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bpas Reproductive Review

Issues in abortion, pregnancy and birth

Jennie Bristow, Editor
Reproductive Review

Welcome to the first issue of bpas Reproductive Review

The re-branded, wider-focused incarnation of *Abortion Review* will continue to report on clinical, political, and cultural developments in abortion, situating these within the range of issues and experiences that affect women over the course of their reproductive lives.

For over many years, *Abortion Review* has been reporting on clinical, political, and cultural developments in abortion. *Reproductive Review* will continue to do this, only more so. With our expanded focus, we will situate abortion in its proper place, within the range of issues and experiences that affect women over the course of their reproductive lives.

We know that the women who seek abortions are no different from the women who have children, or want to have children. In October 2012 bpas launched its 'Mother, Daughter, Sister, Friend' campaign (pictured on the back page) in mainline train stations across Britain to highlight this reality. The campaign was not controversial, and the public response was appreciative. Statistics tell us that one in three women will have an abortion in her lifetime, and experience tells us that these women do not exist 'out there', but among our friends and family. Abortion has been legally available and widely accessible in Britain for over 40 years, and has enabled three generations of women to take for granted opportunities that their ancestors could only dream of.

The 'normalisation' of abortion on a social and cultural level has been reflected and also enabled by advances in medical technology and practices. The development of early medical abortion (EMA, the 'abortion pill') has transformed abortion from an operation performed by surgeons to a pill swallowed by women themselves that safely induces a miscarriage. This has had a huge impact on the potential for the demedicalisation of abortion services throughout the world. Improvements in the sensitivity of pregnancy tests mean that women can know they are pregnant almost as soon as it happens, and emergency contraception has now been developed that is effective up to five days after intercourse. For centuries, women sought a way of 'bringing on their period' - in an increasing proportion of cases, this is what we have today.

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bpas Reproductive Review

Opponents of abortion decry these developments as 'trivialising' abortion - the reality, as we know, is that better methods and a more accepting culture do not encourage women to have abortions rather than continue their pregnancy; they enable women who have decided to end their pregnancy to act on that decision earlier, facing fewer unnecessary, punitive barriers.

As Clare Murphy writes, there are a number of ways in which abortion intersects with other aspects of women's reproductive health and pregnancy decision making, from the management of spontaneous miscarriage to the use of fertility treatment to the 'hyper-regulation' of women carrying wanted pregnancies. All of these issues demand our attention, and require an impassioned defence of women's freedom to decide for themselves not only *whether* to be pregnant, but also *how* to be pregnant.

But while it is right to recognise the widespread cultural acceptance of abortion, and to aspire for a world where abortion care is situated within the wider spectrum of reproductive healthcare, it is also important to understand the ways in which abortion is different to other gynaecological procedures.

For example, the ethical and political debates about abortion have gained momentum in Britain over the past two years, showing that the question of the 'morality of abortion' is far from settled. A society in which people hold a range of religious beliefs, and in which the idea of the fetus invokes a range of deep-seated emotional responses, will always need to debate the rights and wrongs of a procedure that deliberately ends a fetal life. The role of *Reproductive Review* is to engage with these issues and debates.

We believe that the doctors and nurses who help women to end unwanted pregnancies do so because of a humane and progressive commitment to the women in their care. Without control over their fertility, women will never be able to play a full and equal role in society. We fully subscribe to the statements set down by the London Declaration of Pro-choice Principles, published on page 3, which represents the outcome of a discussion among leading providers of, and advocates for, abortion care.

However, our support for choice stems from our belief in the individual's moral autonomy - and this includes women's choice not to abort a pregnancy, doctors' choice not to perform an abortion, and campaigners' freedom to argue the case against abortion. The law should not seek to insist that women have abortions any more than it should restrict women from having abortions, or doctors from performing them. In a liberal society, provision should be made for people to act on their own choices and beliefs. This means that debates about abortion need to be had out in public, not manipulated through changes in legal regulations.

Over the past two years, vocal campaigners in and around Parliament have attempted to restrict women's access to abortion, through pushing for changes to the regulations surrounding abortion counselling, attempting to lower the upper gestational limit at which abortions can be provided, and misinterpreting the existing law to imply that doctors are acting illegally when they are not. These attempts to restrict choice have been exposed and successfully challenged, but they are likely to return in different forms.

To ensure that abortion is provided well, effectively, and widely, it has to be advocated for. The provision of abortion can never been assumed. The recent experience of British politics highlights the need for more, and better informed, debate about the morality of abortion and the principle of women's autonomy in reproductive decision-making. In 2013, bpas will be hosting a range of discussions and debates, on these pages and through our events programme, outlined on page 8.

Welcome to *bpas Reproductive Review.*

From Nuvarings to epidurals:
What does it mean to be pro-choice?

Clare Murphy
Director of External Affairs, bpas

Delivering your baby in your own front room may not be for everyone, just as the prospect of an epidural in your hospital bed is heresy to home-birthers. But to be pro-choice is to respect women's bodily autonomy and ability to make the decision that is best for her across the reproductive spectrum of her life: from choice of contraception, the decision to keep or end a pregnancy, to how she feeds a much-wanted baby in the first months.

For too long, abortion has often been divorced from discussion about other areas of women's reproductive healthcare. But while abortion may be specialised, it may not be as special as it sometimes appears.

Without a doubt it is the choice with the most profound consequences when it is denied - and the one which presents the greatest ethical complexities as we weigh up the respective moral values of woman and fetus. But the only ethical solution to reconciling these complexities is to conclude that it is for the woman herself to decide how she approaches these.

Clarity about the moral value of the fetus may make one woman certain she cannot end an unintended pregnancy - but this value may be felt even more keenly in another woman who knows abortion is the right thing for her and her family - while another woman may see abortion as a straightforward medical answer to a contraceptive failure. How can we judge whose view is right?

Yet the entire spectrum of women's reproductive healthcare and decision making is one in which others feel at liberty to weigh in with their own moral conclusions. Consider for example

how we set up the model responsible 'contracepter' - for example, the woman who chooses an implant - against the woman who uses the morning after pill to prevent an unwanted pregnancy. Consider public policy and perception of women who drink in pregnancy and the refusal to entrust women with the available evidence on alcohol consumption.

Women's choice of how they deliver their child is also viewed as something of a public free for all: from she who is branded 'too posh to push' for requesting a C-section to she who is accused of putting her baby at risk by delivering at home. And that's before we get on to the woman who chooses formula milk over breastfeeding.

To be pro-choice is to believe that it is she whose body is at issue who is best placed to make what she may or may not see as an ethical decision. And we should be clear: her decision may not always be the one we ourselves might make - but that is the nature of choice. It has little meaning if only the decisions we like are respected.

Reproductive events, whether miscarriage, abortion or childbirth, may well be stressful, painful, emotionally and physically draining. We cannot control for how a woman feels about her pregnancy but we can ensure she has a choice of clinical and non-clinical options which enable her to find the resolution best suited to her.

Women who have experienced miscarriage should always be offered the choice of conservative, surgical or medical management. We must call for an end to differences in clinical options to women based on the reasons for their predicament: it is not right that women who have suffered a miscarriage are legally able to take the medication needed to expel the pregnancy in the comfort and support of their own homes, while those undergoing treatment for abortion must travel sometimes long distances at great expense to take the very same medication for the same clinical outcome in front of a doctor.

It is not right that women ending pregnancies for fetal anomaly in the NHS are rarely offered access to surgical methods but solely induction of labour. It is not right that so many women report inadequate pain relief during gruelling childbirth - under as well as over intervention - to the point that some consider whether they are physically capable of bearing another child.

Women's reproductive choices are and must remain personal and private. But this does not mean it a privatised issue in which society has no stake: as a society we should have every interest in supporting and facilitating women's ability to exercise reproductive choice. A woman denied control over the decision if, when and how to be a mother, will have little control over anything else in her life. That's why we are pro-choice.

