Positively protecting life

Supporting women and their children
by providing positive alternatives to abortion

The Pro Life Campaign
Submission to the Crisis Pregnancy Agency

Pro-Life Campaign
104 Lower Baggot Street
Dublin 2

Phone: **01-6629275**
Fax: **01-6629302**
Email: **prolife@indigo.ie**
Website: **www.prolifecampaign.ie**

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Introduction

The needs of women facing unexpected pregnancy present a major challenge to society. The attitude society adopts is a crucial factor in determining the decision women will make. If supports for pregnant women are in place, the numbers choosing abortion will decline. If they are not, abortion figures will continue to rise.

It is generally agreed that the Government has not yet found a coherent strategy to address the disturbing rise in the number of women seeking abortions in Britain. The *Pro-Life Campaign* strongly encourages the Crisis Pregnancy Agency to develop and support a range of social measures to meet the needs of women in crisis pregnancy, in tandem with the fullest possible protection for the unborn child.

In a poll conducted by Irish Marketing Surveys (August 2000) on behalf of the *Pro-Life Campaign*, 80% of respondents who expressed an opinion favoured the idea of a Government campaign to offer women in crisis pregnancy positive alternatives to abortion.

The rising abortion trend is not inevitable. Statistics from Poland (see Appendix Six) and parts of the US show that, when the conditions that pressurise women to opt for abortion are addressed, the abortion rate can be reduced.

Ireland should benefit from the experience of other countries in preventing teenage pregnancies and consequent abortions. By examining the best practice in these countries and adapting what is best suited to our own environment, we should avoid engaging in strategies that have proven unsuccessful elsewhere

The *Pro-Life Campaign* calls on the Crisis Pregnancy Agency to adopt a more balanced approach which:

- recognises the need for significantly-increased funding of voluntary organisations which offer women real and positive alternatives to abortion
- ensures that adequate supports are made available to meet the social and economic needs of women in crisis pregnancy
- promotes positive attitudes to adoption
- reduces the stigma associated with single parenthood
- promotes thoughtful and reasoned programmes which encourage teenagers to delay early sexual activity
- provides supports for families with special needs, including respite care for parents of babies with multiple special needs

If we wish to foster a caring and life-affirming culture, respect for the inherent dignity and value of each human life must form the basis of public policy concerning unexpected pregnancy.

Pro-Life Campaign
14th June 2002

Outline of the Issues to be Addressed

1. The Scale of the Irish Abortion Problem

In 1999, 6,226 Irish women went to Britain for abortions. 640 were married and 5,040 single. 546 were divorced/widowed/separated or did not state their marital status. 927 were teenagers. In 2000, 6,391 Irish women went to Britain for abortions and the figure for non-marital births was 17,235. The provisional figures for 2001 are higher still.

The age breakdowns for 1999 for both abortions and non-marital births were as follows:

Ages	**Non–marital births**	**Abortions**	**Assumed crisis pregnancies**	**% Total**
Under 20	3,165	927	4,092	18%
20-24	5,949	2,301	8,250	36%
25-29	4,032	1,519	5,551	24%
30-34	2,038	749	2,787	12%
35-39	952	502	1,454	6%
40-44	214	196	410	2%
Over 45				
And NS	111	32	143	1%
Totals	**16,461**	**6,226**	**22,687**	**100%**

Sources: Office of National Statistics (London) - *Abortion Statistics 1999*
Central Statistics Office, Dublin - Vital Statistics: Fourth Quarter and General Summery 1999

2. Why women choose abortion

Until recently, there was little more than anecdotal information about the factors which led Irish women to have abortions. However a report was commissioned by the Government in 1995 which aimed to identify the factors leading to crisis pregnancies and abortions. *Women and Crisis Pregnancy*[1] features the experiences of 88 women who chose abortion.

The Report observes that only 17 women used 'right to choose' language to explain or justify their decision.

The most striking thing about the information presented here is that most of the factors which could be said to pressurise women into choosing abortion are amenable to social and/or financial support

Issues relating to the decision to have an abortion	**Number of women mentioning each issue (Total is 88; More than one theme per woman)**
Career/ job concerns	36
Stigma of lone parenthood	30
Child needs	30
Financial concerns	28
Not ready for a child now	27
Could not cope	24
'My body, my right'	17

[1] Evelyn Mahon, Catherine Conlon and Lucy Dillon (1998), *Women and Crisis Pregnancy - A Report Presented to the Department of Health and Children*, Presented to the Department of Health and Children, March 1998

Research carried out by the *Caring Foundation* (USA)[2] tells a similar story; it revealed that one of the key factors causing women to have abortions was fear that having a child would destroy their lives and careers, affect their personal identity, and deprive them of control over their lives.

The impact of stigma on continuing a pregnancy

In *Women and Crisis Pregnancy*,[3] 30 out of the 88 participants identified stigma as a basis for their decision to choose abortion instead of continuing the pregnancy.

The same report refers to the impact that "secrecy and shame" can have on women in unanticipated pregnancies, indicating that it can be a causal factor in the choice of abortion.[4] The Report further holds that, while attitudes have changed, there is considerable room for improvement in Irish society.[5]

It is often the fear of a lack of social support that causes women to believe that abortion is their only solution. Women sometimes feel that an uncaring environment will be created around them and their child, that avenues of education and other opportunities will be closed to them and that they will be seen as "welfare spongers".[6] These perceptions are aggravated by negative media reports on lone motherhood.[7]

The stigma attaching to single motherhood is due in part to a realistic awareness of the greater difficulty which a single parent experiences in bringing up a child. This intuition is well substantiated by studies which show a greater incidence of disadvantage experienced in many forms by children of single parent families. But a society which intends to promote a caring and life-affirming culture must work towards creating a welcoming environment for single mothers. Instead of being stigmatised into making a decision to opt for an abortion, single mothers should be encouraged and supported for making what is sometimes a difficult life-giving choice, by continuing with pregnancy.

It would be regrettable indeed if the stigma caused in the past by strict attitudes to sexual mores should be replaced by one which is today motivated primarily by financial considerations.

