



## ABORTION: A SOLUTION TO A PROBLEM

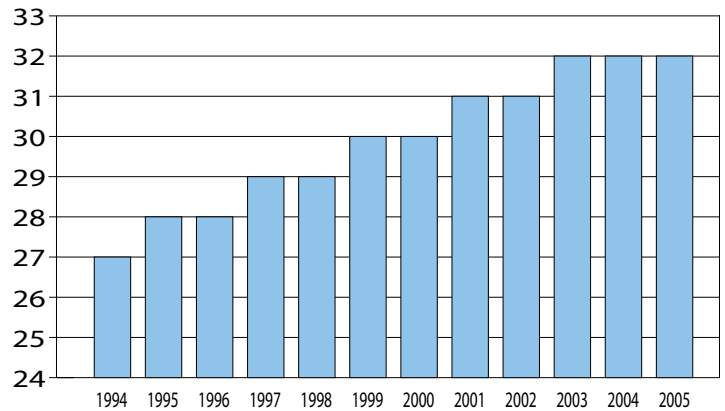


By Ann Furedi,  
Chief Executive of BPAS

The 'problem' of the rising abortion rate has been the subject of much policy and media discussion in recent years. The number of abortions in Britain has been steadily increasing, reaching 193,700 in 2006. This is a source of frustration to government ministers because it is happening at the

same time as a concerted drive to implement a sexual health strategy to reduce the number of abortions, which has meant that many more resources are being put into reducing the need for abortion. What has also emerged as a source of distress to policymakers is that the number of women having 'repeat' abortions also seems to be increasing: almost one third of women under the age of 25 who have one abortion report that they have had one previously. This is despite the fact that a wider range of contraception is available, and the current policy to encourage the use of the long-acting reversible methods of contraception (LARCs).

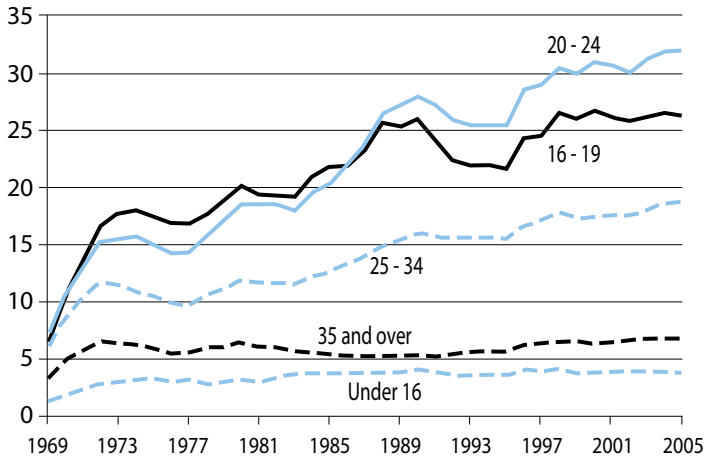
% women under 25 reporting a previous abortion



Abortion rates<sup>1</sup> by age

### England & Wales

Rates per 1,000 females



<sup>1</sup> The rates for females aged under 16 are based on the population of females aged 13 - 15. The rates for women aged 35 and over are based on the population of women aged 35 - 44.

Source: Office for National Statistics; Department of Health

Why is there a continuing high rate of abortion? In my view it is quite simple: there are a lot of people out there having sex who don't want to have children. This might sound facetious but it is not. In Britain today there is a clearly-defined trend for women to delay the age at which they start to have children. In the mid-1970s, women were on average starting their families in their mid-twenties - now the age of first childbirth is in the late twenties, and the average age at which women have children has reached 29. This means that there are a lot of people who are sexually active, possibly in ongoing relationships, possibly living with partners, who simply do not want to factor in a child at this point in their lives. It is arguable that, if women in this situation do become pregnant, they are probably much more likely these days to terminate the pregnancy than continue it to term.

There is also an increasing number of women who are choosing to remain childless altogether. One in five women is now childless at 45. There has been some discussion about whether this is to do with increased infertility, perhaps to do with an increased incidence of sexually transmitted infections, but in general statistics reflect a more conscious shift in women's priorities: namely that many women have got many other things to do in their lives, and they do not particularly want to have any family at all at any time. So it puts them in a situation where they are more likely to terminate a pregnancy.

