Abortion Review

ISSUE 28 SUMMER 2009 ISSN 02627299

WILL THE GLOBAL RECESSION LEAD TO A 'BABY BUST'?

By Jennie Bristow, Editor, *Abortion Review*

The economic recession had barely become a reality before commentators began to speculate about its likely impact on the birth rate. An article on msnbc.com by Melissa Schorr in January 2009, titled 'Shaky economy means "bye-bye baby" for some', suggested that, in America, '[w]ith rising job cuts and home foreclosures, many financially crunched families have decided the time isn't right to have a child, or another child.' (1) In February 2009, Gaby Hinsliff, political editor of the UK *Observer*, wrote: 'For couples contemplating starting a family now whose job prospects are uncertain, the temptation may well be to hold off'. (2)

There is a concern that, at a time when couples can no longer be confident that they will receive their next wage cheque, they may decide to save themselves the expense and responsibility of having a child, or more children, perhaps spelling the end of the mini-baby boom we have seen in the UK since the year 2000.

Some have gone so far as to argue that the recession is leading to a rise in the demand for abortion. In April 2009, the UK *Daily Telegraph* reported that vasectomies and abortions were on the rise 'as economic meltdown hits US families'. (3) According to Barbara Zdravecky, president of a Florida wing of Planned Parenthood, in the area covered by her group abortions have risen by 14 per cent in the first two months of this year compared to the same period in 2008, and Planned Parenthood regional offices report similar figures across the country. The *Telegraph* also reports that Vicki Saporta, president of the National Abortion Federation, said there had been a significant increase in calls to the organisation's hotline because of the economy - including many from women struggling to afford the cost of a termination.

Similar concerns have recently been aired in relation to Singapore, which already has in place a national campaign to boost the birthrate through offering incentives to encourage couples to have more babies. According to AFP, government figures show 39,935 babies delivered in 2008, well below the 60,000 Singapore needs to maintain its native population. (4) Reporting that 'Singapore has one of Asia's most liberal abortion policies and the global financial crisis could be prompting more women to terminate pregnancies', this article cited figures showing that there were 12,222 abortions in the city-state in 2008, compared to 11,933 in 2007 (no official figures are available for 2009).

In December 2008, Gabrielle Malone, programme director with the Marie Stopes Clinics in Britain, argued that the increase in Irish women travelling to Britain to have an abortion was '"because they can't afford to keep their baby"'. Malone was quoted in a news article headlined 'Recession linked to rise in women seeking abortions.' (5) In an article in the *Observer* in February, which reported an 'Internet boom in DIY abortion pills', Dawn Purvis, leader of Northern Ireland's pro-choice Progressive Unionist Party, said:

> '"I am hearing more about these 'pills' at the moment with the recession in full swing. Money is short and it's mainly working class women who can't afford to travel. Buying the pills off the net is an easy solution."' (6)

It is true that children can be expensive, and that the recession has added major pressures to individuals' and families' circumstances. But how far is it possible to extrapolate from this the prediction that this will lead to a decline in the birth rate, and a rise in the abortion rate?

Birth rates and recessions

It is historically the case that birth rates tend to fall during times of economic crisis and uncertainty. As Melissa Schorr notes on msnbc.com:

> 'There was a dramatic decline in fertility rates following the Great Depression in the 1930s, when, for the first time in US history, women went from having an average of three children the previous decade to two.
>
> 'In each year after the country's last four recessions, general fertility rates — calculated as the number of women of child-bearing age per thousand who gave birth — dipped slightly. For example, in the year following the 1973-1975 recession, fertility rates dropped from 68.8 in 1973 to 65 in 1976, according to data from the National Center for Health Statistics, part of the Centers for Disease Control and Prevention. Similarly, following the 1980-1982 recession, the fertility rate fell from 68.4 in 1980 to 65.7 in 1983.' (1)

An article in the *New York Times* back in 1991 began: 'Five years of steady increases in the number of births in America ended abruptly this year, and many demographers and economists are blaming the recession.' (7)

Inside this issue:

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

It is implausible to argue that recessions cause more abortions

Similarly, Gaby Hinsliff notes that the birth rate in Britain 'fell in the 1970s during tough economic times' – though she adds that 'that period also coincided with greater availability of contraception and more women taking up careers.' (2) It is this coincidence of economic conditions with other social developments that is key.