3. *The effects of abortion - Post-abortion trauma*

Whereas at one time there was an unhelpful atmosphere of silence and scandal around unexpected pregnancy, an atmosphere which contributed to great unhappiness and on occasions the forced separation of mothers and their children, there is another unhelpful silence today which concerns the adverse psychological consequences of abortion for many women. Reputable and registered caring agencies which offer women support and positive alternatives to abortion have indicated considerable experience of working with women who suffer from trauma or emotional upset after having an abortion, yet this trauma is rarely a topic for discussion in the media or at the level of policy formation.

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[2] Swope, P., (1997), "*A failure to communicate*", Caring Foundation.

[3] *supra*
[4] Ibid, p 72
[5] Ibid, p.101
[6] Per Evelyn Mahon speaking about perceptions of single mothers, Cura Conference, Dublin Castle, Reported in *The Irish Times*, Pádraig Ó Moráin, March 1998 Source – IT On-Line)
[7] Per Evelyn Mahon speaking about perceptions of single mothers, Cura Conference, Dublin Castle, Reported in *The Irish Times*, Pádraig Ó Moráin, March 1998 Source – IT On-Line)

Research has shown that women with a prior abortion experience are four times more likely to abort a subsequent pregnancy than those with no abortion history[8].

Appendices 4, 5 and 7 deal with the range of abortion sequelae.

4. Promoting alternatives to abortion

This includes positive images of motherhood, assistance to all women during pregnancy, promoting a positive image of adopting and preventing unwanted pregnancy.

[8] T.Joyce, et al "The Social and Economic Correlates of Pregnancy Resolution Among Adolescents in New York by Race and Ethnicity: A Multivariate Analysis," *American Journal of Public Health*, 78 (6):626, 1988

Making progress

(i) *Practical assistance to women with unexpected pregnancy*

Assisting voluntary agencies caring for women with unexpected pregnancy

A woman in a crisis pregnancy should be given all the support and help she needs to cope during the pregnancy and until she can make an informed decision regarding her child's future.

Caring agencies play an essential role in supporting women when making the decision to continue their pregnancy by informing them of the range of options available, supplying information on entitlements, giving practical support such as housing or financial assistance where necessary and emotional support throughout the pregnancy.

Any attempt to reduce the numbers of pregnancies ending in abortion must include the provision of realistic levels of funding to these caring agencies, to enable them to give as much support as possible to women who would otherwise consider abortion.

Current levels of funding are not adequate to meet the needs of these agencies.

As the *Women and Crisis Pregnancy* report found, many women contact abortion clinics in Britain directly and do not avail of counselling services before travelling. In the absence of heightened awareness campaigns making counselling services more immediate to women in crisis situations, the likelihood is that they will opt for abortion in increasing numbers (see section on advertising).

The fact that some women chose abortion because they felt unable to care properly for their children challenges policy makers to ensure that adequate practical help is available. A health education policy that encourages and supports women in nurturing and protecting their unborn children should reflect society's recognition of the value of all human life and the consequent need to respond to the concerns of women with crisis pregnancy.

In the light of research indicating that women who have abortions are four times more likely to abort a subsequent pregnancy than those with no abortion history, the provision of psychological services subsequent to an abortion is essential so that, in the event of further unexpected pregnancies, women who have had abortions may be empowered to continue with their pregnancies. This further underlines the need for substantially increased funding to the caring agencies.

Given that the Government has a responsibility both to pregnant mothers and their unborn children, public funding should not be available to organisations which either advocate or facilitate abortion or have any links with abortion providers.

Family support services

The *Community Mothers Programme*[9] run by the Eastern Regional Health Authority is one of the most developed parental support programmes in operation. It operates as a home visitation based programme, which supports and encourages first time parents in disadvantaged situations. One third of parents assisted by this programme are teenage mothers.

The programme is administered by experienced and successful mothers, usually from the neighbourhood, who volunteer to give support and encouragement to first time mothers in the hope of raising their confidence as parents. The programme has been vigorously evaluated using intervention and control groups, showing decisive benefits for both parents and children. As with other interventions, home-based interventions have their limitations and are not as effective with older children or children with severe psychological problems.

Similar programmes are also proving successful in other countries.[10] And again, their effectiveness depends very much on the characteristics of individual families.

The *Community Mothers Programme* operates on a principle of social and community solidarity. Research into programmes of this nature should be encouraged and given increased funding, as should support projects like *Early Start Pre-School Pilot Scheme, Early School Leavers Initiative and Family Resources Centres.*

In 1998 the Government launched *Springboard*, an initiative of 15 family support projects. This was followed in 1999 with a government commitment to establish 100 *Family and Community Centre*s throughout the country. *The National Development Plan 2000-2006* also contains a significant allocation for services directly and indirectly supportive of family life.

It is imperative that the resources available be used in a balanced and compassionate way to deal with the economic hardships experienced by many single mothers. All families, whether headed by lone parents, or couples, deserve the necessary help and support to give their children an adequate start in life.

When considering how best to accomplish this, the Government should take the lead from submissions to the Green Paper on Abortion which argued that more financial support is required in the form of a guaranteed minimum income, better housing, changes to the taxation system, affordable childcare for women who wish to work or continue education, improved child support and free medical care for children.[11] All of these recommendations are reasonable and would contribute to greater financial stability for women facing motherhood. Moreover, it is important to ensure that single mothers are not forced out to work by economic necessity during the child's early years.

Women and Crisis Pregnancy echoes these submissions, recommending that the Government take steps to reduce the costs of pregnancy and parenthood through a change in tax policy, increase in child allowance, mother/child friendly initiatives in places of education, training and supported crèche facilities.[12]

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[9] Department of Health and Children, *A guide to what works in family support services for vulnerable families*, October 2000
[10] Roberts and McDonald, 1999 Page 57-58
[11] *Green Paper on Abortion*, Page 73
[12] Cf. No. 1

Respite care for babies with multiple special needs

A small but increasingly significant number of pregnancies are being aborted because of evidence of foetal disability. It is unfortunate, at a time when there is increasing awareness of the needs of people with disabilities, that procedures such as amniocentesis are being used to detect foetal disability with a view to offering women the possibility of abortion.

