Response from BPAS (the British Pregnancy Advisory Service) to the Science and Technology Committee’s Inquiry: ‘Scientific Developments relating to the Abortion Act 1967’*

*please see accompanying ‘Appendix of Evidence Citations’

Executive Summary:

The charity BPAS (the British Pregnancy Advisory Service) is the largest single provider of early medical abortion in Europe (the ‘abortion pill’ method, used at under 9 weeks’ gestation) having been largely responsible for introducing this non-invasive method to the UK in 1992. BPAS is also a specialist provider for women presenting late in pregnancy for abortion, which involves relatively small numbers of patients, but which tend to be women in especially complex and sensitive circumstances. Annually BPAS undertakes 80% of the abortions taking place between 20 weeks gestation and 23 weeks and 5 days’ gestation in England and Wales.

BPAS will limit our response to our experience of issues concerned with the safe delivery of an up-to-date, client-focused abortion service. BPAS’ view, shared by the medical community internationally, is that abortion is a safe procedure, and an essential provision to be offered in response to the serious public health problem posed by unintended pregnancy. Approximately 55,000 women each year have treatment to terminate a pregnancy at BPAS, after attending for non-directive pregnancy counselling and information. Over 85% of BPAS’ not-for-profit services are performed under contract on behalf of the NHS.

This submission states that:

- the requirement for two doctors’ signatures to certify that a woman meets the legal grounds for an abortion is not clinically relevant, and undermines the provision of an efficient service. This requirement should be removed entirely so that abortion can be provided with one signature on the basis of informed consent.
- the law should be amended to allow other members of the clinical team aside from ‘registered medical practitioners’ to confirm the legal grounds on which an abortion is to be undertaken. It is entirely appropriate for nurses and midwives to carry out abortions in the first trimester and we believe this would improve the quality of care.
- It should be made possible for women to self-administer the second part of the early medical abortion medication in privacy and comfort at home, instead requiring administration in a hospital or clinic.
- If abortion becomes illegal or more difficult to obtain, British women will travel to other countries for treatment, or obtain unsupervised and unregulated treatment via the internet.
1. Response to call for evidence relating to: (2) medical, scientific and social research relevant to the impact of suggested law reforms to first trimester abortions such as: (a) the relative risks of early abortion versus pregnancy and delivery;

1.  The risk of maternal death from legal abortion is associated with the lowest risk of adverse outcome resulting from pregnancy. Of the alternatives to abortion, live birth poses an intermediate risk and ectopic pregnancy and fetal death pose the highest risk. This holds true well beyond the ‘early’ stages of abortion in the first 12 weeks’ gestation. Even at the latest stages of legally-available abortion, abortion is not more risky than birth.

1.1 Of the 106 maternal deaths directly associated with pregnancy, as reported by the Confidential Enquiry into Maternal and Child Health (CEMACH) in their most recent report (2000-2002), 3 deaths were associated with legal termination of pregnancy. The majority were associated with complications of late pregnancy and delivery including thrombosis and thromboembolism, hypertensive disorders and haemorrhage.

1.2 Early abortion has been shown to have no adverse effect on future pregnancies.

2. (2) medical, scientific and social research relevant to the impact of suggested law reforms to first trimester abortions such as: (b) the role played by the requirement for two doctors’ signatures;

2.  It is important to note that the legal requirements for two doctors’ signatures to confirm that the woman meets the legal grounds for abortion is a separate legal exercise to a clinical assessment of the patient to determine the most appropriate treatment.

The requirement for a second referral doctor’s signature to confirm that the woman meets the legal grounds for abortion conflicts with established medical ethical principles of the autonomy of competent patients and is redundant in medical terms. No medical benefit is conferred to the woman by its retention, as it only serves to confirm that the abortion is being undertaken within the terms of the 1967 Abortion Act.

2.1 Currently, the requirement for two doctors to certify that a woman meets the legal grounds for abortion has the potential to delay treatment. It may be difficult for a woman who is concerned about confidentiality to find two doctors to approve her abortion request. There is no central monitoring of delays to treatment of this type, but recently, Tony Calland, the Medical Ethics Committee Chair of the British Medical Association (BMA) said that ‘some women waited up to 13 weeks [gestation] to have their abortion approved by two doctors and removing this requirement would reduce such a wait and the associated risks’. The requirement for two signatures for solely legal purposes also increases treatment costs by introducing unnecessary bureaucracy.

2.2 The Department of Health’s documentation form (HSA1 form) for the recording of each abortion that takes place, provides for both the first and second signatory doctors to ‘sign unseen’ that the woman meets the legal grounds, on the recommendation of other members of the clinical team. This has been discussed with, and confirmed as lawful practice by, the Department of Health. (In terms of clinical assessment however, at BPAS it is considered good practice under the current law, for at least one of the doctors to have seen the woman before treatment.)

2.3 The Committee will be aware that a majority of BMA doctors voted for the removal of this requirement in 2007, arguing that abortion (in the first trimester) should be provided on the basis of informed consent as other medical treatments are.

BPAS would support this position being adopted up until the current legal time limits. A woman’s clinical assessment for treatment and confirmation that she meets the legal grounds for abortion does not require more doctors in the second trimester, than in the first. There is no reason why the confirmation of the legal grounds for abortion requires more doctors in the second trimester than in the first.

2.4 As two doctors can already confirm at all gestations within the current legal limits that a woman meets the legal requirements on the recommendation of a nurse, it would seem logical for nurses to be able to sign in their own right if such a form is required. This would be sensible especially where pertaining to what are currently already virtually nurse-led methods, such as early medical abortions (EMA), or the abortion pill, which is offered up to 9 weeks’ gestation.
3. The wording of the 1967 Act enables abortions to be conducted lawfully only by ‘registered medical practitioners’. This is interpreted as meaning only doctors registered by the General Medical Council, and to exclude nurses and midwives. This definition is now out-dated because today’s modern, less invasive early abortion methods are suitable to be performed by nurses and midwives. Forty years ago when the Abortion Act was drafted, these methods were not available and the nursing role was much more restricted.

We believe it would be appropriate for suitably trained nurses and midwives to be permitted to perform early abortions in Britain as they do in other countries, such as the United States and South Africa.

3.1 Early medical abortion (EMA) is available up to 9 weeks’ or 63 days’ gestation. This increasingly popular non-invasive method relies on the administration of two sets of prescribed medication. During the 16 years that BPAS has provided EMA, we have developed a nurse-led service which has minimised the role of the doctor. This development was in response to observations that nurses are better able to deliver this service as they can often develop a greater rapport with clients. The EMA method requires particularly open and clear communication as the patient is central to the participation in, and management of her treatment. The legal requirements are met by the doctor signing the prescription for the medication, after it has been confirmed by two doctors that the legal grounds for abortion have been met.

