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Morality policy under the lens - evidence based policy making on abortion versus myth-usage

This paper considers global trends in abortion policy using the framework of morality policy. We consider how the controversy over abortion policy restricts legal reform, resulting in legislative lacunae and non-decision making. Using evidence from a British Academy funded analysis of political debate and policy analysis in the Northern Ireland Assembly during the period 1998 to 2016, the authors demonstrate how such trends are visible in the Northern Ireland context. This analysis demonstrates how morality based policy making which does not take account of systematic scientific evidence can be problematic for effective policy making.

Introduction

Abortion is one of the most contested issues in modern society and exploring why it remains so has been the focus of scholars in the field of morality policy. Examining how morality policies are developed and implemented demonstrates frequent disregard of systematic analysis of relevant evidence in policy development.

Morality policies are those which focus on matters such as same-sex marriage; euthanasia, reproductive technologies and abortion and which typically pit religious positions against secular positions (Engeli et al., 2012). The literature on morality policies offers insight into exploring the multifaceted nature of abortion policy and law including consideration of: government structure; politics and party system configuration; health providers; lobby groups; as well as cultural norms and values (Engeli, 2012; Schwartz and Tatalovich, 2009).

Scholars have identified that whilst commonality in matters such as political party systems exists, that variation in cultural and institutional factors occurs within different jurisdictions. Canada and the USA are typical examples of jurisdictions where faith organisations seek to influence policies but with very different outcomes. This is illustrated by the liberal approach to same sex marriage and abortion in Canada, in contrast to the contested approach in the USA (Schwartz and Tatalovich, 2009). Scholars have also identified how in the face of dealing with contentious morality policies

politicians will be mindful of re-election, and the predominant moral values of their constituency (Engeli and Varone, 2011). This consideration may result in a *policy and political non-decision,* followed by actions such as the setting up of commissions or working groups to consult with stakeholders, essentially as a stalling tactic. The Citizens Assembly in the Republic of Ireland and the Fatal Foetal Abnormality Working Group set up in Northern Ireland have both been criticised by campaigners for this very reason.

International Perspective

In western society the religious positioning evident within morality policies debates typically stems from the Christian Right, comprising the Catholic Church and evangelical Protestantism. Both have played a key role in international debates, forming what Berer (2001:8) called "an unholy alliance" with unlikely partners, such as conservative Islamic countries, to stifle focus on widening access to abortion and broader reproductive health needs (Berer, 2001; Buss and Herman, 2003; Chong and Troy, 2011; Haynes, 2013; Hulme, 2009a).

Whilst the current position of the Christian Right is anti-abortion, historically the anti-abortion policy of the Christian churches has not always been so stringent (Rose, 2007). In the 16th century, for instance, abortion up until the point of quickening was permitted by Pope Gregory XIV. Legislation in countries such as Ireland reflected this stance until the 1861 Act was introduced (Pierson and Bloomer, forthcoming). A similar position was also found in the USA during this time period (Rose, 2007) and indeed the American Protestant evangelical movement held liberal views on abortion until the 1960s (Dudley, 2011; Petroni, 2011). This liberal stance was also evident in the Republican Party's position before it was subject to lobbying by the Christian Right in the 1970s (Rose, 2007).

At the United Nations level, morality policy is influenced through the lobbying of faith based organisations. Of the 3,000 non-governmental organisations registered at the UN, 10% are faith based, with Christian organisations being over-represented within that grouping. Whilst the organisations vary in size, it is worth noting that many have significant resources: the three largest having an estimated annual budget equivalent to $6 billion, and bring with them to the UN significant influence (Haynes, 2013). At the UN faith based organisations can be grouped into two main types, those that are conservative and those that are liberal. The conservative grouping, which aligns itself under the banner of 'family values' comprises a variety of faiths – "Mormons, Catholics, Protestants, the Russian Orthodox Church and conservative Muslims" (Haynes, 2013:12). The liberal grouping comprises an alliance of those whose value base is centred on a women's right to choose, with organisations such as Catholics for Choice arguing that it is immoral to restrict access to abortion (Haynes, 2013; Pierson and Bloomer, forthcoming). The conservative grouping seeks to restrict policy and resource allocation to programmes which improve access to abortion, and they do so by attempting to block or weaken the use of liberal language within documents (Haynes, 2013, Hulme, 2009a). One example of this is the absence of 'reproductive health' as a theme in the 2001 Millennium Development Goals (MDG). Whilst this was reversed, in 2005, the lack of focus on reproductive health resulted in an absence of resources for associated programmes and had a detrimental impact on indicators of: maternal health, child mortality, access to education, gender equality, and reducing sexually transmitted diseases including HIV rates (Hulme, 2009b).