Such practices call into question society's real attitude to disability and to people so affected. Thus there is a need to provide resources and support for families of babies who have special needs. Within the diversity of family support services, respite care has consistently been identified by families as a priority need.[13]

The failure on the part of successive governments to provide adequate respite care for babies with multiple special needs to be redressed as a matter of priority.

The *Pro-Life Campaign* strongly urges the Crisis Pregnancy Agency to reject abortion on the grounds of disability as incompatible with the equal dignity and respect for all human life, and to take immediate action in providing the necessary respite care and supports for people with disability and their families.

In Britain, one such service which has been developed in Liverpool by the Life Health Centre, is *Zöe's Place* - an organisation committed to providing palliative and respite care to babies with multiple special needs. *Zöe's Place* offers respite and palliative care from birth to babies and their families. It is dedicated to providing a loving, supportive environment for babies and families, ensuring that pain and other symptoms which can cause distress and anxiety are controlled or prevented It is the first baby hospice of its kind. Most of the babies have life threatening or life shortening conditions. In Ireland, the recently established *Jack and Jill Foundation* operates along the same lines.
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As well as caring for babies with multiple special needs, under the supervision of fully qualified children's nurses, *Zöe's* provides support and encouragement to families in relieving some of the stresses and strains by sharing the task of caring for the babies, thus giving parents the space to devote time to their other children and engage in normal everyday pursuits.

(ii) Positive messages through advertising

The work of the *Caring Foundation*[14] has identified some of the underlying emotional and psychological reasons prompting women to opt for abortion. This research has led to the development of effective strategies to address the concerns of women with crisis pregnancies. The campaigns operate primarily through television advertisements which inform women of the social supports available to them in the event of crisis pregnancy.

The *Caring Foundation* began its work in Missouri, where advertisements have been aired for a number of years. Missouri has the fastest dropping abortion rate among States in the United States - almost six times the national average. From 1988 to 1992 the abortion figures dropped by just 5% nationally, but by 29% in Missouri. This sharp decline in the number of abortions testifies to the success of appropriate advertising.

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[13] Cohen, S., & Warren, R.D. (1985). "Respite care: Principles, programs & policies." Austin, TX: Pro-Ed, Inc.

[14] Swope, P., (1997), "*A failure to communicate*", Caring Foundation.

If the Government makes the necessary resources available, similar programmes could be adapted to work in Ireland and would substantially enhance the work of existing registered caring agencies offering positive alternatives to abortion.

It would be important to stress that to be both acceptable and successful such advertising should avoid the use of emotive terms and images, and the *Pro-Life Campaign* would warn against 'shock advertising' of the kind employed in campaigns against drink driving etc. The aim of such advertising should be to promote confidence among women of their own ability to cope with unexpected pregnancy and to draw their attention to the many supports which are available to them.

(iii) Shaping public attitudes

Perhaps one of the reasons why so little has been done to date to reduce the numbers of women seeking abortions is the belief that a rise in the number of abortions is an inevitability in a modern, pluralist society.

This belief may be linked to the perception that abortion rates remained low when religious practice rates were high and when there was a greater linkage between Church and State than would nowadays attract public support. The fear may also be that it would be impossible to reduce abortion numbers without returning to what are now widely regarded as more repressive attitudes towards sexuality.

While there is truth in the notion that the number of abortions rises in line with an increase in liberalism generally and sexual permissiveness in particular, it is highly likely that by tackling aspects of sexual permissiveness which are of widespread concern (namely premature sexual activity among young people) considerable strides can be made towards reducing the incidence of abortion.

Another reason not to be fatalistic about the rise in abortion rates is the experience of Poland. The abortion statistics for Poland show a decline that almost defies credibility (see Appendix 6). The fall in Poland's abortion rate predated the tightening of Poland's law on abortion and while it may have been due in part to social changes which accompanied the fall of Communism, it seems likely that targeted education campaigns had the dominant effect.

Combating the stigma of single parenthood

Public funding both of caring organisations and of positive advertisements has an important role to play in changing attitudes generally. In particular, the stigma that can sometimes be associated with single motherhood must be addressed.

It is important to have a balanced and mature debate in order to take account of the complexities of this issue. The debate must move to a point at which social support for two-parent families and social support for single parents can be advanced together, neither at the expense of the other and where support for one does not imply a hostile attitude towards the other.

The over-riding consideration must be that any society which wishes to reduce the incidence of abortion must put in place all necessary supports to meet the social and economic needs of single parents. Single mothers must be encouraged and supported for making what is sometimes a difficult life-giving choice, rather than being stigmatised into making a decision to opt for an abortion.

Changing campus attitudes

Many abortions occur when women get pregnant while at college because of the particular vulnerability of women in this situation. As with all women with unexpected pregnancies the decision whether or not to opt for abortion may be heavily influenced by the support given to the woman, the attitude of those closest to her and the policy, if any, of college authorities towards women in her situation.

The US-based group *Feminists for Life*,[15] through its *College Outreach* programme, has devised highly effective on-campus campaigns to communicate with women in crisis pregnancy situations. The programme uses attractive poster campaigns to heighten awareness regarding the supports available to students faced with crisis pregnancy and reminds them that the continuation of pregnancy is a valid choice and one which they will not regret. In doing this, the *College Outreach* programme also seeks to influence the wider student population towards a more supportive on-campus attitude where fellow students have an unexpected pregnancy.

This programme has seen the number of college abortions drop encouragingly in recent years, showing the influence social solidarity can have in helping women in crisis pregnancy to opt for a life-affirming choice.

Such a system can only evolve when the necessary backup supports are put in place. This includes all of the necessary components, from increased crèche facilities in colleges to counselling services offering women positive alternatives to abortion. If Students Unions and college authorities are encouraged to put more support services in place, it will ease the fears of pregnant students and reassure them that their college campus offers a secure environment where they will not be discriminated against for their decision to bring the pregnancy to term.

Adoption

The *Women and Crisis Pregnancy* report points out that whereas 71% of non-marital births were adopted in 1971 only 7% of non-marital births were adopted in 1991. In their analysis of the women who actually chose adoption rather than lone-parenthood or abortion, the report mentions that the women saw adoptive parents

"as people who would be made extremely happy with the opportunity to rear their child, an experience they would otherwise be deprived of…"

and this was a factor which led them to opt for adoption. Given that a conservative estimate of infertility is that ten per cent of couples are affected, this is an aspect of the response to unexpected pregnancy which should receive much more attention.

