For British Pregnancy Advisory Service, choice is at the heart of everything we do. We provide abortions for women who choose to terminate their pregnancies. We advocate for women to be able to make that choice, free of barriers that may be placed in their way by campaigners, politicians and the law.

We also advocate for women to be able to make choices in other aspects of their reproductive lives: from what they eat and drink in pregnancy, to how, when and where they give birth. We do this because we believe that a woman does not become less of a person when she becomes pregnant – she still has the right, and the ability, to make decisions about her life. The person best placed to make choices about her pregnancy is not a doctor, lawyer, or politician, but the woman herself.

Yet as BPAS chief executive Ann Furedi explains in her essay overleaf, some of those who advocate for a woman’s ability to have an abortion when she needs one are becoming increasingly uncomfortable with the concept of choice. Calls for ‘reproductive justice’ instead seek to emphasise that women seeking abortion are often doing so because of wider social circumstances, such as poverty, that constrain the choices that they are able to make. Furedi argues that in replacing the idea of reproductive choice with the demand for ‘reproductive justice’, feminists underestimate women’s capacity for autonomy. ‘Claiming that choice “does not matter”, or is irrelevant, to a group of women because, for example, they are economically or culturally excluded, is both patronising and degrading,’ she writes. ‘It implies they have no interest in making these moral choices for themselves, and perhaps no capacity to do so.’

Are women’s abortion decisions better understood within the framework of reproductive justice? Or is the problem for the pro-choice movement that we haven’t yet won the argument about why women can, and should, make their own decisions about their reproductive lives? At the BPAS annual lecture on 21 November, Ann Furedi will unravel the new challenges to ‘choice’ and begin a discussion about what it means to be pro-choice in the early twenty-first century. For further information, see page 8.
Opponents of the demand for ‘a woman’s right to choose’ have always been against the choice of abortion. So it is confusing and frustrating that feminist friends and colleagues, some of whom provide abortion, have decided to mount their own assault on the notion of reproductive choice. The new anti-choice movement believes the concept of reproductive choice is limited, outdated, culturally specific and that ‘reproductive justice’ better expresses the needs of women.

This debate has not as yet found traction in Europe. But where US movements lead, we normally follow. In an article for RH Reality Check (1), sociology professor Tracy Weitz provides a summary of the objections to the concept of reproductive choice. The most influential points are firstly, that reference to choice is seen by some as trivialising the abortion decision, ‘suggesting that what a woman does about a pregnancy is simply another choice like picking a red or blue car... and women don’t always have a true “choice”, which is only possible when women have the resources to select the option they want’.

Secondly, it is argued that the concept of choice is elitist, exclusivist and irrelevant to the lives of many women. Weitz namechecks philosophy professor Marlene Gerber Fried, who (although an unequivocal supporter of abortion rights) has argued for many years that framing abortion in terms of a woman’s right to choose is problematic. Fried claims that because choice appeals to those who have options, but is relatively meaningless to those who do not, it is politically divisive. Plus it ignores the fact that race and class are culturally specific and that ‘reproductive justice’ is inevitable and redefines what we mean. This much we understand what we mean. This much we know from experience.

These are not new arguments. It is obvious, and always has been, that the right to decide on abortion is not enough: a woman needs the means to implement her decision. This is why those of us who support reproductive choice fight for the laws and access to services that women need. It is also obvious that people understand the concept of reproductive choice differently according to their circumstances. Choice to a family that struggles to decide whether to spend its pitiful income on food or shelter means something different than it does to a family that struggles to decide whether to take a holiday in Europe or Asia. But then, the concept of ‘struggle’ means something different in these circumstances, too, and we feel no need to find a new word for that.

Nevertheless, the pressure to replace the C-word with ‘reproductive justice’ is mounting. Reproductive justice, we are told, is an essential shift because it goes ‘beyond choice’ and redefines what we stand for (3). For groups such as Sistersong, ‘reproductive justice is not a label — it’s a mission. It describes our collective vision: a world where all people have the social, political and economic power and resources to make healthy decisions about gender, bodies, sexuality, reproduction and families for themselves and their communities. And it provides an inclusive, intersectional framework for bringing that dream into being.’ (4)

It is wrong to see this as an irrelevant semantic squabble or, simply, a distraction from the many attacks on abortion access in the US. For this is a debate that has serious consequences.

What’s in a name? In January 2013, the Planned Parenthood Federation of America (PPFA) was the first major institution to distance itself publicly from support for choice. PPFA is a colossus in birth-control care, providing contraception and abortion to tens of thousands of US residents. It’s decision to distance itself from choice was presented as a matter of ‘messaging’ rather than an ideological shift: a response to research that showed that the pro-life/pro-choice framework for abortion failed to resonate with the general public (5,6). PPFA said it was responding to polling and focus groups that had shown that views on abortion are nuanced and context-specific in a way not captured by the label ‘pro-choice’. Its poll of 1,000 voters had shown that: 40 per cent said the morality of abortion ‘depends on the situation’; 25 per cent said it was always morally unacceptable; and 16 per cent said it was always acceptable. In short, for most people, the rightness or wrongness of an abortion depends on circumstances. These poll results, as some commentators have observed, do not support stepping away from a pro-choice identity (7). The poll data shows simply that voters see the complexity of abortion in a way that is not reflected in rhetoric, especially that of politicians for whom abortion tends to be a matter of abstract principle, reasoning and belief. For most people, abortion is not a matter of politics; it is considered in the context of a person’s life. This is why abortion doctors treat so many women who say that they think that abortion is ‘wrong’ but their abortion is ‘right’ — or, at least, not as wrong as any other decision would be.

This is neither a new discovery nor difficult to understand. Considering abortion as a political matter is different to considering whether to have one — or even considering whether you think your friend should have one. Individual abortions are not statements of belief but medical procedures to solve problems. You do not have an abortion to demonstrate that you are pro-choice any more than you decide to have a baby because you are pro-life. In this case, the personal is not political.

It does not take a doctorate in sociology or psychology to understand why the polarised, political rhetoric that wraps round the public discussion of abortion in the US alienates people. Nor should advocates need advice from top-flight communications consultants to know that the way we discuss issues needs to change constantly if people are to understand what we mean. This much we know from experience.

Ironically, the pro-choice language we use today came from the need to adjust our message to make it more nuanced and inclusive. In the 1980s, ‘the right to choose’ replaced calls for ‘abortion on demand’ as we accepted that the key issue was a woman’s personal freedom to make a decision whether to have or not to have a child. We recognised that, for some women, what mattered was the demand not to have an abortion, or not to be sterilised because they were coerced into procedures that other women were denied.

The matter of ‘Who decides?/Whose choice?’ also applied to the use of new reproductive technologies, as questions were asked about who should and should not be permitted to use them. The Eighties was a decade when technical advances in in vitro fertilisation (IVF) began to offer the hope of pregnancy to infertile married couples, but assisted conception was denied to single women and lesbians. This was also a time when some
governments allowed, and even promoted, coercive sterilisation, while in other countries voluntary sterilisation was not a contraceptive option. (In France, for example, vasectomy remained unlawful until 2001). It was clear to us then that a woman’s choice — her right to decide and not her doctor’s or her government’s — should be at the heart of what we fought for.

Naturally, in the 1980s, there was also opportunism support for the language of reproductive choice. There were some who felt that the A-word was best left unspoken, and the rallying cry of ‘abortion on demand’, which had been chanted so enthusiastically on the demonstrations of the 1970s, sounded strident in the less-radical 1980s. Even before the existence of a sophisticated communications industry, we knew that messaging mattered. But, crucially, there was no mistaken view that talking about ‘reproductive choice’ would make it easier to build support for abortion. We knew that those who opposed abortion would remain as much opposed to it as a choice as they were opposed to it as a demand. This was not seen as a change of labels, it was not a branding exercise; it was a reposing of a principle. A specific commitment to choice was important because it captured what we stood for, and it captures what we stand for now.

**What choice means**

Support for reproductive choice in our movement has traditionally implied support for the decision-making capacity of the person who is the subject of that decision. The concept of reproductive choice is rooted in the liberal concept of autonomy: the idea that each individual should be free to follow their own life plan according to their beliefs, convictions and their conscience (provided others are not harmed).