3.2 If nurses became legally able to perform some methods of abortions, it would then be possible to develop a nurse-prescribing protocol or a ‘Patient Group Direction’ that would allow an abortion nurse to take full responsibility for treatment, as nurses do in other areas of medicine. In BPAS’ view, reducing the involvement of doctors would enable them to use their time in the clinic most efficiently and would reduce costs of the procedure without compromising the quality of care.

3.3 Manual vacuum aspiration (MVA) is a method of early surgical abortion (offered from 4 weeks’ to 12 weeks’ gestation), which involves the removal of the contents of the uterus using a gentle hand-operated suction pump. The level of technical skill required to do this is of a similar level to fitting a contraceptive ‘coil’ (IUD/IUS) which BPAS’ and NHS family-planning trained nurses already routinely do. In some regions of the United States, South Africa and commonly in the developing world, nurses provide MVA treatment. In the UK, the phrasing of the law means that only a doctor can provide this treatment.

3.4 In other areas of more technically-skilled NHS practice, such as gastro-enterology and dermatology, trained nurses have for several years been permitted, for example, to pass investigation camera equipment (endoscopes) into the body and to take skin biopsies. In sexual and reproductive healthcare, nurse hysteroscopists are able to examine the uterus with a camera and nurse colposcopists can examine the cervix with a camera and also take tissue biopsies. It seems anomalous for the law to prevent appropriately-trained nurses in abortion care from developing their roles similarly.

3.5 Greater involvement of nurses in early abortion care would also increase national capacity at early gestations and so reduce treatment delays.

3.6 Later gestation medical induction abortion is a method where the woman has chosen to go through induced labour rather than undergo a surgical termination of pregnancy. This is often chosen in situations of termination for fetal abnormality. Midwives are particularly appropriate to carry out this procedure, which involves offering the woman ongoing emotional support as well as professional technical expertise in labour care. BPAS’ view is that it is not justifiable to legally permit midwives to take responsibility for births at term, but not abortions, which take place at an earlier gestation and are safer than labour and delivery of a full-term pregnancy.

4. At present, the early medical abortion (EMA) or ‘abortion pill’ method, which is used up to 9 weeks’ or 63 days’ gestation, involves the woman swallowing a mifepristone (RU 486) tablet at a BPAS clinic, after which she may either return home or can occupy herself for a few hours nearby to the clinic. This
medication blocks the pregnancy hormones so that the pregnancy ceases to be viable. At least 6-8 hours later, or on the following day, she is required to return to the clinic, where the second part of the treatment, a dosage of the drug misoprostol, is then administered vaginally with a tampon, or is swallowed. Misoprostol causes the uterus to contract and to expel the pregnancy much like a miscarriage. Women go straight home from the clinic after taking misoprostol, in order to make themselves comfortable before this process starts.

4.1 Women are obliged to make a second journey back to the clinic to take the second medication (misoprostol) solely because the law specifies that an abortion may only be carried out in hospitals or a specially approved location. Currently the Department of Health interprets this as meaning that both administrations of the two-stage drug regimen must be administered within an approved location. There is no clinical justification for two separate visits to a clinic.

4.2 In Norway, which has a law similar to the UK, only the mifepristone must be taken in a clinic, as this is regarded as the abortifacient. Misoprostol is viewed as a supporting medication, because it is taken to enable the safe and prompt expulsion of the products of conception. The requirement for two clinic visits can be burdensome for women with caring or other responsibilities to manage at home and can mean that women without a local EMA service near their homes are not able to choose EMA at all. The requirement to administer the misoprostol at a second appointment in a registered place adds unnecessary cost to the procedure. The removal of this requirement could increase national capacity for early abortions, helping to reduce treatment delays.

4.3 Self-administration of misoprostol at home is common in most countries where EMA is available. From a clinical perspective, arguably it would be more appropriate for women to administer the misoprostol at home, as the time from treatment to the expulsion of the pregnancy can be variable and unpredictable. There is no evidence that self-administration of tablets is unsafe, or that home-use is unacceptable to patients.

4.4 UK women in other medical situations can already self-administer misoprostol at home. For example women who have experienced a spontaneous miscarriage are given a dose of misoprostol to take home and insert vaginally themselves, in order to ensure the prompt and safe expulsion of the miscarried pregnancy. BPAS sees no reason why abortion patients should continue to be excepted from this provision.

5. 3. Evidence of long-term or acute adverse health outcomes from abortion

BPAS is not aware of long-term or acute adverse health outcomes arising specifically from abortion, although as with any medical treatment, complications can result. Abortion is a very safe procedure compared to many other medical interventions and earlier abortion is particularly safe.

5.1 Abortion has not been shown definitively to be associated with adverse psychological health outcomes. The British Royal College of Obstetricians and Gynaecologists (RCOG) considers published studies on this issue, when drawing up its evidence-based guidance on abortion. The RCOG states, on the basis of the available evidence: ‘Some studies suggest that women who have had an abortion may be more likely to have psychiatric illness or to self-harm than other women who give birth or are of a similar age. However, there is no evidence that these problems are actually caused by the abortion; they are often a continuation of problems a woman has experienced before’.

5.2 As an abortion provider since 1968, BPAS has had little experience of women undergoing long term negative psychological consequences from abortion. We provide a post-abortion counselling service and our staff see a small number of women each year experiencing feelings of regret. These feelings are usually focused on regret about the circumstances of the unplanned pregnancy. Sometimes women report that they regret the abortion, while still believing it was the right decision for them at the time. Some women continue to hold the belief that abortion is morally wrong, while continuing to believe it was right for them, and that choosing abortion was the ‘least worst’ option available to them.

5.3 BPAS believes it is essential that women continue to have access to pre- and post- abortion counselling, to enable informed decision-making and support whatever the woman has decided.

6. ‘3. Evidence of long-term or acute adverse health outcomes …from the restriction of access to abortion’

6. Unintended pregnancy continues to be a serious public health problem. Restriction of access to
abortion would impact adversely on the health of large numbers of women experiencing unintended pregnancy.

6.1 Compelling evidence on adverse health outcomes from restriction of access to abortion in the UK can be found in a review of maternal mortality associated with abortion prior to the 1967 Abortion Act, published by the Confidential Enquiry into Maternal and Child Health (CEMACH). This stated that: ‘the most striking change during the first 50 years of this report has been the disappearance of illegal, unsafe abortion as a cause of early pregnancy direct deaths which followed the passage of the Abortion Act in 1967. The first CEMACH Enquiry Report, covering the years 1952-1954, described 153 deaths from ‘abortion’, of which 108 at the least had been procured illegally. [...] Around 30 deaths per year from illegal abortion continued through the 1950s and 1960s. The first full working year of the Abortion Act was 1969 and the number of deaths “clearly due to illegal abortion”, fell, that year to 17.’

