Abortion Review

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FORTY YEARS ON: WHY THE ABORTION LAW STILL MATTERS

By Ann Furedi, Chief Executive of bpas

'It is a common misperception that British law allows abortion on demand,' wrote *Times* science editor Mark Henderson on 28 November, before explaining that women seeking an abortion 'must first jump through several medical and legal hoops' - including obtaining the approval of two doctors, who must justify their decisions on medical grounds. The two-doctor rule, he argued, 'does little but waste medical time and resources', and makes the abortion procedure more stressful for women than it needs to be: 'Some women … find it humiliating to be declared at psychological risk when making a choice to end a pregnancy.'

Henderson was responding to a major poll about attitudes to abortion in the UK, conducted by Ipsos Mori on behalf of **bpas**. This follows two previous polls, in 1997 and 2001, and gives some important insights into the British public's views about abortion and how these have changed. So in 2006, it emerges that 63% of adults in the UK agreed that 'if a woman wants an abortion, she should not have to continue with her pregnancy', while only 18% disagreed. Furthermore, 59% agreed that 'abortion should be made legally available for all who want it'. This would require a change to the existing law, which requires two doctors to confirm that a woman meets certain criteria. Indeed, a change to this frankly arcane law, which as Henderson suggests serves no medical purpose, is long overdue.

Forty years on from the 1967 Abortion Act, the reality of abortion in the UK is very different. The abortion rate in 2005 was 17.8 per 1000 women aged 15-44, compared with 8 per 1000 women in 1970. At least one in three women in the UK can expect to have an abortion. Major advances have also been made in the provision and procedure of abortion: in particular, the development of Early Medical Abortion (the 'abortion pill') which provides a low-risk and easily administered form of termination of early pregnancy. It is now accepted that abortion is a fact of life: a necessary back-up to birth control for couples who want to plan their families. No woman ever wants to need to have an abortion, but those who do not want it to be legal are in a minority.

Despite the mainstreaming of abortion in practice, however, the law on abortion remains restrictive. Britain is one of the few countries in Europe and North America that does not allow abortion on the woman's request at any stage. Abortion is our most tightly-regulated medical procedure, despite being shown to be a safe solution to a problem pregnancy. And yet, pro-choice advocates in Britain often seem wary of leading a discussion about reforming the abortion law, on the pragmatic grounds that the current legal framework allows women to access abortion on demand, even if it does not give them that right. Is that enough?

It seems unfashionably fundamentalist to defend the notion that women should have a 'right' to abortion. But we should remember what the concept of a right really means. The right to abortion and contraception was a basic tenet of the Women's Liberation Movement in its early years, along with the right to equal pay and equal job opportunities, because activists understood that women needed control over their fertility to play an equal role in public life. When you deny me a means to end my unwanted pregnancy, you deny me the opportunity to participate in society in the way that my brother or husband can. Better nurseries, better financial support can mitigate some of the consequences of motherhood - but nothing can mitigate the impact of pregnancy itself, which is why women need the means to end it.

This has not changed: it is as true in 2007 as it was in 1967. Contraception has improved, but is still fallible. Abortion is a necessary back-up to birth control for any society that is committed to equality of opportunity for women. The discourse of women's equality may have changed, but its fundamental prerequisites have not.

There is also another way in which the right to abortion must be non-negotiable. When we are denied the right to end pregnancy we lose our right to bodily autonomy; a fundamental human right central to Western civilisation. The ethics of modern medical practice is built on the notion that each of us has the right to refuse to compromise our bodily integrity. You might find it morally reprehensible for me to refuse to give up a kidney that could be transplanted to save the life of my son, but there is no law to force me to do it. In the UK, the same is true of birth decisions. In refusing a Caesarean section delivery, I may condemn my unborn baby to certain death, but I commit no crime in doing so. No doctor can force me to accept a medical intervention against my consent, unless I am mentally incompetent.

The law forces us to draw a distinction between what is legal, and what we regard as morally right and wrong. We accept this because we accept that a society able to compel medical intervention without consent in the interests of someone else is a greater social evil than an occasional un-palatable individual choice. So it is interesting, for example, that in a question about approval of abortion in different circumstances, the recent Ipsos Mori poll found that less than half of the respondents - 48% - said that they did not approve of abortion when the woman does not wish to have a child. But despite the fact they might not approve of abortion under particular circumstances, people thought women should be able to exercise that choice: with 63% agreeing that if a woman wants an abortion, she should not have to continue with her pregnancy.