I would argue that we have a large cohort of people who either don't want to have children or don't want to have children at this particular time. As a society, we have a very high expectation of

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## There is a far greater sense of reproductive choice than in the past

family planning and birth control: we expect to be able to decide when to have children, there is a far greater sense of reproductive choice than there was in the past, and in Britain and America certainly, there is a strong sense of the need for parents to be responsible for their children. The popular press is full of discussion about the 'problem' of parents who do not pay enough attention to their children, who do not think carefully enough about their needs, and this illustrates a general climate in which parenting is seen to be something that should be taken very seriously, and opted into with a great deal of forethought. The idea that you would become a parent because a condom split is something that people don't generally find very acceptable; and in this context abortion is seen as a responsible decision.

### Abortion and parental responsibility

The *Times* (London) columnist Caitlin Moran argued this point eloquently in April 2007, in an article headlined 'Abortion: why it's the ultimate motherly act'. 'My belief in the ultimate sociological, emotional and practical necessity for abortion [became] even stronger after I had my two children,' she wrote. 'It is only after you have had a nine-month pregnancy, laboured to get the child out, fed it, cared for it, sat with it until 3am, risen with it at 6am, swooned with love for it and been reduced to furious tears by it that you really understand just how important it is for a child to be wanted. And, possibly even more importantly, to be wanted by a reasonably sane, stable mother.'

Moran's own abortion was, she says, 'one of the least difficult decisions of my life':

'I'm not being flippant when I say it took me longer to decide what work-tops to have in the kitchen than whether I was prepared to spend the rest of my life being responsible for a further human being...While there was, of course, every chance that I might eventually be thankful for the arrival of a third child, I am, personally, not a gambler. I won't spend £1 on the lottery, let alone take a punt on a pregnancy. The stakes are far, far too high.' (1)

A study by Rachel Jones and colleagues at the Guttmacher Institute in New York, published in January 2008, gives some empirical context to the viewpoint argued by Moran. (2) The study, titled "I Would Want to Give My Child, Like, Everything in the World": How Issues of Motherhood Influence Women Who Have Abortions', began by noting that, contrary to the general perception that women who have abortions are a different group to those who are mothers, 61% of the women who have abortions in the USA already have children. Jones et al's qualitative study of 38 women found that key reasons behind their decision to have an abortion were 'the material responsibilities of motherhood, such as the care for their existing children, as well as the more abstract expectations of parenting, such as the desire to provide children with a good home.' The authors further noted:

'The women believed that children were entitled to a stable and loving family, financial security, and a high level of care and attention...The findings demonstrate reasons why women have abortions throughout their reproductive life spans and that their

decisions to terminate pregnancies are often influenced by the desire to be a good parent.'

The expectation that we have of family planning, our sense of reproductive choice, and the seriousness with which we take the decision to have children, may form part of the reason why the abortion rate is going up. But these are not bad things, and certainly not developments that we would want to reverse at all. My view is that abortion is not the problem. The problem is unintended pregnancy, and abortion is the possible solution to unintended pregnancy. This begs the question, what strategies might be considered to reduce the incidence of unintended pregnancy?

### Contraceptive use

One obvious strategy is to increase contraceptive use among non-users. It is the case that approximately 40% of BPAS clients say they didn't use contraception at the time they conceived. However, we also have to acknowledge that contraception fails. People may fail to use it but it also fails; and it fails much more commonly than people tend to think. Family planning doctors don't like to talk about contraception failing, and prefer to concentrate on the problem of people failing to use it. But contraceptive failure is a problem that we need to face up to. Data produced by James Trussell and Lisa Wynn in the USA show the gaps that exist between the way contraception should be used, and the way it is typically used. Of the 3.1 million unintended pregnancies in the USA in 2001, Trussell and Wynn found that 48% result from contraceptive failure. (3)

### % women with unintended pregnancy in first year of contraceptive use

	Perfect use	Typical use
Spermicide	18%	29%
Diaphragm + spermicide	6%	16%
Male condom	2%	15%
Pill	0.3%	8%
Depo-Provera	0.3%	3%
Implanon	0.05%	0.05%
Mirena	0.2%	0.2%
Copper IUD	0.6%	0.8%

It is very important to take on board the fact that contraception is fallible, because it very much affects how they think about abortion and future family planning strategies. When we at BPAS see women who have not used a method of contraception, they admit that they know where they went wrong, and often joke: 'I'll never let him near me again without making sure I'm properly protected'. But if someone has used contraception and it has let them down, they really don't know where to go, which makes it very difficult for them.