Worldwide, death and ill health are reported where there is a lack of access to safe and legal abortion.

6.2 In the 2000- 2002 CEMACH enquiry report, out of 15 deaths attributed directly to early pregnancy complications (out of 106 maternal deaths directly associated with pregnancy as a whole), 3 were attributed to termination of pregnancy.

6.3 In BPAS’ experience, the denial of abortion causes deep distress to women. We are concerned for the well-being of women who present to us seeking abortion, but who are unable to access treatment as they are beyond the legal gestational limit. We ensure that these women are promptly referred into antenatal care and are concerned about their needs for appropriate emotional support to cope with this.

6.4 BPAS sees several hundred clients each year who have travelled to Britain because abortion is illegal in their own country. Typically, these women present at later gestations, often into the second trimester because of the increased costs and other problems associated with accessing information and travelling. Our experience of collaboration with the Irish Family Planning Association and the Crisis Pregnancy Agency in Ireland suggests that women who travel may also have difficulty accessing post-abortion advice and care and experience additional psychological burdens because of the need to conceal the abortion.

6.5 BPAS is aware that young people aged under 24, who are especially in need of quality sexual health services, would be particularly at risk if greater restriction was placed on abortion. The Brook Advisory Service has shown that that confidentiality is key to young people’s willingness to access sexual health services. It is BPAS’ experience that the great majority of young people voluntarily involve their families when accessing services in any case, and where they are not able to do so, they report compelling reasons for this.

6.6 In a survey conducted on adolescent BPAS clients in 2007, responding centres found that no client aged under 16 had attended her abortion consultation or treatment appointment alone. The most frequent accompanying person in any category was one or both parents, with 56% of clients attending with their mother, whether or not accompanied by additional escorts.

6.7 As a further potential source of delay for women who seek to terminate a pregnancy, BPAS is concerned that unlicensed, unregulated ‘Crisis Pregnancy Counselling’ networks (which often have a political or religious bias against abortion) operate widely in the UK, outside the standards of the Department of Health’s Register of Pregnancy Advice Bureaux. There is no central collection of the numbers of these networks, which do not refer women for abortion or adhere to any minimum standard of information-giving. A quick glance at the websites of some ‘Crisis Pregnancy Counselling’ organisations shows that some poor quality information and advice is offered about abortion or the health risks associated with abortion by some of them.

6.8 BPAS is concerned that in some local areas, unregulated services appear to have received funding support from local NHS Primary Care Trusts and also to be permitted to ‘train’ doctors in local NHS hospitals.

6.9 BPAS would like to see ‘Crisis Pregnancy Counselling’ services required by law to be registered and to adhere to minimum standards of non-directive, accurate information-giving about pregnancy options and abortion and emergency contraception. Where services will not refer a woman for abortion, we believe that such services should be required by law to clearly state this fact on their literature and publicity, as is required in other countries. There is no central collection of data on the delays to treatment experienced by women seeking abortion after attending unregulated ‘Crisis Pregnancy Counselling’ services. BPAS believes that the law should ensure that all women with unintended pregnancies should be able to access clearly signposted, non-directive advice and information meeting minimum quality standards, to enable them to make an informed decision, and to facilitate prompt referral for antenatal care, or abortion treatment as appropriate.
**About BPAS:**
Approximately 55,000 women each year have treatment for termination of pregnancy at BPAS after attending for non-directive pregnancy counselling and information, which is monitored by and registered with the Department of Health. BPAS is the largest provider of early medical abortion in Europe (the ‘abortion pill’ method, used at under 9 weeks’ gestation) having been largely responsible for introducing this non-invasive method to the UK in 1992. BPAS is also a specialist provider for women presenting late in pregnancy for abortion, which involves relatively small numbers of patients, but which tend to be women in especially complex and sensitive circumstances. BPAS undertakes 80% of the abortions taking place between 20 weeks’ gestation and 23 weeks and 5 days’ gestation in the England and Wales each year, under contract to the NHS. Beyond 24 weeks’ gestation, all terminations in the UK take place in NHS premises.

BPAS is regulated by the Healthcare Commission in England, Healthcare Inspectorate Wales, NHS Quality Improvement Scotland and the Department of Health. BPAS works closely on policy and training issues with the Royal College of Nursing, Royal College of Obstetricians and Gynaecologists, and the Faculty of Family Planning and Reproductive Health Care. BPAS is a research-led organisation and facilitates academic and Department of Health research projects under the scrutiny of its independently-constituted Research Ethics Committee.

The British Pregnancy Advisory Service (registered charity number 289145) was set up in 1968 after the implementation of the 1967 Abortion Act in order to provide services, train doctors and provide premises for safe legal abortion, at a time when the NHS not always able or prepared to provide abortion services.

BPAS’ abortion treatments, comprehensive counselling services, male and female contraceptive and sterilisation services and sexually transmitted infection testing and treatment are all not-for-profit. All of the charity’s services are conducted according to the relevant professional guidance under the scrutiny of BPAS’ independently-constituted Clinical Governance Committee. For further information about the charity or its services, please see [www.bpas.org](http://www.bpas.org).

---

**This submission compiles evidence from:**
Ann Furedi, Chief Executive of the British Pregnancy Advisory Service (BPAS),
Dr Patricia A. Lohr MD, MPH, Medical Director of BPAS,
Mandy Myers RGN, MPhil, Director of Nursing at BPAS.

**Professional affiliations, Memberships and declaration of interests:**

Ann Furedi, Chief Executive of BPAS
is an Associate of the Faculty of Family Planning and Reproductive Health, Royal College of Obstetricians and Gynaecology;
Member, Institute of Directors.
Declaration of Interests: provider of a termination of pregnancy service.

Dr Patricia Lohr, Medical Director of BPAS
is a Diplomat, National Board of Medical Examiners (USA), and an Active Candidate, American Board of Obstetrics and Gynecology; is also a member of Physicians for Reproductive Choice and Health; Society of Family Planning, Junior Fellow; National Abortion Federation; American College of Obstetrics & Gynecology, Junior Fellow; Association of Reproductive Health Professionals.
Declaration of Interests: provider of a termination of pregnancy service.