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

In the News

JANUARY 2013

USA: Main abortion advocacy organisation moves away from 'pro-choice' label

Two weeks before the 40th anniversary of *Roe v Wade*, Planned Parenthood announced that it has reoriented its branding from being a 'pro-choice' group to not labelling itself, in an effort to attract the support of people who don't identify with either group. *14/1/13*
http://www.reproductivereview.org/index.php/site/article/1314/

UK: bpas medical students scheme launched for second year

Following the success of its scheme in 2012, bpas is offering week-long externships in London in summer 2013 for medical students from the UK and Ireland interested in learning about abortion care and contraception. Students will have the opportunity to observe each step of the patient care pathway including pregnancy options counselling, obtaining consent, medical and surgical abortion procedures up to 24 weeks and aftercare. Students with appropriate experience will also be able to perform scanning procedures and assist with theatre preparation. All participants will have the opportunity to spend half a day with the support organisation Antenatal Results and Choices (ARC) learning about the issues facing couples who have received a diagnosis of fetal anomaly.
http://www.reproductivereview.org/index.php/site/article/1310/

USA: Report details extent of abortion restrictions

Over the course of the year, 42 states and the District of Columbia enacted 122 provisions related to reproductive health and rights, the Guttmacher Institute reports. *3/1/13*
http://www.reproductivereview.org/index.php/site/article/1306/

UK: Baby boom reveals problems in maternity care

The NHS is struggling to keep up with the increase in England's birth rate, midwives have warned.
http://www.reproductivereview.org/index.php/site/article/1316/

Comment and opinion

- **The hypocrisy of abortion policy - the lessons of Romania and Ireland**
Bpas chief executive Ann Furedi writes in the Guardian.
http://www.reproductivereview.org/index.php/site/article/1312/

- **The 'generation war' over abortion rights**
The shift away from 'choice' to 'reproductive justice' will do younger generations of women no favours, argues Jennie Bristow.
http://www.reproductivereview.org/index.php/site/article/1315/

DECEMBER/NOVEMBER 2012

UK: Cross-party inquiry into unplanned pregnancy publishes findings

The inquiry by Conservative MP Amber Rudd, Liberal Democrat Lorely Burt and Labour's Sandra Osborne concludes that the teenage pregnancy strategy of the previous government had been a success, and should be resumed and extended to cover older age groups. It places particular emphasis on sex and relationships education in schools.

Bpas welcomed the report and supported its recommendations, including the following:
- PCTs should ensure that older women are able to access the kind of services currently available to the under-25s.
- Long Acting Reversible Contraceptives (LARCS) to be made available to all women, while recognising that not all women will find them suited to their needs and lifestyles.
- Postnatal contraception advice and services to be a standard part of follow up care after delivery.
- Steps to be taken to improve understanding and availability of vasectomy as a safe and reliable form of male contraception and efforts to avoid cuts in funding in this area. *20/12/12*
http://www.reproductivereview.org/index.php/site/article/1308/

UK: Dedicated NHS service recommended for women with a suspected miscarriage or ectopic pregnancy

The NHS should consider setting up dedicated services for pregnant women who may have an ectopic pregnancy or who experience pain or bleeding before 13 weeks gestation, according to a new guideline published in December by the National Institute for Health and Clinical Excellence (NICE) on the diagnosis and management of ectopic pregnancy and miscarriage in early pregnancy. *11/12/12*
http://www.reproductivereview.org/index.php/site/article/1307/

Ireland: Government to legislate for abortion

The Irish government has announced it will legislate for abortion in circumstances where the mother's life is at risk. This follows the death of Savita Halappanavar, who died in Galway in October following a miscarriage; she was reportedly refused a termination because there was a fetal heartbeat.*17/11/12; 19/11/12; 18/12/12*
http://www.reproductivereview.org/index.php/site/article/1258/
http://www.reproductivereview.org/index.php/site/article/1294/
http://www.reproductivereview.org/index.php/site/article/1305/

Comment and opinion

• **Savita Halappanavar's death, and Ireland's law**
Ruth Fletcher, senior lecturer in law at Keele University, writes on Reproductive Review. 29 November 2012
http://www.reproductivereview.org/index.php/site/article/1292/

• **The royal fetus in the spotlight**
The confirmation of Kate Middleton's pregnancy has sparked some insightful commentary about today's tendency to see a woman's pregnancy as a public spectacle, and her fetus as a person in its own right.
http://www.reproductivereview.org/index.php/site/article/1299/

• **On abortion, both Britain and Ireland need to rediscover the spirit of 67**
We pander to the anti-abortion lobby, and are too willing to settle for a few scraps of reproductive rights, writes Zoe Williams in the Guardian.
http://www.reproductivereview.org/index.php/site/article/1303/

USA: The Secret History of Sex, Choice and Catholics

The Secret History of Sex, Choice and Catholics, a new documentary-style film produced by Catholics for Choice, sets the record straight about Catholic social teaching on issues related to sex and sexuality. *28/11/12*
http://www.reproductivereview.org/index.php/site/article/1298/

OCTOBER 2012

UK: Government drops abortion counselling consultation

Health minister Anna Soubry said the government no longer plans to undertake its own consultation on abortion counselling. Ms Soubry told MPs the government 'did not intend to change either the law or the guidelines', and said ministers would look at recommendations from an inquiry being held by a cross-party group of MPs. That group was set up after MPs voted last September against proposals that would have stopped abortion providers offering counselling to pregnant women.

The counselling proposals, supported by three cabinet ministers, were brought forward by Conservative MP Nadine Dorries. Ms Dorries, who called the debate in which the minister made her announcement, accused the government of reneging on its promise to look at the issue. 'It is not a case of changing the law, it is a case of changing the government's commitment. There was an absolute commitment by the government that a consultation would be taken,' she said. However, Ms Soubry said: 'There is other work we should be doing on counselling. I take the view that this is not the primary function we should be addressing and that is why I have taken the decision that I have.'

Shadow public health minister Diane Abbott welcomed the cancellation of the consultation as a 'victory for women, families and pro-choice campaigners across the country'. She said the government had 'finally conceded defeat' on efforts to prevent abortion providers offering counselling to pregnant women. 'The message that people have forced this government to listen to is that British women's right to choose is here to stay,' she said. 'I think it's been a particularly tough period for those people who provide care and support for women seeking an abortion, who have repeatedly faced the most appalling attacks, smears and misinformation about their work in the media, and in Parliament.' *31/10/12*
http://www.reproductivereview.org/index.php/site/article/1251/

UK: Debate sparked by Health Secretary's support for 12-week abortion time limit

The government has 'no plans' to bring in new laws governing when women can legally have an abortion, Prime Minister David Cameron said in October, speaking after Health Secretary Jeremy Hunt told the *Times* newspaper he personally favoured a move to halve the abortion limit from 24 weeks to 12. The health secretary said he had reached the conclusion after studying the evidence, adding it was his personal view over what remains an 'incredibly difficult question'. Mr Cameron said Mr Hunt was 'entitled to hold an individual view' but insisted it was not government policy. Mr Cameron said he 'personally' favoured a 'modest reduction' from the current limit of 24 weeks, 'because I think there are some medical arguments for that'. But he said he did not agree with the 12-week limit.

Responding to his comments, Home Secretary Theresa May told the BBC she 'probably' backed a change to a 20-week limit but also said that was a personal view. Earlier in that week, Women's Minister Maria Miller told the *Daily Telegraph* she would vote to lower the abortion limit from 24 weeks to 20 weeks, saying: 'You have got to look at these matters in a very common-sense way. I looked at it from the really important stance of the impact on women and children. What we are trying to do here is not to put obstacles in people's way but to reflect the way medical science has moved on.'

The *Times* reported a number of critical reactions alongside Hunt's comments. Clare Murphy, Director of External Affairs at bpas, said: 'Ministers are absolutely entitled to their own personal convictions

about abortion, but health services need to be constructed on the basis of what women need. There is certainly no scientific basis for any reduction in the time limit, but just as importantly, the reality of women's lives means a relatively small yet consistent number of women will need access to abortion up until 24 weeks.'