## The impact of contraceptive services can be overestimated

For people who are using contraception, those involved in family planning may be able to help reduce their risk of unintended pregnancy by encouraging the use of LARCs, implants, and IUDs, which don't require that they remember to use a barrier method, or take a pill every day. Emergency contraception (EC) is also a very positive development, because it can be so forgiving, allowing women to use the contraception after they have had sex.

However, I think that all of our best intentions are confounded by a number of things. People's knowledge of, and access to, contraceptive services is one of the things that limits contraceptive use. But even here, it is important to understand that the impact of contraceptive services can be overestimated. A study published by Anna Glasier and colleagues in 2006 randomised women seeking repeat abortions between an ordinary family planning service, and a service offering specialist contraceptive advice and enhanced provision: the idea being that you could see how the quality of a family planning service and advice influenced whether or not they needed a subsequent abortion. The study found no statistical difference between the two groups at all. In fact, a slightly larger number of women in the specialised family planning services needed a repeat abortion. (4)

There have been a large number of studies about the impact of sex education on abortion rates and pregnancy rates, and these frequently tend to show that they are not having the kind of impact that family planning specialists want. They mainly make us feel good that we're educating people more thoroughly, but they do not seem to have much impact on the abortion rate.

### Sex, risk and intimacy

One area that has been rather less well studied relates to people's perceptions of risk. Women have lots of misconceptions and misunderstandings about their fertility, their fertile period, when it is safe for them to have sex and when it is not. They also have lots of misunderstandings about contraception, and about the chances of unwanted pregnancy. We need to understand that at the end of the day, for lots of women, their motivations to use contraception may not be as high as we might think or hope, because contraception is about doing something to prevent something that might not happen anyway.

Further to this, there is an element in women's risk-taking that is often completely forgotten by those involved in sexual health provision: which is that non-use of contraception may be hooked into something else. It may be hooked into a desire for intimacy, a desire for closeness: in other words, it may be hooked into something that is not entirely dysfunctional. We tend to think of non-contraceptive use as being dysfunctional, a thing that people shouldn't do, whereas if we take a step back from the view of sex that is generally held by family planning doctors to imagine the woman's viewpoint, we start to see things quite differently.

Family planning doctors, in general, see sex in terms of risk. Good sex for family planning doctors is safe, planned, under control, negotiated, responsible - all of these things. For other people, however, good sex is more to do with opportunity: it's about it

being edgy, exciting, spontaneous, passionate, lost in the moment, carried away, romantic. All of those things that people look for in their relationships mitigate against the planning, preparedness, the loss of control. For many people, relationships really are a balance of risks, and balancing risks against a desire to take things for granted, to be spontaneous.

There is some literature coming out of the gay community that looks at this sexual risk-taking in relation to gay couples who are not of equivalent HIV status. This has found that non-condom use for committed gay couples can be seen as an act of trust, closeness, intimacy, and togetherness. When we look at why people take risks with heterosexual sex, we may find that the situation is not going to be resolved by people vowing to use contraceptives better.

Those involved in sexual health provision tend to get caught up in a medical model of looking at things, which can blind us to some of the more vague and messy aspects of human relationships that we really don't yet understand. We shouldn't be defensive about this, and we should challenge a lot of the received wisdom. In particular, we need to think about the subjects that we deal with from the point of view of people who are not professionals working in a particular area.

The Clintons in the USA have a great deal to answer for, in popularising the notion that abortion should be safe, legal and rare. (5) There is a very easy way to make abortion rare, and that's to ban it, or to take away services, or to stigmatise it so people don't feel able to have recourse to it. Do we really want to go there, as a society? We have a choice to make: either we continue to see abortion as a problem, or we allow people their moments of intimacy, we allow them to enjoy sex, and we allow them to make use of abortion as a back-up to contraception.

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### WHY DON'T ABORTION RATES DECLINE?