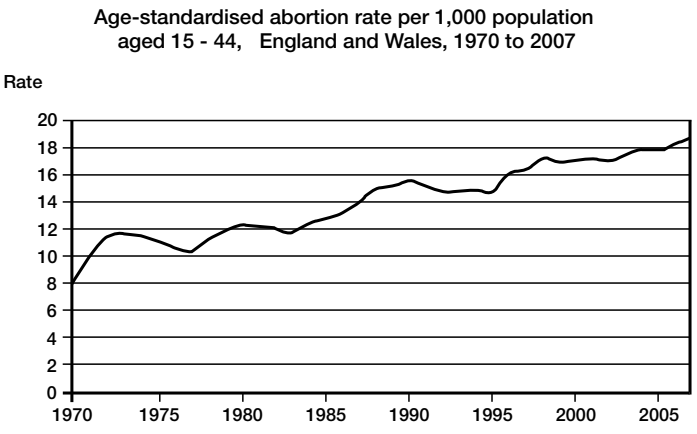
In historical terms, the key explanation for major declines in the birth rate is economic development. This is distinct from the specific pressures caused by short economic cycles. The concept of the 'demographic transition' sums up this process, by which declines in mortality and fertility result in 'an older stationary and stable population corresponding with replacement fertility (i.e., just over two children on average), zero population growth, and life expectancies higher that 70 years.' (8)

The process of demographic transition began in the developed world from the eighteenth century onwards, way before the existence of modern methods of contraception or abortion, indicating that people's desire and ability to control their fertility does not depend wholly on scientific birth control. The decline in the birth rate following the Great Depression of the 1930s coincided with major strides in the development and availability of contraception; however it worth noting the major differences between then and now: abortion was still illegal and contraception not freely available to all. Therefore, while it is plausible that times of economic hardship leads people to delay, or to decide against, having children, it is not evident that they are able to do that because of the availability of contraception and abortion. It is just as plausible to argue that birth rates go down because people have less sex, or have sex at a different time of the month – data that would be pretty hard to collect.

Abortion rates and recessions

This point is borne out by the differences in the abortion rates in the USA and the UK. As has been discussed at length elsewhere, the abortion rate in England and Wales has steadily increased since abortion was legalised in the 1967 Act. (Figure 1)

Figure 1



Source: Department of Health

If one were to correlate the abortion rate with periods of economic recession - the mid-1970s, the early 1980s, the early 1990s – if anything it appears from the graph below that the abortion rate declined during those periods, while it has increased during the recent 'mini-baby boom'. When we take account of the fact that correlation does not mean causation, it is implausible to argue that recessions cause women to have more abortions – or even that recessions correlate with women having more abortions.

A similar point is true for the USA, where the abortion rate has been steadily falling since the beginning of the 1990s (the time of the last economic recession). (Figure 2)

Figure 2

Source: Guttmacher Institute

The discussion as to why the US birth rate is falling is both unclear and highly politicised: as Nancy Gibbs has argued in *Time* magazine:

> 'The problem is that no one can prove what complex chemistry of cause and effect, culture and calculation, explains the falling rates — and for people who have devoted their lives to this issue, there's no glory in achieving one's ends if the means are anathema. Pro-choice groups credit comprehensive sex education and access to contraception, strategies that social conservatives often resist. Pro-lifers credit campaigns to tighten laws controlling access to abortion and to warn women about abortion's risks — which the other side deplores.' (9)

The major social differences between the USA and the UK mean that the factors affecting the abortion rate are likely to be very different. One important difference is that, unlike in the UK, most women in the USA have to pay for contraception and abortion. A recent survey commissioned by the American College of Obstetricians and Gynecologists (ACOG) found that three percent of women of child-bearing age had stopped using birth control because they could not afford it: according to the ACOG, these findings suggested that the recession may be leading to more unintended pregnancies. (10) In general terms, it is worth considering the relationship between a society's birth rate and the cost and availability of contraception and abortion.