Of the 88 women in the study who chose abortion some did, in fact, consider adoption. Yet they ultimately rejected this option because they felt they would not be able to part with the baby, having continued the pregnancy.

The study suggests that changing attitudes to lone parenting and the availability of legalised abortion in Britain have been the main factors in the declining number of adoptions. While we cannot change the fact that abortion is legal and readily available in Britain, positive health education policies directed at promoting and facilitating adoption would encourage and

[15] Information about the Feminists for Life plan of action is available at http://www.feministsforlife.org

reassure more women to avail of this option, thus helping to reduce the abortion rate and to minimise the physical and emotional harm endured by many women following an abortion.

Recent media attention has drawn attention to negative attitudes to adoption. There needs to be more information about the changes that have taken place in adoption procedures in recent decades. Negative media coverage of now abandoned procedures may have influenced perceptions of adoption. While the negative attitudes of some social workers towards adoption is hopefully being addressed, there is a responsibility on the social services as a whole to take a more proactive role in lessening the trauma for birth mothers and would-be-adoptive parents by informing them of contemporary procedures of adoption with the degree of commitment and dedication they deserve.

The discussion of this developing area deserves further consideration and research on possible new models of 'open adoption' is desirable.

Given the significant disparity between the number of domestic adoptions and the number of abortions, there is room for a more proactive stance in this area on the part of the Government. In addition, a Government-funded campaign to stress the positive nature of adoption as an option in an unanticipated pregnancy could have a significant effect on the number of women who choose adoption over abortion. Furthermore, the Government should ensure that those engaged in pregnancy counselling should have detailed and positive information about adoption to hand, as a matter of course, and Government Departments should also encourage a more positive attitude towards adoption among health care professionals and social workers.

(iv) Preventing teenage pregnancy

While the provision of positive alternatives to abortion and social support for families is one approach to rate reduction, it is better to prevent unexpected pregnancy in the first place.

In 1978, 4.3% of births were to lone mothers, whereas in 1998 this figure had risen to 28.3%.[16] Similarly, in 1999 there were 4,092 pregnancies to unmarried teenagers, more than double the 1,914 pregnancies in 1980. While not all of these pregnancies were either unexpected or unwanted, it is safe to suggest that a large proportion of them were. What is perhaps most surprising about the growth in these figures is the fact that the increases occurred during a period in which access to contraception had been greatly expanded.

The scale of morbidity associated with teenage sex is sobering and underlines its inappropriateness. Rather than adopting tired and inadequate responses, which may simply be contributing to spiralling figures for teenage pregnancy, consideration could be given to the many thoughtful and reasoned advocacy programmes which encourage teenagers to abstain from early sexual activity.

Learning from experience

The last 15 years in the United States have brought increased willingness to confront issues of teenage sexuality. During this period, there have been a number of programmes, sponsored by both Government and voluntary groups, promoting delayed sexual activity amongst teenagers as a holistic response to unintended pregnancy. *The Alan Guttmacher Institute*[17] calculates that roughly one-fourth of the drop in the teenage pregnancy rate between 1988 and 1995 resulted from delayed sexual activity programmes for teenagers. While there is no direct experience of such programmes in Ireland, how they have been effectively implemented in other countries should be examined.

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[16] Department of Health and Children, *Health Statistics 1999*

[17] The Alan Guttmacher Institute, *Why is teenage pregnancy declining?, 1999.*

A number of local authorities in the US have engaged in educational and media campaigns to encourage teenagers to postpone sexual activity. For instance, Monroe County in New York State launched the *Not Me, Not Now* campaign.[18] This campaign was launched in response to figures which showed that Monroe County had the highest adolescent pregnancy rate in New York State.

Monroe County recently conducted formal impact evaluations of the *Not Me, Not Now* campaign. The findings suggest that well-designed and competently-implemented programmes promoting the postponement of early sexual activity can have a measurable impact.[19] There was a statistically significant decrease in teenagers engaging in sexual intercourse in Monroe County between the commencement of the programme and the impact evaluations. In the 15-17 age category the rate of sexually active teenagers declined from 46.6% to 31.6%. This led to a corresponding drop in teenage pregnancy rates.

The United States Government has been supportive of abstinence-oriented programmes like the Monroe County initiative. The *Personal Responsibility and Work Opportunity Reconciliation Act* of 1996 authorised $50 million per year in federal funds (with a mandatory $37.5 million in matching State funds) to support abstinence-only educational initiatives aimed at adolescents.

These programmes are motivated by a clear-sighted health strategy dealing with some of the ill-effects arising from early casual sexual activity. There is now a recognition that potential effects of teenage sexual activity go beyond the issues of unexpected pregnancy and sexually transmitted infections. For instance, in one leaflet published by the US Department of Health and Human Services[20] entitled *"No one's invented a contraceptive against getting hurt"*, teenagers are encouraged to be aware of the negative emotional and psychological dimensions of early sexual activity. This approach seems enlightened in the light of recent Scottish research which indicates that 45% of girls and 32% of boys regret initiating sexual activity as early as they did.[21]

Practical Help for Teenagers

Part of the effectiveness of these programmes in promoting a deferral of sexual activity amongst teenagers lies in the awareness of the need to go further than merely telling them to "just say no". Research suggests that in a significant number of cases early sexual activity is an expression of non-sexual needs, with the desire for acceptance or conformity as key motivations.[22] Thus there is an urgent need to develop skills in motivation and discernment among teenagers. In recent British research featuring a nationally representative sample of 2,250 13-15 year olds, 32% of respondents reported that they either had "no choice" in the initiation of sex (4%), that they were drunk (19%), that they succumbed to peer pressure (3%) or that they were talked into it (6%). When this is combined with the 30% of respondents who reported that "it just happened", it leaves only one third of the sexually active teenagers who made a conscious decision to engage in sex for the first time.[23]

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[18] See http://www.notmenotnow.org for details

[19] Impact Evaluation of the *Not Me, Not Now* Program, *Journal of Health Communication*, Volume 6, Issue 1, Feb 2001

[20] See Stammers, T. and R. Ingham, (2000), "Education and Debate: Doctors should advise adolescents to abstain from sex" *British Medical Journal*, December, pp. 1520-1522

[21] Wright, D., Henderson, M., Raab, G., Abraham, C., Buston, K., Scott S. et. al. (2000), "Extent of regretted sexual intercourse among young teenagers in Scotland: a cross-sectional survey", *British Medical Journal*, Vol. 320, pp. 1243-1244

[22] Cohen, M.W., (1995), "Adolescent sexual activity as an expression of non-sexual needs", *Pediatr Ann* 24, pp. 324-329

[23] Hill, C., (2000), "Sex under Sixteen: Young people comment on the social and educational influences on their behaviour", Family Education Trust, London.

