Papers from the bpas conference,
London, 25 - 26 June 2008

Inside this issue:

Are there too many abortions?
*Ann Furedi*

Is repeat abortion a problem?
*Sam Rowlands*

How late is too late for women?
*Ellie Lee*

Why contraception fails.
*James Trussell*

The morning after – what use is emergency contraception?
*Kate Guthrie*

How important is choice and care?
*Chris Plummer*

What is different about young people?
*Lisa Hallgarten*
INTRODUCTION
By Jennie Bristow, Editor, Abortion Review

The groundbreaking bpas conference The Future of Abortion: Controversies and Care brought together clinicians, academics, policymakers and advocates from the UK, Europe and the USA for a discussion about all aspects of abortion provision. Taking place during a critical Parliamentary debate about the UK abortion law, the conference engaged with a number of timely and important debates.

In order to maximise the strides made by The Future of Abortion conference in taking forward an international, inter-disciplinary discussion, Abortion Review is producing a series of special editions in which we have published edited transcripts of the presentations. In this second edition, Abortion and Women’s Lives, the presentations examine the hard questions about why women need abortions, and what this means for the kind of service that needs to be provided.

Ann Furedi, Chief Executive of bpas interrogates the question of whether there are too many abortions. While it is often taken for granted that the UK’s abortion rate is too high, Furedi argues that the context of women’s lives is one in which ‘a lot of people who don’t want to have children are having sex’, and contraceptive failure is a reality. Abortion is a necessary back-up to contraception, she says, and a society that allows women to have sex without having to bear unwanted children is a positive development.

Addressing a similar ‘numbers question’, Sam Rowlands, Visiting Senior Lecturer at Warwick Medical School, discusses the literature on repeat abortions, challenging the idea that Britain currently has too many repeat abortions and that it is within the power of policymakers to bring these numbers down. In her presentation on ‘How late is too late for women?’, Dr Ellie Lee, Senior Lecturer in Social Policy at the University of Kent, addresses the emotive issue of second trimester abortion by discussing her research findings about why women present for abortion later in pregnancy. She questions the extent to which factors at the level of policymaking or service delivery can significantly reduce the need for abortion up to 24 weeks’ gestation.

Professor James Trussell, Director of the Office of Population Research at Princeton University, presents powerful US data on contraceptive failure. This illustrates how fallible certain methods of contraception can be at preventing unintended pregnancy, and Trussell considers ways in which this problem may be addressed. In tackling the question ‘What use is emergency contraception?’, Kate Guthrie, Clinical Director of Hull and East Riding Sexual and Reproductive Healthcare Partnership, argues that the real value of EC must be considered in terms of individual women, rather than in over-optimistic ideas about its ability to affect abortion rates.

Chris Plummer, Director of Strategy at bpas, discusses the centrality of choice and care to abortion provision, and suggests ways in which service delivery and monitoring could become more focused around women’s wants and needs. The presentation by Lisa Hallgarten, Head of Policy and Communication at Education for Choice, examines the specific challenges involved in providing sexual health advice and abortion care for young people.

One collection of papers from the bpas conference, Abortion, Ethics, Conscience and Choice, has already been published on the Abortion Review website. It can be downloaded for free here:


Subsequent special editions of Abortion Review will examine the themes ‘Abortion and Clinical Practice’ and ‘Abortion, Policy, and Law’.

For further information about the 2008 Future of Abortion conference, including a summary of the event overall, the programme and full speakers’ biographies, please visit: http://www.futureofabortion.org
ARE THERE TOO MANY ABORTIONS?

Ann Furedi
Chief Executive, bpas

It is often assumed that the answer to the question, ‘Are there too many abortions?’ is, obviously, ‘Yes’. In fact, this is quite a complex issue, and the answer may well be, ‘No’.

How many abortions are there?

So far as the media and the UK Government are concerned, there certainly are too many abortions. The official abortion statistics for England and Wales in 2007 were published in June 2008 to a huge amount of hoo-ha in the press, largely because they demonstrated that the number of abortions had increased: not hugely, but significantly, given that there has been a national sexual health strategy aimed at reducing the number of abortions for several years now. In Scotland, the number of abortions has gone up by four percent more than in England and Wales. There is some question about whether this increase in the number of abortions is because the population has changed, giving us a huge influx of fit and fertile female migrants from Eastern European countries. But when you look at the figures, it is not just the number of abortions that has increased: the rate of abortion has also nudged up slightly.

Figure 1: Total abortions for British residents

Figure 2: Age-standardised abortion rates (per 1000 women residents aged 15-44)

Why are women having abortions?

Ninety-nine percent of abortions are carried out on ground C or D of the Abortion Act. These are the grounds that essentially say that a woman can have an abortion if continuing the pregnancy is going to put her physical or mental health more at risk than having an abortion. We all know, if we are honest, that ground C is a kind of code for ‘it’s an unwanted pregnancy’. Most humane doctors will agree that compelling a woman to continue a pregnancy and give birth against her will is going to be more damaging to her mental health than terminating the pregnancy.

So we can be fairly honest that the reason why the number of abortions is relatively high is because women are ending pregnancies that are unwanted. It would be great if the Parliamentary discussion of the Human Fertilisation and Embryology Bill resulted in a law that acknowledges this, rather than the situation we have at the moment where women have to pretend they will have a nervous breakdown if they continue the pregnancy, and doctors pretend to believe them. The current situation makes actors of both women...
and doctors; it would be far better if the law was explicit and if women were able to obtain an abortion because the pregnancy is unwanted.

**Sex and normal life**

Why is there a high level of unwanted pregnancy? I think it is simply because a lot of people who don't want to have children are having sex. I was amused by a report from Jeremy Laurence, the health editor of The Independent, which claimed that experts remain 'baffled' by the rising abortion rate, which has defied improvements in contraception, family planning services and sex education. One Home Counties GP said, 'from what I see there's a lot of spontaneous sex going on, and these women are unprepared. Abortion is now on demand, all you need is a signature on a bit of paper'. (1) It is indeed interesting how, as experts, we remain 'baffled' by what is blatantly obvious to most people who are living normal lives.

A lot of people who don't want to have children are having sex: and what's wrong with that? They are having sex in a modern society that expects us to be able to have sex without getting pregnant. We expect to protect ourselves against pregnancy. We expect our birth control to work, and we expect to be able to right the wrong when it doesn't. We expect our birth control to work in the same way that we expect our cars to start when we turn the ignition key in the morning and we expect our computers to work when we turn them on - and we are intolerant when these things fail to happen. The problem, as James Trussell discusses in his presentation on 'Why contraception fails', is that contraception does not work as well as it should. We expect it to work; we never expect it to fail – but it does.

As a family planning movement we don't talk about contraceptive failure all that much. I have had my wrist slapped at many a family planning meeting for talking about contraceptive failure, in case it somehow puts people off using it, but we have to be honest. We know that a significant proportion of the women who come to bpas clinics have been using a method of contraception at the time that they conceived. Sure, some of them say they did when actually they didn't. Lots of women may talk about a condom failure when what they actually mean is that they failed to get it out of the packet. Fair enough – we all make mess-ups in our lives. But we know, and those who work in our clinics tell me, that there is nothing like the distress of a woman who has seriously tried to prevent her pregnancy, who feels that she has done everything that she could possibly do, yet who still ends up in our clinic with an unwanted pregnancy. That woman is baffled, and she does not know what she can do to prevent it the next time. So it is important that we recognise the fact that contraception doesn't work all of the time. In fact, in real life it actually works much less effectively than is suggested by many of the official figures and the figures used in family planning leaflets.

**Sex, risk and knowledge**

Why is it so difficult for couples to use contraception effectively? I think that this is one problem that is recognised in family planning circles. We give a lot of attention to better sex education: we think that if women understood their bodies better, or really understood how their method of family planning worked, or were better empowered to negotiate their relationships, then maybe they would be able to use contraception more effectively. We talk about empowering couples to discuss contraception with each other. But it doesn't work; and I would hazard a guess that the reason it doesn't work is that the family planning movement overcomplicates things. We think that getting people to understand contraception, and giving them access to it, is the decisive factor: whereas maybe, we have to accept that there's something about sex that is different.

As sexual health professionals, we tend to see sex in terms of risk. For us, good sex is risk-free sex. It is:

- Safe
- Planned
- Under control
- Negotiated
- Responsible

We are always talking about how the movies get it wrong, when they never show James Bond putting on a condom as he gets into bed with a woman. Some of us have been in campaigns to say that this *should* happen in films, and it doesn't. And why doesn’t it? Perhaps because our perception of good sex is not actually what normal people think of as good sex. We see sex in terms of risk - they see sex in terms of opportunity.

For most people, good sex is:

- Edgy/exciting
- Spontaneous/passionate
- ‘Lost in the moment’
- Carried away
- Romantic

Good sex is the back seat of the car, behind the photocopier, in the store cupboard. There is an element to it that is not planned, prepared for, responsible. It's part of a relationship. And that doesn't lend itself to family planning in the way that we think about it. Someone once made the point to me: 'Sex is hot; contraception is cold'. And I think that's true. It is one reason why Long Acting Reversible Contraceptives (LARCs) are so much more effective, because they recognise the fact that when you're in the mood you really don't want to be thinking about your contraception. Sex is hot, contraception is cold, and I honestly think that that means whatever our sex education is like, whatever our access to services is like, whatever our support is like, people are going to slip up - and that means abortion needs to be there.

So we have to think: what kind of society do we want to live in? Do we want to live in a society that allows people to have the kind of sex that they are having at the moment? Or do we want to live in a society that says that sex should only take place in the way that sexual health professionals think that it should take place? That's not really a world that I want to live in - and I'm not even a teenager.
There is a greater sense now that abortion can be a responsible, indeed a moral, choice.

Taking parenthood seriously

Women today expect to be able to protect ourselves against pregnancy, we expect our birth control to work (though it doesn’t always), and we expect to be able to right the wrong when it fails us. We also have a greater sense now about reproductive choice and the timing of when we have children. Even 25 years ago there was much more of a sense that a woman’s destiny was that she was going to become a mother, and that that was the most significant thing she could do. As a woman you might get a job, but eventually the time would come when you would put your typewriter away and get the nappies out, and you’d have your child and that would be your life. But now, things are really different for women. We still want to have children, most of us, and we love our children dearly, but we expect to be able to plan when this is going to happen. And it is increasingly happening later. Between 1971 and 2006, the average age of mothers at childbirth in England and Wales has increased by more than three years, from 26.2 to 29.5. For first births it has increased by four years, from 23.6 to 27.6. (2)

What does this mean? There are a lot of younger women having sex who are not prepared to entertain the idea of having a child at that time in their lives. There is a larger pool of fit and fertile women who are having sex who don’t want to have children, and who arguably are not prepared to put up with it if they happen to become pregnant. This marries with a strong sense that we have in society these days that becoming a parent is a hugely responsible task. It’s not something that should be engaged in by chance, because the condom split - or because you couldn’t be bothered to get it out the packet. Or because you got carried away, or because the pill failed, or because you couldn’t get your prescription.

We, as a society, expect people to take their responsibilities in parenting very very seriously. This is reflected in legislation – and by the ongoing discussions led by the Government about making parents responsible for the antisocial behaviour of their children. But right the way down the line, we have a very strong sense of the responsibilities of family life.

This sentiment has even been reflected in some of the recent Parliamentary debate about abortion. Abortion has traditionally been seen as a bit of a lefty, feminist issue; but I have had several discussions with Conservative MPs, who get the point that there is an issue about what happens to these children, and these families, if you deny women an abortion when they really need it. Even Conservatives can accept that forcing women to have children against their will does not produce the kind of responsible, caring parenting that we expect today.

Abortion as a responsible choice

There is a greater sense now than there has ever been that abortion can be a responsible, indeed a moral, choice that women can make. Abortion is no longer seen as something that is shameful for women to undergo – it can represent a woman taking control of her life and making a decision that can, in fact, be a deeply responsible decision. It is interesting that the proportion of conceptions that end in abortion has risen among younger people, and there is an argument to be made that this is perhaps because more teenagers are accepting that now isn’t the right time for them to have a child, and they want to put off that decision and that is a good thing for them to do.

It is interesting to look at opinion poll research, and see just what the support for legal abortion is. Figure 4 shows the results of one bpas poll, conducted by Ipsos MORI in 2006, which asked a particularly stark question. The pro-choice movement is often accused of trying to manipulate the questions of opinion polls to get the best possible answer. And of course you can do that: how you ask the question completely shapes the answer you can get. If you ask whether a woman should be allowed to have an abortion if she has been raped, or if she is a victim of incest, you will get an extraordinarily high percentage of people who will agree with it. But in this poll, we simply asked whether people agree with the statement: ‘If a woman wants an abortion she should not have to continue with her pregnancy’.

There is no time limit here, no qualification about whether if a woman wants an abortion early in her pregnancy, or whether if woman has conceived as a result of contraceptive failure, she should have to continue her pregnancy. This is the starkest question you could possibly ask: whether if a woman has an unwanted pregnancy, she should be able to have an abortion. And look at the response.