Both economic determinism and political determinism are inadequate explanations for demographic trends

However, one common point between the UK and the USA seems to be that there is no clear link between economic crises and whether, or not, people decide to have an abortion. There are many factors that influence whether women have abortions, to do with their relationships, family dynamics, beliefs, and sense of personal identity (11).

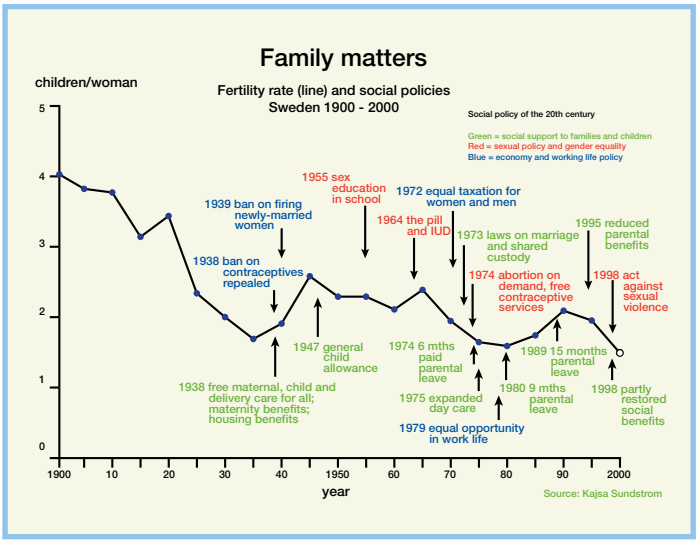
The 'second demographic transition'

Does this mean that the legal availability of abortion and contraception has no impact on demographic trends? No. These developments have been key to what theorists have described as the 'second demographic transition': the period in economically developed society characterised by 'sub-replacement fertility, a multitude of living arrangements other than marriage, the disconnection between marriage and procreation, and no stationary population.' (8)

In this context, the impact of demographic changes such as later motherhood, female employment and immigration have a significant impact upon the birth rate, and there is no doubt that contraception and abortion play an important role in enabling individuals to make choices about whether and when to have children, and how many children they have. These issues have been discussed by Ellie Lee on *Abortion Review*. (12) The key point to note, however, is that even here the relationship between scientific developments, reproductive health policies, individuals' choices and demographic trends is far from clear.

For example, in an interesting article titled 'Can governments influence population growth?', Kajsa Sundström, of the Karolinska Institute, Stockholm, and the women's health and empowerment group Qweb, examines why in Sweden 'almost a century of policies to encourage larger families has failed to boost birth rates.' (13) She produces a diagram (Figure 3) showing the dates of certain policy developments, and their relationship to the birth rate. From this diagram, it seems that none of the social policy developments had their intended effect of raising the birth rate.

Figure 3



When it comes to broad demographic trends, both economic determinism and political determinism are inadequate explanations. History can tell us that uncertainty about the immediate economic future may have a negative impact upon the birth rate following a major recession, although the wealth of other social and cultural factors that impact upon reproductive decision-making today – for example, risk consciousness and the pressures of modern parenting culture (14) - mean that even this should not be assumed.

We can be reasonably confident, however, that the current economic recession will not 'cause' either a rise or a fall in the abortion rate. Women's decisions to terminate pregnancies through abortion are not motivated by rational economic factors, but by a host of broader social and personal circumstances.

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WHAT DOES CEDAW DO?

Abigail Fitzgibbon, BPAS Press and Public Policy Officer, examines what the UN Convention on the Elimination of All Forms of Discrimination Against Women means for abortion rights in the UK.