Mandy Myers, Director of Nursing at BPAS
is a member of the Royal College of Nursing’s ‘Nurses working in Termination’ Group.
Declaration of Interests: provider of a termination of pregnancy service.
Appendix of evidence citations in support of the Response from BPAS (the British Pregnancy Advisory Service) submitted to the Science and Technology Committee's Inquiry: 'Scientific Developments relating to the Abortion Act 1967'*

*(please see accompanying ‘Response from BPAS to the Science and Technology Committee’s Inquiry: ‘Scientific Developments relating to the Abortion Act 1967’. This Appendix offers an evidence basis in support of the Response, grouped by the paragraph numbers that used in the Response.)*

1. ‘(2) medical, scientific and social research relevant to the impact of suggested law reforms to first trimester abortions such as:
(a) the relative risks of early abortion versus pregnancy and delivery;’

<table>
<thead>
<tr>
<th>Paragraph</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>‘Despite impressive gains in safety in recent decades, pregnancy remains risky. [...] From early in pregnancy until some weeks after its conclusion, pregnant women are at increased risk of morbidity and mortality compared with women who are not pregnant. This review summarizes recent national data from the U.S. Centers for Disease Control and Prevention, including vital statistics from the National Center for Health Statistics. Ectopic pregnancy is substantially more dangerous (38 deaths/100,000 events) than either childbirth (nine) or legal abortion (less than one). The three leading causes of maternal death today are pregnancy-induced hypertension, hemorrhage, and pulmonary embolism. Although comprehensive data on pregnancy-related morbidity are lacking, about 22% of all pregnant women are hospitalized before delivery because of complications. Women of minority races have much higher risks of death than do white women, and the same holds true for older women and those with limited education. For most women, fertility regulation by contraception, sterilization, or legal abortion is substantially safer than childbirth.’</td>
</tr>
</tbody>
</table>

| 1.1 | ‘The comparative safety of pregnancy outcomes has clinical and public health importance. Using national statistics for 1991 to 1999, I estimated the risk of maternal death associated with various outcomes. Abortion (legal and spontaneous) was associated with the lowest risk, live birth intermediate risk, and ectopic pregnancy and fetal death the highest risk.’ |

| 1.1 | ‘Of 758 maternal deaths directly related to pregnancy in the UK between 1985- 2002, 15 deaths (1.97%) were directly related to termination of pregnancy. Of 106 maternal deaths in the UK directly related to pregnancy in 2000- 2002, 3 were directly related to termination of pregnancy. For more on this data, see Table 6.1 ‘Numbers of Direct Deaths in early pregnancy by cause, United’ |


Kingdom 1985-2002’, shows in 2000-2002, 15 direct deaths attributed to early pregnancy complications, 3 of which were attributed to termination of pregnancy.

(1.2) 'The long-term safety of surgical abortion in the first trimester is well established. Despite the increasing use of abortion by means of medication, limited information is available regarding the effects of this procedure on subsequent pregnancies. We identified all women living in Denmark who had undergone an abortion for nonmedical reasons between 1999 and 2004 and obtained information regarding subsequent pregnancies from national registries. Risks of ectopic pregnancy, spontaneous abortion, preterm birth (at <37 weeks of gestation), and low birth weight (<2500 g) in the first subsequent pregnancy in women who had had a first-trimester medical abortion, were compared with risks in women who had had a first-trimester surgical abortion. Among 11,814 pregnancies in women who had had a previous first-trimester medical abortion (2710 women) or surgical abortion (9104 women)… we found no evidence that a previous medical abortion, as compared with a previous surgical abortion, increases the risk of spontaneous abortion, ectopic pregnancy, preterm birth, or low birth weight. The gestational age at medical abortion was not significantly associated with any of these adverse outcomes.'


2. (2) medical, scientific and social research relevant to the impact of suggested law reforms to first trimester abortions such as: (b) the role played by the requirement for two doctors' signatures;

2. Competent pregnant women in medical situations (aside from abortion) are legally permitted to make choices about their medical treatment on the basis of informed consent, without a doctor scrutinising their reasons. This applies even if their choice threatens or could end the life of the fetus. Abortion is exceptional in remaining legally contingent upon two doctors' approval of the woman's reasons for requesting medical assistance to safely end her pregnancy. 'In St. George’s Healthcare N.H.S. Trust v S [1998] 3 W.L.R. 936, The Court of Appeal found that a competent adult woman was entitled to refuse a caesarean section, even if her decision would lead to the death of a 36 week old fetus. Judge L.J. said: 'The autonomy of each individual requires continuing protection, particularly when the motive for interfering is readily understandable, and indeed to many would appear commendable'. He said 'Pregnancy does not diminish a woman's entitlement to decide whether or not to undergo medical treatment. Her right is not reduced or diminished merely because her decision to exercise her right may appear morally repugnant.' […] If the law has established that a woman's decision should be respected, even if it will

cause the death of a 36 week old fetus, is there some inconsistency with the Abortion Act's requirement that a woman's reasons for terminating a pregnancy of much shorter gestation must be judged acceptable by two medical practitioners?"

2.1, 2.3 ‘Early abortions should be available without the need for two doctors’ approval, doctors at the [BMA] ARM agreed. Doctors leaders said removing the requirement of two signatures on a termination form would speed up the procedure and reduce risks. […] Speaking outside of the meeting, MEC chair Tony Calland said some women waited up to 13 weeks [gestation] to have their abortion approved by two doctors and removing this requirement would reduce such a wait and the associated risks. Two doctors’ signatures should not be necessary for abortions within the first trimester, the Representative Body said.’

3. ‘2. medical, scientific and social research relevant to the impact of suggested law reforms to first trimester abortions such as: (c) the practicalities and safety of allowing nurses or midwives to carry out abortions

3. The RCOG stated in 2007: ‘The proposal… that present legislation would allow nurses to perform surgical abortions should be further explored.

The Royal College of Obstetricians and Gynaecologists (RCOG) believes that access to high quality family planning and termination of pregnancy services are essential factors in the provision of good health care for women. After appropriate encompassing training, many nurses working in the NHS have already taken on extended responsibilities. If legislation allows, and only working closely as part of a medical team, the option of fully trained nurses helping to provide early surgical termination of pregnancy services merits further evaluation.’

3 and 3.3 ‘South Africa's Choice on Termination of Pregnancy Act, which took effect in 1997, legalized abortion and stipulated that registered midwives can perform abortions for women with pregnancies of no more than 12 weeks’ gestation. A program was initiated to train registered midwives throughout South Africa to provide abortion services at primary care facilities. From October 1999 through January 2000, an evaluation was conducted at 27 public health care facilities in South Africa's nine provinces to assess the quality of care provided by midwives who had been trained and certified to provide abortion services. Data were collected by observing abortion procedures and counseling sessions, reviewing facility records and patients’ charts, and interviewing patients and certified midwives.