In relation to abortion, support for reproductive choice means a woman being able to make a decision for herself about what she wants to do. In making a choice about the future of her pregnancy, she engages in an act of moral self-governance. She decides for herself, according to her own conscience, what is right for her. The fact that it is she who decides what is right for her — and not anyone else — is important in itself, regardless of whether she is able to follow through her choice.

This does not mean we ignore the very real issues of access to resources and services, or the inequalities caused by socioeconomic conditions, the need for structural change. It does not mean that we ignore the impact of race or class. The point is this: life is full of decisions, and it is who makes them that matters. This is not an exclusive class-based, ethnically specific framework; it is as true for economically disadvantaged women and women of colour as it is for WASP university graduates. It is as true for women in Pakistan as it is for women in Britain. Claiming that choice ‘does not matter’, or is irrelevant, to a group of women because, for example, they are economically or culturally excluded, is both patronising and degrading. It implies they have no interest in making these moral choices for themselves, and perhaps no capacity to do so.

We may not be able to provide women with the social and economic resources to live their preferred lives. But we should not add to women’s burdens by refusing to acknowledge the importance of what they do have; what some people call agency, others call decision-making capacity, and some of us call choice. Affirming the value of choice is a precondition for creating the circumstances in which it can be exercised. If a person has no concept that they might make a choice, they cannot determine what resources are required for them to exercise that choice.

As I explained in the journal *Conscience* recently: ‘Making a choice is, in itself, a demonstration of a freedom of sorts — the freedom to influence and take responsibility for what happens next. Our lives are made richer if we can direct them according to our personal values and convictions — even if our lives are not made richer by the options available to us. A “rock” and a “hard place” can be equally uncomfortable even when you have chosen which to sit on. The point is this: life is full of decisions, and it is who makes them that matters.’ (8)

Moral philosophers, from Kant to the recently deceased Ronald Dworkin, have acknowledged that there is a special inequality to moral decision-making (such as that involved in abortion). Making decisions is part of what it means to be human. We may have no control over what we ‘are’, in the sense that our nationality and background may be set, but we do have some choice about what we ‘do’.

Socially constructed value systems do not predetermine all the decisions we make, although they can shape them. People in similar situations make different choices based on their values. The abject poverty that drives one woman to have an abortion may drive another to decide to have a child that she places for adoption. A diagnosis of Down’s syndrome may compel one woman to end her pregnancy, while another decides to embrace the child as ‘special’. The fact that a woman is black, or poor, or alone, or stigmatised, clearly will influence her decision — but it does not take away her capacity to decide, to make a choice.

Law professor Emily Jackson spells it out in her book, *Regulating Reproduction: Law, Technology and Autonomy*: ‘The decision to have an abortion...is made because, for a variety of reasons, this particular woman does not want to carry a pregnancy to term. That she is not in control of these reasons should not lead us to ignore her deeply felt preference even if we recognise that social forces may shape and constrain our choice. Our sense of being the author of our own actions, especially when they pertain to something as personal as reproduction, is profoundly valuable to us.’ (9)

Our ability to make moral judgements, decisions and choices is part of what makes us whole, competent human beings. It is what differentiates us from animals that act on instinct and habit. To take the capacity to make reproductive choices away from women is to take away their moral agency — it is to deny their humanity. As Jackson says, ‘we cannot believe all our preferences are not ours without our sense of self effectively collapsing’. It follows that if people say they no longer identify themselves as part of a pro-choice movement, then we need to consider very carefully what is being implied here.

**What it means to give up on choice**

For example, what should we make of the decision of the American group, Physicians for Reproductive Choice and Health (PRCH), which, in the wake of the PPFA decision, announced it would change its name to Physicians for Reproductive Health? In its own words, it did so ‘to more accurately reflect how our doctors think about their work and the full range of care they provide’.

Do the doctors who belong to this organisation really believe that choice is incidental, and that it is sufficient to commit to reproductive health? This seems unlikely. The organisation formally known as PRCH was (and presumably PRH still is) made up of good doctors who, presumably, would say their views haven’t changed. However, saying you support women’s reproductive health is just not the same as saying you support women’s choice. Especially when you are a doctor.

Every day, doctors find themselves frustrated by patients who choose to ignore recommendations and interventions that would improve their health, who choose to continue to smoke, drink, take drugs and overeat. Reproductive health doctors are similarly frustrated by people who continue to choose to practise unsafe sex despite education about the consequences. Some 14-year-old girls refuse to choose the most effective contraceptives and then choose to become mothers, even where it seems obvious that delaying motherhood would be better not just for them, but for their future families, too.

In these circumstances, the value accorded to the woman’s autonomy — that is, her choice — is not merely a matter of labelling that can be stripped out of the garment as you would cut an annoying brand tag from a shirt. Support for the woman’s choice...
determines the kind of service she receives. To be a doctor for women’s choice privileges respect for women’s autonomy above all. To be a doctor for reproductive health can mean something very different.

Where will the doctors in PRCH stand when faced with the controversies about women who base their reproductive decisions on issues that are nothing to do with reproductive health at all? I know what a doctor in PRCH will say about a 35-year-old woman who chooses to have an abortion because she prefers to delay starting her family. That doctor will support her patient’s choice. But if the doctor is only interested in her patient’s reproductive health? Given the increase in risks with maternal age, I’m not so sure what she’ll say in the above situations.

Our reproductive choices do not always accord with what is best for us, any more than our choices in other areas. But still our choices should be ours to make.

A declaration for choice

It is simply wrong to say that evidence shows that a commitment to reproductive choice is out of touch with public opinion. Even if it were, it would be our task to put this right.

In Europe and the US, there is ample evidence to suggest that people see pregnancy decisions as serious, complex, deeply personal and context-specific. Even among the most conservative of thinkers, there seems little desire to compel women to have children they do not want. If this does not accord with their perception of what it means to be pro-choice, then it suggests that serious public education is needed to put that right.

In September 2012, the secular UK abortion provider British Pregnancy Advisory Service and the international Catholic advocacy group, Catholics for Choice jointly hosted a colloquium of activists, doctors, lawyers and academics from across the world to discuss the meaning of a commitment for choice. It seemed to some a surprising alliance, but both organisations had found that they had a similar core commitment: a commitment to personal autonomy that manifested as commitment to reproductive choice.

The outcome was a declaration of what it means to be pro-choice. To those who wish to drop the C-word: with what, in this declaration, do you disagree?

The London Declaration of Pro-Choice Principles is a simple statement of what it means to be pro-choice. To renounce ‘reproductive choice’ is to renounce more than a label: it is to renounce what this movement stands for and it is to renounce what all women need.

LONDON DECLARATION OF PRO-CHOICE PRINCIPLES

We believe in a woman’s autonomy and her right to choose whether to continue or end a pregnancy. Every woman should have the right to decide the future of her pregnancy according to her conscience, whatever her reasons or circumstances. A just society does not compel women to continue an undesired pregnancy.

We recognise that support for choice in itself is not enough. Access to abortion is an integral part of women’s reproductive health care, and we believe in the right to receive this. Women need access to resources and services, including the counsel of the professionals, friends and family they choose to involve. Legal, political, social and economic changes are necessary to allow the exercise of reproductive choice, and a commitment to such changes is part of a commitment to choice.

We express solidarity with those who provide abortion care, and we recognise the moral value of their work. We recognise and respect that some health care personnel may choose not to provide abortions, but we believe it is ethically imperative for them to ensure that a woman receives a referral to a willing provider.

We believe there is a profound moral case for freedom of reproductive choice. We are committed to explaining why abortions are necessary and why women are competent to make decisions and act on them responsibly.

To be pro-choice is to be committed to the right of women to make their own reproductive decisions and to:

- Strive to create the conditions in which reproductive choice may be exercised.
- Support reproductive autonomy.
- Advocate for legal frameworks that allow autonomous decision-making.
- Educate the public and policymakers globally about the value of reproductive autonomy.

Women are the only ones who can make the right decision for themselves. This is the very essence of what it means to be pro-choice.