Kate Guthrie, spokeswoman for the Royal College of Obstetricians and Gynaecologists, said she was mystified by Jeremy Hunt's reference to making his decision after looking at evidence. 'What evidence is he thinking of? I can't think of anything,' she said. Dr Guthrie said if women were not allowed legal terminations they would resort to buying abortion pills over the internet and other risky methods. 'That's why we have the abortion law in the first place, to stop women dying," she said. She said that even if the Health Secretary had no plans to change the law, his comments were a sign that he might seek to restrict abortion by other means. "Subtly and from the sidelines you can tweak here and tweak there and make women's lives harder,' she said. *6/10/12; 2/10/12*
http://www.reproductivereview.org/index.php/site/article/1238/
http://www.reproductivereview.org/index.php/site/article/1236/

Comment and opinion

• **Wasting time on the time limit - the real issues in women's reproductive healthcare**
Clare Murphy writes on the Huffington Post UK. 19/10/12
http://www.reproductivereview.org/index.php/site/article/1248/

• **Abortion - why does Maria Miller prefer emotions over facts?**
Emma Barnett writes in the Daily Telegraph. 20/11/12
http://www.reproductivereview.org/index.php/site/article/1295/

• **32 reasons for 24 weeks**
Anonymised case-study audit of abortion requests above 22 weeks' gestation at bpas in 2008.
http://www.bpas.org/js/filemanager/files/bpas_press_briefing_late_abortion.pdf

UK: MSI opens abortion clinic in Northern Ireland

The first private clinic to offer abortions to women in Northern Ireland was opened in the centre of Belfast on 18 October. MSI says it will provide terminations within Northern Ireland's current legal framework, where abortions are not illegal but are very strictly controlled.

Northern Ireland, unlike the rest of the UK, does not have an Abortion Act. In Northern Ireland abortions can be carried out only to preserve the life of the mother or if continuing the pregnancy would have other serious, permanent physical or mental health effects. There is strict assessment regarding any impact on mental well-being and the woman must consult with two clinicians. The MSI clinic says it will carry out medical, not surgical, procedures only up to nine weeks gestation and only within the existing legal framework. *11/10/12*
http://www.reproductivereview.org/index.php/site/article/1244/

SEPTEMBER 2012

UK: Abort67 court case collapses

A campaigner who displayed large banners of outside an abortion clinic in Brighton was cleared of public order offences. The case against Andrew Stephenson, from the Abort67 campaign in Worthing, West Sussex, collapsed after the judge ruled there was insufficient evidence to proceed. Reacting outside Brighton Magistrates' Court, Mr Stephenson said: 'What the police have been doing in shutting us down has had a chilling effect on free speech. Hopefully this will have a chilling effect on the police now to hold back on their over-enthusiastic, over-reaching arm of the law.' Sussex Police said they never sought to stop protests at the bpas clinic, and were acting on public complaints.

Commenting on the verdict, Abortion Rights said: 'As a society we should be able to guarantee the privacy and safety of those seeking to access a legal medical treatment. We respect people's right to protest and to express their views, but this cannot take precedence over access to vital healthcare services. It is time we had a clear statement from the Department of Health on this issue. Ministers should be speaking out to condemn these tactics and should be investigating what powers are available to police and other agencies to tackle the problem. They have a responsibility to step in and protect women's health and safety."

In a statement, bpas commented: 'The case against the protesters outside our Brighton clinic was not brought by bpas, and we had no involvement in the prosecution of these people. bpas does not take a position on the legality of what these people do - we question the morality of their actions. We are very supportive of people's right to freedom of speech, and we are always keen to debate and defend the services we provide and why women need them. However what takes place on a regular basis outside our clinic is not about debate or changing public opinion – it is simply about causing distress to individual women on what may already be a difficult day.

'The number of women undergoing abortion treatment at our Brighton clinic has not changed since the protesters first arrived two years ago, but the proportion of abortions taking place at later gestations has increased. We know there are some women who simply feel unable to make their way past the line of protesters on the days they are there – these women do not decide against abortion, they simply come back at a later date for treatment at a later gestation.' *17/9/12*
http://www.reproductivereview.org/index.php/site/article/1224/

UK: Questions raised about sentence in Sarah Catt case

A woman who aborted her own baby in the final phase of her pregnancy was jailed for eight years, causing outcry among women's groups. Sarah Louise Catt, 35, of Sherburn-in-Elmet, North Yorkshire, took a drug when she was 39 weeks pregnant, to cause an early delivery. She claimed the boy was stillborn and that she buried his body, but no evidence of the child was ever found. Catt made a 'deliberate and calculated decision' to end her pregnancy, a Leeds Crown Court judge said. *19/9/12*
http://www.reproductivereview.org/index.php/site/article/1221/

UK: 'Coat-hanger' protest highlights need for abortion rights

Six hundred coat-hangers were delivered to the Department of Health by pro-choice activists anxious about possible attacks on abortion provision under the new health secretary, Jeremy Hunt. Marking the Global Day of Action for Access to Safe and Legal Abortion, the hangers were deposited by activists with a speech about the dangers of limiting safe and accessible abortion in the UK. 'We are sending Hunt a reminder of what happens when you

restrict abortion rights,' said the stunt organiser, Kate Banyard of UK Feminista. 'It becomes illegal and unsafe.' *28/9/12*
http://www.reproductivereview.org/index.php/site/article/1235/

UK: Call for improved post-natal contraceptive advice

Almost two-thirds of mothers-to-be do not get contraception advice after the birth of their babies, a Mumsnet/bpas survey has suggested. Research found that 61% of women who have given birth in the last three years did not get such advice from healthcare professionals while pregnant. The survey of 1,000 women also found that more than half did not discuss it until their postnatal check at around six weeks or later.

bpas said that it conducted the research after noticing a rise in the number of women experiencing unplanned pregnancy shortly after giving birth. It also noted an increase in the number of women who became pregnant whilst breastfeeding, believing it provided full contraceptive cover. Only 1% of all women discussed newer forms of contraception such as the contraceptive ring and patch. And more than a quarter of women would have liked more support and advice about contraception.

Ann Furedi, bpas chief executive, said: 'There's never going to be a one-size-fits-all answer to postnatal contraception advice - and many women understandably find it laughable that they would want to discuss methods hours after giving birth or indeed find it patronising that it's raised at all. Some women may want to fall pregnant again very rapidly - so healthcare professionals always have to tailor their care to the needs of the individual. But it's vital that women who do want contraception can make their choice from the full range of options'. *28/9/12*
http://www.reproductivereview.org/index.php/site/article/1234/

UK: Bishop condemned for comparing abortion to Auschwitz

Pro-choice campaigners have criticised Bishop Joseph Devine's comments for displaying 'a warped moral view of the world'. *23/9/12*
http://www.reproductivereview.org/index.php/site/article/1225/

UK: Anti-abortion campaigners use Paralympics to attack abortion for fetal anomaly

The success of the Paralympics should trigger a rethink of Britain's abortion laws to make it illegal to terminate a pregnancy because a child will be born disabled, a coalition of campaigners and charities argued in a letter to the *Daily Telegraph. 19/9/12*
http://www.reproductivereview.org/index.php/site/article/1226/

Comment and opinion

• **Right to protest, or just plain wrong?**
Anti-abortionists should have absolute freedom of speech. But that doesn't mean they can do 'pavement counselling' outside abortion clinics, argues Ann Furedi on spiked. 21/9/12
http://www.reproductivereview.org/index.php/site/article/1223/

• **Sarah Catt should never have been convicted**
The case of a Leeds woman jailed for eight years for inducing her own labour raises some serious questions, writes Barbara Hewson. 27/9/12
http://www.reproductivereview.org/index.php/site/article/1233/

• **Why the UK doesn't need an abortion law at all**
Joyce Arthur shares the experience of Canada, where abortion was decriminalised a quarter of a century ago. 28/10/12
http://www.reproductivereview.org/index.php/site/article/1250/

• **'Abortion: The case for decriminalisation'**
In a film for the online Citizen TV channel WORLDbytes, Ellie Lee explains why a liberal position on abortion would mean removing it from the criminal statute. 7/10/12
http://www.reproductivereview.org/index.php/site/article/1246/

• **Science, money and women's reproductive choices**
Clare Murphy, Director of External Affairs at BPAS, writes on the Huffington Post UK. 29/10/12
http://www.reproductivereview.org/index.php/site/article/1257

Events and Resources

Coming up...

