Women's Health Strategy: The Society for the Protection of Unborn Children

The Society for the Protection of Unborn Children is a leading UK pro-life organisation. We have worked for the over 50 years to protect unborn children and their mothers from abortion. We oppose abortion in principle and campaign to end abortion.

We would like to share our expertise in on how women's health is affected by abortion. Evidence is grouped by the relevant core themes identified in the inquiry.

1. Women's voices

Despite the fact that abortion has always been and remains a complex matter with health, social, ethical and legal aspects, it is often characterised simplistically as just another medical treatment, or solely 'a woman's choice', or a woman's 'reproductive right' that must not be restricted in any way. Because of this, when there are reservations about abortion, or when abortion results in adverse outcomes, the voices of the women involved are often ignored or marginalised. This is particularly problematic when women seek help for post-abortion trauma. Even though their suffering is supported by the evidence, it contravenes the mainstream narrative, they become stigmatised, and do not receive the care they need.

Of equal concern is the fact that when women considering abortion present to a healthcare provider, the fact that they may be there under duress mostly goes unrecognised. Reproductive coercion is a recognised phenomenon, and is reported by as many as one quarter of women attending sexual and reproductive healthcare services.[1] Reproductive coercion takes many forms, but can include coercive pressure to terminate a pregnancy. A review of studies of all types of reproductive coercion included one that described women whose partners threatened to use violence to cause an abortion[2].

Abortion coercion can also be far more subtle, and may be far more common than is generally recognised. Anecdotally, a post-abortion counsellor has said: "In my long experience, typically 75 per cent of the women who summon up the courage and bravery to make a call for help regarding an abortion were pressurised or bullied into having one, in almost all cases by the man involved. This is a significant risk-factor for psychological and emotional problems afterwards."[3]

Some studies also found that large numbers of abortions are influenced by male partners who do not want a child, or other partner-related factors that might pressure a woman (i.e., partner being

[1] Rowlands S, Walker S Reproductive control by others: means, perpetrators and effects *BMJ Sexual & Reproductive Health* 2019;**45:**61-67.
[2] Moore et al., 2010
[3] Bremner, Clare, *Hidden victims of coerced abortion being recognised by law at last,* The Times, Feb 2018, https://www.thetimes.co.uk/article/hidden-victims-of-coerced-abortion-are-finally-being-recognised-by-law-hrf63v5pk

the wrong person to have a baby with, in some cases due to abuse; partner being unwilling or unable to support the baby, or new or unstable relationship with partner)[4].

Although it is clear that the extent of coercion to abort varies, from lack of support to death threats, with a whole spectrum in between, it is also clear that abortion is often not a free choice for a woman. It is not difficult to find real women's voices making that point:

- "Married 10 years. 2 kids. Shaky marriage recently but no crisis. Then unplanned pregnancy. Husband wanted nothing to do with it. No positives. Would ruin his life.
  I would have kept with support but didn't want to on my own and didn't want to be the reason our family broke up.
  I had a surgical abortion 6 days ago and am racked with regret, sadness.
  I'm angry he didn't care enough about me and my feelings. I'm angry he let me go through this when I told him I didn't want to and was scared I'd never be the same. I'm angry I wasn't stronger to say no."[5]

- "I had an abortion 2 months ago at 10 weeks and have been devastated ever since. I am mid-30s and childless and was delighted when I discovered I was pregnant - although my relationship with the father was and is not stable, I was happy to have the child as a single mum, am financially secure and have a supportive family.
  I wasn't able to tell the father for some time but his reaction was even worse than I anticipated and in just a few hours he had convinced me to have the termination and one day later I was at the clinic - until you've been in that situation it is hard to see how it is possible for an independent and educated woman to be coerced in that way, and I know now I was so vulnerable with the hormones I was really in no fit state to defend my wishes. The clinic (Marie Stopes) were awful - I was sobbing the whole time I was there and barely able to speak, and their 'aftercare' was a joke. I know I walked in there and signed the consent but I was in a terrible state."[6]

Besides coercion from a male partner, what these accounts also highlight is that healthcare providers failed to properly address the women's circumstances, which raises serious questions about whether they took seriously their obligations regarding informed consent.