Results: Of 96 abortion procedures performed by 40 midwives, 85 involved manual vacuum
aspiration. Midwives’ clinical practice was rated “good” in 75% of the procedures. No complications occurred during abortion procedures or as a result of the procedures, and no abortion clients died. Midwives consistently provided women with contraceptive counseling after the abortion, and most clients (89%) received a contraceptive method before leaving the facility.

Conclusion: **Midwives can provide high-quality abortion services in the absence of physicians.** Training in abortion care should be systematically integrated into midwives’ basic training. This training should use postabortion counseling as an opportunity to inform women about dual protection from unwanted pregnancy and sexually transmitted infections.’

3 and 3.3

‘A hopeful note in the contemporary abortion environment in the United States is the expanding role of advanced practice clinicians – nurse practitioners, physician assistants and nurse-midwives – in first trimester abortion provision. Two national symposia in 1990 and 1996 approved the expansion of early abortion care to non-physicians. **As of January 2004, trained advanced practice clinicians were providing medical, and in some cases, early surgical abortion in 14 states.** This has required not only medical training but also political organizing to achieve the necessary legal and regulatory changes, state by state, by groups such as Clinicians for Choice and the Abortion Access Project. Recent surveys in three states show a substantial interest among advanced practice clinicians in abortion training, leading to cautious optimism about the possibility of increased abortion access for women.’

3.2.

A literature review of research literature on prescribing both in the United Kingdom and in countries with comparable health care systems from 2000 – 2003 found:

‘broad support from patients and professionals for the use of different models of prescribing and supply of medicines in which health professionals adopted a wider prescribing role... evidence of improved patient access to medicines and services as a result of nurse prescribing, the use of patient group directions...Patients and nurse prescribers in several studies reported benefits of nurse prescribing, e.g. timeliness of treatment and improvements in the quality of care.’

3.1.


*Multicenter Trial of a Simplified Mifepristone Medical*
to the clinic for a gynecologic examination. Success was defined as a complete termination without surgical intervention or additional misoprostol by day 21. All participants completed an exit interview before discharge from the study.

Results: Of the women enrolled, 58.8% had gestations of between 43 and 49 days, 54.7% had had a previous abortion, and 76% had had a previous pregnancy. Of the 354 women included in the efficacy analysis, 324 (91.5%) had a successful termination.

The most common adverse effects reported by patients were pain or cramps (93.2%) and nausea (66.6%), followed by weakness (54.7%), headache (46.2%), and dizziness (44.4%).

**Overall acceptability of the regimen was high, with 63.3% of women reporting that it was very satisfactory and an additional 23% reporting that it was satisfactory.**

**Conclusion:** *mifepristone followed in 48 hours by home administration of ... misoprostol is effective, associated with rare severe adverse effects or adverse events, and acceptable for women seeking medical abortion of pregnancies of up to 49 days duration.*

### 4.1

'Studies from the USA have suggested the feasibility and acceptability of home medical abortion, however the issue has not been addressed in the UK. This study aimed to assess the feasibility, efficacy and acceptability of home self-administration of misoprostol for medical abortion up to 56 days' gestation.

**Methods:** Mifepristone 200 mg was given orally in hospital under nursing supervision. Women were provided with misoprostol tablets 600 microg and advised to take them sublingually 36-48 hours later. The main outcome measures were (1) feasibility, assessed through successful completion of abortion at home without the need for hospital admission, (2) efficacy, assessed through complete uterine evacuation without the need for further medical or surgical intervention and (3) women's acceptability of the procedure as assessed by questionnaire.

**Results:** A total of 49 women participated in this study. Of these, 48 women aborted at home while one opted to be admitted to hospital after receiving misoprostol at home. One woman underwent surgical evacuation 5 weeks following abortion for excessive bleeding and retained products of conception. A total of 43/44 (98%) women were satisfied with having the abortion at home.

Side effects experienced by women included nausea [80%], vomiting [42%], diarrhoea [42%], shivering [65%], tiredness [80%], headache [31%], hot flushes [35%], dizziness [62%] and unpleasant mouth taste [50%].

**Conclusions:** *This study suggests the feasibility and acceptability of home self-administration of misoprostol for medical abortion up to 56 days' gestation. These findings need to be assessed in the context of a randomised trial.*

### 4.2

'There are.. important issues to do with the provision and place of services, including medical (non-surgical) methods. **Medical methods of abortion are carried out in only 24% of women seeking an...**

---

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RCOG Statement on the BMA Medical Ethics Committee Briefing on First Trimester Abortions</td>
<td></td>
</tr>
</tbody>
</table>
abortion in England, when evidence suggests that where a choice is available, the uptake would be 60-70% of women.'

| 4.3 | A study assessed the acceptability of home medical abortion to women in UK settings, based in four NHS gynaecology units in England and Scotland, where women underwent conventional, hospital-based, medical abortion up to nine weeks of gestation. Using a self-completed questionnaire, researchers explored the acceptability of abortion in hospital (including pain and bleeding experienced) and at home. Comparisons were made between centres (English and Scottish). Results: 66% (366/553) of the questionnaires were returned. 228/320 said there was nothing that happened during abortion in the hospital that they would have been unable to cope with at home; 123/342 said they would have opted to have home abortion, had that choice been available. However, 219/342 indicated that they would prefer to have abortion in the hospital. The majority of women said they would have coped at home with bleeding (280/355, 79%) and with pain if given analgesia (203/268, 76%) Conclusion: This study suggests that most women would welcome being offered the choice of having medical abortion at home or in hospital. The development of home abortion must be seen as complementary, not an alternative, to hospital services. |

| 4.4 | A US study looked at the effectiveness, safety, time to bleeding, and acceptability of misoprostol administered by vagina at home and repeated, if needed, after mifepristone was administered for abortion in women up to 8 weeks’ pregnant. A prospective trial was conducted with women up to 8 weeks pregnant wanting an abortion. After receiving mifepristone orally, subjects self-administered vaginal misoprostol at home 2 days later. Subjects returned within 7 days, and if the gestational sac was still present on ultrasound, a repeat dose of misoprostol was administered in the office. Subjects completed a daily symptom log and a questionnaire on the acceptability of the procedures. Results: Of the 166 subjects, 163 (98%) had a complete medical abortion. Three subjects presented with persistent bleeding and an incomplete abortion from 27 to 35 days after taking mifepristone and required surgical intervention. Vaginal spotting or bleeding occurred in 104 (62%) subjects before taking misoprostol, and 18 (11%) did not use misoprostol. Bleeding occurred on average 3.5 hours (SD, 3.2) after taking misoprostol. Six (4%) subjects required a second dose of misoprostol. Gastrointestinal side effects were common, mild, and brief. One hundred fifty-nine (96%) subjects agreed that the procedure went well, and 146 (90%) agreed that home administration of misoprostol was acceptable. Conclusion: Two days after taking mifepristone, misoprostol administered by vagina was |
**found to be safe, highly effective, and acceptable to women.** Since only 6 subjects needed a second dose of misoprostol, conclusions about repeat doses are not possible. This procedure is a promising alternative to surgical abortion.