Chandos House, London. September 2012

Ann Furedi’s essay, ‘Remaking the case for a woman’s right to choose’, was first published on spiked on 24 April 2013.

http://www.spiked-online.com/newsite/article/13563

References


(2) ‘The politics of abortion and reproductive justice: strategies for a stronger movement’, by MG Fried, in Different Takes, no 38, Fall 2005


In an article responding to Ann Furedi’s essay, Jodi Magee of Physicians for Reproductive Health, wrote:

‘When Ann Furedi questioned our name change, she asked if we, and the doctors we represent, still support a woman’s right to choose. To me, this was an astonishing question. (As is the statement that we are part of a new anti-choice movement.) The answer is yes, without a doubt. Building public-policy support for allowing women to make their own choices is why Dr. Seymour Romany founded this organization. It remains the core of our work today. We are not replacing one word with another or elevating one service over another. We are instead ensuring that no matter what a woman faces, our doctors are supporting their right to access the full range of reproductive health services. And, just as doctors who provide abortions cannot view this care separate from their overall practice, a woman seeking an abortion does not view it as separate and apart from her overall life circumstances.

‘All issues intersect – from economics to education to employment to sexual violence—and affect each woman and how she chooses to act. Yes, for many it is a choice to end a pregnancy, but for some it is not. This is often because circumstances have left women with abortion as their only option because they didn’t have access to routine preventive health care or birth control. This can also happen because something has gone awry late in pregnancy. “Health,” however, encompasses both women who are choosing abortion and those who may not see themselves as having a real and autonomous choice.…’

We absolutely support the right to choose, by Jodi Magee. spiked, 14 May 2013 http://www.spiked-online.com/news/site/article/13618#.UgljppxziDC5

Responding to Magee, Furedi explained that in Britain, ‘reproductive health is now pretty mainstream’, but ‘we have no mainstream, national organization with professional clout and profile that stands up for a woman’s right to choose’:

‘[P]ersonal, individual “choice” in reproductive decision-making is something special and particular. It relates to the matter of who can make a decision, which refers to the agency and autonomy of individuals. When we talk about reproductive choices, we refer to the private matters that each of us must be able to resolve for ourselves. This is more than health, and extends even beyond equality and justice.

‘Perhaps here in the UK, some of us feel the importance of reproductive choice because none of us have ever known it. Regardless of our wealth, education, or standing, none of us can have a legal abortion in Britain because we decide, personally and for ourselves, that it is right. British abortion law and practice has never acknowledged women’s reproductive choice. Our legislation was drafted in the 1960s to create conditions under which abortion could be delivered safely and regulated closely for the public good — that it should be a right for women was not even discussed.… Our parliament, courts, and medical professionals have never accepted that women have the capacity to decide about abortion for themselves at any stage in pregnancy. Instead the law offers a legal defence for a doctor who decides an abortion is best for a woman’s health…’


An important voice in the choice/reproductive justice is Jon O’Brien, president of Catholics for Choice. In an article titled ‘Why We Are and Must Remain “Pro-Choice”’, O’Brien wrote:

‘Right now, we need every voice and perspective we can get to speak out loudly, strongly, wherever, and to whomever they can, in whatever language they speak best, to protect rights that many thought were guaranteed…. Unfortunately, some advocates for reproductive health, rights, and justice insist we wordsmith the movement rather than take action. Some folks are paralysed by semantics, stuck in a vain search for a magic word or phrase that will convince everybody to agree with us. In doing so, the focus is taken off what we believe and what we need to do, and we are reduced to creating word clouds of marketing frames outlining why we must replace the concept of “choice.”

“Reproductive justice” has been suggested as this magic phrase. Both choice and reproductive justice have a place in our battle for women’s autonomy. But one cannot take the place of the other…’


In response to Planned Parenthood’s decision to drop the pro-choice ‘label’, Jennie Bristow wrote:

‘A further… problem with the reproductive justice argument is that it implicitly endorses the prejudice behind many of the arguments made by opponents of abortion, who stress that women are being compelled to abort their pregnancies by a society that does not care enough for them. For example, in Britain, one of the more pernicious arguments currently being mobilised by anti-abortion campaigners is that women who have an unwanted pregnancy are de facto vulnerable, and are thus incapable of making a genuine choice to end the pregnancy through abortion. This has led to the argument that, merely by offering abortion as an acceptable option, abortion providers are exploiting these women’s vulnerability, and pressurising them into taking a particular course of action.…’

The Journal of Family Planning and Reproductive Health Care has announced that the article ‘Women’s opinions on the home management of early medical abortion in the UK’, by Patricia Lohr, Josephine Wade, Laura Riley, Abigail Fitzgibbon, and Ann Furedi, published in the JFPRHC 2010: 36(1) 21, was one of the five most highly cited articles in 2012. The full study is available here: http://jfprhc.bmj.com/content/36/1/21.full.pdf+html?ijkey=WXLbklSnGexPE&keytype=ref&siteid=bmj journals

This Q&A is based on the JFPRHC study, drawing in some additional recent research.

1) What is the situation regarding the home management of early medical abortion in the UK?

Under the 1967 Abortion Act, any treatment for abortion has to be carried out in a hospital or a place approved for this purpose by the Secretary of State. (1) The Department of Health currently interprets this as meaning that both medications used for early medical abortion (EMA) – mifepristone and misoprostol - must be given in an authorised medical facility.

Practically, this means women must make a separate visit to receive each medication in addition to their consultation and follow-up appointments. Many hospital-based services admit women to the wards after administering misoprostol (2), but most independent abortion providers, like BPAS, discharge women after misoprostol administration to complete the process at home.

This service development occurred in response to clients’ requests to go home and with the knowledge from studies in other countries that completing an early medical abortion at home was safe and acceptable. At the time, there had not been much research in the UK on the home management of EMA so we felt it was important to find out women’s opinions and experiences of this service. We invited all eligible women undergoing EMA at any BPAS clinic during a two-week period to take part. One week after the administration of misoprostol, we contacted them by telephone and asked them to answer a short structured questionnaire. We also included one open-ended question to give women the opportunity to add other comments.

2) What did the results find?

We surveyed 162 women and found that most (86%) would rather go home to complete an EMA than remain at the clinic. The majority (96%) found home management very or somewhat acceptable and 96% felt they could have obtained medical help easily if necessary. Most respondents (62%) would prefer home use of misoprostol as opposed to returning to the clinic to obtain and use the medication. The study also found that Asian women, or those with a gestational age of greater than 49 days, were less likely to prefer home management than others in the sample.

3) What reasons did women give for their preference?

We did not specifically ask women about the reasons behind their preferences. However, in the open-ended question many women chose to comment on the meaning that being at home had for them. They described it as a good experience, commenting on the benefit of being ‘in my own space’, and using words such as ‘right’, ‘comfortable’, ‘relaxed’, ‘convenient’ and ‘private’.

Interestingly, 21% of the women who provided qualitative comments remarked on the difficulty of the journey home after misoprostol administration. They described it as inconvenient or noted that they were very concerned about experiencing symptoms before they got home. Some even commented that they began to have bleeding or cramping on the journey home. However, rather than encouraging them to stay in the clinic for the duration of the abortion, these experiences appeared to increase their support for the idea that misoprostol could be used at home. As one woman said: ‘I felt so anxious because I really felt that I had to hurry home. I would much rather have been able to do the second medicine in the comfort of my own home’.

Relatively smaller numbers of women gave reasons why they would prefer to stay in the clinic, such as reassurance that the abortion was proceeding as expected, or that they were concerned about things that were unexpected, such as variability in the time to complete the abortion. And a few women also took the opportunity to tell us that they felt that the decision to have home management should be an individual choice, emphasising that the option should be available for everyone, even if some choose not to take it.

4) How does this study relate to others in the UK?