UK: Abortion, motherhood and the medical profession

A one-day conference organised by BPAS and the Royal Society of Medicine. *London, 12 June 2013*

Sessions include:

- **Fetal imaging, and imagining the fetus:** What scans can and can't tell us about abortion
- **Information, counselling and the law:** What do women need to know, and why?
- **Testing positive, negative, and in between:** How the semi-quantitative pregnancy test could transform the management of abortion, miscarriage, fertility treatment and ectopic pregnancy
- **A new generation of abortion doctors:** New challenges and opportunities.

Speakers include:

Paul Blumenthal, Professor of Obstetrics and Gynaecology, Stanford University; **Stuart Derbyshire**, Reader in Psychology, University of Birmingham; **Katharine Elliot**, medical student, University of Newcastle; **Roy Farquharson**, consultant gynaecologist, Liverpool Women's Hospital; **Jane Fisher**, Director, Antenatal Results and Choices; **Joanne Fletcher**, Consultant Nurse, Gynaecology, Sheffield Teaching Hospitals NHS Trust; **Patricia Lohr**, Medical Director, British Pregnancy Advisory Service; **John Reynolds-Wright**, medical student, University of Sheffield; **Carol Sanger**, Barbara Aronstein Black Professor of Law, Columbia Law School; **Sally Sheldon**, Professor of Medical Law and Ethics, Kent Law School; **Zoe Williams**, columnist, *The Guardian*; author, *What Not To Expect When You're Expecting*.

See here for further information:
http://www.reproductivereview.org/index.php/site/article/1317/

Past events

UK: Current issues in sexual and reproductive health and abortion care

Royal College of Physicians, London, 18 December 2012
A conference organised by BPAS and the Margaret Pyke Trust brought together general practitioners with specialists in abortion care and reproductive and sexual health. **Clare Gerada**, Chair of the Royal College of General Practitioners, discussed the question of 'Pre-Abortion Counselling – Who? What? When? **Emeka Oloto**, Consultant in contraception and sexual and reproductive health at University Hospitals of Leicester NHS Trust, spoke about 'Post-Abortion Care – Complications and Management in General Practice.' **Professor Anna Glasier**, honorary consultant in obstetrics and gynaecology at the, University of Edinburgh, spoke on the topic of 'Post-Abortion Contraception'. **Dr Jane Dickson**, Community Specialist in SRH at Oxleas NHS Foundation Trust in London discussed the management in primary care of recurrent vaginal discharge, and **Rosemary Cochrane**, Specialist Registrar in sexual and reproductive health at the Chalmers centre in Edinburgh, analysed the problems and risks involved in the issue of obesity and sexual health. **Ann Furedi**, chief executive of bpas, summed up the day with a discussion of 'Abortion: Myths Dispelled in Moments.'
Read a report on the conference here:
http://www.reproductivereview.org/index.php/site/article/1249/

Abortion - a medical or a moral choice?

Barbican, London, 21 October 2012
Senior politicians have recently cited 'the evidence' as their reason for wanting a lower time limit on abortion. But can science give us the answer to moral questions? bpas sponsored this lively and intelligent debate at the Battle of Ideas festival at the Barbican. Speaking were **Dr Sarah Chan**, deputy director, Institute for Science, Ethics and Innovation, University of Manchester; **Steven Edwards**, professor of philosophy of healthcare, Swansea University; **Ann Furedi**, chief executive of bpas; and **Peter D Williams**, media commentator, political lobbyist, and executive officer of Right to Life.
http://www.reproductivereview.org/index.php/site/article/1239/

Freedom of speech, anti-abortion protestors and women: rights and limits

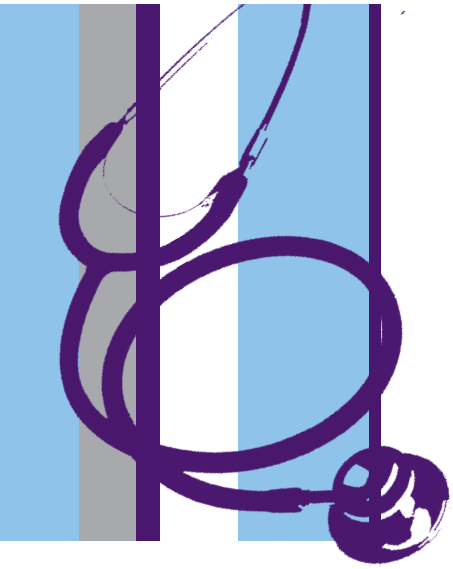
Conway Hall, London, 11 September 2012
The bpas public debate attracted an audience of 300. Chaired by the lawyer and journalist **David Allen Green**, the panel comprised **Andrea Minichiello Williams**, Barrister and CEO of Christian Concern and the Christian Legal Centre; **Ann Furedi**, chief executive of bpas; **Max Wind-Cowie**, who runs the Progressive Conservatism Project at the think-tank Demos; and the journalist **Sarah Ditum**, who has written on pro-choice issues for the *Guardian, New Statesman* and *New Humanist*. Read a report on the event here:
http://www.reproductivereview.org/index.php/site/article/1222/

Fertility Treatment: A life-changing event?

Institute for Child Health, London, 28 November 2012
The annual conference of the Progress Educational Trust (PET) addressed the impact of mothers' and fathers' lifestyles upon conception; the success of fertility treatment; and the health of the resulting child. Sessions included 'NICE Try: The Impact of Policy', 'Calm Down Dear: The Impact of Stress', 'Weighing Up Your Options: The Impact of Weight and Nutrition', 'What's Your Poison? The Impact of Alcohol and Smoking' and 'The Age-Old Question: The Impact of Age'. Speakers and chairs included **Dr Susan Bewley, Professor Jacky Boivin, Fiona Ford, Louisa Ghevaert, Professor Jean Golding, Dr Bas Heijmans, Dr Ellie Lee, Dr Gillian Lockwood, Professor Nick Macklon, Professor Neil McClure, Dr Allan Pacey, Lord Naren Patel, Tracey Sainsbury, Peter Taylor, Professor David Whittingham** and **Zita West**. Read a report on the conference here:
http://www.reproductivereview.org/index.php/site/article/1302/

Unwanted pregnancy – a fact of life

Edinburgh International Conference Centre, 19-20 October 2012
Abortion and contraception providers from Europe and North America met for the 2012 Congress of FIAPAC (International Federation of Abortion and Contraception Professionals) to share clinical and ethical research, experience and concerns, to learn from each others' practice and to be aware of the legal and regulatory situation surrounding abortion in other countries. This event highlighted the clinical improvements in contraceptive and abortion care that have taken place over recent years, and also the fact that the legal and political context is continually shifting. With dozens of workshops on issues ranging from education and training to methods of first trimester abortion to stigma and 'reproductive sabotage', the conference brought together over 400 people in a number of stimulating discussions. Read a report on the conference here:
http://www.reproductivereview.org/index.php/site/article/1261/



Clinical Update

Abortion and preterm birth

By Patricia Lohr
Medical Director, bpas

1) What do studies suggest about the relationship between abortion and preterm birth?

Early studies looking abortion in relation to a range of subsequent adverse pregnancy outcomes generally found no increase in risks with uncomplicated procedures (1-3). Concerns were raised about some subgroups, such as women who had undergone dilation and curettage as opposed to vacuum aspiration, or dilation and evacuation because of the extent of cervical dilation required. Also, because data on women who had undergone more than one abortion were scarce at that time, studies could not draw a conclusion as to whether there was a 'dose response relationship' between multiple abortions and poor obstetrical outcomes.