In the light of these stark figures, the promotion of "safe sex" as a panacea is an ineffective response. If it was the answer, the US and UK would have no teenage pregnancy problem. Indeed the UK has the highest intensity of contraceptive promotion and availability in Western Europe and at the same time has the highest rate of teenage pregnancy. [24]

Teenage drinking, particularly "binge drinking" is a contributing factor in sexual activity, as surveys show. The recently published European School Project Survey (ESPAD) showed that the number of Irish 15-16 year olds using alcohol, cannabis and inhalant use was higher than the average for other countries. Significantly, Irish girls of this age group were almost the highest consumers worldwide of alcohol, cannabis and inhalants.

Any fair assessment of the current situation shows that alternative solutions to the rates of unintended pregnancy must be sought. Programmes encouraging the postponement of early sexual activity need to emphasise that sex can be casual in its intent but never in its consequences.

The effectiveness of teenage programmes encouraging delayed sexual activity

With the increase in positive programmes to promote delayed sexual activity as a viable option for young people, it is not surprising that evidence is now emerging to show the effectiveness of these approaches in reducing teenage sexual intercourse. A 1995 report published in the Lancet,[25] found that there was a pronounced reduction in pregnancy rates amongst those participating in programmes of this nature, compared with those not involved in such programmes. The latter were as much as fifteen times more likely to be pregnant than those involved in abstinence programmes.

(v) Amending the 1995 Abortion Information Act

The Regulation of Information (Services Outside the State for Terminations of Pregnancies Act came into effect in July 1995. For the first six months of 1995, abortions followed the downward trend of England, Wales and Northern Ireland but surged in the latter half of 1995 following the enactment of the legislation. The effects of a revolution in ethical practice are not always immediately apparent but manifest themselves over time. In this case, the effect was immediate. Between 1995 and 2000, abortions surged by 41% in the Republic where they rose only 12% in England and Wales. According to the then Minister for Health, Mr Michael Noonan, scientific studies here and abroad proved that the legislation would reduce abortions by 14-25%.

The 2000 abortion figures for the Republic of Ireland are the highest on record, reaching 6,391, of which 881 were teenage abortions.

It is reasonable to attribute this increase to the legalisation of *de facto* abortion referral. A comprehensive review of this Act should be undertaken as part of any Government strategy seeking to reduce the abortion rate. A more appropriate commitment on the provision of abortion information should involve a proactive strategy to educate people about the nature and effects of abortion, and about the availability of positive alternatives to abortion.

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[24] *Trends in Sexually Transmitted Infections in the United Kingdom 1990-99*, by Collaborative Group of State Health Professionals from the four UK jurisdictions, Population Action International, 2001: *A world of difference – Sexual and Reproductive Health Risks.*

[25] Genuis, S.J. and Genuis, S.K., (1995), "Adolescent sexual involvement: time for primary prevention", *Lancet*, 345, 240-1

Relative Abortions in two jurisdictions (calendar years)

Year	Republic	England & Wales
1995	4,532 (100.0)	154,298 (100.0)
1996	4,894 (108.0)	167,648 (108.6)
1997	5,235 (115.5)	170,005 (110.2)
1998	5,892 (130.0)	176,383 (114.3)
1999	6,226 (137.3)	173,696 (112.6)
2000	6,391 (140.9)	172,477 (111.8)

Summary of Recommendations

Providing real alternatives to abortion

1. Specific funding should be earmarked to develop similar campaigns to those of the *Caring Foundation* (USA), which primarily operate through television advertisements to inform women of the social supports available to them in crisis pregnancy.

2. Additional funding is required for caring agencies to engage in post-abortion counselling. Research indicates that psychological services subsequent to an abortion may intervene in the cycle before a woman is faced with another crisis pregnancy.

3. As a matter of policy Government should back up its commitment to the right to life by giving support and funding only to caring agencies which promote positive alternatives to abortion and do not have links with abortion providers..

Assisting women and families

4. Changes should be implemented in the taxation system to provide attractive tax concessions for parents, to ensure that all children are given an adequate start in life.

5. Programmes such as the *Community Mothers Programme*, run by the Eastern Regional Health Authority, should be developed as a supportive outreach to parents experiencing difficulties in raising their children.

6. Investment is needed in respite care facilities for parents of children with special needs.

7. Funding should be provided towards the development of a baby hospice similar to *Zoe's Place* (see page 8).

Adoption

8. The Crisis Pregnancy Agency should implement and fund an ongoing campaign to emphasise the positive nature of contemporary models of adoption.

9. The Crisis Pregnancy Agency should ensure that those engaged in pregnancy counselling have detailed and positive information to hand, as a matter of course, relating to adoption.

10. Increased funding should be made available to existing adoption agencies, such as PACT and Cúnamh, particularly to enhance their public visibility.

11. A more positive attitude towards adoption must be promoted among health care professionals and social workers. Specific attention should be paid to the initial training of such professionals and their ongoing professional formation.

Preventing teenage pregnancy

12. The Crisis Pregnancy Agency should give consideration to funding proactive and reasoned educational programmes encouraging postponement of sexual activity as a response to current rates of unexpected pregnancy. These programmes should be evidence-based and emphasise the negative emotional and physical dimensions of early sexual activity.

13. More emphasis should be placed on trying to address the underlining causes of early teenage sexuality rather than on the expansion of 'harm reduction' approaches which have proven to be unsuccessful.