Early research in the UK was undertaken with women who had only experienced a medical abortion in clinical setting and reflected a preference for that environment. A 1992 study in Edinburgh found that just 24% of 180 women who had undergone a medical abortion either on a ward or in a sitting room within a hospital would prefer to have the abortion at home. (3) Similarly, a survey of 366 women in four hospital-based services in England and Scotland found that while 71% of respondents reported that there was nothing during their stay in hospital that they could not have managed on their own, only 36% would have opted for a home EMA. (4)

Different data emerged when studies were conducted with women who had experienced a medical abortion at home. The earliest of these was a pilot trial in Aberdeen, in which 49 women up to 56 days’ gestation were treated with 200mg oral mifepristone in a clinical setting. Followed by self-administration of 600 mg sublingual misoprostol 36–48 hours later at home. (5) Forty-five participants returned study questionnaires about their experiences and opinions: most (96%) were very satisfied or satisfied with home EMA, and 93% stated they would opt for medical abortion at home if necessary in future.
Since the publication of our study, two further papers from a service in Edinburgh provide support for offering ‘early medical discharge’ (EMD) where women use misoprostol in the clinic in accordance with the law, but go home to pass the pregnancy. In the first paper, women were offered the option of EMD and those who chose it were asked to complete a questionnaire about their experiences and preferences. During a three month period, 145 women chose EMD and 100 completed questionnaires. Eighty six percent of respondents stated that they would opt for EMD if they needed an abortion in the future and 84% stated that they would recommend EMD to a friend. (6) A retrospective audit of 1128 women in the same service compared the rates of unscheduled re-attendance and uptake of contraception between women who chose EMD and those who remained in a day case unit to abort. In this cohort, 52% chose EMD. Four percent of women in each group had an unscheduled visit and the proportion of women who went home with an effective method of contraception was 61% in the EMD group and 60% in the day case group. (7)

5) How does this differ from studies in other countries?

In many parts of the world, there is no restriction on women taking misoprostol away from the clinic to use at a place of their choosing within a given period of time after mifepristone administration. Multiple studies have assessed this practice’s safety, effectiveness, and acceptability. A pooled analysis of 9 prospective cohort studies with a total of 4522 participants found no difference in complete abortion rates or complications between women who chose to have an early medical abortion at home or in a clinic. Women who had their abortion at home did experience a slightly longer duration of pain and vomiting. Nevertheless, women who chose home-based medical abortion were more likely to be satisfied, to choose the method again and to recommend it to a friend if needed. (8)

Because of the demonstrated effectiveness and acceptability of home use of misoprostol up to 9 weeks of gestation, researchers in the United States are now exploring whether the upper gestational age limit can be extended to 10 weeks gestation. (9) Research on home use of medications for medical abortion hasn’t been limited to misoprostol either. A recent multicenter trial in the US offered women the option of taking mifepristone in the clinic or at home. (10) Of 301 participants, 46% chose to take mifepristone at home and 54% chose clinic administration. The vast majority (95%) of ‘home users’ said that they would take the mifepristone in the same place in the future providers would also recommend home use again for the vast majority of patients.

6) What are the practical implications of this study?

The increasing amount of positive feedback from women about the home management of EMA in the UK supports further development of this as an option. Those designing abortion services need to take care not to assume women’s preferences. Some women may prefer to stay in the clinic, and giving women this option is reasonable if resources allow it. However, our study does indicate, in line with research from other countries where home use of misoprostol is routine, that many women find managing their abortion at home highly acceptable, and voice a preference for administering misoprostol at home rather than having to do so in the clinic. The Royal College of Obstetricians and Gynaecologists (RCOG) has also confirmed that ‘it is safe and acceptable for women who wish to leave the abortion unit following misoprostol administration to complete the abortion at home’, and its evidence-based clinical guideline, The Care of Women Requesting Induced Abortion (published November 2011), states that ‘Services should have a protocol in place allowing early discharge after misoprostol for women undergoing medical abortion up to 9 weeks of gestation’. (11)

References

(1) Abortion Act 1967 (c. 87).
What does ‘pro-choice’ mean today?

BPAS annual lecture
Thursday 21 November 2013, 7pm-8.30pm
Anatomy Lecture Theatre, King’s College London, Strand, London WC2R 2LS

Ann Furedi will unravel the new challenges to ‘choice’ and begin a discussion about what it means to be pro-choice in the early twenty-first century. Are women’s abortion decisions better understood within the framework of reproductive justice? Or is the problem that we haven’t yet won the argument about why women can, and should, make their own decisions about their reproductive lives?

The lecture is free to attend, but please register in advance.
For further information, and to register, contact jennie.bristow@bpas.org

BPAS at the party conferences
BPAS will be holding a panel event at Conservative Party Conference in Manchester on Monday 30 September entitled ‘The politics of motherhood: Are the Conservatives doing enough to support women’s choices?’ We will be holding a similar event at Labour Party Conference on Tuesday 24 September looking at the Labour Party’s policies regarding women’s choices.

Confirmed speakers include:
- Diane Abbott MP, Shadow Public Health Minister
- Eleanor Mills, Sunday Times
- Emma Burnell, Fabian Society
- Scarlet Harris, TUC Women’s Equality Officer
- Jen Howze, Britmums
- Cathy Warwick, Royal College of Midwives

The discussion will consider each party’s support for women’s reproductive choices, from abortion to delaying starting a family, but also looking at wider issues that are affecting women and mothers including childcare, parenting culture, education and employment.
For further information, contact Katherine O’Brien: katherine.o'brien@bpas.org

Event report: Abortion, motherhood and the medical profession

This successful conference, jointly organised by the Royal Society of Medicine’s Sexuality and Sexual Health Section and British Pregnancy Advisory Service (BPAS) on 12 June 2013, aimed to move the discussion of abortion care forward by situating it within the range of reproductive issues and experiences that women may have.

The event started from the understanding that abortion is often discussed as an issue that is entirely separate from other aspects of pregnancy, and that the potential applications of clinical advances in abortion care to miscarriage or assisted reproduction are often not considered.

The first session, ‘Fetal imaging and imagining the fetus’, discussed the intersection of technical advances in ultrasound scanning with cultural trends that shape how the fetus tends to be viewed and discussed today. A session discussing issues to do with information, counselling and the law focused on the fallout from the political interference in Britain’s abortion service during 2012.

The conference’s keynote lecture was delivered by Professor Paul Blumenthal, Professor of Obstetrics and Gynaecology at Stanford University, and concerned the use of semi-quantitative pregnancy tests (SQPT) in early medical abortion service delivery. A panel of expert respondents discussed the potential applications of this new pregnancy test for miscarriage management and fertility treatment.

The conference concluded with a roundtable discussion of the challenges and opportunities facing a new generation of abortion doctors.

Read a summary of the presentations here:
http://www.reproductivereview.org/index.php/rr/article/1422/

Also read:
Semi-quantitative pregnancy tests: an interview with Dr. Paul Blumenthal, Stanford University School of Medicine. Part of the Thought Leaders series, NewsMedical, 12 July 2013.

Pregnant women aren’t incubators - so why does medical advice treat them as though they are?
The idea has been encouraged that the fetus and the women are two separate individuals whose needs are at odds with one another, writes Jennie Bristow in the Independent, 5 June 2013.
http://www.independent.co.uk/voices/comment/pregnant-women-arent-incubators-so-why-does-medical-advice-treat-them-as-though-they-are-8646309.html
The Department of Health’s annual statistics were released in July 2013, showing a fall of 2.5% in the number of abortions. (1) The rate of abortion is at its lowest level for 16 years. There has been a notable drop in the number of teenagers experiencing unwanted pregnancy, which may reflect continuing improvements in access to contraception for young people. In older age groups the fall may indicate that women are better able to avoid unplanned pregnancy in the first place, but women may also be making different choices when faced with such a pregnancy.

The statistics also show the continuing rise in the proportion of women having abortions who are already mothers (52%). The majority of women ending pregnancies are in relationships (66%). The rate of ‘repeat’ abortion has risen by 1 percentage point, in keeping with trends in other developed countries such as France and Sweden. This is to be expected as more women delay motherhood during their highly fertile twenties, when contraception is more likely to let them down. Women expect to control both the timing and size of their families, and may be exposed to unwanted pregnancy more than once during a 30-year reproductive life span.

BPAS Chief Executive Ann Furedi said: ‘Abortion is fact of life and there is no “right number” of abortions. What matters is that every woman with an unplanned pregnancy is able to make the choice that is right for her and access the care that she needs. These statistics confirm that women who have abortions do not fit the stereotype of “the feckless teenager”. Women of all ages and from all walks of life experience unplanned pregnancy. BPAS launched the No More Names campaign last year to highlight precisely this point – that women who have abortions are our mothers, daughters, sisters and friends.’

Below is an analysis of three issues of note.

The proportion of early abortions

It is recognised that one of the ‘success stories’ of abortion provision in recent years has been the shift, within first trimester abortions, to much earlier procedures. In 2012, 77% of abortions took place at between 3 and 9 weeks, compared with 57% in 2002: reflecting advances in pregnancy testing and, in particular, the use of Early Medical Abortion (the ‘abortion pill’). However, in 2012 the proportion of abortions at under 10 weeks (77%) was slightly lower than in 2011 (78%). This development needs monitoring to ensure that women are not experiencing delays once they have presented to healthcare services.