The complexities surrounding a decision regarding abortion place it in a different category to medical treatments, and it should be treated with far greater care by providers. SPUC recommends that more needs to be done to ensure that women's voices are listened to, and that clinics take proper steps to ensure that women do not go through with abortions that they do not want. It is clear that coercion is often not being picked up by clinicians. Even if coercion is not evident, women's testimonies show that clinics perform abortions on women who are clearly unsure about their decision, or who actively do not want to go through with it.

> "We recently terminated, and I waivered in the appt. the Dr missed all sorts of signs that should have been red flags. If you're not 100% sure, trust me, the trauma and regret you'll feel after is so hard to get through with."[7]

[4] Grace, Karen Trister, and Jocelyn C Anderson. "Reproductive Coercion: A Systematic Review." *Trauma, violence & abuse* vol. 19,4 (2018): 371-390. doi:10.1177/1524838016663935
[5] https://www.mumsnet.com/Talk/pregnancy_choices/4210553-Medical-abortion-regrets
[6] https://www.mumsnet.com/Talk/pregnancy/2014517-Struggling-to-come-to-terms-with-abortion-and-post-abortion-regret?msgid=45488749
[7] *https://www.mumsnet.com/Talk/pregnancy_choices/4192668-i-cancelled-my-abortion-today?pg=2*

2. Information and education on women's health

Women considering an abortion must be provided with accurate information about the procedure and its possible effects on their health – not least because it is most often carried out on healthy women.[8] Ambivalence about an abortion decision is common[9], and ambivalence is related to post-abortion distress[10,11,12], which makes the requirement to provide information even more acute.

SPUC is particularly concerned that doctors and other healthcare professionals are not fully aware of the current research that describes the impact of abortion on women.

Accordingly, SPUC has produced *Abortion and Women's Health,* a 33 page, fully referenced, evidenced based review of the current literature for medical professionals.

Here we give some examples of the issues covered in this publication.

Motives Underlying an Abortion Decision

Medical practitioners need to be aware of the motivating factors that underlie an abortion decision, because there may be a need for referral to support services. For example, since intimate partner violence (IPV) is strongly correlated with abortion, practitioners need to ascertain whether a woman is at risk of physical, emotional or psychological harm.[13] Or a woman may wish to proceed with pregnancy but does not have material support, necessitating referral to social services.

Health professionals do not always recognise the complexities of women's lives and are at risk of presuming in favour of abortion. In a study of young pregnant black refugee/migrant women in the care of the UK government, all women (even those pregnant as a result of rape) chose motherhood instead of abortion despite the difficulties they faced and despite the negative assumptions of healthcare professionals.[14] This study highlights the power held by individual healthcare professionals to create a caring environment that is woman-centred and culturally sensitive.

Abortion and trafficking/slavery

Abortion plays a part in the abuse and control of women and girls who are trafficked, not only for sex but also those exploited in labour such as agriculture, fishing, textile, manufacturing, mining, domestic servitude, and 'wives', even in the UK.[15] In a study of 107 survivors of sex trafficking in the USA, women reported a total of 114 abortions, many forced.[16] In the same study, over half the

[8] "In 2015, the vast majority (98%; 181,231) of abortions were undertaken under ground C. A further 2% were carried out under ground E (3,213) and a similar proportion (1%: 1,158) under ground D, whilst Grounds A and B together accounted for about a tenth of one per cent of abortions (219). The remaining 3 cases were performed under grounds F or G." Department of Health (2016), *Abortion Statistics, England and Wales, 2015*, London, UK.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/570040/Updated_Abortion_Statistics_2015.pdf

[9] Kero A *et al.* (2001) Legal abortion: a painful necessity. *Social Science and Medicine* 53:1481-1490.

[10] Kero A *et al.* (2004) Wellbeing and mental growth – long-term effects of legal abortion. *Social Science and Medicine* 58:2559-2569.

[11] Coleman PK *et al.* (2005) The psychology of abortion: a review and suggestions for future research. *Psychology and Health* 20(2):237-271.

[12] Coleman PK *et al.* (2017) Women who suffered emotionally from abortion: A qualitative synthesis of their experiences. *J American Physicians & Surgeons* 22(4):113-118.

[13] Pallitto CC *et al.* (2013) Intimate partner violence, abortion, and unintended pregnancy: results from the WHO Multi-country Study on Women's Health and Domestic Violence. *Int J Gynecology Obstetrics* 120:3-9.