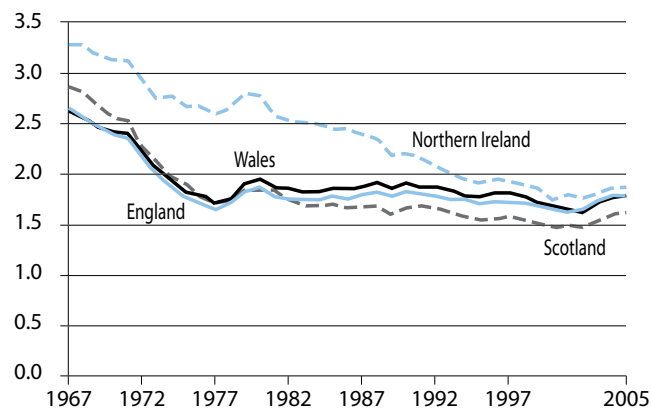
By Ellie Lee

Changes to birth rates are a noteworthy development of the past 40 years, with those of the past decade being the subject of great deal of both scholarly and more popular discussion. In 2005 the Total Fertility Rate (TFR) in the UK was 1.79 children per woman, a rise from 1.77 in 2004 and the fourth consecutive annual increase since the record low of 1.63 in 2001. (1) It is too early to know whether this constitutes a longer-term trend. However, it does not diminish the age-specific pattern, which is of a decline in fertility among women in their 20s, and an increase, though less sizeable, in the birth rate to those aged 35 and over.

#### Total Fertility Rate\*

##### United Kingdom

Children per woman



Source: Office for National Statistics, General Register Office for Scotland, Northern Ireland Statistics and Research Agency

The decline in fertility among women in their early 20s is a long-term trend, evident since the mid-1960s. For women in their late 20s, a trend to declining fertility is more recent, dating from the late 1980s. In general, fertility rates for older women have increased over the same period of time. During the 1970s, fertility rates were highest in the 20-24 and 25-29 year age groups, but throughout the 1980s and 1990s, women aged 25 to 29 had the highest fertility rates. Fertility rates at age 30-34 have increased steadily since the mid-1970s, and by 2004 the rates for women aged 30-34 exceeded those of women aged 25-29. (2)

## Childbearing is now very susceptible to situational factors

### Average age of mother: by birth order

England & Wales	Years				
	1971	1981	1991	2001	2005
1st Child	23.7	24.8	25.6	26.6	27.3
2nd Child	26.4	27.3	28.2	29.2	29.6
3rd Child	29.1	29.2	29.9	30.7	30.9
4th Child	30.9	30.9	31.2	31.5	31.6
5th Child and higher	33.6	33.8	33.5	34.4	34.6
All Births	25.6	27.0	27.7	28.6	29.0

1. Age-standardised to take account of the changing population distribution of women Source: Office for National Statistics

The trend is towards not only delayed motherhood, but also childlessness. There has been an increase in the proportion of women remaining childless in each age cohort born since 1950. The proportion of women who would have no children at the end of their childbearing years (age 45) has risen from 11% of women born in 1940 to 18% of those born in 1960, the most recent cohort of women to have reached the end of their childbearing years. (3)

For an increasing proportion of women, therefore, motherhood is either marginal throughout their lives, or for a longer period than before. How can we understand these fertility patterns? What explanations have been offered for them? And what effect do they have on demand for abortion?

#### Childlessness

Childlessness has become a specific subject of discussion, particularly the extent to which childlessness may be understood as 'voluntary'. Childlessness resulting from an active choice based on negative views towards having children, has been found to exist at lower levels than might be expected across Europe. (4) Fewer than 10% of women are childless by choice in all countries except Belgium and Austria, and in Britain the proportion is only 7- 8% at age 42. Men and women who are uncertain about whether to have children comprise a larger group: in Britain, 12% of women and 21% of men at 42, and one third of women and almost one half of men at age 30.

The relatively larger size of the group of those who are uncertain about whether to have children has led to the conclusion that ambivalence about childbearing and delay in making the decision about whether and when to have children plays a more dominant role than a definite decision to be 'childfree'. Childbearing, it has been argued, is now very susceptible to situational factors (such as changes in the incidence of marriage) and to the social, economic and policy environment.

Delaying having children and not having them at all are largely neither the result of circumstances entirely beyond individual control, such as the effects of war, nor for the most part the result of voluntarism. Rather, current fertility patterns can be best understood in relation to how individuals interact with range of factors that impact on experiences and perceptions of parenthood.

#### Employment

One aspect of the social and economic environment discussed in many studies of fertility is the increase in the percentage of women in employment. Women's participation in the labour force is often on a part-time basis, and in certain sectors of the economy. But the number of women that expect to continue working through their adult lives has increased considerably.