More recent studies using very large population-based data sets have tended to show an increased risk of preterm delivery in women who have undergone an induced abortion, with that association strengthening with the number of abortions (4-7). A systematic review and meta-analysis by Shah et al (8), for example, reported that a history of surgical abortion is associated with an odds ratio (OR) of 1.27 (95% CI 1.12–1.44) for preterm birth, which further increased with more than one abortion to an OR of 1.62 (95% CI 1.27 to 2.07).

2) Is there a risk of preterm birth posed by a) previous miscarriages; or b) previous preterm birth?

Prior spontaneous preterm birth is a strong risk factor for subsequent spontaneous preterm birth but early miscarriage is not (9, 10). Similarly, if the first pregnancy resulted in a medically indicated preterm birth, affected women are more likely to deliver preterm because of medical indications in the second pregnancy as well as to deliver preterm spontaneously (10). This suggests there may common etiological factors at play. Interestingly, a recent Scottish study (5) found that women who have had an abortion are at no significantly greater risk of preterm birth compared with women who have had a previous miscarriage.

3) Is there a difference in the risk posed by medical and surgical abortions?

The data conflict on this issue. A large study of Danish registries found no difference in the risk of subsequent preterm birth amongst women with a prior medical or surgical abortion (12). Their findings confirmed that of a previously conducted prospective multicentre cohort study in China of pregnancy outcomes in nulliparous women with a self-reported history of no prior abortion, one prior medical abortion with mifepristone, or a history of one first trimester surgical abortion (13). In contrast, the Scottish study discussed above did find that one prior surgical abortion appears to be associated with an increased in the risk of spontaneous preterm birth compared with a medical abortion (5).

This study could not demonstrate a relationship between multiple abortions and risk of preterm birth, but a multicentre cohort trial did find that while multiple medical abortions were not associated with an increased risk of preterm birth compared with no abortion, multiple surgical abortions were (14). In neither of these latter two studies was gestational age at the time of the abortion available for inclusion in the analysis.

4) What have been some of the limitations in studies to date?

Epidemiological studies are often methodologically compromised by bias and confounding factors. They also are limited in that they can only ever delineate associations, not causality, and are rarely able to describe associations that are strong enough and consistent enough to make a causal relationship highly likely.

The women who have undergone one or more abortions in these studies are usually different from the women who have never had an abortion. Known differences may

be controlled for to make the groups more similar during the analysis. However, the potential for confounding data that is unrecorded or partially recorded, and which can also increase a woman's risk of complications in pregnancy, means that investigators most often cannot exclude the possibility that some associations are not explained by abortion itself but by the unique circumstances of women seeking abortion.

In addition, it is well known that women under-report abortions because of the stigma surrounding the decision to terminate a pregnancy. The extent of under-reporting has been estimated to vary between 40% and 65% in the literature (15). This can have important effects on findings as exemplified by early studies drawing erroneous conclusions about the impact of abortion on the development of breast cancer. It is now apparent that information bias had a major role in generating early false-positive results in these studies because women who were healthy were less likely to report their previous abortions than women who had been diagnosed with breast cancer (16, 17).

As alluded to previously, many studies also lack a sufficient level of detail about the abortion procedure, the gestational age at which the abortion was performed, and the indication for the abortion, which complicates drawing accurate conclusions about the differential impact between methods.

5) What does guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) say?

The RCOG guidance advises that women should be informed that induced abortion is associated with a small increase in the risk of subsequent preterm birth, which increases with the number of abortions (18). They include the caveat that there is insufficient evidence to imply causality due to the lack of randomised controlled trials as the inability to control for all confounding factors.

The RCOG based its recommendation mainly on a systematic review published in 2009 by Shah, et al. (8); however, it did highlight that other studies have found a similarly increased risk of future preterm birth associated with miscarriage and that, in studies, where medical and surgical methods have been compared, there has been no significant difference reported in the risk of preterm birth between methods.

6) What (if any) are the implications of the abortion/preterm birth risk for women in antenatal care?

A comprehensive antenatal history will include recording any prior induced abortion and related details. For abortions undertaken for non-medical reasons, that background information would usually not influence the course of antenatal care; no additional counselling, testing, or monitoring would be performed. This is in comparison to women who have had a prior preterm birth who would be counselled about increased risks of another preterm birth, and whose antenatal course is closely watched.

It's important to recognise that the associations which have been documented between any prior abortion or even multiple abortions and preterm birth are not very strong and, as discussed, confounding factors limit the degree to which even counselling, much less alterations in care, can reasonably be justified.

Very large epidemiological studies, such as those published on the relationship between preterm birth and abortion, are highly likely to find associations. However, the documented strength of these associations is not very strong. Most studies which do show a positive association are not associated with an increase in risk of greater than 2. Many leading epidemiologists, as summarised in a recent article by Grimes and Schulz (19), have argued that weak associations which are variably defined as relative risks (RR) or ORs less than 4 are more likely to be attributable to bias than to causal association. In their view, unless RRs in cohort studies exceed 2 to 3 or ORs in case-control studies exceed 3 or 4, associations in observational research findings should not be considered credible (19). As they put it, 'Such results generally represent noise, not signal.'

As clinicians, our primary concern is whether an intervention is safe and effective. Multiple studies have shown both to be true for medical and surgical abortion at all gestations and as compared to carrying a pregnancy to term (20). However, the facts of safety and efficacy are not usually the primary concerns of women and couples contemplating abortion although they do come into play once the decision to terminate has been made and a choice of methods is under consideration.

At the outset, other more relevant issues such as finances, relationship status, health status, and the well-being of other children in the family inform abortion decision-making. These factors are of crucial importance and do - and should ¬- impact on the risk/benefit assessment more than, if not to the exclusion of, very small risks of spurious importance such as the apparent but probably unreliable weak and non-causal association between abortion and subsequent preterm birth.

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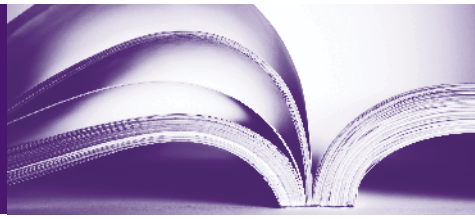
From the Journals



UK: Effect of contraception provided at termination of pregnancy and incidence of subsequent termination of pregnancy.

Cameron ST, Glasier A, Chen ZE, Johnstone A, Dunlop C, Heller R. BJOG. 2012 Aug;119(9):1074-80.

The study's objective was to determine the incidence of subsequent termination of pregnancy (TOP) within a 2-year period in relation to the method of contraception provided to women following the index TOP. This was a case note review set in an NHS hospital TOP service in Edinburgh, with a population of nine hundred and eighty-six women requesting a TOP in 2008. Case notes were reviewed to determine the contraception provided at index TOP and whether women had subsequent TOP at the same hospital within 2 years. The main outcome measures were the incidence of subsequent TOP within 2 years amongst women receiving different contraceptive methods.

One hundred and twenty-one women (12.3%) of the 986 who attended the clinic requesting a TOP returned requesting another TOP in the subsequent 2 years. Both intrauterine contraception and the progestogen-only implant were associated with the lowest incidence of subsequent TOP. Women choosing the implant were significantly younger than those choosing the intrauterine method. The authors concluded that women undergoing a TOP who wish to avoid another unintended pregnancy should consider immediate initiation of either intrauterine contraception or the progestogen-only implant. Service providers should be trained and supported to provide these methods to women at the time of TOP.
http://www.reproductivereview.org/index.php/site/article/1229/

USA: Immediate postabortion intrauterine device insertion: continuation and satisfaction.

McNicholas C, Hotchkiss T, Madden T, Zhao Q, Allsworth J, Peipert JF. Women's Health Issues. 2012 Jul-Aug;22(4):e365-9.