The United Nations (UN) 'Convention on the Elimination of All Forms of Discrimination Against Women' (CEDAW), adopted by the UN General Assembly in 1979, is widely regarded as an international Women's Bill of Rights. However, questions have been raised over how useful it can be in improving the lives of women in developed nations.

A recent conference on 24th March 2009, organised by the Women's Resource Centre (WRC), and supported by the Equality and Human Rights Commission, focused on 'seizing the opportunities of CEDAW' to make a difference to the lives of women. The meeting brought together representatives of Non-Governmental Organisations (NGOs) across the women's sector, concerned with rape, domestic violence, healthcare and advocacy, to discuss a joined-up approach to maximising the power of CEDAW to help women in the UK.

The UK Government's commitment to tackling discrimination against women was last examined at the UN in New York in July 2008. CEDAW's Committee examined the measures taken by the UK in fulfilling the obligations to which it committed by ratifying the Convention, and produced a series of recommendations that must be addressed before the next assessment in four years' time in 2011.

The WRC conference discussion focused on how women's organisations can best work together to hold the Government to account, prior to the next assessment. The Government submits an official report to the Committee, alongside a series of shadow reports by NGOs. It was agreed by organisations at the meeting that, by working together on the official shadow report, NGOs can be a powerful influence on the Committee. The Women's Resource Centre is looking at how best to coordinate this work and ensure that the voice of women's organisations is heard at the next examination.

There are two recommendations to the Westminster Government from the Committee that relate directly to abortion rights. The first of these is that it should 'initiate a process of public consultation in Northern Ireland on the abortion law'. The second is that it should 'give consideration to the amendment of abortion law in Northern Ireland so as to remove punitive provisions imposed on women who undergo abortion'. These are both useful advocacy points. However, in practice there has been little progress in securing abortion rights for women in Northern Ireland, despite these recommendations from what is thought to be an influential body.

CEDAW is a useful campaigning tool

There are barriers to using CEDAW to change abortion law in Northern Ireland. While healthcare is a matter devolved to the Northern Ireland Assembly, abortion, as it is covered by criminal law, has not yet been devolved. Westminster has made it clear that it intends to hand over the responsibility for criminal law imminently, which means that by the time the UK Government is next examined by the UN Committee it will be able to state that abortion is no longer within its remit.

As the UN is concerned with the UK as a whole, it may not be convinced by this argument and it can ask the UK government to put pressure on the Northern Ireland Assembly to make progress on abortion rights. However, as there are no sanctions in the event of inaction on CEDAW recommendations there is nothing to force Westminster to take such action.

Despite these obstacles, it would be unfair to say that CEDAW cannot serve a purpose in the campaign to win abortion rights for the women of Northern Ireland. Last year the UK Government had the opportunity to change the law, via Diane Abbott MP's amendment to the Human Fertilisation and Embryology Bill, but chose to prevent the debate using parliamentary procedure. It was rumoured that this was due to political horse-trading with the Democratic Unionist Party (DUP) MPs from Northern Ireland, whose votes can be critical to Labour in certain circumstances.

The CEDAW Committee will have the opportunity to raise this with the Government's representative in 2011 and, hopefully, will encourage the Government to explain what moves it has made to support the women of Northern Ireland. Should a Conservative Government win the next General Election, it will inherit the CEDAW recommendations and be accountable for abortion rights in Northern Ireland.

CEDAW is a useful campaigning tool that can be used in the work of women's organisations to encourage the Government to take action on specific issues. Liz Kelly, of the End Violence Against Women Coalition, cited CEDAW recommendations as the reason that the Government published the recent consultation on violence against women (1), which does suggest that the Convention has some influence over the executives in developed countries. However, when Governments are prepared to suppress Parliamentarians' opportunities to improve women's reproductive rights, it is debateable how effective CEDAW alone can be in bringing about change.

(1) 'Together we can end violence against women consultation'. Home Office, March 2009 ***http://www.homeoffice.gov.uk/documents/cons-2009-vaw/***

Vasectomy is more popular in the UK than almost anywhere else

IS VASECTOMY ALWAYS A FINAL DECISION?