Figure 4: Public support for abortion

Ipsos MORI poll commissioned by bpas in 2006 tested support for the statement: “If a woman wants an abortion she should not have to continue with her pregnancy”.

<table>
<thead>
<tr>
<th>Agree very strongly</th>
<th>Agree strongly</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Disagree strongly</th>
<th>Disagree very strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>13%</td>
<td>15%</td>
<td>34%</td>
<td>19%</td>
<td>11%</td>
<td>6%</td>
<td>3%</td>
</tr>
</tbody>
</table>

In total, nearly two thirds of people - 62% - say they agree with the statement ‘If a woman wants an abortion she should not have to continue with her pregnancy’. No time limit, no circumstances, no qualification; just that people should be able to have an abortion if they have an unwanted pregnancy. But what’s even more interesting than the high levels of support for this statement is that fewer than one in five people - 19% - disagreed with it. There is a group of people in the middle who are really not sure which way they should go: but the point is that fewer than one in five are prepared to say that they agree with the point that, to some extent women, should be forced to continue their pregnancies. So maybe, another reason why the number of abortions has
increased is that people really find it less stigmatised and more acceptable. And arguably, people today see abortion as being morally more acceptable than having a child that you really don’t want and that you really don’t feel you can raise.

Access to services

There may be one further reason for the increase in the number of abortions, and I thought it was very brave of the Rt Hon Dawn Primarolo MP, the public health minister, to touch on this point in her address to the conference, because it is something that in other times, Government would have been very reluctant to say. This is the point that the number of abortions may have increased because access to services is better. Because if you think, to use the words of Bill Clinton, that abortion should be ‘safe, legal and rare’ - or to use the words of Hillary Clinton, ‘and I do mean VERY rare’ - then there is one easy way of doing this, and that is by making services inaccessible and very difficult to get to. Abortion is safe, it’s legal, but it’s not funded and it’s hard for women to get.

It is demonstrable in Britain that a number of things have changed over recent years, which basically mean that abortion services have become easier for women to access. Funding for abortion services has increased – we are now in a situation where almost 90% of abortions are state funded. This is a difficult situation for pro-choice advocates and providers in the USA to grapple with, because in the USA there are huge funding issues about abortion. It is actually quite a difficult thing for me to get to grips with, because I have been involved in campaigning around abortion services for about 25 years. When I started, I was working with an organisation called Birth Control Trust, which had a target that 75% of abortions should be NHS-funded. We thought that that was a really radical thing to demand – yet we’re now at a situation where nearly 90% of abortions are NHS-funded. Almost 60% of abortions are provided by the independent sector, by specialist services where women know that they’re going to be seen by women who support their choice – in contrast to the past, when women were often having abortions on gynaecology wards in acute hospitals, where they would sometimes be disapproved of by the staff. This just illustrates the rapid rise in the funding that has been made available, and the rapid decline in the number of women who have to pay for their own abortions, so there are not many financial barriers now.

We know that abortions can be provided so much earlier now, and much of that has to do with better access to services and better funding. We’re now in a situation where 90% of abortions are carried out in the first trimester and 70% are carried out in those very early weeks in pregnancy. I was recently involved in a rather bizarre discussion with the bpas clinical governance committee, about the fact that the problem we were having within bpas was not that women were presenting too late for abortion, but that they were presenting too early. What happens when a woman is coming in at 4.5 or 5 weeks pregnant and wants an abortion? Because these days women can do pregnancy tests almost before they’ve had sex to determine whether or not they are pregnant. And they are certainly very on the ball and wanting services very very quickly – which is surely a very good thing too.

Reducing the number of abortions is not necessarily a good thing

Conclusion

In summary:

- We expect to be able to protect ourselves against pregnancy;
- We expect our contraception to work – it doesn’t always, and we expect to be able to right that wrong;
- We have a greater sense of reproductive choice about when we have our children;
- Abortion is more acceptable;
- There is better access to services.

Now these are great things, which we should celebrate about our society. They may have led to an increase in the number of abortions, they may have led to an increase in its acceptability, but can we put our hands on our hearts and say that we would want to turn the clock back in relation to any of these things? I don’t think that we do.

For me, abortion isn’t a shameful thing. The problem is not abortion: abortion is the possible solution to the problem of unintended pregnancy. And of course we want to help women prevent pregnancy. There is not a woman who sits in a bpas clinic who wants to be there. It is no woman’s ambition to have an unwanted pregnancy. Women are sad to be in our clinics, and we want to do everything that we can to help them not be with us. But at the same time, it’s not the abortion that’s the problem. Abortion is the possible solution to that particular problem.

Here are some thoughts to end with. Reducing the number of abortions is not necessarily a good thing. The answer to ‘are there too many abortions?’ is not necessarily ‘yes’, because the number of abortions could perhaps be reduced by making it less legal, more shameful, less available. And I don’t want to go back to a society like that. Reducing the number of abortions is not necessarily a good thing if it means preventing women from exercising their reproductive choice.

A rising number of abortions is not necessarily a bad thing. Maybe we have to accept that until we find, not only a perfect method of contraception, but a perfect way of managing edgy, spontaneous, passionate sex, abortion is going to be there with us. It’s a fact of life and perhaps we should just get over it, and start accepting, in exactly the same way that we accept that accident and emergency care has to be there for people who have car accidents, or who break their legs skiing, that abortion needs to be there as a back-up. And we have to explain why that is.

We should stop playing the game that we can make abortion safe, legal and rare, and we should accept and acknowledge and explain to people that it needs to be safe, legal, and as frequent as it needs to be. It’s as simple as that. We should focus on preventing women’s need for abortion, but we should make sure that while we’re providing the best possible services to those who need them we make no apology for what we do.

A representative of the anti-abortion movement recently said that they wanted to ‘out’ abortion doctors and the people who worked
in abortion services. They wanted to name and shame them. But I think we need no outing. At *bpas*, we are not ashamed of what we do out. We are out and proud of the service that we deliver - we think that what we do is moral, we think it's righteous, we think its necessary. And we make absolutely no apology for providing an emergency service for women in need of it.

(1) Abortion rate hits record high among under-16s. By Jeremy Laurance, Health Editor. *Independent*, 20 June 2008
(2) Table 2.14 *Social Trends* 38. Office for National Statistics, 2008

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**IS REPEAT ABORTION A PROBLEM?**

**Dr Sam Rowlands**  
Visiting Senior Lecturer, Warwick Medical School

Abortion is as old as humanity and probably occurs in all cultures. Throughout recorded history women have resorted to abortion, regardless of religious or legal sanction and often at considerable risk (1).

How should we define repeat abortion? Is it more than one abortion ever? Or is it more than one abortion in close succession? Researchers into teenage pregnancy talk of rapid repeat pregnancy, meaning a second pregnancy within 12 – 24 months of an index pregnancy.

In the literature, those women having more than one abortion have been variously described as recidivists, repeat aborters and habitual therapeutic aborters. These terms are pejorative or at the very least unsympathetic. Note the criminal connotations (repeat offenders).

Just think for a minute about how long a woman is exposed to pregnancy risk in her lifetime: take a biological perspective. Women experience around 450 menstrual cycles in their reproductive careers. The probability of conceiving within 12 months is 0.84 (84%); this is called the time to pregnancy. Think of the definition of a contraceptive in this way: an agent which extends the length of time taken to conceive.

If you look at the table below (Figure 1) you may think it is quite amazing that there aren’t more conceptions; only around 1 in 1000 acts of sex result in abortions.

**Figure 1: Having sex does not often end in abortion**

<table>
<thead>
<tr>
<th>Number of daily events (England and Wales)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acts of heterosexual coitus in women*</td>
</tr>
<tr>
<td>Conceptions</td>
</tr>
<tr>
<td>Abortions</td>
</tr>
<tr>
<td>Births</td>
</tr>
</tbody>
</table>

*based on sex 1.25 times per week

Some people who express concern about repeat abortions come up with some rather simplistic notions.

- ‘Proper’ use of contraception will eliminate abortions.
- Women need to be targeted. (What about the men, I say!)

There can be many factors behind abortion:

- Unconscious desire for pregnancy
- Risk-taking behaviour
- Forced sex: coercion, threats and abuse
- Substance excess/abuse
- Mental health problems
- Peer pressure
- Deferment of child-bearing
Abortion Review Special Edition 2

There is a question about the reliability of statistics

None of these factors specifically relates to contraceptive technology. Factors that more directly relate to contraception, or rather its non-use, include:

- Ignorance due to lack of sex education
- Cultural/religious opposition to contraception
- Contraceptive scares
- Relationship changes

So, preventing one or more abortions happening for an individual woman or a couple is not quite as simple as laying on lots more contraceptive services.

To my chagrin as a health professional, there are personal attitudes of colleagues which have actually been communicated to women requesting abortion. These attitudes can be categorised as moralising, sitting in judgement and giving punishment. My personal view is that some clinicians blame themselves for a perceived deficiency in contraceptive services and then react by rather overzealous promotion of products.

‘To agree to a second abortion would only encourage immorality or at least carelessness’. This is a quote from several decades ago, and hopefully attitudes have changed (2). But even in this decade, this idea is still creeping into service level agreements. A 2004 Survey of Primary Care Trusts found two areas of Britain in which this attitude was captured, expressed as follows (3):

- ‘Consultants are reluctant to undertake repeated terminations’
- ‘If a doctor perceives that the patient regards termination of pregnancy as a form of contraception by virtue of the number of previous procedures had, abortion will not be offered within the service contract.’

This, in my view, is really unacceptable.

In the past, doctors have threatened women with sterilisation if they attend for subsequent abortions (4,5). When you look back at the statistics on cases where women actually were sterilised when they had an abortion, it raises the question of whether there was an element of this when Britain first had an abortion law. In England and Wales, sterilisation was performed with abortion in 1969 in 22% of cases; this had decreased to 7% by 1980. Now, with the advent of long-acting reversible contraceptives, concurrent sterilisation is performed rarely – and indeed, statistics are no longer presented.

There is a question about the reliability of statistics for abortion. In England and Wales the actual definition of previous abortions on the HSA4 form is a legal abortion in this jurisdiction. So technically, an illegal abortion or an abortion done abroad is not recorded. In any country, we suspect that underreporting in the first few months or years after the legalisation of abortion is likely to be very high. There is also a general underreporting due to recall bias, where people don’t disclose things that they don’t really feel like disclosing, and abortion is obviously a very sensitive, private area of their lives. So when we look at our national figures, and the figures from other countries, they are likely to be significant underestimates.

What the statistics show

In a body of work published in the 1970s and 80s, Christopher Tietze (6) showed that as the number of women in the population who have had an abortion increases, the number at risk of having a repeat procedure rises. He also showed that about 30 years after legalisation, when all women of childbearing age have had access to legal abortion, the proportion of repeat abortion tends to reach a steady state. Tietze’s model is useful to bear in mind when looking at the British figures, where we are now more than 30 years beyond the legalisation of abortion in 1967.

One very extreme example of trends in repeat abortion comes from Hungary. Abortion in Hungary was legalised very early, in 1956. In 1958, 17% of women relied exclusively on abortion for fertility control. In 1968, there was an amazingly high incidence of repeat abortion: 58%. But this stabilised, then it decreased – to 54% in 1975, and 49% in 1987.

Tietze also showed that the proportion of abortions that are repeat procedures is affected by the abortion rate; the higher the rate, the more likely it is that a woman in the population will have had an abortion. This is illustrated by the case of Czechoslovakia. When Czechoslovakia had an abortion rate of 47 per 1000 women aged 15–44, compared with 14 in England and Wales, its repeat abortion rate was very much higher (42% compared to 18%), which is as you would expect. Similarly, of Norway’s six counties, three had higher abortion rates and three had lower, and there is a distinction between them in terms of repeat abortions: in the counties with a higher abortion rate, 18% of abortions were repeat, compared to 11% in the counties with a lower abortion rate (7).

Back to England and Wales. The abortion rate continues to go up, although it has not been rising massively over the past few years. The percentage of repeat abortions is shown by the red line in Figure 2, which represents England and Wales. Obviously this begins at a very low level, because no-one could have had a repeat abortion at the beginning; but then there is a gradual rise to 32%. If you go into percentage points, the 2006 figure for repeat abortions was 0.03% lower than the 2005 figure, so we actually decreased a small amount there. To me this indicates that we have stabilised at around 32%. The process has taken 35 years - a bit longer than Tietze’s predicted 30 years – but the pattern seems to be as he suggested.

Figure 2: Proportion of women having abortion who had one or more previous abortions
The figures from Scotland, represented in light blue, indicate that Scotland is mirroring England and Wales, although it is a slightly lower percentage. The violet blobs that represent Canada show that Britain is more or less following what happened there. In the USA, repeat abortions have been a lot higher as a proportion all the way through, and they remain higher; but you can see there that these have already stabilised and they have been coming down. In Sweden and Finland, repeat abortions have also stabilised. So in all these countries, where liberalisation occurred in the late 1960s and early 1970s, there is a pattern of stabilisation of repeat abortions.