<table>
<thead>
<tr>
<th>5. ‘3. Evidence of long-term or acute adverse health outcomes from abortion’</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. <strong>Advice on abortion risks from the RCOG is that:</strong></td>
</tr>
</tbody>
</table>
| ‘16.1 The risk of haemorrhage at the time of abortion is low. It complicates around 1 in 1000 abortions overall. The risk is lower for early abortions (0.88 in 1000 at less than 13 weeks; 4.0 in 1000 at more than 20 weeks).
16.2 The risk of uterine perforation at the time of surgical abortion is moderate. The incidence is of the order of 1–4 in 1000. The risk is lower for abortions performed early in pregnancy and those performed by experienced clinicians.
16.3 Uterine rupture has been reported in association with mid-trimester medical abortion. However, the risk is very low, at well under 1 in 1000.
16.4 Cervical trauma: the risk of damage to the external cervical os at the time of surgical abortion is moderate (no greater than 1 in 100). The risk is lower when abortion is performed early in pregnancy and when it is performed by an experienced clinician.
16.5 Failed abortion and continuing pregnancy: all methods of first-trimester abortion carry a small risk of failure to terminate the pregnancy, thus necessitating a further procedure. The risk for surgical abortion is around 2.3 in 1000 and for medical abortion between 1 and 14 in 1000 (depending on the regimen used and the experience of the centre).
16.6 Post-abortion infection: genital tract infection, including pelvic inflammatory disease of varying degrees of severity, occurs in up to 10% of cases. The risk is reduced when prophylactic antibiotics are given or when lower genital tract infection has been excluded by bacteriological screening.
16.7 Breast cancer: induced abortion is not associated with an increase in breast cancer risk.
16.8 Future reproductive outcome: there are no proven associations between induced abortion and subsequent ectopic pregnancy, placenta praevia or infertility. Abortion may be associated with a small increase in the risk of subsequent miscarriage or preterm delivery.’ |

The RCOG advises with respect to abortion and mental health:
‘16.9. Psychological sequelae: some studies suggest that rates of psychiatric illness or self-harm are higher among women who have had an abortion compared with women who give birth and to nonpregnant women of similar age. It must be borne in mind that these findings do not imply a causal association and may reflect continuation of pre-existing conditions.’

5.1
A recent study in New Zealand of women aged 15-25 who experienced a pregnancy, has been cited in political debate as definitive evidence that abortion and the development of psychiatric conditions are causally linked. However this view has no support from the authors of the paper, who acknowledge confounding factors that their research may not have accounted for. Under-reporting of abortion is a well-known problem with this type of research. In this study, the authors note a statistically significant difference between the rate of abortion in their sample and that of the general population. There are other contextual factors associated with abortion-seeking to which the study could not be sensitive. The authors note: 'It is clear the decision to seek (or not seek) an abortion following pregnancy is likely to involve a complex process' and that as a result, 'it could be proposed that our results reflect the effects of unwanted pregnancy on mental health, rather than the effects of abortion per se, on mental health'. The comparator groups to participants who had an unintended pregnancy and then an abortion in this study, were women who stated that they had not experienced pregnancy and those who continued a pregnancy and became mothers. As the study was conducted in a context where abortion is legal, and available, it may be that the only group among these three groups of women who had experienced a pregnancy that was truly and consistently unwanted, were those who went on to have an abortion. To properly attempt to explore the net impact of abortion in and of itself on psychological morbidity, the most valid comparator group to women who experience unwanted pregnancy and then abortion, is neither women who have not been pregnant, nor willing mothers, but instead women with an unwanted pregnancy who are denied abortion and then give birth. Such women, because legal abortion is available, were not able to be included in this study.

5.1
To explore social outcome data on young women and abortion, 492 women participating in a 25-year longitudinal study of a New Zealand birth cohort were used in regression models that examined the relationship between pregnancy and abortion history prior to age 21 and selected social and economic outcomes at ages 21–25.
Results: **Compared with young women who became pregnant before age 21 but did not seek**
an abortion, young women who had an abortion had significantly better outcomes on six out of 10 measures spanning education, income, welfare dependence and domestic violence. Adjustment for confounding factors indicated that most of these differences were explained by family, social and educational characteristics that were present prior to pregnancy. Nonetheless, even after adjustment for confounding factors, young women who had abortions had higher levels of subsequent educational achievement than those who became pregnant but did not have abortions.

Conclusions: Abortion may mitigate some effects of early unplanned pregnancy. However, further study of its potential risks and benefits is needed so that women can make fully informed decisions as to whether to terminate unintended pregnancies.

March 2007, 39 (1): 6-12
http://www.guttmacher.org/pubs/journals/3900607.html

6. ‘3. Evidence of long-term or acute adverse health outcomes …from the restriction of access to abortion’

6.
Unintended pregnancy remains a serious public health problem in the UK. For some women, the right response when faced with this common problem will be to seek to end the pregnancy. It is important for the health of women to enable them to end a pregnancy safely and legally. There are different routes to unintended pregnancy, but contraceptive failure and couples' imperfect use of contraceptives are an important factor. Unintended pregnancy rates differ between methods, and will depend both on how unforgiving of imperfect use a particular method is, and on how hard it is to use that method perfectly. Recent research from the United States shows that unintended pregnancy rates remain comparatively high, for example with male condom use, when studied according to 'typical' use by couples. In this research, the 'typical use' contraceptive failure rate has been explored as against the 'perfect use' of male condoms, and other contraceptive methods. With 'perfect' use of male condoms, 2% of women will experience an unintended pregnancy within the first year of use. (eg Among couples who initiate use of this method (not necessarily for the first time) and who use it perfectly (both consistently and correctly), this will be the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason. But with 'typical' use of male condoms, 15% of women will experience an unintended pregnancy within the first year of use. (eg Among typical couples who initiate use of a method (not necessarily for the first time), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason).

### 6.1

Worldwide, there is little relationship between abortion legality and abortion incidence, but there is a strong correlation between abortion legality and abortion safety. 68,000 women die each year after unsafe abortion, of the 600,000 annual pregnancy-related deaths worldwide, according to the World Health Organisation. Many thousands of others are left with severe long-term health problems as a consequence.