[14] Mantovani N & Thomas H (2014) Choosing motherhood: the complexities of pregnancy decision-making among young black women 'looked after' by the State. *Midwifery* 30:e72-e78.

[15] Zimmerman C *et al.* (2011) Human trafficking and health: A conceptual model to inform policy, intervention and research. *Social Science & Medicine* 73:327-335.

[16] Lederer LJ & Wetzel CA (2014) The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. *Annals of Health Law* 23:61-91

women said that the doctor performing the abortion was aware she was on the street. One woman's abortions were performed by a doctor who was also her client. Abortion is one of many severe physical and psychological health consequences that trafficked women experience.

SPUC recommends that healthcare professionals must seek training and protocols to identify and assist these women, who at present are often going unnoticed.

Abortion for foetal disability

Abortions of this type lead to more severe consequences not only for the woman but also for her partner. Numerous studies have identified a high incidence of negative emotions[17], psychological distress[18], post-traumatic symptoms[19] and somatic complaints.[20]

Screening for disability is a routine part of prenatal care in the UK. There has been particular debate in the UK over the introduction of non-invasive prenatal testing (NIPT) on the NHS, which screens for Down's, Edward's or Patau's syndrome. Nonetheless, women may not be fully aware of the role and consequences of screening for foetal disability. For example, in relation to screening for Down Syndrome, researchers found that only 37% of decisions were informed, 31% did not know that miscarriage was a potential consequence of amniocentesis, and only 62% knew that abortion would be offered if Down's syndrome was identified.[21]

In a Swedish study, 25.6% of women who opted for an abortion for foetal malformation reported that the "information provided was not adequate to enable a decision".[22] A recent study of 45 women receiving prenatal testing in London found that while they understood the testing, women had a poor understanding of Down syndrome, no knowledge of Edward's and Patau's syndromes, and few knew someone with these syndromes.[23]

Women and their families must be given proper information about screening, and accurate, up to date information about different disabilities and conditions which may be identified during pregnancy.

SPUC recommends that healthcare professionals must have proper training on disability, and not put pressure on parents to abort. Recent studies continue to identify problematic interactions between parents and physicians.[24] Common experiences include being told that their child "was incompatible with life (87%), would live a life of suffering (57%), would be a vegetable (50%), or would ruin their family (23%)".[25]

Campaigners say pregnant women are being "pushed towards terminations" by advice given on Down's syndrome[26]. Tanika Bartlett-Smith, mother of Leo, told ITV News that she faces a constant

[17] White-Van Mourik MCA *et al.* (1992) The psychosocial sequelae of a second-trimester termination of pregnancy for fetal abnormality. *Prenatal Diagnosis* 12:189-204.
[18] Davies V *et al.* (2005) Psychological outcome in women undergoing termination of pregnancy for ultrasound-detected fetal anomaly in the first and second trimesters: a pilot study. *Ultrasound in Obstet & Gynecol* 25:389-392.
[19] Korenromp MJ *et al.* (2005) Long-term psychological consequences of pregnancy termination for fetal abnormality: a cross-sectional study. *Prenatal Diagnosis* 25:253-260.
[20] White-Van Mourik MCA *et al.* (1992) *Op. Cit.*
[21] Rowe HJ *et al.* (2006) Are pregnant Australian women well informed about prenatal genetic screening? A systematic investigation using the Multidimensional Measure of Informed Choice. *Aust & NZ J Obstet & Gynaecol* 46:433-439.
[22] Benute GR *et al.* (2012) Feelings of women regarding end-of-life decision making after ultrasound diagnosis of a lethal fetal malformation. *Midwifery* 28:472-475.
[23] Lewis C *et al.* (2016) A qualitative study looking at informed choice in the context of non-invasive prenatal testing for aneuploidy. *Prenatal Diagnosis* 36:875-881.
[24] Holt LE (2017) Parental opinions about prenatal genetic screening and selective abortion for Down Syndrome. *Electronic Theses and Dissertations*. Paper 2675. See https://doi.org/10.18297/etd/2675 Accessed 20 June 2020.
[25] Janvier A *et al.* (2012) The Experience of Families With Children With Trisomy 13 and 18 in Social Networks. *Pediatrics* 130(2):293-298.
[26] https://www.bbc.co.uk/news/uk-wales-45722880

battle with the medical profession about the language used. "I have been told 'I was one of the unlucky ones'," she said. "Whereas I would say I agree with the phrase 'lucky few' because we are extremely fortunate to have a child with Down's syndrome."[27]