An article on BBC News Online in March 2009 claimed that 'second marriages or starting afresh with a new partner mean a number of men are spending large sums of money trying to reverse their vasectomies'. (1) Clare Murphy reported that vasectomy is more popular in the UK than almost anywhere else, with 16% of men under 70 undergoing the procedure. But if the man later decides he wants to father a child, or more children, vasectomy reversal is difficult to obtain.

Murphy reports that 'reversals are all but banned on the NHS': the UK Government imposed this ban in 2004 'after high demands for the operation put pressure on NHS services'. While it was claimed that the procedures would still be allowed in 'exceptional circumstances', left to be determined by individual health trusts, the case of a Staffordshire man last year who was refused a reversal despite losing his young son to cancer 'was seen as highlighting the extent of rationing'.

Murphy reports that despite the difficulties of vasectomy reversal, clinics report brisk business. She quotes Dr Andrew Dawson, who runs a reversals clinic in Hartlepool which carries out 200 procedures each year. 'We see many people with second wives who had two or three children in a previous relationship and thought they were done, only for their marriage to break down,' Dr Dawson said. 'But there are also some couples who change their mind about more children at key moments - such as when their children go off to school, or university. I don't believe more counselling at the time of the original vasectomy is the answer - for most people that decision was the right one for them at that time.'

Commenting on this story, Dr Sam Nag, a consultant surgeon who carries out reversals for BPAS, said:

'If you are going to put it in terms of cancer drugs versus vasectomy reversals it's not hard to see which should win. But if the NHS is going to offer vasectomies - and it should, as this is a cost effective and efficient way of preventing pregnancy - then there should be funding of reversals. People's lives can change dramatically - we should accept that rather than adopting this "you made your bed now lie in it" attitude.'

(1) Divorce fuels vasectomy reversals, by Clare Murphy. BBC News Online, 18 March 2009

CLINICAL UPDATE

By Sam Nag, FRCS
Consultant Surgeon, BPAS

Vasectomy

1. What is the purpose of vasectomy?

The purpose of vasectomy is to render a man sterile and hence incapable of fatherhood.

2. How is vasectomy performed?

After a local anaesthetic infiltration on scrotum a keyhole / small incision is made. The vas (sperm duct) is exposed and divided. The cut ends are then tied / sealed. Very rarely a general anaesthetic is chosen for a specific reason.

3. How effective is the procedure?

Most men become sterile after 3 months. A small number of men may take longer to become sperm-free. The failure rate is 1 – 2%, mainly due to the re-joining of the vas. This would be detected in post-vasectomy tests and a re-operation under general anaesthetic is done.

4. Are there any complications and side-effects?

Most men resume normal activity after 2-3 days. Recovery can be delayed by 1 – 2 weeks if there is a wound problem e.g. infection (2 -3%) occurs. This settles with antibiotics in a few days. Vasectomy does not affect the sex-life of men and there is no increased risk of cancer of testis or prostate.

5. Can vasectomy be reversed?

Yes, but not always successfully. Vas re-joining success may be 80 – 90%, but the chances of pregnancy are 25 – 50%. High parental age and long time length since vasectomy are the main causes of low pregnancy rate. Unlike vasectomy, this operation is very expensive, not usually available in NHS.

6. How great is the demand for the reversal of vasectomy?

Most requests for reversals are from new relationships following unforeseen circumstances like divorce. The female partner may or may not have had children before. About 6% vasectomised men come back for a reversal of vasectomy and a successful outcome can change their life dramatically.

Riley and Furedi examine current problems with the UK abortion law

NEW BOOK: *REGULATING AUTONOMY*

'In *Regulating Autonomy: Sex, Reproduction and Family*, published by Hart in 2009, a chapter by Laura Riley and Ann Furedi of BPAS examines the question of 'Autonomy and the UK's Law on Abortion'. The chapter notes that 'UK abortion law has changed remarkably little since 1967, although accompanying regulation is updated regularly': the most significant change being the amendment, via the Human Fertilisation and Embryology Act 1990, which reduced the 'time limit' for abortions for reasons other than fetal abnormality from 28 weeks' gestation to 24.