The year-on-year increase in ‘very early’ abortions has not reduced the need for abortion in the second trimester. While the proportion of abortions performed at 13-19 weeks’ gestation has fallen, from 11% in 2002 to 7% in 2012, the figures show a steady and continuing need for abortions at these gestations. Similarly, the proportion of abortions at over 20 weeks’ gestation remains at between 1% and 2%. The need for abortion provision in the second trimester reflects a number of reasons women may have for delay in the abortion decision, including not knowing they are pregnant, needing time to make their decision, and having difficulties in accessing services. (2) It also reflects the situation confronting women who have a diagnosis of fetal anomaly – discussed below – which will often take place in the second trimester, or at the very end of the first.

‘Repeat’ abortions

In 2012, 37% of women undergoing abortions had one or more previous abortions: a rise from 36% in 2011. While these figures are often disparaged as ‘repeat abortions’, it is important to note that of this 37%, the majority (27%) had had one previous abortion, 7% had had two, and 2% had had three. Furthermore, as the Department of Health’s statistics report states: ‘Repeat unintended pregnancy and subsequent abortion is a complex issue associated with increased age as it allows for longer exposure to pregnancy risks’. So women aged 30 or over were far more likely to have had a previous abortion (45%) than younger women.

Termination of pregnancy for fetal anomaly

The 2012 statistics list the principal medical conditions for abortions under Ground E. This is the clause that allows for abortion on the grounds of ‘serious handicap’: such abortions are permitted beyond 24 weeks, although abortions after 24 weeks must take place in NHS hospitals (rather than in independent sector clinics). The 2012 statistics show 2,692 abortions under Ground E, 1% of the total number of abortions, of which 160 took place over 24 weeks’ gestation. This compares to 2,307 and 146 respectively, in 2011. While the rise is too small to be of much significance, it is worth stressing that an increase in Ground E abortions in the current period should not be surprising. It can be seen to reflect, first, the improvements in antenatal screening tests, both in the earlier stages of pregnancy and sonography in the later stages. Second, it could be seen to reflect the wider trend of delayed fertility. It is widely known that women who become pregnant later in life have a higher risk of carrying a fetus with abnormalities; and indeed, the statistics show that 4% of ‘singleton’ pregnancies, in women aged 35 and over were carried out under Ground E, compared to 1% or 0% for other age groups.

This year’s statistics also show the ‘number of mentions’, indicating that abortions for fetal anomaly are often performed because of more that one medical condition. This is a useful reminder that women terminating pregnancies for reasons of fetal anomaly are often grappling with then probability that, if they continue the pregnancy to term, their baby might have a number of conditions, which may range in severity.

One useful addition to the abortion statistics this year is that they reveal the method of termination used in cases of fetal anomaly. For abortions performed under Ground E under 13 weeks’ gestation, 55% are performed surgically and 45% medically. The proportion of surgical abortions decreases with gestation, to 43% at 13-14 weeks; 20% at 15-16 weeks; 10% at 17-18 weeks; 1% at 20-21 weeks; and 3% at 22 weeks and over.

These proportions are in marked contrast to trends in abortions performed in general. Of these, medical abortions account for a high proportion of very early abortions (from 3-9 weeks); after that, abortions are more likely to be carried out surgically. When all grounds are taken together, surgical abortions account for 85% of abortions at 10-12 weeks; 75% at 13-14 weeks; 76% at 15-19 weeks; and 65% at 20 weeks and over.

This reflects that the independent sector – which carries out 62% of all abortions funded by NHS contract – tends, for reasons of best practice, to use surgical methods at gestations beyond 10 weeks. A particularly striking finding is that 80% of abortions at 23 weeks use surgical methods (reflecting the fact that late abortions, in general, are likely to take place in the independent sector), whereas 93% of all abortions at over 24 weeks (performed in the NHS) under Ground E use medical methods.

This raises questions about the extent to which women undergoing termination for fetal anomaly do not have access to the medical methods available to women who access abortion for other reasons (3). For women with a diagnosis of fetal anomaly who present for abortion under 24 weeks, greater collaboration between the NHS and the independent sector could ameliorate this situation.

By Jennie Bristow.

References:
http://www.reproductivereview.org/index.php/rtr/article/1437/
New bpas publication

Britain’s Abortion Law: What it says, and why

The papers in this publication have been written by academics and lawyers to clarify the British abortion law, through explaining both its origins and its application today. These papers explain that the 1967 Abortion Act was very carefully worded to provide doctors with the discretion to manage the abortion question, according to their own professional judgement. The abortion regulations, similarly, are designed to support the law, which has at its heart the discretion of the doctor.

There is no ambiguity to the law, nor has there been any failure in its ability to act as Parliament intended when it was passed in 1967. The failure was in the ability of many in 2012 to understand the law correctly. Britain’s Abortion Law: What it says, and why aims to correct this failure of understanding, and reassure medical professionals where they stand in relation to the authorisation of abortions in Britain today.

Contents

- Key questions and answers about the abortion law
- Recent myths and misunderstandings about the abortion law. By Dr Ellie Lee, Reader in Social Policy at the University of Kent; author, Abortion, Motherhood and Mental Health
- The letter and spirit of the Abortion Act. By Sally Sheldon, Professor of Law, University of Kent; author, Beyond Control: Medical Power and Abortion Law
- The legality of abortion for fetal sex. By Emily Jackson, Professor of Law, London School of Economics
- Certifying abortions: the signing of HSA1 forms. By Dorothy Flower, Partner, RPC
- Abortion for fetal anomaly: The legacy of the Jepson case. By Jane Fisher, Director, Antenatal Results and Choices

Download Britain’s Abortion Law: What it says, and why for free here:


Abortion News

JULY 2013

Ireland: Abortion legalised in limited circumstances

Lawmakers in the Republic of Ireland have voted to legalise abortion under certain conditions for the first time. The move, approved by a 127-31 vote in the lower house (Dáil) and signed into law on 30 July, would authorise a termination when doctors deem that a woman is at risk of taking her life. The vote follows the case of Savita Halappanavar, an Indian woman who died in hospital after she was refused an abortion.

Anti-abortion campaigners say that the bill will allow the intentional killing of the unborn for the first time in the Republic of Ireland. For them, it is not just a religious but a human rights issue as they believe that in any pregnancy the mother and fetus have equal rights to life. Others argue the bill is too limited as it does not allow for terminations in cases of rape or incest, or when there is a fetal abnormality. Nor does it allow for termination when the fetus cannot survive outside the womb. Those who support access to abortion say the bill ignores the fact that, on average, 11 women leave the country every day for an abortion in Britain.

Since a Supreme Court ruling in 1992, known as the X case, abortion has been constitutionally available when a woman’s life, as distinct from her health, is at risk from the continued pregnancy. X was a suicidal 14-year-old schoolgirl who had been raped by a neighbour and was initially prevented from leaving the country for an abortion in Britain. Since then, the credible threat of suicide is, constitutionally, regarded as grounds for a termination. But in the intervening years, until now, no government has introduced legislation to give doctors legal certainty on when an abortion can be carried out. The Fine Gael-Labour coalition government says its proposed legislation will bring the law and constitution into line.

12/7/13

http://www.reproductivereview.org/index.php/rr/article/1449/

USA: Abortion ban passed in Texas

Texas legislators have passed a contentious bill banning abortions after 20 weeks of pregnancy. The legislation, which was debated in the state Senate after passing in the House, will also shut down most of the state’s abortion clinics. Governor Rick Perry has vowed to sign the bill into law amid large protests. The Texas legislation mirrors a series of state laws recently passed in Mississippi, Ohio, Oklahoma, Alabama, Kansas, Wisconsin and Arizona. The bill came near to passage in June but was blocked in the state Senate when Senator Wendy Davis spoke for nearly 11 hours - in a delaying speech known as a filibuster - in an attempt to run out the clock on the legislative session. The filibuster drew nationwide attention and made Ms Davis a heroine of the US abortion rights movement. Anti-abortion and abortion rights protesters have rallied at the state capitol in Austin in large numbers.