This unfashionable privileging of 'rights' is not divorced from the more acceptable stress on responsibility. Surely it is right, if not 'a right', for women to be allowed to make their own moral choices concerning their pregnancy. The decision must be made by someone: why should it not be made by the person whose life is most connected to it? In *Life's Dominion: an argument about abortion and euthanasia,* Ronald Dworkin argues compellingly that part of our belief in human dignity rests on people having 'the moral right and moral responsibility to confront the most fundamental questions about the meaning and value of their own lives for themselves.'

Each of us must be answerable to own conscience and conviction; this, he argues, is part of what makes us human. To take away our responsibility for our moral decisions is to take away our humanity. This

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The morality of abortion cannot be resolved in the abstract

argument implies we must allow people to make decisions that we believe are wrong - because it would be more wrong for us to deny them the capacity to do that. As Dworkin argues eloquently: 'Tolerance is the cost we must pay for our adventure in liberty'.

Of course, we can be pragmatic - we don't have to talk in the language of rights. The UK provides an interesting example of where abortion access has been expanded and improved by a political administration that situates abortion, not as a right, but a public health concern. In the UK, the abortion discourse has been almost silent as to 'rights'. Since abortion was legalised in the 1960s, it has been treated as a matter of public health. The framing of abortion in a personal and public health context has made it difficult to oppose. When abortion is seen as a health matter, to argue against abortion is to argue against a doctor's decision of what is best for a patient.

The public health arguments for abortion have potential to unite social liberals and conservatives. Even those who think abortion is abhorrent draw back from the practical consequences of making it unlawful. In the UK there is a broad consensus that abortion is a 'lesser evil', a wrong that is sometimes right.

It may be that the arguments around public health are where we can establish the greatest consensus on abortion's acceptability. However, any such consensus will be partial because the moral dimension will remain contentious. This is inevitable and insurmountable. There can be no moral consensus that includes those who believe that the destruction of human life in the womb is wrong and those who believe it is not. It may be possible to establish a pragmatic consensus among those who are prepared to discuss which abortions are less wrong than others, but attempts to establish foundations for a broader moral consensus degenerate into glibness.

Witness, for example, the extent to which many opponents of abortion in the UK now focus their arguments on the problem of late abortions, using emotive images of walking and smiling fetuses and contested claims about fetal pain (discussed further inside this issue of *Abortion Review*). Rather than arguing whether abortion is right or wrong, the legal debate tends to become focused around the 24-week 'time limit', and debates about fetal development push the principled issue of women's rights into the background. This is not a debate we can shy away from - and nor should we want to.

The morality of abortion cannot be resolved in the abstract. Each individual abortion takes place within its own complex set of circumstances. To understand abortion we need to understand its place women's lives. From the findings of the Ipsos Mori poll, public opinion seems to be more progressive than politicians think. It may be that we can best build support for legal abortion by putting the spin to one side and telling the whole truth: the truth about what abortion is, the truth about why women have them, and the truth about what it means for women when bodily autonomy is denied. To defend abortion we must win arguments in favour of tolerance and encourage an aspiration for liberty. To win the arguments, first we must have them.

'ATTITUDES TO ABORTION': THE MEDIA RESPONSE

The Ipsos Mori poll 'Attitudes to Abortion', commissioned by **bpas** and released on 28 November 2006, was big news in the UK. 'Abortions should be made easier on demand, says charity', reported the front page of the *Times* (London), reporting **bpas'** arguments that laws that require two doctors to approve an abortion should be dropped to allow women complete control over their family planning, and that abortions should also be made easier by allowing nurses rather than doctors to prescribe Early Medical Abortion to women within the first nine weeks.

The *Guardian* led with the headline 'Poll backs nurses being allowed to give abortion pills'. Its report discussed the role of contraceptive failure in about 40% of cases where women seek abortion, and the extent to which abortion has become a back-up to family planning. The explanation given by Ann Furedi, chief executive of **bpas**, for the 20% rise in abortion between 1995 and 2005, was also discussed. The main reason for the rise, said Furedi, was that 'people who are having sex don't want children'. The fact that 20% of women today are childless at 45 means that many women in their early 20s, at the peak of fertility, were having sex regularly but did not want to have a child. Ten years ago many might have accepted pregnancy - today, says Furedi, 'women are perhaps less tolerant of an unplanned pregnancy.'