97% of parents with children who had severe abnormalities describe a "happy child" who had "enriched their family".[28] Following a decision to abort a baby with a diagnosis of foetal abnormality couples can experience grief and ongoing mental health problems, which has given rise to the development of specific therapeutic interventions.[29]

Pregnant women and their families need accurate, up-to-date information about the care practices, quality of life, and resources available for individuals with disabilities and their families. Healthcare providers need to be aware that their own attitudes toward people with disabilities will have an influence on their ability to provide this information.[30]

3. Research, Evidence and Data

Abortion research suffers from particular obstacles, one of which is reporting bias. In a prospective study of women aged 15 to 27, for example, the reported rate of abortion was 74% of what would be expected from national data sets.[31] In a Dutch cohort study, abortion history was clearly underreported, mentioned by only 1.2% of all women giving birth.[32] Underreporting of abortion leads to an underestimation of its effects.[33] Other sources of bias include the fact that distressed women are often excluded from studies[34], or refuse to participate. Moreover, many studies of the physical risks of abortion include only healthy women[35], specifically excluding women who are at higher risk of complications.

One way around this problem is for researchers is to use record linkage with abortion registries and such is the case in Finland and Denmark. Finland has had a computerised abortion registry since 1983 and Denmark since 1973. These abortion registries are very accurate and record linkage data in these and other countries has been used to investigate outcomes such as preterm birth, maternal mortality and mental health problems including suicide.

The UK is in a unique position to contribute to this research. In 2008, guidance was issued by the Department of Health that the NHS number should be used to identify all procedures commissioned and paid for by the NHS so that an effective audit of outcomes could be done. **Abortion is the one procedure that so far has been able to avoid this requirement**. On the HSA4 form for notifying the Chief Medical Officer, the abortion provider is obliged to provide a reference number but crucially this does not have to be the NHS number. By failing to make this compulsory, the Department of

[27] https://www.itv.com/news/wales/2018-06-11/i-think-it-is-very-much-directed-towards-eliminating-downs-syndrome-the-debate-over-a-new-pregnancy-test-in-wales
[28] Janvier A *et al.* (2012)
[29] Rocha J *et al.* (2018) Women generating narratives after an unwanted prenatal diagnosis result: randomized controlled trial. *Arch Women's Mental Health* 21:453–459.
[30] Choi H *et al.* (2012) Decision making following a prenatal diagnosis of Down Syndrome: An integrative review. *J Midwifery & Women's Health* 57:156-164.
[31] Pedersen W (2008) Abortion and depression: a population-based longitudinal study of young women, *Scand J Public Health* 36:424-428.
[32] Scholten BL *et al.* (2013) The influence of pregnancy termination on the outcome of subsequent pregnancies: a retrospective cohort study. *BMJ Open* 3:e002803.
[33] *Ibid.*
[34] Purcell C *et al.* (2014) Access to and experience of later abortion: accounts from women in Scotland. *Perspectives on Sexual and Reproductive Health* 46(2):101-108.
[35] White K *et al.* (2015) Complications from first-trimester aspiration abortion: a systematic review of the literature. *Contraception* 92:422-438.

Health is unable to establish an accurate abortion registry. In Scotland where most abortions are provided in NHS hospitals, researchers have collected long term data on prematurity - linked to a previous abortion using hospital ID numbers - but this kind of research is not possible in England and Wales.

NHS numbers must be collected on abortion forms so that abortion can be linked with other health outcomes.

Aspects of health or medical research about abortion that have been neglected include:

The mental health impact of abortion on women

Recent research, including a 2013 review by Bellieni and Buonocore, concluded that abortion is linked to a variety of adverse mental health outcomes, arguing that foetal loss is traumatic, whether by miscarriage, induced abortion, or stillbirth.[36] Similarly, a 2018 review by Reardon that was broadly inclusive of a range of studies showed that across all domains – depression, anxiety, substance abuse, PTSD, suicide ideation, and various other disorders – abortion was a risk factor. However, some reviews have advanced a very strong view that there is no link[37,38,39], unprepared to even acknowledge controversy in the field.