In addition to banning abortions after 20 weeks of pregnancy, the bill will require all abortion procedures to be performed at a surgical centre, and mandate all doctors performing abortions have admitting privileges at a hospital within 30 miles (48km) of the clinic. Only six abortion clinics in Texas can be classified as surgical centres, and all are in major metropolitan areas, according to the Texas Tribune. Critics say the provision will force some women to travel hundreds of miles to have an abortion, while supporters say it will protect women’s health and the fetus. 13/7/13

http://www.reproductivereview.org/index.php/rr/article/1451/
The cost of IVF can be cut dramatically from thousands of pounds to around £170 to start a 'new era' in IVF, fertility doctors from Belgium claim. Twelve children have been born through the technique, which replaces expensive medical equipment with 'kitchen cupboard' ingredients. The results, presented to the European Society of Human Reproduction and Embryology conference, showed a pregnancy rate of 30% - approximately the same as IVF.

There has been interest in the results in terms of the potential for the developing world. The researchers believe the cost of IVF can be cut to just 10-15% of services in Western countries. Lead researcher Professor Willem Ombelet said: 'If you don't have a child in Africa, or also South America or Asia, it's a disaster. It's a disaster from an economic point of view, a psychological point of view. They throw you out of the family. You need to help them and nobody helps them.' Even in rich, Western, countries many couples are still unable to afford IVF and the studies are attracting interest. Geeta Nargund, at St George's Hospital, London, is planning to introduce the techniques to the UK: 'We have an obligation to bring down the cost and we will have a situation where only the affluent can afford it.' 8/7/13

http://www.reproductivereview.org/index.php/rr/article/1450/

The case of two Catholic midwives fighting for the legal right to avoid any involvement in abortion procedures will be heard at the UK's highest court, it has been announced. Mary Doogan and Connie Wood won a challenge before three appeal judges at the Court of Session in Edinburgh in April. Their victory followed a ruling against them last year in their action against NHS Greater Glasgow and Clyde. In the latest round of the battle, Supreme Court justices in London are to hear an appeal by the health authority at a date to be fixed.

As conscientious objectors, the women have had no direct role in pregnancy terminations. But the midwifery sisters, who are both in their 50s, claim they should also be entitled to refuse to delegate, supervise and support staff involved in the procedures or providing care to patients during the process. The health board argued that the right of conscientious objection was a right only to refuse to take part in activities that directly brought about the termination of a pregnancy. In the appeal ruling in favour of the women, Lady Dorrian, with Lords Mackay and McEwan, said: 'In our view the right of conscientious objection extends not only to the actual medical or surgical termination but to the whole process of treatment given for that purpose.' After the decision Ms Doogan and Ms Wood voiced their delight and said the ruling affirmed the rights of all midwives to withdraw from a practice that would 'violate their conscience'.

The women were employed as labour ward co-ordinators at the Southern General Hospital in Glasgow. At the time of the original ruling, Ms Doogan had been absent from work due to ill health since March 2010 and Ms Wood had been transferred to other work. Both registered their conscientious objection to participation in pregnancy terminations years ago, under the Abortion Act, but became concerned when all medical terminations were moved to the labour ward in 2007. They said being called up to supervise and support staff providing care to women having an abortion would amount to 'participation in treatment' and would breach their rights under the European Convention on Human Rights.

In the original ruling against them, the judge, Lady Smith, found that the women were sufficiently removed from involvement in pregnancy terminations to afford them appropriate respect for their beliefs. At the Supreme Court the appeal will concern the scope of the right to conscientious objection under the Abortion Act 1967 and in particular the decision of the appeal judges that the women's entitlement to conscientious objection includes the entitlement to refuse to supervise staff in the provision of care to patients undergoing termination. 25/6/13

http://www.reproductivereview.org/index.php/rr/article/1432/

A seriously ill woman who was denied an abortion by the Supreme Court eventually underwent a premature Caesarean section. The 22-year-old woman, referred to as Beatriz, who has lupus and kidney problems, sought to end the pregnancy, which doctors said posed a serious risk to her life.

http://www.reproductivereview.org/index.php/rr/article/1397/
The fetus had anencephaly, meaning that it developed without a complete brain and skull, and died five hours after the C-section. Health Minister Maria Isabel Rodriguez said the baby had died five hours after the C-section. Doctors decided the procedure had become necessary when the woman started having contractions on Sunday night. Ms Rodriguez said. She insisted that the medical intervention did not contravene the court ruling.

Beatriz’s plight drew international attention after the Supreme Court denied her the abortion she was seeking despite the medical risks involved in the pregnancy and the low chances of the fetus surviving beyond birth. A medical committee at her maternity hospital, the Ministry of Health and rights groups had supported her request to terminate her pregnancy. But the Supreme Court argued that the ‘the rights of the mother cannot take precedence over those of the unborn child or vice versa, and that there is an absolute bar to authorising an abortion’ under the Salvadoran constitution. El Salvador banned all types of abortion in 1999. The sentence for doctors and women violating that ban is 50 years in prison. 4/6/13

http://www.reproductivereview.org/index.php/rr/article/1412/

### UK: David Steel attacks ‘repeat’ abortions

A key architect of the Abortion Act has spoken out to warn of the growing ‘problem’ of women having repeat terminations as an alternative to contraception, the Daily Mail reports. Lord Steel said: ‘It’s odd that so many women present for repeat abortions, some more than twice, which does suggest they are treating abortion as contraception. This was never the purpose of the 1967 reform.’

Ann Furedi, chief executive of British Pregnancy Advisory Service (BPAS), said: ‘It is unfair to women and wrong for politicians to assume that women can live a modern life and not have the option of accessing abortion services. Too many politicians - particularly as they get older - forget that abortion is a part of life. Women are not using abortion simply as another method of birth control. Contraception fails, or sometimes we fail to use it properly. When abortion is legal and easily available, it is not surprising if women use it - and that is not a bad thing.’ 19/6/13

http://www.reproductivereview.org/index.php/rr/article/1425/

### US: ‘Masturbating fetuses’ claim used to justify abortion restrictions

An anti-abortion US Congressman has argued that the time limit for abortion should be reduced because male fetuses masturbate. During the House of Representatives meeting, the former obstetrician and gynaecologist said: ‘There is no question in my mind that a baby at 20 weeks after conception can feel pain. The fact of the matter is I argue with the chairman because I thought the date was far too late. We should be setting this at 15 weeks, 16 weeks. The matter is I argue with the chairman because I thought the date was far too late. We should be setting this at 15 weeks, 16 weeks. Watch a sonogram of a 15-week baby, and they have movements that are purposeful. They stroked their face. If they’re a male baby, they may have their hand between their legs. If they feel pleasure, why is it so hard to believe that they could feel pain?’ 19/6/13

http://www.reproductivereview.org/index.php/rr/article/1426/

### USA: Bill passed to restrict terminations to under 20 weeks’ gestation

The Republican-controlled US House of Representatives has passed a bill that would introduce strict abortion limits. The plan to restrict terminations to the first 20 weeks after conception was approved by 228 votes to 196, largely along party lines. But it has no chance of becoming law as Democrats control the Senate and the White House has threatened a veto. 19/6/13

http://www.reproductivereview.org/index.php/rr/article/1424/

### UK: Government backs ‘three-person IVF’

Britain looks set to become the first country to allow the creation of babies using DNA from three people. It will produce draft regulations later this year and the procedure could be offered within two years. Experts say three-person IVF could eliminate debilitating and potentially fatal mitochondrial diseases that are passed on from mother to child. Earlier this year, a public consultation by the Human Fertilisation and Embryology Authority (HFEA) concluded there was ‘general support’ for the idea and that there was no evidence that the advanced form of IVF was unsafe.