This was a retrospective cohort study of women undergoing immediate postabortion IUD insertion. Demographics and clinical data were collected from intake forms and procedure notes. The authors attempted to contact women by telephone to administer a short questionnaire to assess continuation, satisfaction, and bleeding patterns. The study was able to contact 77 of 225 (34%). Women lost to follow-up were more likely to have higher parity or a pregnancy of greater gestational age at the time of abortion compared with women who were successfully contacted. Continuation and satisfaction rates were high (80.5% and 80.6%, respectively). Reported bleeding patterns with IUD use were similar to previously reported patterns. The authors concluded that follow-up of women undergoing immediate postabortion IUD insertion is challenging. However, they found that women choosing immediate postabortion IUD had high rates of continuation and satisfaction.
http://www.reproductivereview.org/index.php/site/article/1268/

UK: Short term outcomes after extreme preterm birth in England: comparison of two birth cohorts in 1995 and 2006 (the EPICure studies).

Kate L Costeloe, Enid M Hennessy, Sadia Haider, Fiona Stacey, Neil Marlow, Elizabeth S Draper. British Medical Journal. 2012;345:e7976.

The study's objective was to determine survival and neonatal morbidity for babies born between 22 and 26 weeks' gestation in England during 2006, and to evaluate changes in outcome since 1995 for babies born between 22 and 25 weeks' gestation. These were prospective national cohort studies, set in maternity and neonatal units in England. Participants were 3133 births between 22 and 26 weeks' gestation in 2006; 666 admissions to neonatal units in 1995 and 1115 in 2006 of babies born between 22 and 25 weeks' gestation. The main outcome measures were survival to discharge from hospital, pregnancy and delivery outcomes, infant morbidity until discharge.

The authors concluded that survival of babies born between 22 and 25 weeks' gestation has increased since 1995 but the pattern of major neonatal morbidity and the proportion of survivors affected are unchanged. These observations reflect an important increase in the number of preterm survivors at risk of later health problems.

In the discussion section of the article, the authors write: 'Overall survival in 2006 has increased since 1995, although not significantly for births before 24 weeks' gestation. This change results from improved survival to the end of the first week, with little difference thereafter. There is evidence of increased adherence to evidence based practice in 2006, which could account for improved condition of babies shortly after birth and explain improved outcomes in the first week. The prevalence of major morbidities in survivors, however, seems not to have improved either when evaluated alone or after adjustment for status within 24 hours of birth.
http://www.reproductivereview.org/index.php/site/article/1301/

UK: The evolution of prenatal screening and diagnosis and its impact on an unselected population over an 18-year period.

Boyd PA, Rounding C, Chamberlain P, Wellesley D, Kurinczuk JJ. BJOG. 2012 Aug;119(9):1131-40.

This study set out to review changes in and impact of prenatal screening and diagnosis over an 18-year period. This was a population-based congenital anomaly register study, set in Oxfordshire. It involved an analysis of proportions of congenital anomalies confirmed and those suspected prenatally, delivered 1991-2008. The main outcome measures were birth prevalence, prenatal detection rates, and pregnancy outcomes.

A total of 2651 (2.3%) infants/fetuses had a congenital anomaly diagnosed. There were 3839 suspected or confirmed cases, 2847 due to a prenatal suspicion, of which 1659 had an anomaly confirmed at delivery, and 1188 false-positive diagnoses, 91% due to reporting ultrasound normal variants. The percentage of prenatal notifications rose from 48% in 1991-93 to 83-88% from 1996 to 2003 and dropped to 61% in 2006-08, partly reflecting changes in the reporting of normal variants. Reporting these increased the prenatal diagnosis rate from 53 to 63% with an increase in false-positive rate from 0.09 to 1.04%. A total of 722 (44% of prenatally detected affected fetuses) resulted in termination; 48% of these had chromosome anomalies, 34% had isolated structural anomalies, 7% had multiple anomalies, 10% had familial disorders; 42% had lethal anomalies and 58% would probably have survived the neonatal period giving an estimated 20% reduction in birth prevalence of congenital anomalies compatible with survival because of terminations.

The authors concluded that there has been an improvement in prenatal detection of congenital anomalies over the two decades studied. The recognition that reporting normal variants, although increasing prenatal detection rates, leads to an increase in false-positive diagnoses has had an impact on practice that has redressed the balance between these two effects.
http://www.reproductivereview.org/index.php/site/article/1228/

USA: Intrauterine anaesthesia for gynecologic procedures: a systematic review

Mercier RJ, Zerden ML. Obstetrics and Gynecology. 2012 Sep;120(3):669-77.

The study found that good evidence supports use of intrauterine anaesthesia in endometrial biopsy and curettage, because five good-quality studies reported reduced pain scores, whereas only one good-quality study reported negative results. The authors found moderate evidence to support intrauterine anaesthesia in hysteroscopy, because one good-quality study and two fair or poor quality studies reported reduced pain scores, whereas two good-quality studies had negative results. Good evidence suggests that intrauterine anaesthesia is not effective in hysterosalpingography; three good-quality studies reported that pain scores were not reduced, and no good quality studies showed a beneficial effect in that procedure. Evidence was insufficient concerning first-trimester abortion, saline-infusion ultrasonogram, tubal sterilization, and intrauterine device insertion. The authors concluded that intrauterine local anaesthesia can reduce pain in several gynaecologic procedures including endometrial biopsy, curettage, and hysteroscopy and may be effective in other procedures as well.
http://www.reproductivereview.org/index.php/site/article/1290/

Sweden: Women and men's satisfaction with care related to induced abortion

Makenzius M, Tydén T, Darj E, Larsson M. Eur J Contracept Reprod Health Care. 2012 Aug;17(4):260-9.

The study set out to investigate satisfaction with abortion care among women and their male partners, and to identify factors associated with high overall contentment with the care received. This was a multi-centre cross-sectional questionnaire survey conducted in 2009 among 798 Swedish abortion-seeking women and 590 male partners was analysed with logistic regression. Overall care satisfaction was rated high by two-thirds (74%) of the women and half (52%) of the men. For women, factors associated with high overall satisfaction with care were: to be well treated by the health care staff, sufficient pain relief, adequate information about the gynaecological examination, suitable contraceptive counselling, and ease of access to the clinic by phone. For men, the factors were to be well treated by the health care staff, and adequate information about the abortion procedure.

The authors concluded that most women and half of the men were pleased with the attention they had received, but one in four women and half the men were not, or not completely, suggesting improvement is needed, especially with regard to men. For both women and men the human aspect of the care, namely, the consideration showed by the attending staff, appears to be the most important factor associated with satisfaction regarding abortion care.
http://www.reproductivereview.org/index.php/site/article/1272/

Australia: Early medical abortion using low-dose mifepristone followed by buccal misoprostol: a large observational study.

Goldstone P, Michelson J, Williamson E. Medical Journal of Australia. 2012 Sep 3;197(5):282-6.

The study's objective was to describe the use of mifepristone in combination with buccal misoprostol in women undergoing an early medical abortion (EMA) in Australia. This was a retrospective, observational study of 13,345 EMAs (gestational age ≤ 63 days) conducted at 15 Marie Stopes International Australia clinics between 1 September 2009 and 31 August 2011. The intervention was oral mifepristone 200 mg, administered at the clinic, followed 24-48 hours later by buccal misoprostol 800 mcg, self-administered at home. The main outcome measure was failure rate (proportion of women with an incomplete abortion requiring surgical aspiration or a continuing pregnancy).

Pregnancy termination follow-up information was available for 83.4% (11 155/13 376) of EMAs. From the patient demographic database, the EMA failure rate was 3.5% (465/13 345). Of these, most (382; 2.9% of total) were incomplete abortions requiring surgical aspiration, and 83 (0.6% of total) were continuing pregnancies. Haemorrhage (16; 0.1%) and known or suspected infection (25; 0.2%) were infrequent. One woman, who did not seek follow-up despite signs of infection, died from sepsis (< 0.01%). In 6755 EMAs with clinic follow-up from April 2010 to August 2011, 6381 women participated in a survey. Most reported medium or heavy bleeding and moderate or severe pain/cramps; most also reported that bleeding, pain/cramps and their overall experience were as expected or better than expected.