The *Daily Telegraph's* front-page news article was headlined 'More women have abortions as it loses stigma', and reported Ann Furedi's argument that women are finding it less acceptable to drift into an unplanned pregnancy than to have an abortion. 'Parenting is considered to be very important and is taken seriously these days,' said Furedi. 'The idea of just drifting into unplanned motherhood is seen not to be a good thing and you could argue that among many groups of people in society abortion is seen as a more responsible response to being a victim of uncontrolled fertility'.

The poll caused hackles to rise amongst the anti-abortion lobby. The Society for the Protection of the Unborn Child (SPUC) told the *Guardian:* '**bpas**, for its own ideological reasons, is pushing for abortion to become even more prevalent, and that is why they are calling for changes in the law.' Life said women should not make choices at the expense of unborn children. A spokesman told the *Telegraph*: 'Society must respect the right to life of all human beings, even those who are small and vulnerable and possibly inconvenient.' Julia Millington, of the Prolife Alliance, said the survey took no account of the fact many believed there should be ways of reducing the number of abortions being carried out each year and the mounting 'concern about the psychological and physical harm to women'.

Writing in the *Times*, Dr Thomas Stuttaford worried that 'the importance of pregnancy is trivialised by repeated abortions', and raised the concern that we might 'revert to the Eastern-bloc methods of the 1950s and 1960s'. Mary Kenny, writing on *Guardian Unlimited*, argued: 'If we thought abortion was morally neutral, we would reward abortion doctors for destroying the unwanted pregnancy, as we admire fertility expert Lord Winston for enabling the wanted one. But nobody ever says at a dinner table, "Oh, I'm an abortionist"'.

At the release of the 'Attitudes to Abortion' poll, Ann Furedi urged MPs to mark the 40th anniversary of the 1967 Abortion Act by updating the legislation. This call was backed by Dr Evan Harris, the Liberal Democrat MP for Oxford West and Abingdon. The current 24-week time limit for abortion was chosen 'on the basis on viability', he said, adding that he did not think the age at which a fetus was capable of surviving outside the mother had changed. But, he stressed, 'I don't think this is something we should be scared of debating.'

Dr Harris backed **bpas'** calls to allow nurses to administer the abortion pill, saying that rules preventing them from doing so were 'outdated and inappropriate'. Tony Kerridge, of Marie Stopes International, told the *Times* that his organisation would go even further by urging MPs to allow nurses to carry out simple surgical abortions.

For more information on the Ipsos Mori poll, read 'Attitudes to Abortion': summary of findings *on Abortion Review online:*
http://www.abortionreview.org/index.php/site/article/103/
or contact Laura Riley in the ***bpas*** *press office on 020 7612 0206.*

There seems to be inability to separate personal emotion from the question of the abortion law

SCIENCE, SMILING FETUSES, AND THE ABORTION DEBATE
Comment by Ellie Lee

It is now three years since the debate provoked by Professor Stuart Campbell's 4-D ultrasound images of the 'smiling' fetus began. Over this time, these images have become ubiquitous. They have been referred to time and again in media commentaries, especially by those contending that abortion should banned in Britain at an earlier stage in pregnancy than is now the case. The claim made throughout this discussion has been that 4-D images provide 'new medical evidence' against legal abortion. These images, it has been argued, prove that the fetus, from quite an early stage, exhibits human feelings and emotions, and that this means that a law permitting abortion to 24 weeks of pregnancy is ethically dubious.

In the light of this it is welcome to find that, at last, those who have expertise in this area have entered the debate. On 2 October 2006 experts on fetal development made comments about what the 4-D images tell us at a meeting held at London's Science Media Centre. In particular, participants addressed the question of whether 4-D tells us anything new, and also of what science does really tell us about the point at which fetus might feel emotion.

Speaking at the event was Donald Peebles of the Department of Obstetrics and Gynaecology at University College London. 'These images don't tell me anything I haven't known for 30 years', he noted. Huseyin Mehmet, Reader in Developmental Neurobiology at Imperial College London, concurred. He also pointed out that much discussion of the 4-D images runs entirely contrary to what scientists know. In contrast to the notion that the developing fetus is biologically mature enough possibly to feel pain (cry) or feel pleasure (smile), he explained: 'Scans that look at the structure of the fetal brain at 23 to 24 weeks show that the human brain is extremely immature. It is the period between 24 and 40 weeks that is largely responsible for brain development'.