The chief medical officer for England, Prof Dame Sally Davies, said: ‘Scientists have developed ground-breaking new procedures which could stop these disease being passed on, bringing hope to many families seeking to prevent their future children inheriting them. It’s only right that we look to introduce this life-saving treatment as soon as we can.’ 28/6/13

http://www.reproductivereview.org/index.php/rr/article/1416/

### UK: RCOG under fire for ‘alarmist’ pregnancy advice

The Royal College of Obstetricians and Gynaecologists has been criticised for saying pregnant women may want to ‘play it safe’ and avoid chemicals found in many common household products. It says there is not enough information about the chemical risks to fetuses from cosmetics and food packaging. Items which it suggests should be avoided include tinned food, ready meals, shower gel and even new cars. However, critics said the advice is unhelpful, unrealistic and alarmist. 5/6/13

http://www.reproductivereview.org/index.php/rr/article/1414/

### MAY 2013

**Dr Henry Morgentaler remembered**

Dr Morgentaler, who led the abortion movement in Canada, died in May at the age of 90. Morgentaler emerged in 1969 as one of Canada’s most controversial figures when he broke the law at the time, and opened the country’s first abortion clinic in Montreal. Over the next two decades, he would be heralded as a hero by some, and called a murderer by others as he fought to change Canada’s abortion laws. Morgentaler, who was born in Lodz, Poland, and came to Canada after the Second World War, emerged in 1967 as an advocate for the right of women to have abortion on demand — a polarizing issue in Canada. His abortion clinic in Montreal was followed by more clinics across the country. ‘His work changed the legal landscape in Canada, and eventually led to the 1988 landmark Supreme Court of Canada decision that gave women the right to obtain abortion care,’ said Vicki Saporta, president of the National Abortion Federation. ‘Dr Morgentaler was a legend, a hero, and a national treasure in both our countries, and we will miss him dearly.’ 29/5/13

http://www.reproductivereview.org/index.php/rr/article/1417/

### UK: Anger at proposals to test pregnant women for smoking

Mothers and midwives have reacted against guidelines that will pressure all pregnant women to take breath tests to check if they have told the truth about smoking. In proposals by the National Institute for Health and Care Excellence (NICE), due to come into force this year, midwives will be told to test mothers’ carbon monoxide levels at their first antenatal appointment. This will reveal if they are being honest about whether they smoke, with those found to have high readings given ‘appropriate support’ on how to quit. Members of website Mumsnet branding the plans ‘utter meddlesome nonsense’ and ‘intrusive nannying’. One member said: ‘I think this is outrageous – why aren’t pregnant women being trusted to tell the truth?’ Another commented: ‘Really terrible idea. Women are not just baby incubators once they’re pregnant.’

Although the tests will not be compulsory, mothers may feel obliged to take them after being asked to do so in hospital. Midwives made it clear that the guidelines are unhelpful, saying
having to carry out tests could undermine the trust between
them and their patients. Louise Silverton, director of midwifery
at the Royal College of Midwives, said: ‘It is a bit draconian. They
are asking us to test each pregnant woman for carbon monoxide
on their very first visit. It is not allowing women to say no or
midwives to use their judgment. And it puts pressure on the
first visit when a lot of women are already dealing with a lot of
information and stress. Our concerns are they may just say no. All
you can really do is make sure that women understand the risks.’
12/5/13
http://www.reproductivereview.org/index.php/rr/article/1405/

US: Kermit Gosnell found guilty of three murders
A Philadelphia doctor has been convicted of the first-degree
murders of three babies delivered and killed with scissors in late-
term abortions, BBC News Online reports. Dr Kermit Gosnell,
72, was acquitted on another charge of killing a fourth baby. He
was also found guilty of involuntary manslaughter of an adult
patient who died of an overdose. Former staff members of the
clinic testified that he had routinely performed illegal late-term
abortions past Pennsylvania’s 24-week limit. Among the untrained
staff who helped to perform the terminations was Gosnell’s wife,
Pearl. She pleaded guilty to a number of charges and testified
against him.

Gosnell’s lawyer, Jack McMahon, had argued that none of the
fetuses was born alive. Gosnell did not testify and no witnesses
were called in his defence. On 15 May, Gosnell was given three
life prison sentences. The trial became a cudgel for those on
both sides of the US abortion debate, BBC News Online reports.
Anti-abortion activists said the case exposed the grim reality of
the procedure, and accused media of ignoring the case because
of liberal bias. But abortion rights groups warned it showed what
would happen if laws on such procedures were tightened, driving
desperate women to unregulated backstreet clinics. 14/5/13
http://www.reproductivereview.org/index.php/rr/article/1408/

UK: Woman with bipolar disorder can make abortion
decision, judge rules
Following a two-day Court of Protection hearing in London, a High
Court judge decided that a woman detained under mental health
legislation was capable of making a decision about terminating her
23-week pregnancy. 22/5/13
http://www.reproductivereview.org/index.php/rr/article/1420/

Scotland: Abortion statistics published
The number of and rate of terminations has continued to fall for
the past four years. 28/5/13
http://www.reproductivereview.org/index.php/rr/article/1419/

BPAS
BLOG

Views and comment from bpas on a range of reproductive healthcare issues

Recently on the bpas blog:
• Working Together for Women - report on our networking event
• The Irish abortion bill is legislation we cannot live with - guest post
  from the Abortion Rights Campaign in Ireland
• Storify of Voice for Choice event on abortion law in Ireland

http://bpasblog.blogspot.co.uk/
France: Continuation of pregnancy after first trimester exposure to mifepristone: an observational prospective study.


This study set out to report the follow-up of continuing pregnancies after first-trimester exposure to mifepristone. It was an observational prospective study set in France, with a sample of patients exposed to mifepristone during the first 12 weeks of pregnancy. The main outcome measure was the rate of major congenital malformations.

A total of 105 pregnancies were included, with 46 exposed to mifepristone alone, and 59 exposed to both mifepristone and misoprostol. There were 94 live births (90.4%) and 10 (9.6%) miscarriages (including one with major malformation). Elective termination of pregnancy was performed after the subsequent diagnosis of trisomy 21 in one case. The overall rate of major congenital malformations was 4.2% (95% CI 1.2-10.4%), with two cases among 38 patients exposed to mifepristone alone, and two cases among 57 patients exposed to both mifepristone and misoprostol. The authors concluded that this first prospective study found that the rate of major malformations after first-trimester exposure to mifepristone is only slightly higher than the expected 2-3% rate in the general population. Such findings provide reassuring data for risk evaluation for continuation of pregnancy after mifepristone exposure.

http://www.reproductivereview.org/index.php/rr/article/1439/

Turkey: Early surgical abortion: safe and effective.


The study's objective was to evaluate patients' characteristics and complications of surgical abortion performed at an early gestation, compared to later gestations. The authors concluded that early surgical abortion (at six - six+6 weeks' gestation) generates few complications. Delaying surgical abortion until a somewhat later gestation causes complication rates (particularly RPCs) to increase.

http://www.reproductivereview.org/index.php/rr/article/1444/

USA: Efficacy and acceptability of early mifepristone misoprostol medical abortion in Ukraine: results of two clinical trials.


The authors noted that abortion services are legally available in Ukraine although there are issues in quality and access. Two open-label clinical trials were conducted at six clinics in Ukraine. Women were given 200 mg mifepristone followed after 48 hours by 400 μg oral misoprostol (Study One) and mifepristone followed after 24 hours by 400 μg sublingual misoprostol (Study Two). Follow-up visits were scheduled for two weeks after mifepristone administration to assess whether complete uterine evacuation had occurred. Success rates were 97% in the first study and 98% in the second one. The vast majority of participants were satisfied or very satisfied with their abortion method (Study One: 94%; Study Two: 98%). The authors concluded that the two studies demonstrate high rates of success and acceptability of early medical abortion in Ukraine.

http://www.reproductivereview.org/index.php/rr/article/1443/

Denmark: Induced abortion and breast cancer among parous women: a Danish cohort study.


This study investigated whether induced abortion is associated with breast cancer when lifestyle confounders, including smoking and alcohol consumption, are adjusted for. It was a prospective cohort study set among a total of 25,576 Danish women from the Diet, Cancer and Health study. The main outcome measures were long-term effects of induced abortion on the risk of breast cancer among women above 50 years of age.

During a follow-up of approximately 12 years, 1215 women were diagnosed with breast cancer. When comparing parous women who had an abortion with parous women who never had an abortion, there was no association between breast cancer risk and induced abortion (ever vs. never), with a hazard ratio 0.95 (95% confidence interval 0.83-1.09), regardless of whether the abortion occurred before the first birth (hazard ratio 0.86; 95% confidence interval 0.65-1.14), or after the first birth (hazard ratio 0.97; 95% confidence interval 0.84-1.13). The authors concluded that their study did not show evidence of an association between induced abortion and breast cancer risk.

http://www.reproductivereview.org/index.php/rr/article/1440/

Mexico: Decriminalization of abortion in Mexico City: the effects on women’s reproductive rights.