The effect of this development on fertility is a source of debate. On the one hand, it is argued that there is an identifiable relationship between employment patterns and fertility patterns (5). While some argue that increased female participation in the labour force is almost inevitably linked with deferred childbearing, others see a more complex relationship between the changed position of women in regard to the labour force, and their postponement or rejection of parenthood. The British Social Attitudes Survey, for example, has suggested that it is 'less than clear' that fertility decisions and family life are taking second place to employment in the minds of the majority of women.

Qualitative research suggests that childless women are not mostly 'driven by ambition'. The evidence challenges the notion that large numbers of women are manifestly placing their commitment to their paid work above having children. As Catherine Hakim notes, the fact that a high proportion of professional women remain childless may be the result of a drive to succeed at work. (6) However, these women constitute a 'tiny fraction' of those without children, since it is still the case that very few women reach top of their chosen profession. Childlessness, rather, is mostly accounted for by those in 'middle and lower grade occupations' who are by no means necessarily career-oriented, nor strongly rejecting of the prospect of eventually having children.

This is not to argue that changes to employment patterns are not important in explaining why fertility has declined, but to suggest that the relationship between fertility and employment is not straightforward. According to Fiona McAllister and Lynda Clarke, fertility outcomes may be better understood as a result of the interaction of employment with other trends, notably those relating to formation of partnerships. (7)

#### Marriage

Marriage patterns also impact on fertility. Marriage now happens in general later in life and less frequently. In England and Wales in 1971 the average age at first marriage was 25 for men and 23 for women; by 2005 this had increased to 32 and 29 respectively. (8) There has been a similar trend across Europe. The proportion of people cohabiting has increased greatly significantly since the mid-1980s, and the Office for National Statistics notes that this may in part be related to people marrying later in life. The proportion of non-married men and women aged under 60 who were cohabiting in Great Britain more than doubled between 1986 and 2005, from 11% to 24% (men), and 13% to 24% (women). (9) Additionally the proportion of people living in couples of any kind, married or cohabiting is falling. The proportion of people living 'solo' has been identified as growing, as has 'living together apart', whereby partners choose to live in separate households. (10, 11)



## Policy may influence fertility through its focus on parenting

These trends are significant for fertility in that non-marital relationships are more likely to be childless. Cohabitation has not simply replaced marriage in this regard. Qualitative research suggests that people who are married and non-married tend to have different expectations. In particular, women who are single are three to four times more likely to say they will remain childless than married women. (12) Ambivalence characterises choices relating to marriage just as it does those relating to having children. In regard to both possible life events, it can be argued that a widespread perception has emerged in which the difficulty looms large of reaching a point of certainty about what is the best life choice, and whether or not to take on the responsibilities associated with certain choices.

### Childcare

Public policies impacting on parenthood are also important in shaping fertility trends, primarily those affecting provision of childcare. (13) Social policies in regard to 'family friendly working' and childcare are likely to make little difference to the 'childfree', but may have a significant effect for the numerically larger group that is uncertain about childbearing. Fertility outcomes are likely to be affected to some degree at least by policies relating to availability of childcare, working arrangements and maternity leave.

Policy may also influence fertility through its reflection and amplification of themes associated with the problem of 'parenting'. The nature of parent-child interactions has been placed increasingly under the spotlight, and policy has been shaped with this in mind. Increasing credence has been given to the notion that the experience of the 'early years' is decisive for a person's future development, and as a result, emphasis on the 'early years' now strongly influences the agenda for childcare policy. This in turn has given added impetus to the idea that it is far better for pregnancies to be planned and wanted, thus impacting on reproductive health policy.

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Little research specifically addresses the extent to which ideas about 'parenting' influence decisions regarding having children. However, a focus on parenting may have heightened concerns about being 'good enough parents', increasing a sense of uncertainty about when is the 'right time' to take on what might now seem to be a considerable challenge.

### Conclusions

The current context is one in which women have fewer children than before and later in life; where cohabitation and solo living are more commonplace; where a very high primacy is placed on pregnancies being planned and wanted; where women expect, and are expected to, take on responsibilities other than motherhood through their 20s; and where 'parenting' has come to be viewed as a skill that is demanding and needs to be acquired rather than something that 'comes naturally'. It is unsurprising given all of this that abortion rates fail to decline. Abortion has come to be perceived as a choice that can be considered when unplanned pregnancies occur, in a way that has not been the case previously.