One prominent researcher has described problems in the field as follows:

> "[there is a] … truly shameful and systematic bias that permeates the psychology of abortion. Professional organisations in the USA and elsewhere have arrogantly sought to distort the scientific literature and paternalistically deny women the information they deserve to make fully informed healthcare choices and receive necessary mental health counseling when and if an abortion decision proves detrimental."[40]

Another researcher has noted that uncertainty in the field does not mean that women should not be informed.

> He says: "… the question of whether a statistically significant risk is *solely due* to abortion, *partially due* to abortion, or *only incidentally associated* with abortion is itself just another of the uncertainties about the procedure, and therefore a true risk about which patients should be informed.[41]

SPUC agrees with these assessments, and advocates for more research into this neglected area of women's health. We believe that there is a huge ticking time bomb around the mental health consequences of abortion. This is backed by research. In a 2016 well-controlled study of 8005 American women, Sullins found a 30% elevated risk of depression and a 25% elevated risk of anxiety.[42]

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[36] Bellieni CV & Buonocore G (2013) Abortion and subsequent mental health: Review of the literature. *Psychiatry & Clin Neurosciences* 67:301-310.
[37] Stotland NL (2011) Induced abortion and adolescent mental health. *Curr Opin Obstet Gynecol* 23:340–3.
[38] Robinson GE *et al.* (2009) Is there an "abortion trauma syndrome"? Critiquing the evidence. *Harv Rev Psychiatry* 17:268–290.
[39] National Collaborating Centre for Mental Health (2011) *Op. Cit.*
[40] Coleman PK (2012) Author reply to "Abortion and mental health: guidelines for proper scientific conduct ignored." *Brit J Psychiatry* 200:74-83.
[41] Reardon DC (2018) The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities. *SAGE Open Medicine* 6:1-38.
[42] Sullins DP (2016) Abortion, substance abuse and mental health in early adulthood: Thirteen-year longitudinal evidence from the United States. *SAGE Open Med* 4:1-11

Sullins, like Coleman *et al*.[43], estimated that approximately 10% of the prevalence of mental health disorders in the community comes from induced abortion.

Preterm births

Numerous studies have identified an increased risk of premature delivery as a result of abortion.[44,45,46,47,48,49] This includes several meta-analyses. [50,51,52,53] The association is stronger for very preterm births and also increases with more prior abortions, which is suggestive of causality.

The proposed mechanism for increased risk is cervical damage from instrumentation, or as a result of abortion-induced infection.[54,55,56] The use of D&C for miscarriage or termination increased preterm birth in subsequent pregnancies by 29%, and very preterm birth by 69%.[57]

Clearly more research is needed on the relationship between medical abortion and preterm birth.

In his analysis of the relationship between abortion and preterm birth, McCaffrey notes that research on the abortion/preterm birth link is stronger than that between smoking and preterm birth, and yet women are widely warned about the latter, but not the former.[58]

Abortion and infertility

Government and advocacy organisations, as well as abortion providers, have publicly declared that there is either no increased risk of infertility from abortion, or perhaps a very small risk if infection after abortion is untreated.[59,60,61] This is an under-researched field; however, abortion is known to cause cervical damage[62], infections that lead to pelvic inflammatory disease (PID)[63], incomplete

