ABORTIONS - HOW THEY'RE DONE
Abortion Methods and Hazards

(Adapted from an article by Life International)

Abortion in Great Britain is regulated by the Abortion Act 1967 and the Human Fertilisation and Embryology Act 1990. Under these Acts abortion takes place either in NHS hospitals or state-licensed fee-charging abortion clinics.

Some 170,000 abortions are now carried out annually in England and Wales. Of the women involved, over two-thirds are single and most have no previous (born) children.

Over half the residents' abortions are done in the private sector, with an increasing proportion being paid for out of NHS funds.

Virtually all non-residents' abortions (some 12,000 a year) are performed in private clinics.

Under this 1990 act the upper age-limit for most abortions is 24 weeks. Burt abortion is allowed up to birth if there is serious risk of grave permanent damage (physical or mental) to the mother or of serious abnormality in the child.

Methods of abortion involve either surgery, drugs and surgery, or drugs only; depending on what stage the pregnancy has reached.

These methods are as follows.

Vacuum Aspiration (suction abortion)

Under anaesthetic, the neck of the womb (or cervix) is opened by probes (or dilators) and a tube is inserted. When the vacuum machine is switched on, the unborn child is sucked down the tube in pieces into a disposable jar.

If the head is too large is will be crushed before being removed.

This is the most common method of abortion. About 85% of abortions in England and Wales are done this way. It is usually used up to about 13 weeks of pregnancy.

Artificial dilation of the cervix in pregnancy carries the risk that the cervix will be damaged and will be insufficiently tight to contain a subsequent pregnancy, so the mother runs of the risk of miscarriage or premature delivery next time she is pregnant.

Dilation and Curettage (D&C)

Instead of a suction tube, a scraping instrument (or curette) is used and the unborn child is scraped, in pieces, from the womb. In some places this method has been almost replaced by the suction abortion.

As with every abortion, unless all the parts are removed it is possible for infection to set in. Infection as a result of retained parts of the child or the placenta can result at worst in such damage to the fallopian tubes and ovaries that the woman is unable to ovulate or the egg to pass through the fallopian tube. Infertility specialists regularly cite abortion as a major cause of infertility.

If infection is not treated quickly the woman will be very ill, sometimes haemorrhaging and needing urgent hospitalisation.

Dilation and Evacuation (D&E)
Instead of a curette, small forceps are used to crush the body and pull it out in bits. As this is used later in pregnancy, the body is larger and, as with D&C, someone must check that every part of the body has been removed to ensure that infection does not occur.

Perforation of the womb is a hazard of D&E abortion.

Prostaglandins (induced premature labour)
This method takes place in the ward, not in the operating theatre. Hormones called prostaglandins are injected or given as pessaries to bring on labour, which may last for 8 to 22 hours. The labour is intense and painful; the child is expelled from the womb.

If this method is used late (after 18 weeks) the child may be alive for at least a short time after delivery. If the neck of the womb has not opened enough, the head may be crushed with forceps before the rest of the body can be removed.

Sometimes the child is poisoned beforehand to make sure he or she is not born alive.

Many late abortions are now performed by bringing on labour in this way.

RU486 – Mifepristone: Chemical-induced abortion
This is an early method of abortion that does not involve surgery or anaesthetic and is being promoted as 'safer' for women. This method is used up to 9 weeks in pregnancy.

Abortion takes place in 4 stages:

1. The woman has medical checks and 'counselling'. There are many medical contra-indications to this drug.
2. Three tables of mifepristone are given. She waits for 2 hours in the clinic. If she vomits this abortion method will not proceed. If she does not she is sent home. After 12 hours, 50% of women start to bleed.
3. The woman returns to the clinic 2 days later for a vaginal pessary of prostaglandin. She waits for 6 hours in the clinic. 90% of women abort during this time. 60% will need strong painkillers. 3% of women have already aborted at home.
4. The woman returns 5 to 9 days later to make sure that abortion is complete. 5% of women will not have aborted and will have to have a D&C abortion. 1% will need a blood transfusion.

Medical and psychological complications from this method of abortion are numerous. LIFE's Briefing Sheet gives the details.

Morning-After Pill
The so-called morning-after pill is increasingly prescribed within 72 hours of 'unprotected' intercourse or when contraception fails. This is usually called emergency contraception. But it is not a contraceptive. It is an abortifacient. However, in most cases fertilisation will not and could not have taken place.

Two tablets of high-dosage combined oral contraceptives (levonorgestrel, 250 micrograms, and ethinyloestradiol, 50 micrograms) are taken within 72 hours of intercourse and a further two tablets 12 hours later.

The risks to the woman's long-term health are: a small risk of thrombo-embolic and cardiovascular complications that increase with age, obesity and smoking. Anyone with a family history of diabetes and hypertension is at increased risk. The textbooks on drugs also caution about the use of this method for people with migraines, epilepsy, depression, asthma, contact lenses, varicose veins.

Because most women who are given this drug are not pregnant, it is impossible to measure how effective it is in procuring early abortion. LIFE has had calls from several women who remained pregnant after using this method.

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Anyone with a problem pregnancy who needs to discuss abortion calmly and factually should phone

PREGNANCY ASSISTANCE
(08) 9328 2929