Northern Ireland Policy on Abortion

Our research addresses how the framework of morality policy can be applied to Northern Ireland and to explore how international trends are replicated in the region. First we consider the policy context to establish if there is evidence of hostility to abortion in policy documents. Specifically we consider guidance documents on termination of pregnancy for health professionals and consider the terminology used in the guidance and factual inaccuracies.

Departmental responsibility for providing policy guidance to health professionals on abortion is held by the Department of Health. This guidance comprises advice to health professionals to enable them to interpret the law. The guidance documents resulted from legal action led by the Family Planning Association (FPA), which argued that the Department was failing to "perform its statutory duty to provide integrated services to women seeking lawful termination of pregnancy in Northern Ireland" (FPA, 2004:1). Whilst the initial ruling was dismissed, the organisation appealed and in 2004 the Court of Appeal issued a judgment that the Department had failed in its statutory duty.

Draft guidelines were issued for consultation three years after the ruling (Department of Health, 2007) and it was a further two years before the guidelines were published (Department of Health, 2009). The guidelines were subject to further legal challenge before being withdrawn, amended and withdrawn again (Department of Health, 2010). Draft guidelines were issued for consultation in 2013, on the eve of a further judicial review by the FPA. The 2013 draft guidelines were widely criticised by medical, midwifery and nursing professional organisations as being flawed and without an evidential base, with the most senior gynaecologist in Northern Ireland stating that they created fear amongst health professionals (BBC, 2013).

A series of flaws are identifiable in the 2013 draft guidelines:

- The phrasing used throughout the document was inappropriate, ignoring common medical terminology. For instance 'unborn child' was used 5 times in the document, with 'foetus' used only once in an appendix and 'mother' was more frequently used as opposed to 'pregnant woman' (10 versus 5).
- The document also argued that abortions were 'highly exceptional' ignoring readily available data relating to the prevalence of abortion in Northern Ireland and elsewhere (Department of Health, England and Wales, 2015).
- The document states that counsellors who provide advice on accessing abortions elsewhere in the UK and beyond do so at their own risk as this is a "grey area" and has not been "tested by the courts". The provision of information to pregnant women concerning abortion facilities abroad is in fact protected under Article 10 of the European Convention; this issue was tested in the Republic of Ireland context in a European Court of Human Rights case dating back to 1992 (Open Door and Dublin Well Women v Ireland).

In Assembly committee hearings that followed the publication of the 2013 draft guidelines, departmental officials admitted that the tone of the document had been intimidatory and as a result of widespread criticism, officials engaged with professional bodies to inform a revised version of the document (Committee for Health, Social Services and Public Safety, 2013).

The revised version of the guidelines was issued in 2016 (Department of Health, 2016). The document is markedly different from the 2013 version, largely reverting back to the tone of the 2009 document, which was widely accepted by health professionals and with a change to terminology and language. For example the guidance refers to woman not mother, foetus not unborn child/ baby. However, these revised guidelines fail to take into account a Judicial Review decision from December 2015 which found that the law in Northern Ireland was incompatible with the Article 8 right to private and family life under the European Convention on Human Rights in cases of fatal foetal abnormality and sexual crime. It does however note the availability of the abortion pill from online providers. This is highly significant, as it is the first time the Department of Health has acknowledged that women in Northern Ireland are self-aborting at home.

In sum, the policy context relating to the publication of guidelines over the last 15 years provides evidence of a reluctance by the state to take action to provide clarity on the law on abortion and how it can be interpreted in practice. The legal battle over the guidelines has resulted in lengthy

periods of time where health professionals had no guidance to enable them to interpret the law or had guidance which was inherently flawed. Both these outcomes can be interpreted as symbolic of an anti-abortion position. The consequences of this are that the absence of guidelines, and the stigma surrounding abortion generated by state institutions has resulted in the denial of legal abortions (FPA et al, 2010).