14. The continuance of health education campaigns addressing the issues of drugs and alcohol abuse is essential.

15. The Crisis Pregnancy Agency should encourage and fund the establishment of *College Outreach* style programmes which offer positive alternatives to abortion to women in third-level colleges.

APPENDIX ONE

ABORTION, NON-MARITAL BIRTHS, AND TEENAGE PREGNANCY – COMPARISONS BY YEAR

The table below highlights the steady increased number of abortions, teenage pregnancies and unwed births from 1970-1999.

Year	Non-Marital Births	Abortions	Non-Marital Teen Pregnancies (abortions + births)
1970	1,709	261	540
1980	3,691	3,380	1,914
1990	7,660	4,063	2,910
1995	10,788	4,532	3,050
1999	16,451	6,226	4,092
2000	17,235	6,388	3,858
% Increase	**908%**	**2347%**	**614%**

Sources: Office of National Statistics (London): *Abortion Statistics 1970-1999*, Central Statistics Office (Dublin), *Vital Statistics: 1979-2000*, Dept. of Health Dublin.

APPENDIX TWO

COMPARATIVE ABORTION RATES IN EUROPE

The Council of Europe's most recent demographic report, publishes the numbers of births and abortions for most European countries. From the data supplied, the abortion rates are calculated as a % of live-births. An abortion rate over 100% of live-births means more abortions than births.

Country	Year	No. Births	No. Abortions	Abortion Rate % Live-Births	%Non-Marital Births
Albania	1995	72,081	32,588	45.2%	N.A.
Austria	1998	81,233	2,367	2.9% *	29.5%
Belgium	1995	115,638	11,224	9.7%	N.A.
Bulgaria	1998	65,361	75,066	114.8%	31.5%
Croatia	1999	45,179	8,064	17.8%	8.2%
Czech Rep.	1999	89,471	39,382	44.0%	20.6%
Denmark	1996	67,638	18,135	26.8%	51.6%
Estonia	1999	12,545	17,027	135.7%	54.0%
Finland	1999	57,574	10,850	18.8%	38.7%
France	1996	734,338	162,792	22.2%	40.0%
Germany	1997	812,173	130,890	16.1%	18.0%
Greece	1994	103,763	12,608	12.2%	3.0%
Hungary	1999	94,645	65,981	69.7%	28.0%
Iceland	1998	4,100	900	21.9%	64.0%
Ireland	**1999**	**53,354**	**6,226**	**11.7%****	**30.9%**
Italy	1998	515,439	123,617	24.0%	9.0%
Latvia	1999	19,396	18,031	93.0%	39.1%
Lithuania	1999	36,414	18,846	51.8%	18.8%
Moldova	1998	46,755	33,229	71.1%	15.7%
Holland	1997	192,443	22,413	11.6%***	19.2%
Norway	1999	59,298	14,251	24.0%	49.1%
Poland	1997	412,635	3,171	0.8%	11.0%
Romania	1999	234,600	259,888	110.8%	24.1%
Russ.Fed.	1995	1,363,806	2,442,074	179.1%	21.1%
Slovak Rep.	1999	56,223	19,949	35.5%	16.9%
Slovenia	1999	17,533	8,707	49.6%	35.4%
Spain	1998	365,193	53,847	14.7%	14.5%
Sweden	1999	88,173	30,712	34.8%	55.3%
Macedonia	1996	31,403	14,164	45.1%	8.9%
Ukraine	1995	492,861	740,000	150.1%	13.2%
UK	1999	700,192	195,394	27.9%	38.8%
Armenia	1999	36,502	14,403	39.5%	13.8%
Belarus	1999	92,975	135,864	146.1%	17.8%
Georgia	1994	57,311	35,563	62.0%	29.2%

Note: The only figures relating to Austria were for people discharged from public hospitals after legal abortions. The figures for Holland are understated as the Dutch do not count early abortions carried out in doctors' surgeries as abortions at all. The figure for Ireland is listed in the foreign nationals section of the English and Welsh figures. The Belgian figures are also incomplete as a further 2,247 Belgian abortions took place in Holland.

Sources: Recent Demographic Developments In Europe 2000 (Published by the Council of Europe, December 2000)

APPENDIX THREE

ENGLISH MORNING-AFTER PILL STATISTICS

In the table below, abortions and births are for calendar years, the statistics on MA pill usage are from 1st April each year to following 31st March. The figures refer to pills distributed at family planning clinics only and do not include the unknown amount prescribed by GPs. **The figures below relate to England only.**

Year	MA Pills	All Abortions	All Non-Marital Births	Teen Abortions	Teen Births
1991	64,700	160,189	198,938	32,577	40.333
1992	78,500	153,645	202,425	29,058	37,162
1993	94,400	150,922	203,581	27,318	35,436
1994	114,600	152,038	202,730	26,981	33,342
1995	161,600	147,875	206,400	26,788	33,661
1996	198,700	160,629	218,224	30,714	36,286
1997	210,200	162,757	223,356	29,949	37,995
1998	217,500	170,042	225,698	34,989	39,701
1999	240,200	166,106	226,626	34,452	39,782

Sources: Office of National Statistics, *Population Trends, Health Statistics, Abortion Statistics 1990-1999,* ***Trends in sexually transmitted infections in the United Kingdom 1990-1999***, Department of Health England, *Statistical Bulletin NHS Contraceptive Services, England 1999-2000.*

The 240,000 MA pills distributed at family planning clinics in 1999/2000, went to the following age groups:

Under 16s		9.7%
	16-19	37.8%
< 20		47.5%
	20-24	26.6%
	25-34	19.6%
Over 35		6.3%

The peak age for clinic attendance was 16-19 and in the year 1999/2000, 23% of women in this age group visited family planning clinics and many of the remainder went to GPs. The reality is that the widespread distribution of the morning-after pill has not reduced unwanted pregnancies.