Canadian research has shown that, in a given year, a woman who has had one or more abortion is more likely to have another than a woman who has never had an abortion is to have a first (8). Figure 3 shows the differences between first abortion rates and repeat abortion rates.

Figure 3: First abortion rates and repeat abortion rates, Canada 1993

<table>
<thead>
<tr>
<th></th>
<th>Abortion Rate</th>
<th>First Abortion Rate</th>
<th>Repeat Abortion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
<td>15</td>
<td>13</td>
<td>27</td>
</tr>
<tr>
<td>15 - 19</td>
<td>22</td>
<td>19</td>
<td>81</td>
</tr>
</tbody>
</table>

The higher rate of repeat abortions compared to first abortions occurs in spite of evidence that contraceptive use improves after an abortion. A Danish study illustrates that women and men are using contraception quite well. This is a record linkage study, which means that researchers are checking up on participants all the way through the system, whether they are in general practice, hospital, or other parts of the healthcare system. Participants were followed for 15 months immediately after the introduction of abortion on demand to 12 weeks’ gestation. There were 27,695 abortions between October 1973 and December 1974, and of those women who had the abortions, 97.1% had one abortion, 2.9% had 2 abortions and 0.05% had 3 abortions. Mathematical modelling, assuming a monthly probability of conception of 20%, suggests that these women were using contraception to an effectiveness level of 98% - much better than condoms or even the pill. So the mathematical model may not be perfect, but all the indications are that women are really trying to use contraception.

As I’ve said, there is a greater chance of a repeat abortion for women who have already had one abortion. These women are in a higher risk group: they are more likely to be in the higher fertility 20-29 age group; more likely to be sexually active; not infertile (by definition); more likely to consider abortion as a method of fertility control; and more likely to have problems practising contraception. Thinking back to the Hungarian figures, things are notably different for England and Wales. There are not huge numbers of people having repeat abortions: the figures represented on the right-hand side of Figure 4 are quite low. It is also quite reassuring, if you compare the number of multiple repeats in England and Wales with those in Finland and USA (Figure 5), England and Wales has lower figures. I conclude from this that by and large abortion is not used as a primary method of fertility control in this country. Abortion is almost entirely being used as an adjunct to contraception, if it fails.

What the studies say

The literature on repeat abortions is not of very good quality. There is only a handful of studies comparing people who have had repeat abortions with those who have had only one abortion, and they are very difficult studies to do. All the studies seem to show is that women having repeat abortions seem to have more sex, which is not an amazing revelation.

Of the studies that exist: one study shows that women who have had a repeat abortion present with less delay; two studies show that they have had an earlier sexual debut; three studies show that...
they have a higher coital frequency; one study shows that they have had a larger number of sexual partners; and one study shows that they have had a sexually transmitted infection (STI) in the past.

Studies suggest that women having a repeat abortion tend to come from lower social classes and are more likely to be immigrants, but I would be cautious about relying on these findings. Four studies show that women who have repeat abortions are more likely to have low socio-economic status; two studies show that they a more likely to have suffered intimate partner violence; three studies show that they are more likely to be immigrants; and one study shows that they are more likely to have no religious affiliation.

Having surveyed the literature, I have been most struck by the lack of differences between those having first abortions and those having subsequent abortions.

There are some other, more qualitative studies, which may flag up some things where we can do research in the future, but should not be taken to give definitive findings. Four such studies show that women who have repeat abortions show a tendency towards having been neglected; having had difficulties at school; having conflicts with their current partner; being immature, dependent and impulsive; and having sexual problems.

Contraceptive use

Many people have been interested in use of contraception in those undergoing subsequent abortions compared to women having first abortions. There are 10 studies on this, and it's quite clear from these that there is no lesser use of contraception in those having repeat abortions. Eight of these studies show better use of contraception; two show greater use of coitus-independent methods (ie methods other than barrier methods); and one study shows a more consistent use of contraception. Work that has been carried out in Newcastle on the use of emergency contraception (10) shows there are no statistical differences between repeaters and first-timers in their use of emergency contraception.

Is it possible that an intervention will prevent repeat abortions? Schunmann and Glasier’s study (11) would indicate that there is no long term benefit on hard outcomes. According to this study, randomisation of participants to specialist contraceptive advice and enhanced provision or standard care had a short-lived beneficial effect on contraceptive uptake and use of LARC in the intervention group. However, there was no difference in repeat abortions between the groups.

Conclusion

My conclusion is that I don’t think that the reaction to repeat abortions by some clinicians and managers and the Department of Health is really based on any science or evidence. There is no cause for alarm and despondency about our statistics for repeat abortion. It should be expected when legal abortion is introduced that the number of repeat abortions will rise. The proportion of repeat abortions is stabilising. Abortion alone is not being used in the West as a means of fertility control. And by and large women having repeat abortions do not differ from those having their first and should be treated no differently.

The literature shows a lack of differences between those having first abortions and those having subsequent abortions.

The ideas in this presentation are developed in Rowlands S.'More than one abortion'. Journal of Family Planning and Reproductive Health Care 2007; 33: 155.

Data sources

- www.dh.gov.uk/publichealthstatistics
- www.isdscotland.org/isd/1916.html
- www.cdc.gov/mmwr
- www.stakes.fi
- www.sos.se
- www.stats.govt.nz

References

HOW LATE IS TOO LATE FOR WOMEN?
Dr Ellie Lee, Senior Lecturer in Social Policy, University of Kent

This presentation relates to a study that I recently conducted with colleagues at Southampton University (1), in which we looked at why women have abortions in the second trimester of pregnancy.

The backdrop to this piece of research was two-fold. The first was a research-based reason. We had conducted a previous research study specifically about teenagers, in which we compared teenagers who terminate pregnancy with those who continue pregnancies to term and have babies (2). One of the issues that emerged from these data was that everybody we asked about it, including hospital gynaecologists, general practitioners, and the young women themselves, all reported that they considered it more difficult for teenagers to get abortions at later gestations of pregnancy than earlier on. So it appeared that there was an issue worth investigating further, to do with women being able to access later abortions.

More broadly, however, there has been an intense debate going on in British society about later abortions, which has focused on the upper legal limit for abortions in this country, and whether that should be reduced. One of the things that we wanted to do was to provide some research evidence about that debate. This debate has been conducted largely through the framework of ‘ethics’, which is a term sometimes used very narrowly in abortion. Almost all of the discussions about ethics focus on the fetus, and when people talk about the ethics of late abortion they generally think that what we should be talking about is the fetus. The Southampton team and I wanted to say something about the women presenting for abortions at later gestations, and try to have that part of the picture included as part of the public debate.

Here I intend to address some of the main issues that arose from our study, and look at some key questions:

- Why do women request abortion after 18 weeks?
- Can we reduce the need for this? What, if anything, can be done to enable women who currently terminate pregnancies in the second trimester, and particularly towards the later end of the second trimester, to terminate their pregnancies earlier on?

‘Social abortion’

Before addressing these points, I want to comment briefly on some of the things that have emerged from the public debate about the abortion law and the upper time limit. In Parliament the vote in 2008 was to keep the upper limit for abortion at 24 weeks. However, I do think it is worth reflecting a bit on the debate that happened, and some of the points that were pressed in particular by those who wanted to reduce the upper limit. The case that they pressed, and the broader media debate that happened around this, was almost entirely about the fetus, focusing on issues about viability and fetal sentence. Very little was said about women, and why they terminate pregnancies later rather than earlier. But some comment was made by opponents of abortion about women who terminate pregnancies later on, and the term that was used in all of this was: ‘social abortion’.

The origin of the term ‘social abortion’ lies in the Abortion Act (1967), which describes abortion as legally permissible if continuing the pregnancy is a greater risk to women’s physical or mental health than terminating the pregnancy. Doctors can take into account the woman’s family circumstances: so they can take into account what is considered to be the needs of her existing children. That is sometimes called the ‘social’ clause in the Abortion Act, together with the part of the Act where doctors can take into account a woman’s ‘actual or reasonably foreseeable environment’.

In other words, doctors are given the space to consider the woman’s social circumstances and her environment, her family and broader circumstances. This allows what has subsequently been termed ‘social abortion’. I’ve never actually seen an academic paper written about the history of the term ‘social abortion’, who coined this term in the first place, and how it subsequently developed - but certainly in recent history it is a term that is used almost exclusively by opponents of abortion, and they use it to try and trivialise or problematise women who are using abortion. Counterpoised to medical reasons for abortion, which can be seen as legitimate and acceptable, ‘social’ reasons for abortion are, for opponents of abortion, seen as unacceptable and unjustified.

Look for example at the arguments put forward by Nadine Dorries MP, who is the leading Parliamentary proponent of a reduction in the upper time limit on abortion. Her campaign to cut the legal upper limit for abortion to 20 weeks was described by the Daily Mail as: ‘…a fight to limit a woman’s right to have abortions for “social reasons”’. Dorries also commented in particular on late abortion, as part of her campaign ‘20 reasons for 20 weeks’. Her ‘Reason 18’ for reducing the upper limit was: ‘Pregnancy testing kits are freely available at chemists so there is little excuse for not diagnosing pregnancy before 24 weeks’. In other words, she seemed to be proposing that those women who terminate pregnancies at later gestational stages – 20 weeks and above – had been feckless and irresponsible, not bothered to go to the chemist and get their pregnancy test earlier on, and so had ended up late and thought, ‘Well, okay, I’ll have a late abortion’.

In addition to examining the data from our study, what I want to do here is to dispute this representation of feckless women having later abortions, on the basis of the evidence that we have from social scientific research about why women terminate pregnancies later in term. Not bothering to get down to the chemist really doesn’t explain what’s going on for women.

‘Late abortion’

It is worth commenting here upon the term ‘late abortion’, in relation to abortions in the second trimester of pregnancy. The term ‘late abortion’ has, I believe, changed in its usage. Until about ten years ago, it was used specifically in relation to post-24 week abortion; and so ‘late abortion’ referred to terminations of pregnancy primarily for fetal abnormality, and also for indications to do with threats to a woman’s life. Now, the term ‘late abortion’ seems to have broadened to encompass every abortion after 12 weeks. So we have ‘early abortion’, in the first trimester; and the term ‘late abortion’ is used to describe the second trimester. I am rather unhappy about this change in language, and I think it
We proposed that there are five stages on the pathway to abortion, and at any of these stages a delay can occur.

**The pathway to abortion**

The way in which we approached doing our piece of research was to use the key concepts of a *pathway to abortion* and the idea of delay. We proposed that there are five stages on the pathway to abortion; and at any of these stages a delay can occur to a woman in getting to the point at which she undergoes an abortion:

1. To suspecting pregnancy
2. Between suspecting and taking test
3. Between test result and decision
4. Between decision and requesting abortion
5. Between requesting abortion and procedure

We wanted to find out about reasons that are significant at all of these stages on the pathway to abortion, but also which of these stages contribute most to the temporal delay (the amount of time taken to get to the end).

Methodology was a self-completion questionnaire, in which we used prompted responses. The questionnaire included a list of 39 specific reasons from which respondents could select those that they felt had applied to their own situation. We also provided room for further comment. Eight hundred and eighty-three women responded, so it was a very large sample compared to previous research, which gives us a degree of confidence in the findings.

These women were recruited at eight **bpa**s clinics and two additional independent sector clinics. Together these clinics carried out about 41% of the 20,000 approx second trimester abortions to **England and Wales residents in 2005, making them representative places from which to recruit.**

We recognised in our write-up that our data wasn’t entirely representative of the national data for second-trimester abortion in Britain. Our sample contained relatively fewer 20-34 year-olds (54% against 60% nationally); relatively higher proportions of under-20 year-olds (38% against 30% nationally); and relatively higher proportions of women undergoing procedures at the later end of the range, with 17% at 21 weeks or over (against 8% nationally), 26% between 18 and 20 weeks (against 19% nationally), and fewer in the 13 to 15 week range (35% against 54% nationally). However, we did weight the data to make it representative.

It is worth at this point noting a particular issue to do with teenagers. The national percentage of under-20s having second-trimester abortions in this country is 30%, so around a third of second-trimester abortions are carried out on teenagers. What that means is that most women having second-trimester abortions, and this also holds for the late part of the second trimester, are not teenagers. I note this because I get slightly irritated when you see commentary that talks about second trimester abortions as only occurring to teenagers or peri-menopausal women. People do this because they want to get sympathy for the women having these abortions, because they’re either very young or they’re peri-menopausal, but actually it’s not true. Most women having these abortions are in the same age range as women who have abortions in general.

does reflect something troubling about the way that abortion is perceived. In our paper, my Southampton colleagues and I have therefore used the term ‘second trimester abortion’ to describe the abortions that we were investigating, because we didn’t want to call them ‘late’ on the grounds that people might perceive that as being therefore worse.

**Studies of women who have second-trimester abortions**

The literature review that we conducted prior to our research revealed two previous studies about Britain. There are some very interesting studies about this subject from the United States, but we excluded those because of the social and cultural differences between the USA and the UK.