The authors concluded that mifepristone, with buccal misoprostol self-administered at home, for EMA up to 63 days of gestation had a low failure rate, was well accepted, and provided an effective treatment option with a favourable safety profile for women seeking an abortion in Australia.
http://www.reproductivereview.org/index.php/site/article/1288/

USA: Psychological outcomes of medical versus surgical elective first trimester abortion.

Crandell L. Nursing and Women's Health. 2012 Aug-Sep;16(4):296-307.

Overall, the majority of the studies demonstrated that psychological outcomes, specifically quality of life, anxiety and depression, are markedly improved following either method; and the studies reviewed suggest that having a choice of method may improve women's psychological outcomes following abortion.
http://www.reproductivereview.org/index.php/site/article/1274/

USA: Critical issues in the initial evaluation and management of patients presenting to the emergency department in early pregnancy.

This clinical policy from the American College of Emergency Physicians is the revision of the 2003 Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy. A writing subcommittee reviewed the literature to derive evidence-based recommendations to help clinicians answer the following critical questions: 1) Should the emergency physician obtain a pelvic ultrasound in a clinically stable pregnant patient who presents to the emergency department (ED) with abdominal pain and/or vaginal bleeding and a beta human chorionic gonadotropin (β-hCG) level below a discriminatory threshold? 2) In patients who have an indeterminate transvaginal ultrasound, what is the diagnostic utility of β-hCG for predicting possible ectopic pregnancy? 3) In patients receiving methotrexate for confirmed or suspected ectopic pregnancy, what are the implications for ED management? Evidence was graded and recommendations were developed based on the strength of the available data in the medical literature. A literature search was also performed for a critical question from the 2003 clinical policy: 1) Is the administration of anti-D immunoglobulin indicated among Rh-negative women during the first trimester of pregnancy with threatened abortion, complete abortion, ectopic pregnancy, or minor abdominal trauma?
http://www.reproductivereview.org/index.php/site/article/1289/

Turkey: Long-term outcomes of radical and conservative surgery for late diagnosed tubal pregnancies.

Ozler A, Turgut A, Evsen MS, Sak ME, Soydinç HE, BaÐaranoÐlu S, Celik Y, Taner MZ. Ginekologia Polska. 2012 Apr;83(4):280-3.

The authors conclude that in late-diagnosed cases with higher serum hCG levels, conservative treatment should not be the first choice. Indeed, their results suggested that the cumulative pregnancy rates are not significantly higher and the risk of ectopic pregnancy recurrence may be increased with conservative surgery in late tubal pregnancies.
http://www.reproductivereview.org/index.php/site/article/1266/

USA: Cost-effectiveness of cytogenetic evaluation of products of conception in the patient with a second pregnancy loss.

Foyouzi N, Cedars MI, Huddleston HG. Fertily and Sterility. 2012 Jul;98(1):151-5.

The study's objective was to compare the cost of two strategies for managing the patient with recurrent pregnancy loss (RPL). Cost analysis using a decision analytic model was used to compare obtaining an evidence-based workup (EBW) for RPL versus obtaining a karyotype of the products of conception (POC) and proceeding with an EBW only in the setting of euploid POC. The setting was outpatient care, with a simulated cohort of patients experiencing a second pregnancy loss. The results found that for all age categories, obtaining a karyotype of POC was less costly than an evidence-based RPL evaluation. The authors concluded that their model suggests an economic advantage for obtaining a karyotype of POC in women with second miscarriage.
http://www.reproductivereview.org/index.php/site/article/1267/

Malaysia: Microarray profiling of secretory-phase endometrium from patients with recurrent miscarriage.

Othman R, Omar MH, Shan LP, Shafiee MN, Jamal R, Mokhtar NM. Reproductive Biology. 2012 Jul;12(2):183-99.

The aim of this study was to identify differentially expressed genes and their related biological pathways in the secretory phase endometrium from patients with recurrent miscarriage (RM) and fertile subjects. The authors concluded that microarray technique is a useful tool to study gene expression in the secretory phase-endometrium of RM patients. The differences in endometrial gene expressions between healthy and RM subjects contribute to an increase in our knowledge on molecular mechanisms of RM development and may improve the outcome of pregnancies in high-risk women with RM.
http://www.reproductivereview.org/index.php/site/article/1279/

Italy: The combined therapy with myo-inositol and D-chiro-inositol reduces the risk of metabolic disease in PCOS overweight patients compared to myo-inositol supplementation alone.

Nordio M, Proietti E. European Review for Medical and Pharmacological Sciences. 2012 May;16(5):575-81.

The authors note that PCOS is the main cause of infertility due to metabolic, hormonal and ovarian dysfunctions. The authors concluded that the combined administration of MI and DCI in physiological plasma ratio (40:1) should be considered as the first line approach in PCOS overweight patients, being able to reduce the metabolic and clinical alteration of PCOS and, therefore, reduce the risk of metabolic syndrome.
http://www.reproductivereview.org/index.php/site/article/1255/

USA: When legislators play doctor - the ethics of mandatory preabortion ultrasound examinations.

Minkoff H, Ecker J. Obstetrics and Gynecology. 2012 Sep;120(3):647-9.

The authors note that many states have proposed or enacted laws that mandate that women undergo ultrasonography before electing pregnancy termination. In some cases, the legislation prescribes the form of ultrasound examination, requires that a woman review the images produced, or both. Although ultrasonography may be a part of good and standard care before many abortion procedures, the authors argue that legislating imaging procedures inappropriately limits women's autonomy and undermines the physician-patient relationship as well as the

physician's professional obligations to the patient. The timing, context, and way in which ultrasonography, or any medical test, is used and viewed should be decisions made between patient and provider, not decisions scripted by law.
http://www.reproductivereview.org/index.php/site/article/1284/

USA: Autonomous abortions: the inhibiting of women's autonomy through legal ultrasound requirements.

Rocha J. Kennedy Institute of Ethics Journal. 2012 Mar;22(1):35-58.

The author argues that proposed ultrasound laws fail to appreciate how personalized an abortion choice must be, and that they would provide the pregnant woman no control over when and to what extent emotion is inserted into her deliberation.
http://www.reproductivereview.org/index.php/site/article/1270/

USA: North Carolina's Woman's Right to Know Act 2011: a legislative history.

Stam P. Issues in Law and Medicine. 2012 Summer;28(1):3-67.

The author argues that legislators considering similar legislation need to be aware of the opposition they inevitably will encounter when passing such a bill. The author expects that this history and the ultimate success of North Carolina will encourage other states' legislators and lawyers and give them the tools to make their case effectively.
http://www.reproductivereview.org/index.php/site/article/1283/

UK: Abortion and regret.

Greasley, K. Journal of Medical Ethics Published Online First: 28 August 2012 doi:10.1136/medethics-2012-100522

The article seeks to remind readers that feelings of regret directed at past decisions are often decoupled from the fact of the matter about their moral or rational justification. Moreover, certain features of reproductive decisions in particular make regret an especially unsuitable yardstick for actual justification in this context, and even less epistemically reliable as evidence for a lack of justification than it may be in other fields of decision-making. The implication is that rates of postabortion regret, even if they can be presumed to be higher than rates of postnatal regret, are not as pertinent to moral and practical reasoning about abortion as is sometimes suggested.
http://www.reproductivereview.org/index.php/site/article/1231/

USA: Recognising conscience in abortion provision.

Harris LH. New England Journal of Medicine. 2012 Sep 13;367(11):981-3.

Lisa H Harris of the University of Michigan writes: 'The exercise of conscience in health care is generally considered synonymous with refusal to participate in contested medical services, especially abortion. This depiction neglects the fact that the provision of abortion care is also conscience-based... The persistent failure to recognise abortion provision as "conscientious" has resulted in laws that do not protect caregivers who are compelled by conscience to provide abortion services, contributes to the ongoing stigmatization of abortion providers, and leaves theoretical and practical blind spots in bioethics with respect to positive claims of conscience — that is, conscience-based claims for offering care, rather than for refusing to provide it...'
http://www.reproductivereview.org/index.php/site/article/1232/

USA: Conscientious objection to sexual and reproductive health services: international human rights standards and European law and practice.