In discussing the question of autonomy in abortion care, the authors envisage autonomy as 'decision-making by a competent individual which may affect various aspects of their life and physical self, in some aspects potentially for an indefinite time'. Within healthcare, 'autonomy is compromised unless offered in a[n] … environment respectful of self-determination, which offers practical support for autonomous decision-making'; and facilitating this environment in abortion care 'requires (for example) accurate, appropriate and timely non-directive information from healthcare professionals to enable each individual to fully explore their options, with a commitment to appropriate confidentiality, and for a choice of appropriate treatment methods to be offered in order to maximise the acceptability and accessibility of each option'.

Discussing the way in which BPAS clients make autonomous abortion decisions, Riley and Furedi note that such decisions 'tend to take into account far-reaching considerations far beyond the risks to life and health involved'. These decisions are often taken with a partner, in the context of the woman's relationship; in relation to a woman's ideas about how she may or may not make a 'good parent' to the potential child; and by 'weighing burdensome pragmatic issues' such as 'the woman's current or prospective economic, relationship and housing situation'.

Examining current problems with the UK abortion law, Riley and Furedi argue that 'autonomy is currently fettered in some areas by over-restrictive statute, and in others, autonomous decision-making is offered little support or protection by law or regulation'. The authors list several aspects of the abortion law where this is the case:

- **The Abortion Exception:** the fact that 'access to abortion in the UK remains legally detached from a competent woman's decision-making, setting abortion apart from the process of informed consent used with other medical treatment';
- **Conscientious Objection:** which leads some women to experience barriers to accessing abortion because their GP has obstructed or delayed their referral;
- **Misinformation:** as provided by some 'crisis pregnancy counselling' agencies in the UK;
- **Choice of Methods:** where access to abortion is impeded by unhelpful regulation – for example, the insistence that women return to a clinic for their misoprostol dose when undergoing an Early Medical Abortion, instead of permitting home use of this drug;
- **Identity Discourse:** where 'contemporary rights and "identity" discourse is being increasingly co-opted into the abortion debate in order to argue for restriction on abortion for fetal abnormality';
- **'Postcode Lottery':** where inadequate resource allocation and local eligibility criteria for abortions can result in long or unnecessary waiting times;
- **Staffing of Services:** where a shortage of doctors and nurses can sometimes pose a problem;
- **Northern Ireland:** where the 1967 Abortion Act does not apply, leaving women in a position where, formally, abortions can only take place as medical emergencies in NHS hospitals, and no funding is available for women who travel to the UK to terminate a pregnancy.

Aside from the problems facing women in Northern Ireland, the current situation, argue the authors, is one in which 'there has never been a greater likelihood of women receiving accessible, NHS-funded abortion care', and as such 'the practical gains from the "public health" approach [to abortion] must not be underestimated'. However, they continue, if this approach 'is the sole direction of advocacy, this risks leaving abortion provision vulnerable and misunderstood'. One example of this is provided by the media debate around the 24-week time limit for abortion, which has been argued out with reference to 'non-evidenced claims about improved survival of extremely premature babies and detailed ultrasound images of fetuses claimed to "walk" in the womb', countered with scientific evidence about fetal viability, 'which in fact does not indicate that preterm survival under 24 weeks has significantly improved in the UK'.

As Riley and Furedi note, 'Policy makers rarely emphasise the point that advances in neonatal care are good news, but irrelevant to the needs of women for abortion. When no ethical case is made for late abortion, a fundamental part of women's healthcare is left vulnerable'. They conclude the chapter with a discussion of how the law could better facilitate autonomy in abortion care.

***Regulating Autonomy: Sex, Reproduction and Family,* edited by Shelley Day Sclater et al, is published by Hart. Find more information about the book, and buy it, here: http://www.hartpub.co.uk/books/details.asp?isbn=9781841139463**

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