**Dr Ellie Lee is a Senior Lecturer in the School of Social Policy, Sociology and Social Research, University of Kent, and co-ordinator of Pro-Choice Forum ([www.prochoiceforum.org.uk](http://www.prochoiceforum.org.uk)) This is an updated and edited extract from Ellie Lee's chapter in K. Wellings and A. Glasier (eds) (2005). *Contraception and Contraceptive Use*. London: RCOG Press.**

\* *The Total Fertility Rate (TFR) for a given year is the average number of children per woman a group of women would have if they experienced the age-specific fertility rates in the given year for their entire childbearing years.*

## CLINICAL UPDATE

By Patricia Lohr,  
Medical Director, BPAS

In a new Q&A column for Abortion Review, BPAS' Medical Director examines developments and discussions in abortion provision. This edition:



### Home Use of Misoprostol

#### Q) What is misoprostol?

Misoprostol is a prostaglandin analogue that is registered for the prevention of gastric ulcers caused by nonsteroidal anti-inflammatory drugs. However, it also softens the uterine cervix and causes uterine contractions. These mechanisms of action have led to its use for a variety of indications in obstetrics and gynaecology, including abortion (1).

#### Q) How is it administered in Early Medical Abortion (EMA) in Britain?

In Britain, misoprostol is used with mifepristone for EMA. Mifepristone, an oral tablet, is given first in order to destabilise the pregnancy. Anywhere from 6 hours - 3 days later, misoprostol is administered, which causes expulsion. Misoprostol can be used orally, buccally, sublingually, and vaginally for medical abortion.

According to UK law, abortions can only be performed only in facilities approved by the Department of Health. This requirement has also been applied to medical abortion and the law has been interpreted such that both mifepristone and misoprostol must be given in an authorised medical facility. This requires that a woman attend at least 3 appointments during the course of her abortion; twice for administration of medications and once to confirm that the procedure has been successful. In some cases, a facility may also require that the woman remain and be observed for 4-6 hours after receiving misoprostol. In others, she may be allowed to go home immediately after using the misoprostol.

#### Q) How does the use of misoprostol in EMA in Britain differ from that of other countries?

The experience of women in Britain is similar to those in many other European countries. However, in the United States and some countries, like Sweden, misoprostol tablets are given to the woman so that she can self-administer the medication at home.

#### Q) What would be the potential benefits of allowing women to self-administer misoprostol at home?

Many women choose medical abortion because it is perceived as being more private than a surgical procedure (2). Using misoprostol at home allows women to have that private experience. It also helps women feel more in control of the process, not only of the abortion and where it happens, but when. In most cases, bleeding and cramping begins about 2-4 hours after the misoprostol is used, but can begin earlier (3, 4). This means that some women who receive misoprostol in a clinic and then are allowed home will develop symptoms while in transit. Even for women who are observed for several hours, approximately one-quarter will not abort during that time depending on how the misoprostol is used (5, 6). Because women are rarely observed overnight for an EMA, those who have not aborted despite the 4-6 hours will be sent home anyway. This seems to obviate the need for prolonged observation for a significant proportion of women.

Probably the most compelling reason for allowing women to take misoprostol at home is because most women prefer it. In a trial by Schaff et al, women were given the option of returning to the clinic or taking the misoprostol at home - over 99% chose to take the medication at home. In a small UK trial of home use, 93% of subjects stated that they would undergo an abortion at home again should one be necessary (7).

#### Q) What might be the potential problems with home use of misoprostol?

Multiple, large studies have shown that women are very capable of using misoprostol at home and that it is safe (2, 3, 8). An important part of providing medical abortion in this way, however, is anticipatory guidance. Women need to know what the experience is going to be like, what is expected and what signals a possible complication. They need to receive information about managing pain and side effects, and they need access to a 24-hour advice line to call if they have concerns and which can refer them to emergency care in the rare instance where it is necessary.

#### Q) What, in your view, would be the best practice approach to administering misoprostol?

Some women may desire a period of observation or even treatment in a hospital setting. In an ideal world, women would be offered a choice. However, with an ever-increasing proportion of women choosing the early medical option this is unlikely to be feasible. The argument for home administration of misoprostol is compelling - not only is it a safe and effective way of providing medical abortion, women who have participated in studies of home use report that it is highly acceptable and even preferred because it fits with their reasons for choosing medical abortion in the first instance (9, 10).

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