Zampas C, Andión-Ibañez X. European Journal of Health Law. 2012 Jun;19(3):231-56.

The authors note that the use of conscientious objection by health care providers to reproductive health care services, including abortion, contraceptive prescriptions, and prenatal tests, among other services is a growing phenomena throughout Europe. This article outlines the international and regional human rights obligations and medical standards on this issue, and highlights some of the main gaps in these standards. It illustrates how European countries regulate or fail to regulate conscientious objection and how these regulations are working in practice, including examples of jurisprudence from national level courts and cases before the European Court of Human Rights. Finally, the article provides recommendations to national governments as well as to international and regional bodies on how to regulate conscientious objection so as to both respect the practice of conscientious objection while protecting individual's right to reproductive health care.
http://www.reproductivereview.org/index.php/site/article/1240/

Australia: Decriminalisation of abortion performed by qualified health practitioners under the Abortion Law Reform Act 2008 (Vic).

Mendelson D. Journal of Law and Medicine. 2012 Jun;19(4):651-66.

The background to, and the structure of, this novel statutory regime is examined, with a focus on conscientious objection clauses and liability in the tort of negligence and the tort of breach of statutory duty.
http://www.reproductivereview.org/index.php/site/article/1273/

USA: Circumvention tourism.

Cohen G. Cornell Law Review. 2012 Sep;97(6):1309-98.

This article comprehensively examines a subcategory of medical tourism that the author calls 'circumvention tourism', which involves patients who travel abroad for services that are legal in the patient's destination country but illegal in the patient's home country - that is, travel to circumvent domestic prohibitions on accessing certain medical services. The four examples of this phenomenon that the author dwells on are circumvention medical tourism for female genital cutting (FGC), abortion, reproductive technology usage, and assisted suicide.
http://www.reproductivereview.org/index.php/site/article/1282/

USA: Trends in self-reported spontaneous abortions: 1970-2000.

Lang K, Nuevo-Chiquero A. Demography. 2012 Aug;49(3):989-1009.

The author notes that little is known about how the miscarriage rate has changed over the past few decades in the United States. In this article, data from Cycles IV to VI of the National Survey of Family Growth (NSFG) were used to examine trends from 1970 to 2000. After accounting for abortion availability and the characteristics of pregnant women, the rate of reported miscarriages increased by about 1.0% per year. This upward trend is strongest in the first seven weeks and absent after 12 weeks of pregnancy. African American and Hispanic women report lower rates of early miscarriage than do whites. The probability of reporting a miscarriage rises by about 5% per year of completed schooling.

The article states that the upward trend, especially in early miscarriages, suggests awareness of pregnancy rather than prenatal care to be a key factor in explaining the evolution of self-reported miscarriages. Any beneficial effects of prenatal care on early miscarriage are obscured by this factor. Differences in adoption of early-awareness technology, such as home pregnancy tests, should be taken into account when analysing results from self-reports or clinical trials relying on awareness of pregnancy in its early weeks.
http://www.reproductivereview.org/index.php/site/article/1227/

USA: Estimated pregnancy rates and rates of pregnancy outcomes, 1990-2008.

Ventura SJ, Curtin SC, Abma JC, Henshaw SK. National Vital Statistics Reports. 2012 Jun 20;60(7):1-21.

These statistics show that pregnancy rates for women in their early 20s declined to the lowest level in more than three decades, although the declines have been more modest than for teenagers. Pregnancy rates for women aged 25-29 have changed relatively little since 1990, while rates for women in their 30s and early 40s increased.
http://www.reproductivereview.org/index.php/site/article/1285/

USA: Why is the teen birth rate in the United States so high and why does it matter?

Kearney MS, Levine PB. Journal of Economic Perspectives. 2012 Spring;26(2):141-66.

The authors' reading of the totality of evidence leads them to conclude that being on a low economic trajectory in life leads many teenage girls to have children while they are young and unmarried and that poor outcomes seen later in life (relative to teens who do not have children) are simply the continuation of the original low economic trajectory. That is, teen childbearing is explained by the low economic trajectory but is not an additional cause of later difficulties in life. Surprisingly, they note, teen birth itself does not appear to have much direct economic consequence. Moreover, no silver bullet such as expanding access to contraception or abstinence education will solve this particular social problem.

The authors' view is that teen childbearing is so high in the United States because of underlying social and economic problems. It reflects a decision among a set of girls to 'drop out' of the economic mainstream; they choose non-marital motherhood at a young age instead of investing in their own economic progress because they feel they have little chance of advancement. This thesis suggests that to address teen childbearing in America will require addressing some difficult social problems: in particular, the perceived and actual lack of economic opportunity among those at the bottom of the economic ladder.
http://www.reproductivereview.org/index.php/site/article/1269/

Poland: Irrational non-reproduction? The 'dying nation' and the postsocialist logics of declining motherhood.

Mishtal J. Anthropology and Medicine.2012;19(2):153-69.

The author notes that Polish birthrates during the state socialist period, 1948-1989, stayed above replacement level but since 1989 fell dramatically to one of the lowest in Europe, at 1.29 in 2010. This paper shows that far from irrational rejection of motherhood, Polish middle-class women are guided by pragmatic reasons when delaying parenthood in order to navigate the new political landscape marked by job insecurity and gendered discrimination in employment. Yet, rather than implementing work-family reconciliation policies that have stimulated fertility elsewhere in Europe, the Church and state insist on blaming women for 'irrational' non-reproduction, thus betraying a lack of political commitment to gender equity in employment, reproductive health, and in the family.
http://www.reproductivereview.org/index.php/site/article/1277/

Italy: Reproducing Italians: contested biopolitics in the age of 'replacement anxiety'.

Marchesi M. Anthropology and Medicine. 2012;19(2):171-88.

This paper examines how reproduction in contemporary Italy has emerged as a contested social, political, and moral issue that invests Italian and migrant women in different ways, engendering different forms and terms of resistance and contestation.
http://www.reproductivereview.org/index.php/site/article/1276

What Do You Call a Woman Who's Had an Abortion?

Mother. Daughter. Sister. Friend.

In October 2012, bpas launched the first ever nationwide campaign in support of women's choice. Recent comments by cabinet ministers combined with an upsurge in anti-abortion activity outside clinics show we cannot take for granted that the women we know will always have access to the services they need, when they need them.

The discussion about abortion exists at a number of levels, but rarely does it reflect the reality and diversity of the tens of thousands of women who come to us for advice about unplanned pregnancy every year. Sadly stereotypes often prevail - women are often cast as feckless and irresponsible for seeking abortion after finding themselves with an unwanted pregnancy - or career women interested only in their own personal goals. Recent comments and campaigns by politicians opposed to abortion often imply that women do not know what they are doing when they request abortion and need protecting from themselves, or that what they are doing is morally wrong - and that their pregnancies need protecting from the women themselves.

One in three women will have an abortion in her lifetime. They are not a particular 'type' of woman, they are everywoman - of all ages and all circumstances. Contraception fails, and sometimes we fail to use it properly. Amid incessant talk of infertility, many women - both young and middle-aged - underestimate how easy it is to get pregnant. bpas sees women with unplanned pregnancies not long after giving birth, having been told that breastfeeding provides effective contraceptive protection. We also see women whose lives have been turned upside down when a problem is found with a much wanted pregnancy, or when personal circumstances change so much that a planned pregnancy can no longer be carried to term.

These women do not have abortions because they do not know what they are doing, or because they have no sense of right and wrong. They have abortions because it is the right thing for them and their families at that time in their lives. Only the woman herself can make that judgement - not the banner-bearing protester outside, the health secretary - or even the doctor providing her care.

These women will be mothers, daughters, sisters and friends. They will be women we all know, and that is what we hope to bring home with our campaign. We live in a country where the majority of us support a woman's ability to make a choice when faced with an unplanned pregnancy, but where a vocal and determined minority have the potential to undermine women's access to care - if we are not careful.

Abortion is a fundamental part of women's reproductive healthcare. For all the women in our lives, let's make sure we protect it.