The third participant at the event was Professor John Wyatt of University College Hospital London. Wyatt is one of Britain's most eminent and highly-regarded neonatal paediatricians, but often a vocal opponent of abortion. Yet he too, speaking as a scientist, agreed. 'It is clear that the vast amount of activity is happening mainly in the last three months of pregnancy', he stated. 'The link between cortex and the rest of the body doesn't come into play until 23 to 24 weeks'.

These doctors have made some very important points clear. First, there is nothing new at all, in a medical sense, about what 4-D ultrasonography shows us. Second, this technology does not and cannot contribute to helping us understand the development of consciousness and emotion; on the contrary, discussion provoked by these ultrasound images to date has actively misrepresented understanding about this issue.

The absence of anything 'new' associated with 4-D is a well-made point. The scientific question of at what point a fetus become sentient has been the subject of serious discussion for over a decade. Debate goes on about what true emotional experience constitutes, but there is no serious body of opinion that considers fetal imaging pertinent to this debate, or which considers there to be evidence of even the biological basis for emotional experience before very late gestational stages.

Clarification of the scientifically illiterate nature of the debate about 4-D is welcome, and it is to be hoped that, in the future, more medical experts will take the lead of those who spoke out this week, contest bogus claims about science, and clarify these matters in public. This

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For a regular update on abortion news and medical developments from around the world, visit Abortion Review online. Access is free, with a searchable archive and links to original news sources. Recent reports include:

- bpas launches a new campaign urging women to keep the emergency contraceptive pill ready at home, 'just in case';
- A study in the *American Journal of Public Health* examines pregnancy decision-making among women seeking abortion or prenatal care;
- The Nuffield Council on Bioethics publishes its report on preterm babies;
- A £4m campaign by the UK government urges young adults to carry condoms when they are out 'on the pull';
- Voters in South Dakota, USA, have rejected a near-total ban on abortion;
- A study gives perspective on the deaths of five women in North America following mifepristone-induced abortion;
- In a letter to *The Times* (London), 15 senior doctors claim that women who have abortions are risking mental illness and should be told of the dangers;
- Nicaragua has approved a sweeping new law banning abortions - even in cases where the mother's life is at risk;
- A study published in the *International Journal of Cancer* has found that abortion does not affect the risk of breast cancer.

should not, however, be confused with the process of clarifying the abortion issue.

That this is the case was illustrated by Professor Campbell's riposte to the Science Media Centre discussion. Writing in the *Daily Telegraph*, he argues: 'There is something deeply moving about the image of the baby cocooned inside the womb. When four-dimensional scans first became available three years ago, I sat with parents who trembled at the sight of their soon-to-be newborn…We have to draw the line [on legal access to abortion] somewhere, and 24 weeks is too late' (6). In other words, Campbell, working on a daily basis with prospective parents viewing 4D images of much-wanted pregnancies, cannot reconcile this experience with allowing women legally to terminate pregnancies, certainly past 18 weeks.

Anyone who has had a wanted pregnancy, seen the scan images, and so wondered at the amazing progression over 40 weeks of a pregnancy from ball of cells to waking baby, will also have felt deeply moved, just like Professor Campbell. Yet many of us also understand this experience is of no relevance for the abortion law. We separate our perceptions and emotions of our own pregnancies from this issue.

It seems, however, that an inability to separate personal experience and emotion from the question of the abortion law is now central to the issue of abortion. A kind of emotional dissonance between personal experiences in regard to wanted pregnancies, and the legal provision of abortion, is now increasingly articulated in public. Indeed, if there is anything 'new' at all about the abortion debate as it currently exists, it is this.

It is, for example, just this sort of dissonance that is leading to criticism of legal abortion from unexpected quarters. Feminist commentators, including Naomi Wolf and Allison Pearson, have thus come out against the current abortion law, citing their own personal experience of pregnancy and that of their friends, as evidence. Politicians, not only those who are paid-up members of anti-abortion campaigns such as Life and SPUC, also draw upon just this sort of sensibility born of the experience of pregnancy and parenthood, when they express their distaste and discomfort with the current abortion law.