The authors concluded that Mexico City’s abortion legislation is an important first step in improving reproductive rights, but unsafe abortions will only be eliminated if similar abortion legislation is adopted across the entire country.

http://www.reproductivereview.org/index.php/rr/article/1441/

UK: Medical treatments for incomplete miscarriage.


The authors note that miscarriage occurs in 10% to 15% of pregnancies. The traditional treatment, after miscarriage, has been to perform surgery to remove any remaining placental tissues in the uterus (‘evacuation of uterus’). However, medical treatments, or expectant care (no treatment), may also be effective, safe
and acceptable. The objective of this study was to assess the effectiveness, safety and acceptability of any medical treatment for incomplete miscarriage (before 24 weeks).

Twenty studies (4208 women) were included. There were no trials specifically of miscarriage treatment after 13 weeks’ gestation. Three trials involving 335 women compared misoprostol treatment (all vaginally administered) with expectant care. There was no statistically significant difference in complete miscarriage, or in the need for surgical evacuation. There were few data on ‘deaths or serious complications’. Twelve studies involving 2894 women addressed the comparison of misoprostol (six studies used oral administration, four studies used vaginal, one study sub-lingual, one study combined vaginal + oral) with surgical evacuation. There was a slightly lower incidence of complete miscarriage with misoprostol but with success rate high for both methods.

Overall, there were fewer surgical evacuations with misoprostol but more un planned procedures. There were few data on ‘deaths or serious complications’. Nausea was more common with misoprostol. Five trials compared different routes of administration and/or doses of misoprostol. There was no clear evidence of one regimen being superior to another. Limited evidence suggests that women generally seem satisfied with their care. Long-term follow-up from one included study identified no difference in subsequent fertility between the three approaches.

The authors concluded that the available evidence suggests that medical treatment, with misoprostol, and expectant care are both acceptable alternatives to routine surgical evacuation given the availability of health service resources to support all three approaches. Women experiencing miscarriage at less than 13 weeks should be offered an informed choice. Future studies should include long-term follow-up.

http://www.reproductivereview.org/index.php/rr/article/1447/

New Zealand: Testing times: do new prenatal tests signal the end of Down syndrome?


The authors note that since 2010, prenatal screening for Down syndrome (DS) has been offered to all pregnant women in New Zealand. The programme has been criticised by several groups, on claims that screening is eugenic and discriminatory towards those with DS. Recently, tests have been developed that may one day prove more efficient than current screening methods. They are an example of ‘Non-Invasive Prenatal Diagnosis’ (NIPD), which enables diagnosis earlier in pregnancy with less risk of complications. If the current programme raises objections, what threats does this new and seemingly more attractive technology pose to the DS community?

The authors argue that NIPD is simply an extension of current screening methods, raising similar ethical concerns. Presently, the programme shows little evidence of ‘eugenics’, demonstrated by moderate uptake rates and varying attitudes towards disability. The authors do not regard the offer of screening to be threatening, as women choose whether or not to be screened depending on their own personal circumstances. One day, prenatal testing may result in fewer people with DS, but past and present trends indicate these individuals will continue to be supported, irrespective of ‘group size’. Care and respect for the disabled will remain essential, regardless of a woman’s decision over her pregnancy.

http://www.reproductivereview.org/index.php/rr/article/1428/

UK: Implementation of maternal blood cell-free DNA testing in early screening for aneuploidies.


This study set out to explore the feasibility of routine maternal blood cell-free (cf) DNA testing in screening for trisomies 21, 18 and 13 at 10 weeks’ gestation. In this prospective study, women attending The Fetal Medicine Centre in London, UK, between October 2012 and April 2013, with singleton pregnancy and live fetus with CRL 32–45 mm, were screened for trisomies 21, 18 and 13 by cfDNA testing at 10 weeks and the combined test at 12 weeks.

cfDNA testing was performed in 1005 singleton pregnancies with a median maternal age of 37 (range, 20–49) years. Risks for trisomies were provided for 957 (95.2%) cases and in 98.0% these were available within 14 days from sampling. In 48 (4.8%) cases no result was provided due to problems with delivery to the laboratory, low fetal fraction or assay failure. Repeat sampling was performed in 40 cases and a result obtained in 27 (67.5%) of these. In 11 cases the risk score for trisomy 21 and in five cases that for trisomy 18 was > 99%, in one the risk for trisomy 13 was 34% and in 968 the risk for each of the three trisomies was < 0.01%. The suspected trisomies were confirmed by karyotyping after chorionic villus sampling (CVS), except in one case of trisomy 18 in which the karyotype was normal. On the basis of the maternal age distribution of the study population, the expected and observed numbers for each of the three trisomies were similar. Both cfDNA and combined testing detected all trisomies, but the estimated false-positive rates (FPR) were 0.1% and 3.4%, respectively.

The authors concluded that routine screening for trisomies 21, 18 and 13 by cfDNA testing at 10 weeks is feasible and has a lower FPR than does combined testing, but abnormal results require confirmation by CVS.

http://www.reproductivereview.org/index.php/rr/article/1430/

BioNews

For news and comment on genetics, assisted conception, embryo/stem cell research and related areas, you may be interested to read BioNews, published by the Progress Educational Trust.

http://www.bionews.org.uk/home
What do you call a woman who’s had an abortion?


Abortion. No more names.

@bpas1968
#nomorenames

[Image]

Canada: Selected pregnancy and delivery outcomes after exposure to antidepressant medication: a systematic review and meta-analysis.


The authors note that untreated depression during pregnancy has been associated with increased morbidity and mortality for both mother and child and, as such, optimal treatment strategies are required for this population. There are conflicting data regarding potential risks of prenatal antidepressant treatment. The study’s objective was to determine whether prenatal antidepressant exposure is associated with risk for selected adverse pregnancy or delivery outcomes.

The results of this meta-analysis found that there was no significant association between antidepressant medication exposure and spontaneous abortion. Gestational age and preterm delivery were statistically significantly associated with antidepressant exposure, regardless of whether the comparison group consisted of all unexposed mothers or only depressed mothers without antidepressant exposure. Antidepressant exposure during pregnancy was significantly associated with lower birth weight; when this comparison group was limited to depressed mothers without antidepressant exposure, there was no longer a significant association. Antidepressant exposure was significantly associated with lower Apgar scores at 1 and 5 minutes, regardless of whether the comparison group was all mothers or only those who were depressed during pregnancy but not exposed to antidepressants.

Although statistically significant associations between antidepressant exposure and pregnancy and delivery outcomes were identified, group differences were small and scores in the exposed group were typically within the normal ranges, indicating the importance of considering clinical significance. The authors concluded that treatment decisions must weigh the effect of untreated maternal depression against the potential adverse effects of antidepressant exposure.

http://www.reproductivereview.org/index.php/rr/article/1442/

UK: Can a gene test screen for postnatal depression?

The results of a study published in the Journal of Psychiatric Research, examining the genetics of postnatal depression hit the headlines on July. This analysis, by the NHS Choices website, reviews the findings.

The study in question – ‘Association of glucocorticoid and type 1 corticotropin-releasing hormone receptors gene variants and risk for depression during pregnancy and post-partum’ by Neelam Engineer et al. - looked at small genetic variations called single nucleotide polymorphisms (SNPs), which previous research suggested can increase the risk of postnatal depression. Women were tested for these SNPs, and a screening test for postnatal depression was given both before and after birth. Researchers found that two SNPs were associated with elevated depression screening test scores, and therefore may be associated with an increased risk of developing the condition.

The NHS Choices analysis claims that an accurate screening programme for postnatal depression risk would potentially be beneficial. But, as the study’s authors concede, this small study has not established that a blood test can accurately diagnose the condition. The research did not look at the associations between these variations and whether there was a confirmed diagnosis of postnatal depression among new mothers. It also did not assess the effectiveness or the cost effectiveness of using this test as a screening tool.

Media coverage of the research focused on the potential for an inexpensive diagnostic test to detect postnatal depression, rather than covering the study itself. The NHS Choices analysis argues the researchers went to great pains to outline the limitations of their study, such as its size and the fact that it did not assess associations with diagnosed postnatal depression, and that these should have been made more explicit by the papers. Many papers also quoted that blood tests would cost £10, but it is uncertain where this cost has emerged from.

http://www.reproductivereview.org/index.php/rr/article/1445/