George and Randall’s 1996 study, ‘Late presentation for abortion’, was a retrospective analysis of 111 women who had had an appointment during the first year of a second trimester unplanned pregnancy counselling clinic. (3) So this was women presenting for abortion in the second trimester. This study was important because it identified that the majority of women presenting in the second trimester presented for reasons that the authors of the paper defined as ‘unpreventable’: only 13% of the abortions that were presented for were ‘preventable’ by service improvements.

The study was notable for this finding, which really challenged the idea that you can significantly reduce the proportion of second trimester abortions by making earlier abortions more accessible – an idea that has been long held, particularly by people in the pro-choice movement. George and Randall’s study confounded that view, and recognised that actually, most women didn’t present for the abortion until it was already the second trimester of the pregnancy. Reasons for late presentation included concealed teenage pregnancies, peri-menopausal women, or women with irregular menstrual cycles who did not associate amenorrhea with pregnancy and pregnancies that were initially wanted.

The other study prior to ours was by Marie Stopes International (MSI), published in 2005. This looked specifically at women undergoing abortion between 19 and 24 weeks’ gestation. (4) It was an interview study with 26 women and a questionnaire study with 84 women. The issues that emerged from this study as significant were the varied nature of reasons for late abortion. So there were lots of reasons that explained why women terminated pregnancies later on. The difficulty in decision-making was important; that was something that a lot of women mentioned as a reason why they ended up having abortions later on. Some women reported significant delays in accessing services. However, the study’s authors noted that, given that most did not realise they were pregnant until relatively late, the effect was mostly to push abortion procedures later into the second trimester rather than to prevent an early abortion. So those findings backed up the findings of George and Randall.

These two studies helped frame our research questions. In addition, we carried out detailed interviews with staff at the clinics where we conducted our research, about why they thought women presented later.
Overall findings

Two tables show our overall findings. Table 1 shows the reasons – a whole list of them – reported for delays by at least one-fifth of the sample. So these were reasons for delay that people mentioned right across the pathway to abortion.

Table 1: Specific reasons reported for delays over whole sample

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was not sure about having the abortion, and it took me a while to make my mind up and ask for one</td>
<td>41</td>
</tr>
<tr>
<td>I didn’t realise I was pregnant earlier because my periods are irregular</td>
<td>38</td>
</tr>
<tr>
<td>I thought the pregnancy was much less advanced than it was when I asked for the abortion</td>
<td>36</td>
</tr>
<tr>
<td>I wasn’t sure what I would do if I were pregnant</td>
<td>32</td>
</tr>
<tr>
<td>I didn’t realise I was pregnant earlier because I was using contraception</td>
<td>31</td>
</tr>
<tr>
<td>I suspected I was pregnant but I didn’t do anything about it until the weeks had gone by</td>
<td>30</td>
</tr>
<tr>
<td>I was worried how my parent(s) would react</td>
<td>26</td>
</tr>
<tr>
<td>I had to wait more than 5 days before I could get a consultation appointment to get the go-ahead for the abortion*</td>
<td>24</td>
</tr>
<tr>
<td>My relationship with my partner broke down/changed</td>
<td>23</td>
</tr>
<tr>
<td>I was worried about what was involved in having an abortion so it took me a while to ask for one</td>
<td>22</td>
</tr>
<tr>
<td>I didn’t realise I was pregnant earlier because I continued having periods</td>
<td>20</td>
</tr>
<tr>
<td>I had to wait more than 7 days between the consultation and the appointment for the abortion*</td>
<td>20</td>
</tr>
<tr>
<td>I had to wait over 48 hours for an appointment at my/a doctor’s surgery to ask for an abortion</td>
<td>20</td>
</tr>
</tbody>
</table>

Respondents could give more than one reason  
*Adjusted for missed appointments

There are basically four areas that emerge. The first is uncertainty about ending the pregnancy or continuing the pregnancy. The highest percentage reported (41%) is women saying that they were not sure about having the abortion, and it took them a while to make their mind up and ask for one. In addition, 32% report ‘I wasn’t sure what I would do if I was pregnant’, which is a similar kind of uncertainty finding.

The second area is women saying they didn’t realise they were pregnant, or that they didn’t accept they were pregnant even if they subconsciously realised they were. So 38% of women said they didn’t realise they were pregnant because their periods were irregular. Other women provided reasons such as: ‘I didn’t realise I was pregnant earlier because I was using contraception’; and then ‘I suspected I was pregnant but I didn’t do anything about it until the weeks had gone by’.

The third area relates to delays in access. These certainly do feature as significant reasons – women reporting that they had to wait for appointments at various times, or that something about their interaction with a healthcare provider created a delay in access.

The fourth area is to do with factors associated with women’s relationships: relationships with parents for younger women, and with partners for all women. So women reported that a relationship with a partner had broken down or changed, and that led to delays in decision-making; or women were worried about how their parents would react. Notably this wasn’t just teenagers: older women also reported that they were worried about what their parents would say.

I will focus now on overall results within these stages on the pathway to abortion. Table 2 shows high percentages of women reporting at least one reason for delay at all stages, apart from between the test result and the decision. So what seems to be the case is that there are all sorts of reasons for delays that a lot of women report. The only area when a significant proportion of women don’t report delays is when they have made the decision and then they request an abortion.

Table 2: Percentages overall with at least one reason reported at each stage

<table>
<thead>
<tr>
<th>Stage of pregnancy</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspecting pregnancy</td>
<td>71%</td>
</tr>
<tr>
<td>Between suspecting and taking test</td>
<td>64%</td>
</tr>
<tr>
<td>Between test result and decision</td>
<td>79%</td>
</tr>
<tr>
<td>Between decision and requesting abortion</td>
<td>28%</td>
</tr>
<tr>
<td>Between requesting abortion and procedure</td>
<td>60%</td>
</tr>
</tbody>
</table>

It is worth looking at each stage separately, in a bit more detail.

Table 3: Delay in suspecting pregnancy

The three highest percentages for delays in suspecting pregnancy, where more than the median reported delay

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Because my periods are irregular</td>
<td>49%</td>
</tr>
<tr>
<td>Because I continued having periods</td>
<td>42%</td>
</tr>
<tr>
<td>Because I was using contraception</td>
<td>29%</td>
</tr>
</tbody>
</table>

I am told by medical professionals that ‘continued periods’ actually means breakthrough bleeding, which women mistake for having a period. This is one piece of information that very much confounds Nadine Dorries’ position, because these women just don’t think they are pregnant, so they would not have any reason to avail themselves of a pregnancy test.
Women need to be able to take the time that they need to make the decision

One of the key issues that seems to explain the overall picture of later abortions is difficulty in decision-making, and that was certainly confirmed by our study. So 65% reported that they were not sure about having the abortion, and women took on average 21 days to make that decision. Many of the difficulties in decision-making seem to be about a woman’s own perceptions about whether she wants to have the abortion or continue the pregnancy, and issues around her relationship with her partner. Again, I don’t think it would be right to rush women around these things.

When it comes to delays in first asking for an abortion, the main thing worth noting here is the relatively small proportions reporting delay at this stage (28%) and the relatively short times caused by the delay.

Table 6: Delay in obtaining abortion
Reasons cited by >15%

<table>
<thead>
<tr>
<th>Reasons provided (service related)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I had to wait more than 5 days before I could get a consultation appointment to get the go-ahead for the abortion*</td>
<td>32</td>
</tr>
<tr>
<td>The person I first asked for an abortion took a long time to sort out further appointments for me</td>
<td>30</td>
</tr>
<tr>
<td>I had to wait more than 7 days between the consultation and the appointment for the abortion*</td>
<td>27</td>
</tr>
<tr>
<td>There were confusions about where I should go to have the abortion</td>
<td>24</td>
</tr>
<tr>
<td>reasons provided (personal related)</td>
<td></td>
</tr>
<tr>
<td>I was having second thoughts about having the abortion I had asked for; so I missed/cancelled some appointments and then re-booked them</td>
<td>16</td>
</tr>
</tbody>
</table>

Percentages add to more than 100 since multiple responses were permitted *Adjusted for missed appointments

We divided this into what we might call ‘service-related reasons’ and ‘woman-related reasons’. We did this because it is often assumed that the reason why there is a delay in a woman getting an abortion once she has requested it is something to do with the services. In fact, one of the things that is interesting is that 16% of the women reporting a delay in this area essentially said that it was to do with them; they kept cancelling, re-booking, cancelling, re-booking. Again, this seems to be a manifestation of women not being clear about what they want to do and taking a bit of time to get there. However, as Table 6 indicates, there were also delays that were certainly service-related.

Women at 18+ weeks

In our research, the only way that we could study the particular group of women who terminated pregnancies at 18 weeks’ gestation and over was to compare them to women who terminated pregnancies at 13-17 weeks, because we didn’t have any women in our study who terminated first trimester pregnancies. Another point to note is that the demographic characteristics

There is one statistic here that the Nadine Dorrieses of this world may well construe as a sign of fecklessness and irresponsibility, and this is that 45% of women reported that they thought they were pregnant but didn’t do anything about it. But the idea that women just did not bother to do the pregnancy test would, in my view, be a wrong interpretation. I think that this reason for delay is often mixed up with the other two reasons in Table 4 about why women prevaricate – why, even if they think they are pregnant, they don’t do anything about it – which are to do with how their parents and partners might react to their pregnancy, and how the woman might react herself. It’s almost as if, if you face up to it and confirm the pregnancy with a test, then you’ve got to act; and I think that sometimes women don’t want to get to that point, because for one reason or another they are not sure what they would do once the pregnancy is confirmed.

One conclusion that you might draw from this finding is that this prevarication is acceptable. It is acceptable for women to take as much time as they want, if you like, to come to the point of recognition of their pregnancy and then have the space to decide what they want to do. It seems to me that trying to have a law and policy that forced women into making decisions, which implied that a woman is irresponsible if she doesn’t make the decision quickly, would not be a good thing, because women need to be able to take the time that they need to make the decision about whether to continue the pregnancy or end it. But obviously that is a policy matter for debate.

Table 4: Delay in taking the pregnancy test
Reasons cited by >15%

<table>
<thead>
<tr>
<th>Reason</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected they were pregnant but ‘didn’t do anything about it until the weeks had gone by’</td>
<td>45%</td>
</tr>
<tr>
<td>‘Not sure about what they would do if they were pregnant’</td>
<td>37%</td>
</tr>
<tr>
<td>Fears over the reactions of their parents and partners</td>
<td>29%</td>
</tr>
</tbody>
</table>

Table 5: Delay in deciding to have abortion
Reasons cited by >10%

<table>
<thead>
<tr>
<th>Reported reasons</th>
<th>Per cent</th>
<th>days</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was not sure about having the abortion, and it took me a while to make my mind up and ask for one</td>
<td>65</td>
<td>21</td>
</tr>
<tr>
<td>My relationship with my partner broke down</td>
<td>30</td>
<td>14</td>
</tr>
<tr>
<td>I thought the pregnancy was much less advanced than it was when I asked for the abortion</td>
<td>29</td>
<td>4</td>
</tr>
<tr>
<td>I was worried about what was involved in having an abortion so it took me a while to ask for one</td>
<td>27</td>
<td>14</td>
</tr>
<tr>
<td>I was hoping/waiting to see if my partner would support me in having a baby</td>
<td>20</td>
<td>14</td>
</tr>
<tr>
<td>My partner changed his mind about having a baby</td>
<td>11</td>
<td>21</td>
</tr>
</tbody>
</table>
of this group: our sample didn’t contain higher proportions of teenagers or of peri-menopausal women than the 13-17 week group. So it is worth re-emphasising the point that most women who have abortions at 18 weeks and over aren’t teenagers and aren’t peri-menopausal.

What emerged as significant differences between women having abortions at 18+ weeks and those having abortions at 13-17 weeks were the following points:

- Woman terminating at 18+ weeks took longer to suspect that they were pregnant, and to confirm the pregnancy with a test, than women who had abortions at earlier gestations. Indeed half the women who had an abortion at 21+ weeks had reached a gestation of at least 18 weeks 2.5 days prior to taking a pregnancy test.
- Women who had an abortion at 18+ weeks were significantly more likely to have experienced continuing periods, which delayed the suspicion that they were pregnant.
- Women who had had an abortion at 18+ weeks, as opposed to 13-17 weeks, were significantly more likely to report: ‘The person I first asked made it hard for me to get further appointments’. This is a big issue for service provision. It does seem to be the case that doctors whom women might approach to seek an abortion at later gestational stages somehow make it difficult for them to get further down the line. So what is already a late referral ends up even later.

**bpas study**

Subsequent to our study, in the run-up to the Parliamentary debate about the abortion law, bpas conducted a smaller study of its own, of 32 women. This focused specifically on women who had gestations of greater than 22 weeks when they terminated the pregnancy.