### 6.1

An estimated 19 million unsafe abortions occur worldwide each year, resulting in the deaths of about 70,000 women. Legalization of abortion is a necessary but insufficient step toward improving women’s health. Without skilled providers, adequate facilities and easy access, the promise of safe, legal abortion will remain unfulfilled, as in India and Zambia. […] Timely and appropriate management of complications can reduce morbidity and prevent mortality. **Treatment delays are dangerous, regardless of their origin.** […] While the debate over abortion will continue, the public health record is settled: safe, legal, accessible abortion improves health.

Grimes DA. ‘Unsafe abortion: the silent scourge’ *British Medical Bulletin* 2003; 67: 99–113

### 6.1

CEMACH’s report, ‘Why Mothers Die’ (2000-2002) states of early pregnancy deaths’ that: ‘the most striking change during the first 50 years of this report has been the disappearance of illegal, unsafe abortion as a cause of early pregnancy direct deaths which followed the passage of the Abortion Act in 1967.

The first Enquiry Report, covering the years 1952-1954, described 153 deaths from ‘abortion’, of which 108 at the least had been procured illegally. […] Around 30 deaths per year from illegal abortion continued through the 1950s and 1960s. The first full working year of the Abortion Act was 1969 and the number of deaths “clearly due to illegal abortion”, fell, that year to 17. […] It is quite possible that the number of deaths from illegal abortions was underestimated. The 1979-81 Report noted that the number of deaths attributed to spontaneous miscarriage had decreased from 1970, in parallel with those from illegal abortion.’

For data see Figure 6.1 ‘Maternal mortality rate from all maternal deaths from miscarriage (embryonic deaths) and terminations of pregnancy; England and Wales 1952-84, and United Kingdom 1985-2002’ for data

---


Figure 6.1 ‘Maternal mortality rate from all maternal deaths from miscarriage (embryonic deaths) and terminations of pregnancy; England and Wales 1952–84, United Kingdom 1985–2002’, in ‘Why Mothers Die 2000-2002 (Full report)’ *p.103,* [http://www.cemach.org.uk/getdoc/0dd34f16-5488-4c85-b9c8-567d44208abe/Chapter6.aspx](http://www.cemach.org.uk/getdoc/0dd34f16-5488-4c85-b9c8-567d44208abe/Chapter6.aspx)
### 6.1
In 2005, the Department of Health produced a partial regulatory impact assessment of the ‘Prohibition of abortion (England and Wales) Bill’. This Bill had the main intention of prohibiting abortion except where the woman’s life was at risk, or if the pregnancy resulted from rape. The Department found that a restriction of this nature would be likely to bring about ‘a high risk of up to 15 deaths a year, 15,000 extra teenage mothers a year, and 12,000 children a year neglected/abused.’

---

### 6.5
53% of 729 respondents attending Brook Advisory Centre’s sexual health services who were aged between 12 and 25 and ‘who gave a single answer as requested, said that confidentiality was the single most important thing for them when they were seeking sexual health advice. The next most popular answer was ‘not being judged by anyone’, accounting for 19% of responses, closely followed by ‘that it is free’, which was the answer chosen by 18% of respondents. The findings suggest that confidentiality is particularly important for young people under the age of 16. 62% of this age group said that confidentiality was the single most important thing for them. 18% said not being judged was the most important thing for them, and 14% said that the fact the services were free was most important.’

---

### 6.5
Restrictions on the right of Gillick-competent young people to receive abortion and contraceptive care after a confidential discussion with a healthcare professional would have an adverse effect on their health. In fact most young people in any case involve their parents, another adult and their partner (in many cases all of the above) in discussions of this kind. The abortion provider MSI surveyed 108 clients aged under 16 between 18 April and 17 July 2005. They found that 79% of clients ‘had informed a parental figure’, and a further 21% had told a friend or sister, (some of whom would be likely to be over 18) potentially adding to the 79% of informed adults. 94% of respondents were accompanied to the centre the day they completed the questionnaire.

---

### 6.5
A small survey carried out by BPAS aimed to discover the extent to which young women aged under 16 were, or were not accompanied to BPAS for consultation on pregnancy options, and were, or were not accompanied to BPAS for abortion treatment. If accompanied, some details were given about their escort(s).

**Method:** in a two week period in August 2007, BPAS Consultation centre staff spoke confidentially and anonymously to all BPAS clients aged under 16 and then completed a questionnaire noting the presence of their escort(s), if any, whether the escort(s) were aged under or over 18, and the

---


‘Snapshot survey of BPAS clients aged under 16 years old at Consultation and Treatment: Is the client accompanied by an escort, and if so, by whom?’, 2007
escort(s) relationship to the client. 51 escorts were surveyed. **Result:** Responding centres found that no client aged under 16 had attended her appointment alone for consultation, or for treatment. The most frequent escorts were the client’s parents, 55% of escorts at consultation being the client’s mother or father, and 45% of escorts being the client’s mother or father at treatment. 56% of clients overall attended their BPAS appointments with their mother, whether or not also accompanied by additional escorts. At consultation appointments, 80% of the 20 surveyed clients’ escorts were adults aged over 18, and at treatment appointments 74% of the 31 surveyed escorts were adults aged over 18. At consultation appointments, 3 out of 16 (20%) of clients were solely escorted by someone aged under 18. At treatment appointments, 2 out of 25 (8%) of clients were solely escorted by a person aged under 18.

It is difficult to draw firm conclusions from a survey of this size, but these results accord with BPAS’ experience that when young women come for advice or treatment they are nearly always supported by a family member or other adult, except where this is not possible usually due to the nature of relationships within the family.

**Note:** As staff were recording all activity involving clients under 16 years old, one case was submitted which does not fall within the survey parameters, but which is included here for interest. An under 16-year-old attended a BPAS consultation centre for counselling on pregnancy options but did not in fact receive this. This was because the routine ultrasound scan at her visit showed the pregnancy to be beyond 24 weeks’ gestation. She was therefore referred into antenatal care, in accordance with the law.