[43] Coleman PK (2011) Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009. *The British Journal of Psychiatry* 199(03):180-186
[44] Van Oppenraaij RHF *et al.* (2009) Predicting adverse obstetric outcome after early pregnancy events and complications: a review. *Human Reproduction Update* 15(4):409-421.
[45] Ancel PY *et al.* (2004) History of induced abortion as a risk factor for preterm birth in European countries: results of the EUROPOP study. *Human Reproduction* 19(3):734-40.
[46] Brown JS Jr *et al.* (2008) Previous abortion and the risk of low birth weight and preterm births. *J Epidemiol & Community Health* 62(1):16-22.
[47] Van Oppenraaij RH *et al.* (2009) *Op.Cit.*
[48] Scholten B *et al.* (2013) The influence of pregnancy termination on the outcome of subsequent pregnancies: a retrospective cohort study. *BMJ Open* 3:e002803.
[49] Moreau C *et al.* (2005) Previous induced abortions and the risk of very preterm delivery: results of the EPIPAGE study. *Brit J Obstet & Gynaecol* 112(4):430-7.
[50] Swingle HM *et al.* (2009) Abortion and the risk of subsequent preterm birth: a systematic review with meta-analysis. *J Reprod Med* 54:95-108.
[51] Shah PS & Zao J (2009) Induced termination of pregnancy and low birthweight and preterm birth: a systematic review and meta-analyses. *Brit J Obstet & Gynaecol* 116(11):1425-42.
[52] Lemmers M *et al.* (2016) Dilatation and curettage increases the risk of subsequent preterm birth: a systematic review and meta-analysis. *Human Reprod* 31(1):34-45.
[53] Saccone G *et al.* (2016) Prior uterine evacuation of pregnancy as independent risk factor for preterm birth: a systematic review and metaanalysis. *Am J Obstet & Gynecol* http://dx.doi.org/10.1016/j.ajog.2015.12.044.
[54] Woolner A *et al.* (2013) The effect of method and gestational age at termination of pregnancy on future obstetric and perinatal outcomes: a register-based cohort study in Aberdeen, Scotland. *BJOG* 121:309-318.
[55] Saccone G *et al.* (2016) *Op. Cit.*
[56] Malosso ERM *et al.* (2018) US trends in abortion and preterm birth. *J Maternal-Fetal & Neonatal Med* 31(18):2463-2467.
[57] Lemmers M *et al.* (2016) *Op. Cit.*
[58] McCaffrey MJ (2017) The Burden of Abortion and the Preterm Birth Crisis. *Issues in Law & Medicine* 32(1):73-98.
[59] Abortion risks, NHS. See https://www.nhs.uk/conditions/abortion/risks/ Accessed 15 Aug 2019.
[60] Planned Parenthood America, What facts about abortion do I need to know? See https://www.plannedparenthood.org/learn/abortion/considering-abortion/what-facts-about-abortion-do-i-need-know Accessed 15 Aug 2019.
[61] British Pregnancy Advisory Service, Abortion Frequently asked questions: will abortion affect my ability to get pregnant in the future? See https://www.bpas.org/abortion-care/considering-abortion/ Accessed 15 Aug 2019.
[62] See https://www.nhs.uk/conditions/abortion/risks/ Accessed 15th Aug 2019.
[63] Charonis G & Larsson PG (2006) Use of pH/whiff test or QuickVue Advanced® pH and Amines test for the diagnosis of bacterial vaginosis and prevention of postabortion pelvic inflammatory disease *Acta Obstetricia et Gynecologica* 85:837-843.

abortion that causes infections and follow up surgery[64], intrauterine adhesions (IUAs)[65], and endometrial thinning.[66,67] In turn, each of these has been shown to lead to infertility – cervical damage[68], PID[69], IUAs[70], and endometrial thinning.[71] There are therefore concerning theoretical grounds for a pathway from abortion to infertility. Clearly, more research is needed, especially given the high value women place on their fertility.

Abortion related maternal deaths

Risk of death resulting directly from complications arising from abortion is rare, but increases with each week of gestation.[72]

However, deaths can also be abortion related but not an immediate result of the procedure itself. When compared with other causes of maternal mortality, abortion related deaths have not been subject to the same scrutiny. There are many barriers to measuring abortion related deaths, which include women's and doctors' unwillingness to participate in research, misclassification of deaths and complications, and underreporting. Abortion related deaths may be misclassified because of similarities to other pregnancy related complications such as miscarriage, haemorrhage or sepsis. In the USA, doctors fail to report recent or current pregnancies on a minimum of 50% of death certificates.[73] This can lead to abortion appearing safer than it really is.

Despite the limitations, there are several studies that found an increased risk of death after abortion. Some of the best of these come from Finland, where, as noted, accurate abortion registries are record linked with other health outcomes. In a 1997 study, compared to women who gave birth, those who had an abortion had a 63% elevated risk of death from natural causes, a 324% increased risk of death from accidents, a 546% increased risk of death by suicide, and a 1297% increased risk of death by homicide.[74] More recently, deaths from suicide after abortion were nearly 7-fold higher compared with after giving birth. [75]

The data from countries with good abortion records shows significant concerns around maternal mortality related to abortion, and this relationship should be investigated in the UK.