**Table 7: bpas survey key findings (clients with gestations >22 weeks)**

- Ages ranged from 14 years old to 31 years old. 10 of 32 were teenagers (about the same as the national statistic: about 1 in 3);
- 11 of 32 already had children. Many requested to end this pregnancy in order to be able to cope with the needs of their existing family. Some mothers had children in care;
- 3 of 32 were on drug treatment programmes or drug users. 1 of 32 had reported her partner to the police for abusing her daughters;
- 8 of the 32 did not know they were pregnant until some time into the pregnancy, others went into ‘denial’, or ‘hoped it would go away’.

What I found of particular interest here was the significance of women’s family circumstances. It is notable that about a third already had children, and that was very influential in terms of their referring themselves for abortion. Some of the women were on drug treatment programmes, or had partners abusing their existing children, and so considered they weren’t in a position to be a good enough mother to further children. So the context of women’s family lives and perceptions about motherhood influenced what was going on. As our study, the bpas study picked up on the point about women going into denial about the pregnancy or hoping it would go away, which I do think is very significant in why women sometimes do not take pregnancy tests.

**Conclusions**

So - back to the questions set at the beginning. Can we reduce the need for abortion at 18 weeks and over? I would say we probably can but only to a limited extent, and the limited extent to which this can be achieved needs to be recognised. From all of the existing research, service factors do emerge as important; and this is the area I think where we could do something to push the gestational stage backwards. So in our study, the doctor that was first approached was important in creating delays to women who had abortions at 18 weeks and over. Sometimes that appeared to be because the doctor was just difficult with them and didn’t want them to have a later abortion; sometimes it was because the doctor didn’t know where to send them. I think this is because of the structure of abortion services and the way they work at the moment, where many doctors won’t see large numbers of women who refer themselves late, and when they do there is confusion about whether you send them to an NHS hospital or an independent provider.

So lack of knowledge on the part of the referring doctor can create a delay. This is something policymakers could act upon too try and improve services; and I think in that regard everybody who is concerned about access to abortion could do worse than to take on board the recommendations of the Chief Medical Officer’s 2005 report on the abortion service at 20-23 weeks’ gestation:

- The development of a best practice protocol;
- Commissioning of a review by the Department of Health of access to abortion services including support and counselling for women;
- Service providers should review staff training needs;
- Staff involved in commissioning services should be familiarised with the abortion law;
- Healthcare providers should identify sources of delay to make sure all abortions are carried out as early as possible in line with agreed performance indicators.

To my knowledge these recommendations still haven’t been systematically worked on, and if they were I think some of the incidence of later abortion could be reduced. However, we do have to recognise that what acting on these points wouldn’t do is push those late abortions into early abortion; it would just make them happen a bit earlier in the second trimester.

Crucially, we do have to recognise that the reason why most women who have abortions later on have these abortions is not to do with service-related factors, and so it is difficult to address through policy and service modifications. Woman-related factors – difficulty in decision-making, issues to do with circumstances in relationships, and so on – these are the factors which most significantly explain the incidence of abortion at 18 weeks and over.
And it seems to me that our reproductive lives are a bit messy, that we sometimes don’t recognise what is going on in our bodies, we misinterpret signs and symptoms of pregnancy, and we live in relationships that can be very messy and unpredictable. As long as that is the case, there will be a need for later abortion and we’ve just got to accept that as part of the way things are and do our best for women who present later on.

Finally, this brings us back to the question of social abortion and whether it is appropriate for members of Parliament to trivialise women who terminate pregnancies later on as having ‘merely social reasons’ for doing so. In my view that is inappropriate and also unethical. There are many points that could be made about the wrongness of presenting late abortion in this particular way. An important one is that social scientific research does strongly contest this idea, and on the basis of the research information that we have we can say for sure that the reason why women have late abortions isn’t because they are using abortion as contraception, or that they couldn’t be bothered to avail themselves of a pregnancy test. It’s much more complicated than that, and we need to get as many people as possible to understand the complexity of this particular area of women’s request for abortion.

WHY CONTRACEPTION FAILS
Professor James Trussell
Director, Office of Population Research, Princeton University, and Visiting Professor, the Hull York Medical School

Unintended pregnancies are defined as the sum of mistimed and unwanted pregnancies. Mistimed pregnancies occur when a woman would have wanted children later but not now, so they come too soon. Unwanted pregnancies occur when a woman would never have wanted any, or more, children. So the first is a timing failure, and the second is a number failure. Most unintended pregnancies – more than two-thirds - are mistimed: they just come too early.

Unintended pregnancy

The information that I present here comes from the United States: not because I was too lazy to look it up for the UK, but because the UK does not collect statistics on unintended pregnancy, or do the kind of surveys that are necessary to estimate contraceptive failure. So in the United States there were 3.1 million unintended pregnancies in 2001: the last year for which we have data. Half (49%) of all pregnancies are unintended. In contrast, in the only study of which I am aware in the UK, in Edinburgh, 28% of pregnancies were estimated to be unintended - but the methodology was not remotely the same in the two studies.

Of the half of pregnancies that are unintended in the US, half (48%) resulted from contraceptive failure and the other half resulted from no contraceptive use at all. Forty-two percent of unintended pregnancies end in abortion, and the rest end either in spontaneous abortions, or birth. Thirty-five percent of births result from unintended pregnancy. What is, to me, the most mind-boggling statistic is that half (48%) of women aged 15-44 in the US have ever had an unintended pregnancy. So when you walk down the street in New York, half of the women you see will have had an unintended pregnancy.

Figure 1 shows the rate of unintended pregnancy by age: this is the fraction of pregnancies that occur in each of these age groups that is unintended. Not surprisingly, you see that virtually all of those pregnancies to women up to age 15, and most of those to women aged 15-19, are unintended. There’s an interesting up-turn in the age group over 40, which typically occurs because of union dissolution, and you find women unexpectedly getting pregnant in a new relationship.

(1) Ingham, Roger, Lee, Ellie, Clements, Steve and Stone, Nicole (2008) Second trimester abortions in England and Wales (Summary of research findings)
http://www.soton.ac.uk/lateabortionstudy/late_abortion.pdf/
(4) Marie Stopes International (2005) Late abortion, a research study of women undergoing abortion between 19 and 24 weeks gestation, London, MSI.
Contraceptive failure

In discussing the issue of contraceptive failure, I will focus on four issues:

- Efficacy versus effectiveness
- Typical versus perfect use
- Results from the literature
- Communicating the risk of contraceptive failure

Efficacy versus effectiveness

Efficacy tells us how well a method works under ideal circumstances. Effectiveness tells us how well a method works in the real world. We are interested in both of these aspects of these. From a policy / public health point of view we are clearly interested in its effectiveness: how well is it working in the real world, because that’s actually what we see. But an individual woman would also be interested in efficacy: how well would the method work if I actually used it correctly and consistently? You can measure efficacy in a clinical trial, whereas effectiveness would be, and typically has been, measured in a survey or a chart review. There have been surveys around the world but not in the UK.

We have rich sources of data in the United States. One of these is the National Survey of Family Growth (NSFG), which was conducted in 1973, 1976, 1982, 1988, 1995, and 2002. Estimates of contraceptive failure have been derived from all of these, as well estimates of unintended pregnancy. These have the advantage of being nationally representative, but they have the disadvantage of being retrospective: women are asked to report what contraceptive method they were using in each month going back over the past three years.

Now it would be very easy for somebody whose partner has had a vasectomy for many years to fill in that chart. But for many women, there is a multitude of methods that have been used, and actually remembering what happened each month - going back three years - can be problematic. We know that there is underreporting of abortion in the NSFG, as there is in all surveys – only half of abortions are reported, so if you are going to do analytical work you have to figure out what to do about the half of abortions that are missing. And then there may be overreporting of a contraceptive failure leading to a birth, because it’s always easier to rationalise and blame the methods: to say ‘there was a contraceptive failure’ rather than ‘I didn’t use anything at all’.

Clinical trials are the other major source of data. These are, of course, generally conducted by drug companies in order to get approval for a product. We have the problem of the Hawthorne effect and inference beyond trial setting. The Hawthorne effect refers to the fact that, not surprisingly, sometimes people change their behaviour when they are being observed. So we have to be careful that what we observe in a clinical trial can actually be extrapolated beyond a clinical trial setting. In clinical trials, one can look at cycles of perfect use – that is, when a method is used correctly and consistently, and identify pregnancy rates during perfect use. But, of course, adherence to a method is self-reported.
Let's look at the first of these problems, which is underreporting of abortion. Figure 3 shows, for three methods – the pill, the condom, and fertility awareness-based methods - the results of correcting for under-reporting of abortion. For some methods, like the pill, the correction is minimal – it adds just one whole percentage point to the failure rate. But in other methods, like the condom, it adds a lot more, where the failure rate goes up from almost 14% to 17.5.

![Figure 3](image)

What about self-reporting of adherence? Well, there has only been one study of this type ever done, it's never been repeated, although many people wanted to. (In this study compared self-reports of missed oral contraceptives (OCs), compared with electronic recording on punched pills, among 103 women for 3 cycles. So it wasn't a large study, but they were pretty striking findings. An OC pack with a computer chip actually measured when pills were punched out: it couldn't measure whether they were put in the mouth and swallowed, but at least it could measure whether they were punched out. When women reported in their daily diary how many pills they missed, 53-59%, depending on the cycle, said that they didn't miss any pills – but the computer found that only 19-33% of them had actually taken all the pills. There was also vast under-reporting of missing 3 or more pills. So the daily diaries said that 10-14% missed 3 or more pills in a cycle, whereas the computer put the figure at 30-51%.

There is another useful example that we can draw from the microbiocide world. In a recent study conducted by the Population Council of a vaginal microbiocide, the investigators were extraordinarily clever. There was a device that looked like a tampon inserter: women were supposed to tear off the end, put the inserter into the vagina, and squeeze the gel out into the vagina. But the researchers developed a way to test whether the applicator had actually been in the vagina – if you stained it, it turned bright blue. Even if the woman washed the applicator afterwards, the stain would still show up.

Now in this trial, women came back periodically and they had to bring all of their applicators. So they brought their used applicators and their unused applicators, and these were supposed to total the number that they had been issued. And then they were given a new set to take home for the next period of time. When the investigators examined the used applicators – that is, those that had the gel squeezed out – more than one third had never been in the vagina.

This is the extent to which clinical trial subjects will go to please the investigator. So if you're thinking of doing studies where you ask people what they actually did, you're going to hear what they think you want to hear, rather than what actually happened.

**Typical versus perfect use**

What about typical use versus perfect use? These are terms that we now use commonly in the literature. Contraceptive failure during typical use can be measured in a clinical trial or in a survey. Contraceptive failure during perfect use has been measured only in clinical trials, since retrospective reporting of adherence in surveys is likely to be truly terrible.

What is typical use? By definition, a woman is a user whenever she considers herself to be using a method. Hence, typical use of a barrier method does not imply that it is actually used at every act of intercourse. Typical use includes both inconsistent use and incorrect use as well as perfect use. Perfect use, on the other hand, requires actual use according to the directions for that method. So perfect use of a barrier method requires that it be used correctly at every act of intercourse. Perfect use does not imply no pregnancies, only that the rules were followed.

But there is a logical error in the literature, which has persisted from the beginning. Suppose in a contraceptive trial there are 100 years of exposure to risk of pregnancy. Fifteen pregnancies occur during a cycle of imperfect use, and 5 pregnancies occur during a cycle of perfect use. What is the method-related pregnancy rate (pregnancy rate during perfect use)? The traditional answer is 5/100 – which equals 5 per 100 woman-years of exposure. But there is a logical error here, because the denominator cannot be all exposure – which equals 5 per 100 woman-years of exposure. You couldn't answer the question, because you didn't have enough information. You would have to know how many years of exposure to perfect use there were. If there are only 50 woman-years of perfect use, the correct answer is 5/50, or 10 per 100 woman-years of exposure.

Now it would not surprise you to learn that every clinical trial conducted by drug companies makes this error - because they get a lower failure rate. And the reason is that there is actually a flaw in the design of most clinical trials, because information on perfect (correct and consistent) use is generally obtained only when pregnancy occurs. So in a clinical trial, if you get pregnant, you will be interrogated mercilessly to find out if you actually followed the rules or not. But only the women who get pregnant are so interrogated. Therefore, correctly computed method use or failure rates cannot even be computed. But they are computed, and reported, incorrectly.
Imperfect use is probably the single biggest determinant of contraceptive failure

We have real problems in comparing the failure rates for different methods when the results come from different sources. Results, where available, for typical use come from the NSFG, adjusted for underreporting of abortion. But the more important problem is that women choose which method to use and are not randomly assigned to methods. Women who choose to use spermicides are probably very different from those who choose to use IUDs. And if all of the women reading this article were forced to use spermicides I have no doubt that you would wind up with a much higher effectiveness than women who typically choose to use spermicides.

With that caveat in mind, please look at Figure 5. At the top we see chance, where the estimate is that about 85% of women would become pregnant in the first year. Then we see the condom, where with a typical use the pregnancy rate is 17% and the perfect use rate is 2%. What's the difference between the 17% and the 2%? The condom never goes on the penis.