Political Discourse

The second phase of the research focused on an analysis of political debates in Northern Ireland on abortion. Five debates in the Northern Ireland Assembly, between 2000 and 2016 (Hansard, 2000; 2007; 2013; 2015; 2016) were analysed through both quantitative and qualitative content analysis. A series of themes were identified in the analysis. These include: Northern Ireland exceptionalism ("we are a place apart"), religiosity, use of terminology with regard to abortion and factual inaccuracies about abortion. In this paper we shall concentrate on the use of factual inaccuracies, referred to in the academic literature as abortion myths. Specifically we focus on three common myths: (1) abortion is unsafe, (2) restricting access to abortion reduces the demand for abortion and (3) women who seek abortions are particularly vulnerable. In the text that follows, we firstly present examples of the usage of the myths in the Northern Ireland Assembly debates and then consider the scientific evidence.

Myth 1 Abortion is unsafe

"Medical evidence has proven that abortion increases the chance of breast cancer by 50%." (Hansard 2000:35)

"Women face potential safety issues as a result of having an abortion. The number of deaths is very small, but damage, or infection, to the uterus or fallopian tubes may occur and may lead to infertility. Menstrual difficulties can also result. Women may suffer significant emotional trauma." (Hansard, 2007:2)

Unsafe abortion is defined by the World Health Organization (WHO) as a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both. The WHO (2012) states that where legislation allows abortion within a broad framework, the incidence of and complications from unsafe abortion are generally lower than where abortion is legally more restricted.

Myths exist with regard to the after effects of abortion, both to physical and mental health. 'Post-abortion syndrome' is commonly cited as a physiological after effect of abortion. There is no scientific evidence to support this claim. Systematic scientific reviews have shown that 'post-abortion' syndrome does not exist, the syndrome is not recognised by either the American Psychiatric Association nor the Royal College of Obstetricians and Gynaecologists. Scholars have stated categorically that it has no basis in science (Major et al., 2009). Systematic reviews of scientific literature have concluded that there are no differences in the long-term mental health of women who obtain induced abortions as compared to women in appropriate control groups (Charles et al, 2008; National Collaborating Centre for Mental Health, 2011).

Two of the most common myths with regard to physical health consequences of abortion are that abortion increases a woman's risk of developing breast cancer and that abortion decreases future fertility or ability to carry a pregnancy to full term. This hypothesis has been robustly rejected by a plethora of international health bodies including the WHO, the National Cancer Institute, the American College of Obstetricians and Gynaecologists and the Royal College of Obstetricians and Gynaecologists. A recent study which systematically analysed studies on the links between breast

cancer and found there to be no sufficient evidence to support the positive association between abortion and breast cancer risk (Guo et al., 2015).

In specifically considering the myth that abortion negatively impacts on fertility and future pregnancies, historically there may have been a limited risk associated with some methods for termination. However advancements in medical knowledge have improved the safety of abortion procedures, with several large scale studies noting no increased risk (Raatikainen et al., 2006; Virk et al., 2007). In a study in the USA of legally induced abortion, Raymond and Grimes (2012) found evidence that the risk of death associated with childbirth is approximately 14 times higher than that with abortion procedures which adhere to international and national safety standards. The evidence on the safety of abortion is clear - if carried out according to clinical standards it is safe and women who have abortions are not at adverse risk of complications or longer term problems.

Myth 2 Restricting access to abortion reduces the demand for abortion.

"The number of women recorded as having travelled to England for abortions has fallen, even as abortion has become less of a taboo. The number travelling is far fewer proportionally than the number of abortions carried out in England and Wales, which are not such different societies from ours in Northern Ireland. There can be no doubt that we have a problem, but my favoured solution is for more funding for unwanted pregnancy counselling, rather than an extension to Northern Ireland of the Abortion Act 1967. That would create an abortion culture, resulting in more abortions in the long term." (Hansard 2000:13-14)

Research evidence demonstrates that making abortion illegal does not stop women seeking to access abortion. The effects of restrictions on access are that women will experience unsafe abortions and incur financial hardship in doing so. The WHO (2012) estimates that 21.6 million women experience an unsafe abortion each year worldwide. The rate of abortion is often higher in countries where abortion is illegal compared to countries where abortion is available. These are often countries with poor sexual health and relationship education and poor access to contraception, such as those in South America. The abortion rate in South America is 29 per 1,000 women of childbearing age, in Western Europe, where most countries have liberal laws, where the abortion rate is 12 per 1,000 (Cohen; Sedgh et al, 2012).