Empirical evidence from BPAS shows that for clients to present close to the legal abortion limit for pregnancy counselling is rare, but not unknown. Late presentation is comparatively more common within the younger client age group. Recent research from the University of Southampton supports this.

| 6.7 The Department of Health’s advice to the public on unregistered counselling is: | ‘Women under 18’, in ‘Second-Trimester Abortions in England and Wales’ by Roger Ingham, Ellie Lee, Steve Clements, and Nicole Stone, 2007, (p.3) [http://www.soton.ac.uk/lateabortionstudy/late_abortion.pdf](http://www.soton.ac.uk/lateabortionstudy/late_abortion.pdf) |
|———|———|
| ‘There are a number of organisations advertised in phone directories and on the internet offering free pregnancy testing and counselling. Some of these organisations do not refer women for termination of pregnancy. We would advise women to check this before making an appointment’ | UK Department of Health, ‘Register of Pregnancy Advice Bureaux’, 1 August 2007. [http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Sexualhealth/Sexualhealthgeneralinformation/DH_4063860](http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Sexualhealth/Sexualhealthgeneralinformation/DH_4063860) |

6.7 The practices of ‘Crisis pregnancy’ centres (CPCs) and their numbers have not been well-researched in the UK, and BPAS is not aware of published evidence concerning them.
However, a body of evidence exists upon the need for patients to make free and informed decisions about their medical care, and of increased risks to women’s health posed by unnecessary delays to abortion or antenatal care.

6.7 The websites of some of the UK’s ‘Crisis Pregnancy’ organisations show a variety in the quality of information that is provided by some on the risks posed by abortion. To give one example from one such organisation, the ‘Care Confidential’ website offers information to the public on abortion. In the section ‘What are the health risks?’ ‘Care Confidential’ states: ‘[…] There have been suggestions that abortion is linked to breast cancer.’

While it is of course true to state that suggestions about this link have been made in the past, this link has not been supported by evidence. The RCOG’s factsheet ‘About abortion care: what you need to know’, offers patients clear and unequivocal information on this.

Under the section ‘How safe is abortion?’, the RCOG has the question ‘Does abortion cause breast cancer?’ and it answers: ‘Research evidence shows that having an abortion does not increase your risk of developing breast cancer.’

The standard RCOG guidance to healthcare professionals states under recommendation ‘2.2: Information for women’, ‘Recommendation 16: Clinicians providing abortion services should possess accurate knowledge about possible complications and sequelae of abortion. This will permit them to provide women with the information they need in order to give valid consent.’ Some examples of relevant medical information for women are then given, including: ‘16.7 Breast cancer: induced abortion is not associated with an increase in breast cancer.’

‘Care Confidential’ is a department of CARE, a Christian charity. ‘Care Confidential’ offers a national phoneline, web-based counselling and refers women to local crisis pregnancy centres for face-to-face advice. Care Confidential does not refer women for abortion and is not on the Department of Health Register of Pregnancy Advice Bureaux.

6.8 The quality of information given to women about mental health and abortion by some of the ‘Crisis Pregnancy’ Centres websites seems to vary. For example, the website of the ‘Norwich Pregnancy Crisis Centre’ (‘PC-N’) states that: ‘Post-abortion stress is an increasingly recognised condition affecting at least 10 percent of women who have had a termination.’ In Norfolk, current statistics suggest that around 180 women each year are in need of support.

Care Confidential (website): ‘What are the health risks?’ in ‘Your questions answered: What about abortion?’
(accessed on 30 August 2007)

RCOG Information for patients:
‘Does abortion cause breast cancer?’, within ‘How safe is abortion?’, within ‘About abortion care: what you need to know’,
(accessed on 30 August 2007)

RCOG information for professionals:
‘2.2 Information for women’, within ‘Summary of Recommendations, p8, ‘RCOG ‘Care of women requesting induced abortion’, 2004,
(accessed on 30 August 2007)

http://www.careconfidential.com/AboutUs.aspx
http://www.care.org.uk/

From the website of the ‘Norwich Pregnancy Crisis Centre’/ ‘Pregnancy Crisis – Norfolk’,
Under the section ‘Post-abortion stress’
http://www.pregnancy-crisis.org.uk/

(accessed 30 August 2007)
| 6.8 | BPAS is concerned that in some local areas, unregulated Crisis Pregnancy centres appear to have received funding support from local NHS Primary Care Trusts and appear to be permitted to ‘train’ doctors in local NHS hospitals on conditions such as ‘Post Abortion Stress’ which are not professionally recognised. One example of this could be the Norwich Pregnancy Crisis Centre (NPCC), which appears in Norwich PCT’s ‘Health Development Fund 2004/05 - End of Year Report’. Under ‘Projects that have service level agreement commitments into 2005/06’, they record under ‘Budget Position’, ‘First year funding paid (£9,000) [to Norwich Pregnancy Crisis Centre]’ [...] also, ‘As [NPCC] have trained four more counsellors they have spare capacity and could see more clients, NPCC are actively approaching GPs and other health professionals in order to offer training courses on post-abortion stress. Often post-abortion stress goes unrecognised and the training equips health professionals to more easily pick up those patients who could benefit from support. The Health Development Fund has enabled NPCC to continue to offer pregnancy loss counselling within the Norwich area and to increase the understanding of health professionals about post-abortion stress.’ Norwich PCT Health Development Fund 2004/05 - End of Year Report, p.12, http://www.norwichpct.nhs.uk/documents/Aug%202005%20Agenda%20Item%2007%20Health%20Development%20Fund.pdf Norwich Pregnancy Crisis Centre website: http://www.pregnancy-crisis.org.uk/ (accessed 30 August) |
| 6.9 | The Irish Family Planning Association has produced a paper called ‘Rogue Crisis Pregnancy Agencies in Ireland’, which states: ‘The IFPA believe that the Government should bring forward statutory regulation for all pregnancy advice and counselling services, prescribing minimum codes of practice and standards, to ensure that they do not impart misleading and incorrect advice. In addition, it should be mandatory for all services to register with a recognised authority.’ ‘Legislation for RCPA’s’, (p.6), in ‘Rogue Crisis Pregnancy Agencies in Ireland’, published by the Irish Family Planning Association http://www.ifpa.ie/public.html#publications |
In the Republic of Ireland, the statutory Crisis Pregnancy Agency was established in October 2001, with functions including: 
the promotion of state-funded crisis pregnancy counselling services to tackle the problem of “rogue counselling agencies”.
The Agency developed a highly visible Positive Options press campaign, highlighting that the services promoted under Positive Options were state-funded, non-judgemental and trustworthy. The Manual of Good Practice for Crisis Pregnancy Counsellors was completed in 2006. The Agency began work with NUI Maynooth on the development of a new, accredited course in crisis pregnancy counselling skills. Our research shows that a woman with a crisis pregnancy needs to be able to access support services in her local area. The expansion of counselling services was thus a priority for the Agency in 2006 and will continue to be a priority in the years ahead.

The National Abortion Federation (USA) produced a report on American and Canadian Crisis Pregnancy Centres in 2006, which provides documentation as to the barriers to healthcare that may be experienced as a result of unregulated services and the remedies in several states that have been taken to enforce the ‘clear labelling’ of such services.


http://www.crisispregnancy.ie/publications.php