This approach is both morally and intellectually bankrupt. In focusing on what a fetus looks like and a wanted pregnancy feels like, over and above what science tells us about fetal development, its advocates display a profound lack of respect for science. Yet at the same time they are willing to cite 'science'- in the form of 4-D technology, or exaggerated claims about survival rates for premature babies - to justify their position. In this way, 'science' is used to dress up personal feelings and experiences, and to avoid the real issues of the abortion debate: the experience of those women who seek abortion, the social problem of involuntary parenthood, and the moral issue of the right of women to decide about their lives and futures.

But this quasi-scientific emotional approach has become widespread, and is rarely challenged head on. It is important that those who are concerned about the abortion debate as it currently exists do not assume that science, even in its best and most robust form, can be relied upon to address the key questions. While it is useful to clarify the scientific value - or otherwise - of 4-D images, the debate also has to tackle a broader cultural problem, where subjective claims and references to personal experience increasingly frame the abortion issue.

As psychologist Dr Stuart Derbyshire, perhaps Britain's most prolific scientific commentator on these issues, has succinctly put it: 'The question of who should and should not continue a pregnancy is not one that science can resolve. Trying to do so is likely to produce both bad science and bad law'.

__Dr Ellie Lee__ is a lecturer in social policy at Kent University, and co-ordinator of Pro-Choice Forum. www.prochoiceforum.org.uk

New foetal scans 'clouded debate on abortion', *Times (London), 3 October 2006.* ***Don't tear a smiling foetus from the womb,*** *Telegraph, 4 October 2006.* ***Why I see no place for science in the abortion debate,*** *Stuart Derbyshire, Times Higher Educational Supplement, 21 January 2005.* ***Late abortion: a review of the evidence,*** *Pro-Choice Forum*

MP MOUNTS CAMPAIGN FOR MORE RESTRICTIVE LAW

Labour MP Chris McCafferty described the Dorries bill as cynical, cruel and inhumane

Members of Parliament on 31 October voted against a bill calling for the legal time limit for abortions to be cut from 24 weeks to 21 weeks. Conservative MP Nadine Dorries, who introduced the bill, had argued that a fetus may feel pain from 21 weeks. She also wanted a 10-day 'cooling-off' period between a request for an abortion and it being performed, for the woman to receive counselling. But Labour MP Chris McCafferty called it 'an attack on women's reproductive rights'. MPs voted 187 to 108 against.

Ms Dorries said the usual argument for reducing the time limit centred on viability - the likelihood of the fetus surviving outside of the womb - which is considered to be 23 weeks. 'However, my argument for reduction rests not on viability, but on the issue of fetal sentience - how fetuses respond to pain, sound etc,' she said. 'The latest scientific research puts the case of sentience at around 21 weeks.' During the 'cooling off', a woman should be given access to information and counselling about the medical risk of termination as well as of carrying a pregnancy to term 'as a condition of informed consent', Ms Dorries said. Providing such information and counselling was based on experience in Western Australia, where abortions have dropped since it was introduced in 1998. However, there is no waiting period in Western Australia.

Chris McCafferty said the bill was 'ill-informed' as there was only a very small proportion of late abortions performed each year. She described the bill as cynical, cruel and inhumane. Forcing a woman to have counselling went against the whole principle of counselling, while the 10-day delay could prompt women to travel abroad for abortions 'when they are in a vulnerable state' or resort to illegal abortions.

Ms Dorries introduced the issue as a Ten Minute Rule Bill - allowing her to talk in the House of Commons for ten minutes, before Ms McCafferty argued the counter case. Even if MPs had backed it, the government only rarely allows a Ten Minute Rule Bill to progress far enough to become law so MPs tend to use this procedure simply as a way of gaining publicity for a particular issue, and for testing the mood of their fellow MPs.

Despite the rejection of her bill, in December Dorries announced that she would publish a new version of it, which would limit the timescale for terminations to 20 weeks and call for a one-week 'cooling-off' period. She said that she hoped the bill would remain on the list of pending parliamentary business until the 40th anniversary of the 1967 Abortion Act.

Abortion time limit cut rejected, *BBC News, 31 October 2006;* ***New call to reduce abortion limit,*** *BBC News, 14 December 2006.*

REDUCING UNINTENDED PREGNANCY IN THE UNITED STATES

By James Trussell and Lisa Wynn

Half (49%) of all pregnancies in the United States are unintended: there were 3.1 million in 2001 alone, the last year for which data are available. (1) These statistics were the same in 1994. (2) One of every two women aged 15-44 in the United States has experienced at least one unintended pregnancy. (2) What is responsible for the unacceptably high incidence of unintended pregnancy, and what can be done to reduce this incidence?

