor, *Abortion Review*.**

The Royal College of Psychiatrists' draft review of the evidence on the mental health effects of induced abortion, published for consultation on 6 April, is a welcome contribution to the ongoing discussion of this issue. In finding no causal relationship between abortion and mental health problems, the report confirms the findings of other authoritative reviews: most notably, the 2008 report by the American Psychological Association's Task Force on Mental Health and Abortion.

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

This review provides useful reassurance for women seeking abortion, and those who treat them. It also confirms the point made by the draft guidance on induced abortion produced by the Royal College of Obstetricians and Gynaecologists, published in February: that women seeking abortion should be informed that most women who have abortions do not experience adverse psychological sequelae, and that therefore, 'Women who are certain of their decision to have an abortion should not be subjected to compulsory counselling'.

But it is also to be hoped that, with this latest review of the evidence about abortion and mental health, the debate about abortion can move beyond this narrow framework. For in reality, women do not have abortions because they are good for their health, or in spite of them being bad for their health. Abortion is a part of the messy reality of life, subject to a whole range of personal, moral, social and relational factors; and the preoccupation with its health effects can skew the debate away from more subtle questions.

The RCPsych's insistence that the mental health outcomes of abortion and birth are likely to be the same for the woman carrying the pregnancy, depending on any pre-existing mental health conditions she may have, is an implicit recognition of the wider factors at play within the abortion decision. All reproductive outcomes can have some psychological impact, and in today's society the risk of post-natal depression is widely highlighted as one of the outcomes of birth. Yet women who want to have babies run that risk, because their desire to have a child outweighs their fear of suffering mental health problems. It would be profoundly wrong – both morally and empirically - to counsel a woman with a history of depression that she *should* have an abortion because it would be better for her mental health.

By the same token, women who have abortions do so because they do not want, or cannot cope with, having a child or another child at this point in their lives. It would be profoundly wrong to counsel this woman that she *should* have a baby because this would be better for her mental health. That woman is confronted with a choice, which she can only make by weighing up a complex set of personal and emotional factors. Her decision to have an abortion, or a child, is not a health option but a life decision, and one that only she not doctors, psychiatrists, or counsellors can make.

Some argue that the way to avoid women suffering potential mental heath problems from abortion or childbirth is to ensure that all pregnancies are wanted, or at least intended, through pushing for better use of contraception. But here again, women's life circumstances and decision-making are not so clear cut.

An unintended pregnancy for example, coming from a failure to use contraception properly, can be a happy surprise, or become a wanted pregnancy; a carefully-planned pregnancy can become unwanted or problematic if a woman's circumstances change. The pain experienced by women who cannot get pregnant intentionally when they want to have a baby is arguably far greater than that experienced by many women who find themselves needing an abortion, and afterwards experience an overriding sense of relief that they are no longer pregnant.

None of these experiences or emotions can be properly understood through the narrow prism of mental health: they can only be appreciated in the context of women's lives, the problems and pressures they face, and the available means they have of resolving these things.

As the RCPsych, the RCOG, and the APA recognise, some women who have abortions - as with those who carry their pregnancies to term - suffer from mental health problems that require proper psychiatric care. But this will not be achieved through attempting to provide routine counselling for women considering abortion, when most women do not need it and in environments where specialist mental health skills are always going to be lacking.

Meanwhile, the focus on abortion and mental health has often had the unfortunate consequence of professionalising the understanding of women's problems and the help and support that they need. It is often felt that doctors need to 'do more' to help women make their decisions, or to cope with the consequences of their decisions. But while kindness and caring are important qualities for those working in abortion services, they are not qualities that are limited to health professionals.

Women generally make their decisions about abortion or motherhood with the support of their partners, families and friends. When they make their decision, the primary role of abortion services should be to respect their autonomy to make it.

**Induced Abortion and Mental Health: A systematic review of the mental health impact of induced abortion.** Live consultation from the National Collaborating Centre for Mental Health (NCCMH), 6 April 2011.
**http://www.rcpsych.ac.uk/members/nccmh/consultations.aspx**
Read related news and commentary in the Mental Health section of *Abortion Review Online*:
**http://www.abortionreview.org/index.php/site/C28/**

Example of a recent campaign. Please contact marketing@bpas.org for more details.