On average, 39 abortions per year are carried out in Northern Ireland in the NHS. In contrast an average of over 1000 women per year travel to England to access abortions which they must pay for, despite being UK tax payers (Bloomer and Hoggart, 2016). Others access the abortion pill online from 'Women on the Web' or 'Women help Women' to self-abort at home. Whilst exact numbers are not published for Northern Ireland a recent study using data from Women on Web indicated that over a five year period they had received inquiries from 5650 women across the island of Ireland (Aiken et al, 2016). Women accessing abortions are from a range of social backgrounds, ages and marital status, as demonstrated by data published by the Department of Health (England and Wales) (Bloomer and Hoggart, 2016).

It is evident that restricting abortion does not stop women seeking abortion, rather it displaces the activity elsewhere, whether that be self-abortion at home or travelling to other jurisdictions.

Myth 3 women who seek abortions are particularly vulnerable

"Pro-abortionists like to remind us of how many women have to travel to England to seek abortions. They fail to point out that the overwhelming bulk of abortions are for purely social reasons. Very few are because the mother's life is at risk. The issue is about cramping women's personal style. It is about their perceived loss of freedom to do all the things that they want.

They see the child as an enemy who must be eliminated. That is why they have abortions. Pro-abortionists want the rest of society to participate in public wickedness." (Hansard, 2000:27)

"We had a real opportunity to do something very positive: to protect mothers and their unborn children. For all sorts of reasons … we have wasted an opportunity to protect the most vulnerable in our society: women in crisis pregnancy and their unborn children." (Hansard, 2013:81)

There is a growing propensity to position women seeking abortion as in some way 'vulnerable' or 'at risk'. Globally anti-abortion discourse argues that, "restrictions on legal abortion are necessary to stop weak and irrational women from making bad decisions that harm them" (Cannold, 2002:174). This was a switch in tactics from previously positioning those seeking abortion as "bad women" to now position them as "mad women" (Leask, 2013:114) and is evident in the debates in the Northern Ireland Assembly. The change in tactics reflects a public sentiment of sympathy towards those seeking abortion. However, the positioning of women as vulnerable is without a sound evidential base. Research indicates that women who have already visited an abortion provider for information rarely struggle with the choice of having an abortion (Ralph et al., 2016). Some experience regret, others ambivalence about their decision (Hoggart, 2012). Other studies indicate that those who seek abortion and are denied it, due to time limit issues, experience more regret and anger than those who obtained abortions just within the time limit (Rocca et al., 2013). Much remains unknown about the influence of abortion stigma, influenced by cultural and societal issues and how this may impact on women seeking abortion (Schellenberg, et al., 2011).

The effect of this myth is two-fold. Firstly, it continues to propagate the myth that women wishing to access abortion are in a risky or highly emotional situation where they may not be making the right choice or are open to manipulation. The result of this positioning is that it becomes easier to argue that women's mental health will be compromised by having an abortion or that they will experience regret about the abortion. Consequently, such discourses have material implications for women's life choices and their access to healthcare. Secondly, the rhetoric of vulnerability positions women as those in need of help or protection and positions those who have the power to legislatively restrict access to abortion as protectors.

Conclusion

This policy briefing has considered the language used in abortion policy and political discourse in Northern Ireland. The research highlights that abortion mythology and misinformation is common in Northern Ireland and results in legal challenges to restrictive policy guidelines, the denial of abortions which would be legal under the current law and stalling of legislative reform mandated by the High Court. Northern Ireland is not unique and presents a classic case study within morality policy whereby moral arguments are valued over evidence based policy and law making. The outcome of this policy is not to stop abortion but to displace a healthcare procedure outside of the NHS system and either to another jurisdiction or to women self-aborting.

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