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**Figure 4**

**Correct Analysis by Cycle**

<table>
<thead>
<tr>
<th>Woman 1:</th>
<th>Woman 2:</th>
<th>Woman 3:</th>
<th>Woman 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

P = pregnancy

Cycles: imperfect use 1/3

Cycles: perfect use 1/15

Rates: all 2/18

---

**What are the factors that are now known to influence failure?**

One of them, and an extremely important one, is the inherent efficacy of the method. Some methods are so inherently efficacious that they are going to work. Imperfect use is probably the single biggest determinant of contraceptive failure. The extent of imperfect use will presumably depend on the motivation to avoid pregnancy.

A third factor is frequency of intercourse: if you don’t have intercourse very often, then you’re probably at a much lower risk of getting pregnant than if you have intercourse often. Frequency of intercourse declines with both age and marital duration. A colleague of mine describes a plot of coital frequency by age as ‘the saddest curve in the world – it looks like a train going off a cliff.’

Another factor that influences failure is individual level of fecundity, which also declines with age. A further factor is the competence or honesty of the investigator.

One of the problems that we frequently encounter is a high percentage not completing the trial – women are simply lost to follow-up, and you have no idea whether they got pregnant or not. There is underreporting of abortion; there is incorrect calculation of method failure; in many fertility-awareness-based trials they don’t include the ‘learning’ phase, so if you get pregnant during the learning phase, you don’t get reported in the main analysis. Another interesting practice is to discontinue non-adherent women: if you do so, then you’re going to get a lower failure rate in your clinical trial than if you allow them to continue. Frequently this problem applies to Depo-Provera injection trials: women are discontinued who are late for an injection. They are counted as discontinuers, rather than being allowed to continue and wind up getting pregnant.

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**Figure 5: Probabilities of contraceptive failure during the first year of typical and perfect use**

<table>
<thead>
<tr>
<th>Method</th>
<th>Typical Use</th>
<th>Perfect Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chance</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Condom</td>
<td>17%</td>
<td>2%</td>
</tr>
<tr>
<td>Pill, patch, ring</td>
<td>9%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Depo Provera</td>
<td>7%</td>
<td>0.3%</td>
</tr>
<tr>
<td>ParaGard IUD</td>
<td>0.8%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Mirena IUS</td>
<td>0.2%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Implanon</td>
<td>0.05%</td>
<td>0.05%</td>
</tr>
</tbody>
</table>

(Source: Kost K. Contraception 2008;77:10-21)
What does this table show? It shows that methods requiring adherence generally have a big difference between perfect-use and typical-use failure rates. The most effective methods during typical use are those not requiring adherence, and that is why there is a big push in the UK to get people to use those methods that do not require adherence. And of course the most effective methods against pregnancy are not those that protect against STIs, so that raises the need for dual use of condom and an effective contraceptive if one wants to avoid pregnancy while one is at risk of STIs.

**Contraceptive methods**

It is extremely sobering to examine the contraceptive failure rates for the methods that are actually used. Figure 6 shows the methods that are actually used in the US, in 2002, and in the UK, in 2006/7.

**Figure 7: Percentage of women at risk of unintended pregnancy by contraceptive method used**

![Results from the 2002 NSFG: % becoming pregnant in the first year of use uncorrected and corrected for underreporting of abortion](chart)

<table>
<thead>
<tr>
<th>Method</th>
<th>Uncorrected</th>
<th>Corrected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td>7.7</td>
<td>8.7</td>
</tr>
<tr>
<td>Condom</td>
<td>13.9</td>
<td>17.4</td>
</tr>
<tr>
<td>FAB-methods</td>
<td>23.0</td>
<td>25.3</td>
</tr>
</tbody>
</table>

Kost, Contraception 2008:77.10-21

Chance. Those women who are at risk of unintended pregnancy – they don’t want to be pregnant, they are having sex, but they don’t use any contraceptives – is used by 11% in the United States. Those contribute one half of all the unintended pregnancies. In the UK, that number is much lower, at 3%. But consider the LARC methods, highlighted in green – 4% in the UK use Depo-Provera, 8% use IUD/IUS, and 1% use Implanon. If you look only at the most effective and exclude Depo-Provera, then only 9% of women at risk of unintended pregnancy in the UK are actually using the most effective methods.

The problem, of course, is that the most effective methods in the top tier are infrequently used both in the US and in the UK. Unless we can figure out how to get a much larger fraction of women to choose to use methods in that top tier, the rate on unintended pregnancy will remain unacceptably high.


Only 9% of women at risk of unintended pregnancy in the UK are using the most effective methods
THE MORNING AFTER: WHAT USE IS EMERGENCY CONTRACEPTION?
Kate Guthrie
Clinical Director, Hull and East Riding Sexual and Reproductive Healthcare Partnership

In the early days of Emergency Contraception Pills (ECPs), our hope was that widespread use of them could prevent half of all unintended pregnancies and abortions each year (1); and this hope has been republished many times.

Now, 15 years later, twelve studies (2-14) have examined the impact of increased access to ECPs on pregnancy and abortion rates, and none have shown any benefit. It is very important that we take that sad fact on board in the UK and internationally in terms of service advertising and commissioning; in terms of what we understand, as clinicians who deliver contraception and emergency contraception; and how we explain this to the public that we serve.

Here I would like to review these 12 studies, and discuss some of the possible explanations for the disappointing findings.

These studies were conducted between 1998 and 2006. There were 10 randomised trials and one cohort study, which between them involved a total of 12,276 women, and one very large demonstration project up in Scotland. The women were followed up for up to a year, and these studies compared increased access to EC with standard access to EC. If we look at five of these studies, the largest ones, we can see that they involved very large numbers, and several regimens: levonorgestrel alone, mifepristone, and combined levonorgestrel and ethinyl estradiol (the Yuzpe regimen). These studies showed no statistical difference between the pregnancy rate in the intervention and control groups. In fact, one study showed there was a slight increase in the incidence of pregnancies in the advance provision group. (Figure 1)

Figure 1

<table>
<thead>
<tr>
<th>N</th>
<th>Regimen</th>
<th>% Pregnant</th>
<th>% Pregnant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Intervention</td>
<td>Control</td>
</tr>
<tr>
<td>---</td>
<td>---------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>1083</td>
<td>Yuzpe</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>1030</td>
<td>LNG</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>2000</td>
<td>mife</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>2117</td>
<td>LNG</td>
<td>8%</td>
<td>9%</td>
</tr>
<tr>
<td>1490</td>
<td>LNG</td>
<td>9%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Why is this? There are a few explanations worth considering.

1) Were there flaws in the studies?

Some of the studies had problems. Some had a small sample size (ranging from 160-2,868 women). Like any studies there was loss to follow-up (ranging from 1-62%), which was significant in some of them. Sometimes the intervention itself was weak – some of the studies only gave one packet of ECPs in advance. The comparison group sometimes had very good access to emergency contraception. The baseline risk of pregnancy is quite low, so there is not much room for improvement by use of ECPs. And some of these studies were not randomised.

However, not all of the studies had all the problems, and some of the studies were extremely good. So it’s quite difficult to ignore the consistency of findings despite the differences in the studies.

2) Did women in the advance provision group increase risk-taking, because they had easy access to ECPs?

There was no evidence of an increase in unprotected sex or a decrease in the use of regular contraception with enhanced ECP access – so easy access doesn’t seem to affect women’s behaviour. Some studies suggest that women’s behaviour ‘improved’ – the Hawthorne effect that James Trussell discusses in his presentation. I think that the mere fact that a study, which informs women, means that they change their behaviour positively - the improved behaviour was more use of condoms - is an important issue that we can pick up and take hope from. So that is one positive: don’t knock counselling and information-giving, because it works!

All of these risk-taking behaviours were self-reported. But three of the studies had a hard endpoint: Sexually Transmitted Infections (STIs). If women were having a large amount of unprotected sex because the fallback for pregnancy was emergency contraception, you would expect to see a rise in STIs, and this did not show up in these studies.

Re-analysis of one of these studies, which looked at women who were actually pregnant after EC use, does suggest that maybe easier access to EC may have increased the frequency of coital acts with the potential to lead to pregnancy. (15) In other words: it may be that if women have EC in the cupboard, they have more risky sex.

3) Are ECPs less effective than we originally thought?

Emergency hormonal contraceptive efficacy conveys the reduction in pregnancy risk after a single episode of sex. The packaging for Levonelle (LNg regimen), which is currently available in the UK, it says that it is 84% effective. The published literature for LNg regimens gives effectiveness from 60-94%; for the Yuzpe regimen, the regimen that was used before we moved on to Levonelle in the UK and Plan B in the USA, was estimated to be 56-89% effective.

Failure rates for emergency contraception are calculated quite differently from the way that failure rates for regular contraception are calculated. In a group of ECP users, we compare the observed number of pregnancies against the expected number of pregnancies.
A recent pilot study in 41 women in Chile added the Cox-2 inhibitor meloxicam to Levonelle-type EC (20). The study found that adding meloxicam 15mg significantly increased the proportion of cycles with no follicular rupture or ovulatory dysfunction (88% versus 66%, p=0.012); and that adding a Cox-2 inhibitor can disturb the ovulatory process after onset of the LH surge. In other words, it increased the chance of an emergency contraception intervention preventing the pregnancy. Now this needs further study, but it is very hopeful that this simple intervention could increase the effectiveness of ECPs: because we know that ECPs are less effective once the LH surge has occurred, and of course when do most women think, ‘Oh golly, I really do need emergency contraception’? It’s when they think they have had intercourse exactly at the time of ovulation: the very time that, as studies now show, hormonal emergency contraception is least effective, if effective at all.

4) Was there insufficient use of ECPs?

Another explanation for the not-hoped-for effect of ECPs is insufficient use. In nearly all studies, increased access resulted in substantially increased use. But repeated use was uncommon, and many unprotected acts remained uncovered by ECPs. In the San Francisco study, 45% of the women in the advance provision (AP) group who had unprotected intercourse did not use ECPs. (7) In the Chinese study, 30 women in the AP group did not use ECPs in the cycle in which they became pregnant. (8) In the Nevada/NC study, 33% of women in the AP group had unprotected intercourse at least once without using ECPs; 57 did not use ECPs in the cycle in which they became pregnant. (11) And if you don’t use it, it ain’t going to work. There’s no magical effect coming from the drug cabinet in the bathroom.
What probably happened in the Lothian study was that women most at risk did not get ECPs. (14) The researchers advertised well ahead of time that emergency contraception was available, and it was also given to women coming to anybody providing EC and contraception: GPs, family planning clinics, GUM clinics. But very few women came forward seeking advance provision even though it was available. So it looks like the women who got the advance supplies were those who were locked into contraception anyway, and the intervention actually had no impact upon women out there who were taking risks but not accessing care.

Why do women fail to use emergency contraception? The single most important reason is failure to perceive pregnancy risk. How individuals perceive risk is very variable, as we know. Take the example of the risk of breast cancer associated with HRT: some women look at the published risk and say, ‘There is no way that this tablet will pass my lips because what this says to me is that my perceived risk is high’; whereas another woman looking at the same data will say, ‘No problem at all’, because her perceived risk, with the same information, is low.

Another reason for women’s failure to use EC is that they just plain forget. They may not be motivated to use EC; studies looking at whether pregnancies were intended or unintended have found that one third of women say, ‘Well, it wasn’t either intended or unintended’. The whole question of what an intended or unintended pregnancy is quite fascinating; and amongst those who are ambivalent about pregnancy you’ll have the women who weren’t motivated to do anything to prevent pregnancy, including using emergency contraception.

There are limits to ECP use in the real world. Women find it inconvenient, and it is expensive. If you can get it for free then that’s fine, but if you can’t it costs over £20. There are side effects — though these are minimal with Levonelle. In the UK today we still do have access at whether pregnancies were intended or unintended have found.

**Conclusion**

There were flaws in all 12 of these studies, but their findings were consistent and that consistency is compelling. Was there increased risk-taking? The evidence is mostly against this. Low ECP efficacy – in fact, the precise efficacy of ECP is unknown. And insufficient use – the motivation on behalf of women – is definitely a problem.

So what do we do? What we don’t do is promise that ECPs will have a public health impact. We do not oversell by implying ECPs will reduce unintended pregnancy or abortion rates. That goes back to commissioning and service provision. My fear is that in the UK, we have forgotten, or have liked to marginalise, the emergency IUD. Of course it’s much easier, and you don’t need the same degree of training, to provide emergency hormonal contraception as opposed to the emergency IUD, but the effectiveness of the emergency IUD is significantly higher, and unlike ECPs, it provides long-term protection after the act.

As clinicians and commissioners, the message that we have to give is that the reality of EC is not what we would like to think. ECPs are not the magic bullet that will cut unintended pregnancy and abortion rates by half. But the other thing to stress is that at an individual level, emergency contraception is still incredibly important and valuable. You don’t punish somebody by not allowing access to EC. Everyone deserves a second chance to prevent an unintended pregnancy.


HOW IMPORTANT IS CHOICE AND CARE?