Information on levels and trends in contraceptive use in the United States is based on the National Surveys of Family Growth (NSFG), periodic surveys conducted by the National Center for Health Statistics in which women ages 15 to 44 are interviewed about topics related to childbearing, family planning, and maternal and child health. Among the 61.6 million women of reproductive age (ages 15 to 44) in 2002, about 62% (38.1 million) were using some method of contraception, according to the 2002 NSFG. Among the 38% (23.5 million) who were not currently using a method, only about one-fifth were at risk of pregnancy. The remaining four-fifths were not at risk because they had been sterilized for noncontraceptive reasons, were sterile, were trying to become pregnant, were pregnant, were interviewed within 2 months after the completion of a pregnancy, or were not having intercourse during the 3 months prior to the survey. (3)

As can be seen in Table 1, almost 90% of the women at risk for an unintended pregnancy were using a contraceptive method, but 10.7% of all women at risk of unintended pregnancy were not using any contraceptive method. Today, the most popular contraceptive methods are oral contraceptive pills (11.6 million), female sterilization (10.3 million), male condoms (6.8 million), and male sterilization (3.5 million). (3) The mix of methods shown in Table 1, including the 10.7% of women at risk who do not use any method, resulted in the staggering 3.1 million unintended pregnancies in 2001. Nearly half (48%) of unintended pregnancies result from contraceptive failure, but the majority of unintended pregnancies (52%) are contributed by the small minority of women who use no method at all. (1)

Table 1: **Percent and number of women at risk* and percent at risk currently using various methods from the 2002 National Survey of Family Growth**

	Percent Using among Women at Risk						
Contraceptive method	**15-44**	**15-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**
Pill	27.2	43.5	46.1	33.7	28.6	16.8	10.0
Female sterilization	24.1	0.0	3.2	13.5	24.9	37.2	45.8
Condom	16.0	22.1	20.2	18.4	15.5	14.1	10.5
No method	10.7	18.0	12.1	10.5	9.2	9.8	8.8
Male sterilization	8.2	0.0	0.7	3.7	8.4	12.8	16.8
Depo-Provera	4.8	11.4	8.8	5.8	3.8	1.8	1.5
Withdrawal	3.6	2.1	4.5	6.9	3.4	3.1	1.3
Intrauterine device (IUD)	1.9	0.2	1.6	3.3	2.8	1.3	1.0
Fertility awareness-based methods	1.3	0.0	1.1	0.9	1.5	1.8	2.0
Calendar rhythm	1.0	0.0	1.1	0.4	1.2	1.4	1.5
Implant, Lunelle or Patch	1.2	1.0	1.3	2.2	1.2	0.7	0.3
Other methods**	0.6	1.0	0.1	0.4	0.1	0.4	1.2
Diaphragm	0.3	0.0	0.1	0.4	0.2	0.0	0.5
Spermicides	0.3	0.5	0.1	0.1	0.4	0.3	0.3
	Number of Women in Cohort, Percent and Number at Risk						
Number (millions) of Women	61.6	9.8	9.8	9.2	10.3	10.9	11.5
Percent at Risk	69.4	38.4	69.2	76.0	76.2	78.6	75.9
Number (millions) at Risk	42.7	3.8	6.8	7.0	7.8	8.5	8.7

Source: Trussell J. Contraceptive efficacy. In Hatcher RA, Trussell J, Nelson A, *et al.* *Contraceptive Technology: Nineteenth Revised Edition.* New York NY: Ardent Media, 2007 (in press).

Notes:
* At risk = those who *either* are current contraceptive users *or* are nonusers who have had sex in the past three months and are not trying to become pregnant, are not pregnant, or were not interviewed within two months after the completion of a pregnancy and are not sterile. Percentages may not add to 100 due to rounding.
** Other methods = cervical cap, sponge, and female condom.