Women aged 16-19 were also the leading victims of sexually transmitted diseases, often from relations with older men as the peak for males affected older age groups. The Report, *Trends in Sexually Transmitted Infections in the United Kingdom 1990-1999* states:

> "The highest rates and increases in STI diagnoses are focused on those aged 16 to 24 years, peaking earlier in females than males. Young people are behaviourally vulnerable to STI acquisition as they are more likely to have higher numbers of sexual partners and a higher frequency of partner change than older age groups. Young women may be at particular risk through lack of skills and confidence to negotiate safer sex, resulting in inconsistent use of barrier contraception. They are also more likely to have older male sexual partners who have a relatively high rate of partner change. These factors may explain the high STI incidence seen in young people and the high rate of teenage pregnancy in the UK, the highest in Western Europe".

Sources: Office of National Statistics, *Population Trends, Health Statistics, Abortion Statistics 1990-1999,* ***Trends in sexually transmitted infections in the United Kingdom 1990-1999***, Department of Health Ireland and England, DHSS, Belfast, *Statistical Bulletin NHS Contraceptive Services, England 1999-2000,*

APPENDIX FOUR

FINLAND-BIRTH, ABORTION AND MORTALITY

Finland is one of the few countries in the world which has accurate birth, abortion, death and hospitalisation linkages which provide very useful information:

Risk of Pregnancy-Related Death: Register Linkage Study; Finland 1987-1994

	Birth	**Miscarriage**	**Abortion**	**No Pregnancy**
Age adjusted deaths per 100,000 cases	29.4	51.3	103.2	58.8
Non age adjusted per 100,000	27	48	101	—
Odds Ratio				
Total Mortality	0.50	0.87	1.76*	1.00
Natural Deaths	0.49	0.43	0.80	1.00
Accidents	0.49	1.40	2.08*	1.00
Suicides	0.57	1.44	3.68*	1.00
Homicides	0.31	1.82	4.33*	1.00

Statistically significant within 95% confidence limits

Note: The study took women's deaths one year after pregnancy outcomes. The general suicide rate for Finnish women in their reproductive years was 11.3/100,000. After births it was 5.9/100,000, miscarriages 18.1/100,000, abortions 34.7/100,000. For all the ills listed, accidents, suicides, homicides or natural deaths, having given birth presents the very lowest risk and having had an abortion the highest risk.

Sources: Pregnancy Related Deaths in Finland 1987-1994 – Definition Problems and Benefits of Record Linkage, M. Gisslet et Al, Acta Obstet. Gyncol. Scand. 76:651 1997.

APPENDIX FIVE

ABORTION AND SUICIDE

Mika Gissler and colleagues, Elina Hemminki and Jouko Lonnqvist of Finland's National Research and Development Centre, checked national statistics on suicides (1987-1994) up to one year after a pregnancy ended whether by birth, miscarriage or abortion; there were 73 pregnancy linked suicides in that period, representing 5.4% of all female suicides in the fertile age groups. The findings were published in the *British Medical Journal* 2/12/1996 p. 313.

SUICIDE RATES OF FINNISH WOMEN

Condition	**Suicide Rate/100,000**
After birth	5.9
General Female	11.3
After Miscarriage	18.1
After Abortion	34.7

Note: Women after birth had only half the suicide rate of the general female population, while women after abortions were six times more prone to suicide. The researchers noted that women were frequently depressed after the birth but this only rarely translated into suicide.

Source*:* *British Medical Journal* 2-12-1996 p. 313.

APPENDIX SIX

Decline of abortion in Poland

From 150,000 per annum in 1960 to 253 in 1998.

Abortion on demand was introduced in the Communist era. The incredibly sharp decline in abortions started before the 1993 law prohibited most abortions. They dropped steadily from 123,500 in 1987, to 59,500 in 1990, to 11,500 in 1992, to 1,200 in 1993 (the year the law was changed), to 559 in 1995 and 253 in 1998.

It was forecast that the decline would lead to a surge in births, more illegal abortions posing as miscarriages, more maternal deaths, and increased infanticide and child murder. Polish social statistics showed no significant change in any of these; there was indeed a marked decline in hospitalisation after miscarriages and maternal deaths declined. Admissions for complications of pregnancy dropped from 178 to 144 per 10,000 women.

Dr. Pawel Woiciki, President of the Polish Federation of Pro-Life Movements, says the decline began with education on the reality of unborn life and abortions declined long before the 1993 law was enacted prohibiting most abortions. The other factor was the arrival of pro-life politicians publicly articulating a pro-life ethic.

Year	Births	Abort-ions	Non-Marital Births	Maternal Deaths	Miscarriages
1960	669,485	150,418	5.0%		
1970	547,819	148,219	5.0%		
1975	646,381	138,634	4.7%		
1980	695,759	137,950	4.7%		
1985	680,091	135,564	5.0%		
1986	637,213	129,716	--		
1987	607,790	123,534	--		
1988	589,938	108,367	--		
1989	564,431	82,137	--		
1990	547,720	59,417	6.2%	70	59,454
1991	547,719	30,878	-	70	55,992
1992	515,214	11,640	7.2%	51	51,802
1993*	494,310	777	8.2%	44	53,057
1994	481,285	782	9.0%	36	46,970
1995	433,109	559	9.5%	26	45,308
1996	428,203	495	10.2%	21	45,054
1997	412,635	3,047	11.0%		44,185
1998	397,000	253	—		

Note: Births abortions, non-marital births from **Recent Demographic Developments in Europe 2000** published by the Council of Europe. The number of abortions for the 1990s varied marginally from the publication according to Polish Department of Health. Maternal deaths and Miscarriages were supplied by the Polish Ministry for Health and Social Welfare. Legislation restricting abortion was enacted in 1993. The law was reversed by the next Government in 1996 and then reversed again by the Polish Constitutional Court back to what it was after the 1993 law.

Sources: **Demographic Situation in Poland**, reports 1993-1998, **Statistic Yearbook** 1995-1998, GUS, Warsaw, **Demographic Yearbook** 1995-1998

APPENDIX SEVEN

ABORTION SEQUELAE: General and Psychological

Reproduced from *Valuing All Human Life,* the Pro-Life Campaign Submission to the Oireachtas All- Party Committee on the Constitution.

GENERAL

Notwithstanding some high profile cases of abortion survivals the mortality rate for the unborn child in abortion is effectively 100%.