Chris Plummer
Director of Strategy, bpas

When looking at the importance of choice and care, the first question to ask is: from whose viewpoint? There are three main players in providing abortion services: the provider, the funder and the client.

In the early days of abortion provision, back in the 1980s, most of the focus was on providing a service from a delivery viewpoint. There were few private clinics, lots of legal and clinical issues, and grateful clients. However things soon moved on, to the point where nearly 90% of abortions are now funded by the National Health Service (NHS), and over half of these are carried out by independent providers working under NHS contract. (Figure 1). It is interesting that the number of abortions carried out by the NHS today is almost the same as it was in 1981, despite being a much smaller percentage of the overall number of abortions.

Figure 1: How delivery of abortion has changed in England and Wales

Why is the funding route important? There is no such thing as free money, and the public want to see what their taxes are being spent on. So there has been a growing focus on contracting from a purchaser viewpoint. When you’re commissioning using public money you want to know that you’re achieving public performance targets, value for money, statistics. To some extent there has also been a commensurate lowering of client expectations, because they no longer have to pay. Within bpas we certainly see a difference in terms of complaints between clients that are paying for themselves and those that are NHS-funded.

Performance measures

This places commissioners very much in the driving seat. However, it begs the question, what can they use to steer? High-level performance measures define outcomes and make international benchmarking possible; and one of the most often quoted is

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Director of Strategy, bpas

When looking at the importance of choice and care, the first question to ask is: from whose viewpoint? There are three main players in providing abortion services: the provider, the funder and the client.

In the early days of abortion provision, back in the 1980s, most of the focus was on providing a service from a delivery viewpoint. There were few private clinics, lots of legal and clinical issues, and grateful clients. However things soon moved on, to the point where nearly 90% of abortions are now funded by the National Health Service (NHS), and over half of these are carried out by independent providers working under NHS contract. (Figure 1). It is interesting that the number of abortions carried out by the NHS today is almost the same as it was in 1981, despite being a much smaller percentage of the overall number of abortions.

Figure 1: How delivery of abortion has changed in England and Wales

Why is the funding route important? There is no such thing as free money, and the public want to see what their taxes are being spent on. So there has been a growing focus on contracting from a purchaser viewpoint. When you’re commissioning using public money you want to know that you’re achieving public performance targets, value for money, statistics. To some extent there has also been a commensurate lowering of client expectations, because they no longer have to pay. Within bpas we certainly see a difference in terms of complaints between clients that are paying for themselves and those that are NHS-funded.

Performance measures

This places commissioners very much in the driving seat. However, it begs the question, what can they use to steer? High-level performance measures define outcomes and make international benchmarking possible; and one of the most often quoted is
the number of abortions per 1000 women aged 15-44. This is interesting, not least because there are women both below age 15 and above age 44 who are receiving treatment. But, more importantly, this benchmark raises the question: ‘Can abortion numbers be controlled?’ Other presentations at the bpas conference have discussed this question in terms of contraceptive failure; women’s changing needs; expectations of society; sex education; and the fact that people just do risky things.

An interesting piece of research carried out by the Journal of Sex Research in August 2005 found that 44% of male respondents said they were either definitely or probably more likely to take higher risks or engage in behaviour they would later regret when sexually aroused. A typical comment within that study was; ‘It’s okay as long as you’re having sex, but 30 seconds after you come you’re like “No. Why did I do this!”’ The simple fact is that a lot of people are having a lot of sex, and one consequence of this is unwanted pregnancy.

The fundamental issue is that using high-level statistics just isn’t going to cut it in terms of managing abortion funding. This realisation has led to the development of detailed service specifications, which attempt to define what a service should look like. They are used as a tool to evaluate quality and provide a superficial basis for the evaluation of tenders in terms of best value. But this development raises the question, what does a process-driven service-specification tell us about the client experience and is it better to define the process of service delivery, or the preferred outcome of the service?

**Woman-Centred Commissioning**

At this point I would like to propose radical new concept number one, which we could call WCC – Women-Centred Commissioning. This concept is actually already being used in some places by Primary Care Trusts (PCTs). It puts the client at the focus of delivery, and looks at providing the service that most closely meets what the client wants. This means managing expectations where compromises are needed and exceeding expectations for service delivery.

However, that also raises some issues. What might clients want? Here is a list of things that have come to bpas’ attention as being the sort of things that women look for:

- Choice over type of procedure
- Choice of location
- Choice of appointment availability (how many appointments there are) and easy access routes (how they get to them)
- Appropriate environment for treatment – cleanliness in particular
- Caring and kind staff
- Safe services
- Professional services
- Confidentiality
- Joined up sexual and reproductive health services – Education, STI, Abortion, Contraception

But how do we find out what it is that they really value? This is where we come up with radical new concept number 2: we ask them!

**What do women want?**

There has been very little research done about what women want from abortion. Most of the research seems to be why they have abortions in the first place. However, at bpas we provide a client feedback form called ‘Your opinion counts’, which has proved to be very interesting. Over 24% of clients return them, which is an extremely high figure for this type of form. We analyse the complaint statistics as well, and work with client support managers within our units and our telephone contact centre to identify opportunities to streamline the processes and improve the client experience. We also share best practice of service delivery from internal and external sources; ensure complaints are dealt with in a positive way; and co-ordinate legal, clinical and management responses to complaints, to make sure they are dealt with in a robust and fair way.

We then use the results to implement a system of proactive client care (Figure 2). This starts with an initial complaint, goes through client feedback, and from that we can identify any gaps in the service. This results in an improved service delivery, which we hope reduces the number of complaints, and so on.

**Figure 2**

What sort of detailed feedback do we actually get within these feedback forms?

Ninety-seven percent rate our service as good or excellent. We could leap up and down with joy and say what a great figure this is, but I think you have to dig a little bit deeper into it and start asking, why? Why is that figure so high? One reason is that we give these forms out to our clients just before they leave. They come into the unit pregnant, and often with the whole weight of the world on
their shoulders. They leave not pregnant and substantially happier. And so clearly at that stage they are extremely satisfied with the service that has been delivered. As yet we have no real mechanism to follow that up later to see if they remain happy, and this would be an interesting piece of work to do.

Overall, we find that only about one in a thousand clients complain. Areas of typical complaint focus on four main aspects: 1) mis-information; 2) service from staff; 3) retained products of conception; 4) other poor clinical outcome. But over half of the complaints relate to the service rather than clinical issues. So the way service is delivered really does matter. Many of the complainants just needed the ability to complain (the process, and the option), and felt better as a result of it - this was very interesting. But the most interesting point that has come out of this work so far is that over 60% say it is the quality of the staff that makes the single biggest difference to their experience.

Why might caring staff matter? Marie Stopes International Australia carried out a piece of research a couple of years ago, which came up with this fascinating little gem. It asked the question: ‘How difficult was it to decide what to do with an unplanned pregnancy?’ and 48% of women said ‘difficult’, which sounds reasonable. Thirty-five percent said ‘easy’, which also sounds about right. But an important point is that a large proportion of the women coming into these units – 17% - were struggling with their decision, so being greeted by a caring and friendly environment that helps them to consider their options in an impartial and unbiased way will clearly help them.

From the work that bpas has undertaken, what might women be prepared to compromise on?

A quick ‘back-of-a-fag-packet’ calculation of the figures on how much the NHS is putting into abortion at the moment comes out with a figure of about £95 - 100 million a year. There are always going to be resource constraints and competing pressures for that money, which means that inevitably the service is going to have to be compromised in some way. But in what areas might these compromises happen?

- **Choice of procedure**: clearly many women will have a preference between surgical or medical procedure and between general anaesthetic and local anaesthetic. But generally they will compromise the procedure in favour of other factors.
- **Choice of location**: how far can women travel? Quite often that depends on their gestation, with women prepared to travel much further at higher gestations as the number of providers significantly declines. However, at lower gestations the location and particularly convenience are powerful motivators.
- **Availability and access**: will the most desperate pay to get their treatment sooner, and is it right that they do?
- **Environment and cleanliness**: what happens with a lack of investment in infrastructure?
- **Care and kindness**: would we want to see a very process driven, ultra-efficient service that gets clients through quickly, or do we want a more kind and caring environment, or do we want both – or either?

What happens if staff salaries and training opportunities are reduced to save money?

- **Health and Safety issues**: can they ever be compromised!
- **Professional standards of staff**: is it necessary to have clinical governance for abortion and can parts of the service be de-skilled?
- **Joined up services**: what happens if abortion, contraception, sexual health screening and education services are disjointed, as has been the case in many areas up until now?

Looking at this list in the light of bpas’ experience it would appear that the things that women might be prepared to compromise on are:

- **Choice of treatment type**
- **Degree of co-ordination within services**
- **Choice of location**

The things that cannot, or should not, be compromised are:

- **Availability**: especially time to treatment
- **Accessibility**:
  1. Referral route – and one of the things that helps with that is self referral
  2. Access – an easy booking system
  3. Client Pathway: We summarise this as call, consult, clinic, and it should be as simple as that.
- **Safety**
- **Cleanliness**
- **Kind/caring staff**
- **Professional standards**
- **Confidentiality**

Of course this doesn’t mean that we should compromise, and we shouldn’t if we don’t have to; but if we do have to compromise it can only be in the former areas and not the latter. A gold standard service should seek to make no compromises, offering women the choice of treatment they want, at a convenient location and with the provision of full contraceptive services and a sexual health screen at the time of treatment.

If we pull this together, it leads to a slightly different approach to commissioning abortion services. We should establish a basis for understanding what really matters to women, and focus on what they really want in order to build the service around this, so far as is possible.

**Contracting for TOP Services**

In preparing contracts, we should fully understand any compromises that are being made and be prepared to explain them to commissioners and, if necessary, our clients. For instance, a local service providing EMA to 9 weeks’ gestation only may not be as good as a local service providing all choices of treatment, but it is better than the alternative of requiring all women to travel further for more treatment options.

When it comes to management of the contract, it is important to recognise that there are different reasons why information
In managing the contract, there are different reasons why information is needed.

is needed. A Common Data Set, which is a huge amount of information about the way in which procedures are being delivered, where they're delivered, gestation and so on and so forth may be useful for feeding into national statistics, but shouldn't form a basis for contract management — a few performance measures that are clearly outcome-based, and particularly outcome-based in terms of women's needs, would be a far better way in which to manage the contract.

At bpas, we fully understand that there are also ad hoc information requests that particular commissioners need at certain times, and we are very happy to work with them in order to prepare them. But often I think that it would be helpful for us to understand exactly what it is that the commissioner is trying to get at, because it may be that we could find a better way in which we could find that information, or we may be able to capture it during the TOP process more effectively. This requires a good understanding between the commissioner and supplier and regular communication. Particularly as some of the information we get asked for gets very close to the point of breaching client confidentiality, and this is something that we are acutely aware of.

Since TOP services from different providers are often apparently quite similar, I think that a very useful test when commissioning is to consider which service women would prefer and on what basis they would make that judgement? The key question has to be: Who are women likely to want to go to? Involvement of target groups of women in the decision making process and the use of women-focused output and quality measures are needed for determining between bids and these quality measures will also provide a basis for subsequent contract management.

Below are just a few ideas of the sort of measures that could be used. Clearly we are not going to get away from using headline measures for international benchmarking, such as the ‘Number of abortions per 1000 women aged 15-44’ – that's there and it's going to stay. But the sort of service measures we could look at are:

✓ Clients treated.
✓ Average cost per client (not too low or too high).
✓ Average wait for treatment (from the point at which they have decided to proceed with treatment). This is absolutely fundamental, and if it starts to slip, it shows that things are starting to go wrong.
✓ Average satisfaction with treatment, which obviously can only be gained from having some system for capturing it.
✓ Complaint rates.
✓ Complication rates.
✓ Percentage of clients within an area who are self-funding.
✓ Clients receiving consultation of contraception options.
✓ Percentage uptake of Long-Acting Reversible Contraceptives (LARCs).
✓ Percentage of clients screened for Chlamydia, Gonorrhoea and HIV, with appropriate treatment or referral of positives.

The last few items imply that there is a properly joined-up service.

Conclusion

I will conclude by returning to the original question, 'how important is choice and care?' From an abortion provider and commissioner perspective it should be as important as a prospective client sees it. In practice, many women will not have a real choice in some aspects of abortion provision available to them. But that may not matter if compromises are considered and can be explained, so they are logical and are of an appropriate nature; and customer focus, care and kindness are at the heart of everything that we do.

What follows is a typical statement from one of our feedback forms in February 2008, from an Early Medical Abortion client. And to me this really explains why we do what we do:

'Thank you for all of your help. This was something I absolutely dreaded and you made it better than my imagination would let me believe.

'Not a very glamorous job, but you were all terrific and I am so grateful to you for it. Thanks again.'
WHAT IS DIFFERENT ABOUT YOUNG PEOPLE?
Lisa Hallgarten
Head of Policy and Communication, Education for Choice

The question 'What is different about young people?' seems to me a bit like that Freudian question, 'What do women want?' It implies that they are somehow unique, different, opaque; that their needs are knowable; and that the bottom line is that, like women, young people are awkward creatures. I would like to begin by challenging that sentiment.