***Table 2.* Percentage of women experiencing an unintended pregnancy during the first year of typical use and the first year of perfect use of contraception and the percentage continuing use at the end of the first year. United States.**

	% of Women Experiencing an Unintended Pregnancy within the First Year of Use		% of Women Continuing Use at One Year***
Method	**Typical Use***	**Perfect Use****	
No method	85	85	
Spermicides	29	18	42
Withdrawal	27	4	43
Fertility awareness-based methods	25		51
Standard Days method		5	
TwoDay method		4	
Ovulation method		3	
Sponge			
Parous women	32	20	46
Nulliparous women	16	9	57
Diaphragm	16	6	57
Condom			
Female (Reality)	21	5	49
Male	15	2	53
Combined pill and minipill	8	0.3	68
Evra patch	8	0.3	68
NuvaRing	8	0.3	68
Depo-Provera	3	0.3	56
IUD			
ParaGard (copper T)	0.8	0.6	78
Mirena (LNG-IUS)	0.2	0.2	80
Implanon	0.05	0.05	84
Female sterilization	0.5	0.5	100
Male sterilization	0.15	0.10	100

Emergency Contraceptive Pills: Treatment initiated within 72 hours after unprotected intercourse reduces the risk of pregnancy by at least 75%.
Lactational Amenorrhea Method: LAM is a highly effective, *temporary* method of contraception. However, to maintain effective protection against pregnancy, another method of contraception must be used as soon as menstruation resumes, the frequency or duration of breastfeeds is reduced, bottle feeds are introduced, or the baby reaches 6 months of age.

Source: Trussell J. Contraceptive efficacy. In Hatcher RA, Trussell J, Nelson A, *et al. Contraceptive Technology: Nineteenth Revised Edition.* New York NY: Ardent Media, 2007 (in press).

* Among *typical* couples who initiate use of a method (not necessarily for the first time), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason.
** Among couples who initiate use of a method (not necessarily for the first time) and who use it *perfectly* (both consistently and correctly), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason.
*** Among couples attempting to avoid pregnancy, the percentage who continue to use a method for 1 year.

In Table 2, we show estimates of contraceptive failure rates in the United States. Pregnancy rates during *typical use* show how effective the different methods are during actual use (including inconsistent or incorrect use). Pregnancy rates during *perfect use* show how effective methods can be, where perfect use is defined as following the directions for use; for many methods, perfect use requires use at every act of intercourse. The difference between pregnancy rates during *imperfect use* and pregnancy rates during *perfect use* reveals how forgiving of *imperfect use* a method is. Scrutiny of Table 1 reveals four important findings:

1. The most effective methods during typical use are generally those not requiring adherence.
2. Methods requiring adherence generally show a big difference between perfect-use and typical-use failure rates.
3. Even the least effective methods are much more effective than no method at all.
4. The most effective methods do not protect against sexually transmitted infections (STIs).

Comparison of Tables 1 and 2 shows clearly that with the exception of sterilization, the most effective reversible long-term methods not requiring adherence (IUDs and implants) are not used very frequently. Implanon was not approved by the FDA until mid-2006 and thus could not appear in Table 1, but Norplant, which is no longer marketed, was used by only 1.3% of women at risk of pregnancy in 1995. (4) This comparison, therefore, suggests three strategies for reducing unintended pregnancy:

1. Increasing contraceptive use among those not using a method
2. Increasing use of the most effective long-term methods not requiring adherence among those using less effective methods requiring adherence
3. Simultaneous use of condoms and a more effective method among those at risk of sexually transmitted infection.

Table 2 also suggests that widespread use of emergency contraceptive pills as a last chance to prevent pregnancy after no method was used, or a condom broke or slipped off the penis, or several oral contraceptive pills were missed could help to reduce unintended pregnancy. What is the potential for increasing emergency contraception (EC) usage? In the past two decades, researchers have evaluated numerous interventions intended to accomplish this goal, including promotional campaigns, provision of EC pills in advance of need, distribution by pharmacists or over the counter, and prescription by telephone. (5-13) Most of these interventions have increased EC use - some substantially - but whether any of these increases were sizeable enough to produce a large public health effect is doubtful. Almost all the studies that collected data on EC use found that only a minority of women exposed to the intervention ever used EC, and few of those who became pregnant had tried to prevent the pregnancy using EC. No study to date has yet directly shown that any intervention has actually reduced pregnancy rates. (7-13) And it seems unlikely that EC will ever have a dramatic public health impact.

Clearly the strategies suggested above, including widespread use of EC pills, would have the intended effect of reducing unintended pregnancy if they were successfully implemented. But family planning providers have long encouraged and promoted use of contraception, use of the most effective methods, and use of EC pills with no apparent success.