[64] Mentula M *et al.* (2018) Intrauterine adhesions following an induced termination of pregnancy: a nationwide cohort study. *BJOG* 125:1424–1431.
[65] Hooker A *et al.* (2016) Prevalence of intrauterine adhesions after termination of pregnancy: a systematic review. The *Europ J Contracept & Reprod Health Care* 21(4):329-335.
[66] Azumaguchi A *et al.* (2017) Role of dilatation and curettage performed for spontaneous or induced abortion in the etiology of endometrial thinning. *J Obstet Gynaecol Res* 43(3):523–529.
[67] Wang Y *et al.* (2018) Association between induced abortion history and later in vitro fertilization outcomes. *Int J Gynecol Obstet* 141:321–326.
[68] https://www.nhs.uk/conditions/infertility/causes/
[69] Brunham RC *et al.* (2015) Pelvic Inflammatory Disease. *N Engl J Med* 372:2039-2048. DOI: 10.1056/NEJMra1411426
[70] Schenker JG (1996) Etiology of and therapeutic approach to synechia uteri. *European J Obstet & Gynecol & Reprod Biol* 65:109-113.
[71] Kasius A *et al.* (2014) Endometrial thickness and pregnancy rates after IVF: a systematic review and meta-analysis. *Human Reproduction Update* 20(4):530–541.
[72] Diedrich J & Steinauer J (2009) Complications of surgical abortion. *Clin Obstet & Gynecol* 52(2):205-212.
[73] Horon I (2005) Under-reporting of maternal deaths on death certificates and the magnitude of the problem of maternal mortality. *Am J Public Health* 95:478-82.
[74] Gissler M *et al.* (1997) Pregnancy-associated Deaths in Finland 1987-1994 – definition Problems and Benefits of Record Linkage. *Acta Obstet Gynecol Scand* 76(7):651-657.
[75] Karalis E *et al.* (2016) Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population-based register study of pregnancy-associated deaths in Finland 2001-2012. *BJOG* DOI 10.1111/1471-0528.14484.

4. Impacts of COVID-19 on women's health

Many of SPUC's concerns on abortion during the pandemic have been outlined in our submission to the consultation on home use of both pills for early medical abortion, which falls outside the scope of this inquiry. However, some general points on abortion during the pandemic can be made.

Abortion statistics

The Department took the unusual step of publishing abortion statistics mid-year, detailing abortions recorded in England and Wales between January to June 2020[76].

They show an increase in abortions at the beginning of the pandemic - Between January to June 2020, there were 109,836 abortions performed on residents of England and Wales, compared with 105,540 over the same period in 2019. It is tragic that in addition to the lives lost to coronavirus, so many have been deliberately killed. The jump of over 4000 from last year is significant – was this due to the stresses of the pandemic and lockdown, or the ease of being able to obtain abortion pills at home?

Women being denied in-clinic care

There is evidence that abortion providers have used the home-abortion policy to deny in-clinic care to those who wanted it.

Sophie was told by the medical professionals at Marie Stopes that she was five weeks and two days pregnant, and that if she wanted to terminate the pregnancy, she could take two abortion pills at home.

"I said that I didn't want to take them at home as I would be on my own," she said. "But I was reassured that 98% of women do not experience complications and it would be just like bad period cramps."[77]

A user reviewing Marie Stopes in South London said: "Unfortunately during my phone assessment I was not given the choice of ending my pregnancy medically or surgically. It was assumed I would go with the results of my assessment which suggested it was safe for me to carry out my termination at home medically. It was when I spoke to a nurse I realised I had an option."[78]

These cases suggest that COVID-19 restriction have actually limited choice for women, rather than expanding it.

[76] https://www.gov.uk/government/statistics/abortion-statistics-during-the-coronavirus-pandemic-january-to-june-2020/abortion-statistics-for-england-and-wales-during-the-covid-19-pandemic
[77] https://christianconcern.com/news/nurse-considering-legal-action-after-horrific-diy-abortion/
[78] https://www.iwantgreatcare.org/clinics/marie-stopes-south-london-clinic?&all=&caretype=&patienttype=&page=5