It is quite easy to know what women want – you just ask them – and the same goes for young people. If you talk to them, then you can work out what their needs are quite straightforwardly. The question also suggests a kind of homogeneity, as if there is this thing that is young people, that they are all the same and have the same needs. But when is this magic moment when young women are no longer young women; and at this magic moment do their needs change radically, are their needs radically reduced? I will come back to that question at the end of my presentation.

What are we worried about?

When thinking about young people and abortion, we need to think about a continuum of care. We need to think about abortion from before it happens to after it happens, and everything in the middle. And I'm going to start by talking about information, and education.

What do we worry about in terms of young people and abortion? We worry about the fact that young people are being presented quite late for abortion, identifying their pregnancies quite late, and are disproportionately represented in figures for late abortion. We at Education for Choice are not very surprised that that happens, because when we go into schools and say, 'Do you know what the time limit is for abortion?', they all know the time limit is 24 weeks. This is because the media is obsessed with abortions that take place at 24 weeks. What young people don't know is that abortions are harder to access after 12 weeks; that they might have to travel large distances after 12 weeks, with no financial support and no moral support to do so; and that abortions become riskier as pregnancy continues, so there is a great incentive to get people in much earlier.

As professionals, we are worried about young people making decisions under pressure, young people being coerced, because they might find it much harder to untangle their own feelings from the feelings of people around them. A lot of young people spend their whole life up to a certain point being told that someone knows better than them - their teachers, their parents, and everyone else - and suddenly they become pregnant and everyone says, 'Your decision'. So we are really worried about how young people manage that situation.

We are worried about people making decisions about pregnancy by default: i.e., not making a decision at all. We are worried about people making decisions based on the community they live in, whether that's because of the high visibility of young motherhood and the invisibility of abortion in their community, or whether it's because of the lack of visibility of young motherhood. So I think that women from both social classes actually can feel quite pressured in going one way or another with their pregnancy.

We are worried about abortion being a stigmatising experience for young women, and we're worried about abortion being a wasted opportunity. Because what the people we work with all the time say to us is, 'Actually, when young people come to us, quite often abortion is the presenting symptom. But it's not the real problem. And thank God they got pregnant, because now we've got them! Before they got pregnant we didn't know they were out there with these very complex needs, and them coming to us with a positive pregnancy test is a real opportunity for us.' And we worry that those opportunities are not being grasped, to give those young people the additional support and help that they need.

Finally we are worried about repeat unintended conceptions. I say repeat unintended conceptions and not repeat abortions, because once somebody has that repeat unintended conception, I don't believe that them choosing to have an abortion, even if it's their second or third abortion, is in itself a problem. The problem is that they got pregnant again and they didn't want to be.

What do young people worry about?

But what do young people worry about? Young people worry about their fertility. It's not an accident that they worry about their fertility – this is the result of deliberate misinformation on the part of people who go into schools and say, 'If you have an abortion, you will be made infertile'. Now we might just think that it's a really bad idea to give people misinformation, that it's unethical - and it clearly is. But let's also look at the knock-on effects of that. We know from anecdotal evidence from around the country, that young people who have abortions and believe they are infertile get pregnant again very quickly. They test their fertility: they want to know. 'Is it true that I'll never have a baby again?' Either that or they just think, 'Why use contraception? I'm bound to be infertile, I've had an abortion.' So we know that in fact, misinformation has the opposite effect to that which is desired. It doesn't stop young people having abortions, and it might even be increasing the number of abortions.

Young people worry about: Will an abortion be painful? Will it be expensive? They are amazed to find out -- even the professionals that we train are amazed to find out -- that nearly 90% of abortions are funded by the National Health Service. In soap operas, people normally have to steal from their grandmother's knicker drawer to get the money together to have an abortion.

And young people worry about confidentiality – that's probably the key concern that they have, and it's the thing that you have to say at least 10 times in a 40 minute session in a classroom. It can be kept confidential, it will be kept confidential, obviously within the parameters of child protection issues.

What can education do?

So what can we achieve with good education and how do we do it? To communicate with young people, you need to be open, you need to be honest, you need to give them evidence-based
When we do education well it supports prevention. The young people we talk to say: ‘That’s made me think twice about having sex, it’s made me think I want to use a condom’. It doesn’t simplify the issue of abortion: it shows people that it might actually be quite complex, and that it might be easier to use contraception in the first place than to be faced with that particular dilemma. We get them to think about all the decisions that might lead to, and result from, unintended pregnancy. So we don’t just talk about abortion as a moral issue, right or wrong: we talk about how we get to that position, how we can avoid getting to that position, what it might be like to make that decision, and how we might move on from that.

It gives people the confidence to talk to professionals. They know and understand about confidentiality; they know what their local services are, where they can reach them, and it gives them speedier access to services, which is a real issue for young people: not only seeking abortion, but young people who are choosing to continue with pregnancies, and currently accessing antenatal care later than they could have. It gives them reassurance about the safety of abortion and of their fertility.

**Pregnancy decision-making support**

The next part in the continuum of care is about pregnancy decision-making. It is essential that young people have access to support to make decisions about pregnancy in a wide range of settings. Traditionally, if a young person came to their youth worker or their Connexions worker or somebody like that and said, ‘I’m pregnant and I don’t know what to do,’ they would have been told to go to their GP, or their family planning clinic; in other words, they would have been dropped like a hot potato. What Education for Choice is trying to say is, ‘Don’t drop them, there’s quite a lot that you can do’. Most people who work in these settings have really good listening skills and basic counselling skills; they need a bit of extra information confidence and support in order to say, ‘I can hold this person a bit longer’. But if you can hold onto that person a bit longer and give them a guided referral to their GP, they will actually get to their GP. If you drop them like a hot potato, they might never make it.

What does good pregnancy decision-making support do? It ensures confidence in the decisions that young people make. We know that ambivalence is one of the risk factors for regret following abortion, and that feeling confident in your decision is really important. Good pregnancy decision-making support helps with the appropriate involvement of parents and partners. We use the word ‘appropriate’ markedly, because it isn’t always appropriate to include the parents and the partner, but in fact most parents are a really good source of support for young people, and if that piece of care can be done carefully it can be very positive.

Good pregnancy decision-making support can be an important way of identifying additional issues that are going on for that young person in their life, and I think that it’s a really good place to do it. If the young person has come to a particular worker and trusts that person, that person is going to get a lot more out of the young person about all the circumstances surrounding the pregnancy. Good pregnancy decision-making support can also speed access to antenatal and abortion services, and I think that’s because once you have talked to one professional and realised that they are not going to bite, and they’re not going to judge you, you are going to be much more confident about going to the next step.

It is really important that pregnancy decision-making support is non-directive, impartial, provides evidence-based information, and provides literature which is accessible to people with a whole range of different language abilities. It is extremely important that this is the stage where post-abortion or post-maternity contraceptive planning takes place. There are services that offer support around pregnancy decision-making and do not understand that there’s a fundamental connection with the next step: especially with young people who don’t believe they’ll be fertile after having an abortion, and probably don’t believe they’ll ever have sex again after having a baby. Now, we know that women are fertile again within a couple of weeks of having an abortion and within a couple more after having a baby, so it’s essential this work goes on before they’ve had the abortion, because once they’ve had it they tend to think, ‘Thank God that’s done and I’m out of here’. This bit of work is something that a lot of people are already trained to do – asking basic questions such as: ‘How did you get into this situation?’ ‘How could you avoid it in the future?’ ‘What kind of contraception might it be easier to manage?’ ‘How might you go about accessing that?’

A word of warning to commissioners. There is a perception that there is this vacuum out there of pregnancy decision-making, that there isn’t enough support, that there aren’t enough places for people to go to, that there’s not enough time given for this area. I think this is a perception, because in reality the people are there and we have to empower them to do that bit of work. But what is filling the vacuum is a whole range of independent pregnancy services – some of which are not behaving in ways that are ethical, constructive or healthy. There is a whole spectrum of people targeting vulnerable young women with their marketing, who do have an agenda, which is that they want young women not to have abortions. And even some of the centres that don’t behave that badly, ultimately I would question whether someone who thinks abortion is wrong is ever going to be the right person to support young women in a non-directive way.

**The abortion consultation**

The next part of the continuum of care is the abortion consultation. One of the things that costs absolutely nothing is kindness: remembering that for that woman, this is a unique and extraordinary situation, even though it’s a really ordinary situation.
Abortion Review Special Edition 2

The question of young people and abortion is all about continuity of care

for the staff in the clinic. It is important that, in the pre-abortion consultation, the young woman is given a realistic expectation of what this procedure is going to be like. We know that in the early days of Early Medical Abortion, some people had a very unrealistic expectation that it was a kind of pill that you took and your pregnancy almost miraculously disappeared, rather than it being a process that is initiated. If people don’t have a realistic idea about the abortion they can have quite unhappy experiences, whereas women who are very clear about what to expect normally report it as being a very satisfactory experience.

The abortion consultation is a good point at which to check again for ambivalence; to check how a person came to that decision and that they are happy with it. And again, to think about post-abortion contraceptive planning; that should be thought about at every possible moment. The young person might have additional support needs that can be picked up at the abortion consultation, whether it’s about substance use, being in an abusive relationship, having the capacity (or not) to negotiate contraceptive use with a partner, family relations – those are the sort of things that can be picked up.

Communication

Although it’s difficult when many different agencies are being commissioned to provide services, we need to have communication between those to share information that will be to the benefit of that young person. It’s interesting that when a young woman has a baby, there’s a huge amount of intensive support that kicks in, to make sure that she’s housed and looked after, that she goes back to college or she gets a job or goes into training. Quite often the young women who are presenting for abortion have very similar circumstances to the young women who has a baby, yet as soon as she’s had the abortion a lot of that stuff falls away. Some of that is not because the services aren’t there to give them the support that they need and to deal with those difficult and complex things, but because the information isn’t shared. There is also an issue about how we ensure information is shared at the same time as confidentiality is respected and we have the consent of the young woman involved.

Abortion care

Another interesting difference between young women having an abortion and those experiencing maternity is that people from different agencies are welcomed onto maternity wards, and it’s really quite easy to chat to a young woman there. But in NHS settings, people are very protective of their abortion wards. There is a sense in which young people need to be protected from harassment or something; but actually it means that these young people are missing out. One contraceptive nurse I met said, ‘There’s no better opportunity to sit and have a chat with a young woman about contraception than when she’s in the hospital waiting the four hours that that hospital thinks she needs to stay in after taking her misoprostol [as the first part of her EMA treatment]. She’s got nothing to do, and there’s no better time to sit and chat to her.’ But actually people are very protective of their abortion wards and a bit worried about letting people in. So maybe we should not be so scared and think that women don’t want to talk about it. Maybe they do want to talk; maybe we’re all being a bit protective of them, and maybe we should be a bit braver. Let’s not deprive young women who are having abortions of the same kind of intensive support that is available to the similar young women who are experiencing maternity.

When it comes to the young woman having the abortion, let’s be kind, let’s be nice. That makes a huge amount of difference to someone’s experience. And again, let’s not be scared about talking to people. They might have feelings that they want to talk about. They might want to talk about something completely separate, but let’s be bold about that, and let’s give people the kind of care we would if we were working in any other part of health services; not feel that this abortion, this is different, this is special, this is scary.

Issues for commissioners

There are some important issues for commissioners, and one of these is travel. This is a major issue for young women. Young women are more likely to present late with their pregnancies, so they’re more likely to slip over the 12 weeks, which in so many areas means they’re going to have to travel out of area. Now for some people that might mean hopping on a half-an-hour train journey, but for people in Truro it means going to Bournemouth. It’s definitely an overnight stay and a long train journey each way. There is a huge financial burden, and if a young person’s doing this without family support, that’s hugely problematic as well. Some PCTs do provide funds for travel, but there’s almost no funding for somebody to accompany the person who needs to travel to have the abortion. This is something we really need to take account of.

Conclusion

In summary: it seems to me the question of young people and abortion is all about continuity of care. It’s about good information, good care. It’s about being honest, and it’s about making the links between all the different parts of the service. And I’m going to end with the question I asked right at the beginning, which is: what’s so different about young people? Is there anything about what I’ve said that wouldn’t be a brilliant benchmark for a really good universal abortion service? Don’t all women want good information, good support, good services? Aren’t there older women who are vulnerable, who are illiterate, who are struggling in difficult and violent relationships, and aren’t there younger women who are articulate, thoughtful, literate, able to make decisions?

We have to see women as women – but I do think there’s a real benefit in taking the most vulnerable, which if you want a shorthand might be young people, and building a service that is good for them. If it’s going to be good for them, it will be good for everyone. If you look at something like the ‘you’re welcome’ criteria that the Department of Health has just brought out, there’s so many things in that that could be applied to universal services. Shouldn’t everyone have a nice place to go, shouldn’t everyone know what the rules are about confidentiality, stuck right up on the wall, shouldn’t everyone have unbiased and non-directive support? So I ask again, when is this magic moment when we stop having these needs that young people have?