Although advances in technology in the form of long-acting reversible methods not requiring adherence may be helpful, technology alone is not sufficient. Many policies discourage consistent, effective contraceptive use, and deserve to be reconsidered. Women are concerned with the costs of contraceptive options. Medicaid covers

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contraceptive supplies and services for poor women. And the federal government covers contraceptive supplies and services for its employees and their dependents. In 2002, almost every reversible contraceptive supply and service was covered by at least 89% of private insurance plans, and 86% of plans covered the five most popular prescription contraceptives. (14) Twenty-four states require private-sector insurers that cover prescription drugs to provide coverage for prescription contraceptives and related services (these mandates do not apply to the half of employees who have insurance through employers that self-insure). (15) In those states, plans were much more likely to cover the five leading prescription contraceptives (87-92% versus 47-61%).

Although there has been considerable improvement in coverage of contraceptive supplies and services, some women are still not covered, and for many who are, the copays and deductables constitute a considerable economic burden. Coverage rules that impede consistent use also deserve attention. A delay in obtaining a needed contraceptive refill may result in significant reduction of contraceptive efficacy and is a very common reason for contraceptive failure. Yet many insurance plans require women to fill prescriptions for contraception on a monthly basis. Because pregnancy is so expensive, marginal savings gained by limiting refill access are almost certain to be overwhelmed by added costs of pregnancy caused by reduced contraceptive effectiveness.

Reducing unintended pregnancy is a formidable challenge. There seems to be no magic bullet. Between 1994 and 2001, the rate of unintended pregnancy declined among college graduates and the wealthiest women but increased among poor and less educated women. (1) No matter how dedicated, family planning providers cannot fix such structural problems.

James Trussell, PhD, *is Professor of Economics and Public Affairs and Director of the Office of Population Research, Princeton University, USA.* ***Lisa Wynn, PhD,*** *is Associate Research Scholar at the Office of Population Research, Princeton University.*

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Information bulletin

MARIE STOPES INTERNATIONAL ANNOUNCES GLOBAL CONFERENCE ON ABORTION

On 23-24 October 2007, Marie Stopes International will hold a major international conference at the Queen Elizabeth II Conference Centre in Westminster to mark the 40th anniversary of the Abortion Act in the UK.

The conference: Safe Abortion - Whose right? Whose choice? Who cares? (working title) will confront both international and national issues associated with unsafe abortion, focusing on rights, advocacy and funding.

For more information, please contact Tony Kerridge on +44 (0)20 7574 7353 or Diana Thomas on +44 (0)20 7574 7416, or email press@mariestopes.org.uk. If you are interested in attending this event, please contact Laura Brownlee on 0207 324 4372, or email laura.brownlee@neilstewartassociates.co.uk.

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Brook's training programme includes five training courses for professionals. These courses are available as open training to all on pre-set dates, or can be run in-house within your organisation. Brook also holds conferences at least three times a year, based around topical issues.

Conferences

13 February 2007: Sharing answers on teenage pregnancy, London
27 February 2007: Confident about Confidentiality, Birmingham

Training

15 February 2007: Sex, young people, confidentiality and the law
15 March 2007: How to deliver young people friendly sexual health services
19 April 2007: Promoting sexual health and positive relationships to 'hard to reach' and at risk young people
19 April 2007: Training for reception staff
19 May 2007: Supporting young people to negotiate safer sex

For more information, see:

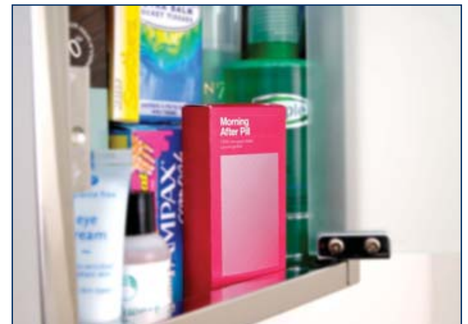
http://www.brook.org.uk/content/M1_Brooktrainingconferences.asp

Abortion Review is circulated to over 1000 subscribers consisting of health care professionals and advice agencies. If you would like to tell them about a key point of interest relating to abortion and sexual health or would like to promote a training event or seminar within the publication, please contact the marketing department on 01789 265009 or email abortionreview@bpas.org

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

Just in case

Wouldn't you want to be prepared?



Every day women in the UK experience a contraceptive failure - the condom splits, they've missed pills or had unprotected sex.

Taking the Morning after Pill (Emergency Contraception) within 12 hours of having unprotected sex will increase its likely effectiveness by 50%. Getting the pill in time can, however, be difficult especially around public holidays.

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