While the introduction of so-called ‘lunch-time’ or ‘quickie’ abortion would seem to emphasise the safety of the procedure for the mother yet there is significant maternal morbidity and even mortality. The report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1991-1993 reports 5 deaths directly related to abortion, a further 2 deaths due to suicide within 42 days of the abortion and another 2 deaths in women known to be substance abusers who died of injecting substance abuse overdose within 1 year of an abortion.[26] The report for the following three years 1994-1996 reports a total of 12 deaths related to abortion: 1 direct, 1 suicide; 2 deaths from thrombosis/thromboembolism; 1 death from myocardial infarction; 1 death from a ruptured ectopic pregnancy after an induced abortion had supposedly been performed; and finally 6 deaths occurred in a women who had so called medically indicated induced abortion for cardiac conditions such as primary pulmonary hypertension and Eisenmenger's.

A survey of abortion mortality in the United States from 1972-1987 found 240 maternal deaths: the main causes of death were sepsis, haemorrhage and anaesthetic complications.[27]

A study of maternal mortality in Finland found the suicide rate following abortion was much higher than that associated with birth. The mean annual suicide rate was 11.3 per 100,000; the rate associated with birth was 5.9; the rate associated with induced abortion was 34.7.[28]

Abortion begets abortion. A study of 2,925 women in Norway showed that the incidence of repeat induced abortion doubled from the second to the third abortion, indicating that the moral threshold for choosing an abortion after recognition of an unplanned pregnancy is the first induced abortion.[29] In a review of women having abortions in 1987, 59% were under 25 years of age and 42% had had a previous abortion.[30] In another review of 2,001 women seeking abortion in Wichita, Kansas in 1991-1992, 34% had had a previous abortion.[31] In a study of 163 women seeking abortions who attended Irish Family Planning Association clinics in a 1 year period 10 of the women had had an abortion in the past with 4 of these having had 2 previous abortions. One teenager had 2 abortions during the study period of 1 year and returned for a third abortion one month after the study ended.[32]

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[26] Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1991-1993.
[27] Lawson HW, et al. Abortion Mortality, United States, 1972 through 1987 Am J Obstet Gynecol 1994: 171(5)
[28] Gissler M, Hemminki E, Lonnqvist J. Suicides after pregnancy in Finland 1987-94: register linkage study. BMJ 313(7070) 1431-4, 1996
[29] Skjeldestad FE, The incidence of repeat induced abortion - a prospective cohort study. Acta Obstetricia et Gynecologica Scandinavica 73(9) 706-10, 1994
[30] Henshaw S K, Koonin LM, Smith J C. Characteristics of U.S. women having abortions, 1987. Family Planning Perspectives 23(2) 75-81, 1991
[31] Westfall J M, Kallail K J. Repeat abortion and use of primary care health services. Family Planning Perspectives 27 (4) 162-5, 1995
[32] Irish Medical Times page 5, April 18, 1997

Incidence of postabortal upper genital tract infections varies across populations. Incidence rates range at 5-20%. Infecting organisms include Chlamydia Trachomatis, Neisseria gonorrhoea, Mycoplasma hominis, Ureaplasma urealyticum, Group B streptococci and Human Papillomavirus. Long term sequelae of postabortal infection include chronic pelvic pain, ectopic pregnancy, dyspareunia and infertility.[33,34]

A number of studies have suggested that induced abortion may be a risk factor for developing Breast Cancer. One study suggested that women age 45 or younger who have had induced abortions have a relative risk of 1.5 (50% increased risk) for breast cancer compared to women who had been pregnant but never had an induced abortion. The highest risk was for women who had an abortion younger than age 18 or older than 30.[35] The meta-analysis of 28 papers concludes that even one abortion significantly increases the risk and that overall the relative risk of breast cancer for women who have had an abortion is 1.3.[36]

PSYCHOLOGICAL

Short-lived adverse psychological sequelae following induced abortion occur in up to 50% of women studied. Psychiatric disturbance is marked, severe or persistent in 10 - 32%.[37,38,39]

Both women and men are severely impacted by post-abortion syndrome (PAS), according to diagnostic features developed by Rue et al[40] based on DSM-111 criteria for post-traumatic stress disorder. Certain factors predispose particular individuals to its development. Individuals at greatest risk include:

- a woman who is advised or coerced into having an abortion for medical reasons - either illness in the mother or deformity in the foetus;[13,41,42,43]
- a woman who has a previous psychiatric history;[13]
- a woman who has current or past interpersonal relationship difficulties and a premorbid personality vulnerable to trauma;[15]
- a woman who intends to have further children at some stage;[44]
- teenagers;[13]
- those with a history of previous abortions;[13]
- women who have second trimester abortions.[45,46]

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[33] Sawaya G.F., Grady D., Kerlikowska K., Antibiotics at the time of Induced Abortion: the case for universal prophylaxis based on meta-analysis. Obstet Gynecol 87(5) 884-90, 1996

[34] Stray-Pedersen B, et al; Induced abortion: micrological screening and medical complications. Infection 19(5) 305-8, 1991

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[36] Journal of Epidemiology and Community Health 50: 481-96,1996

[37] Dagg: The psychological sequelae of induced abortion. Am J Psychiatr 148: 578-585, 1991.

[38] Ashton JR: Psychological outcome of induced abortion, Br J Obstet Gyn 87: 1115-22, 1980.

[39] Wallerstein JS et al, Psychosocial Sequelae of Therapeutic Abortion in Young Unmarried Women, Archives of General Psychiatry, 27: 832, 1972

[40] Rue V et al: The psychological aftermath of abortion: A White paper presented to C. Everett Koop, Surgeon General USA: A review of 225 articles, 1987.

[41] Blumberg et al: The psychological sequelae of abortion performed for a genetic indication. Am J Obsstet Gynecol 122-799, 1975

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[43] Iles S, Gath D, Psychiatric outcome of termination of pregnancy for foetal abnormality. Psychological Medicine 23, 407-413, 1993

[44] Greenglass E: Therapeutic abortion, fertility plans and psychological sequelae. Am J Ortho Psychiatr 1:119-126, 1977.

[45] Zolese, Blacker: The psychological complications of induced abortion. B J Psychiatr 160:742-749, 1992.

[46] Kaltreider et al: The impact of mid-trimeter abortion techniques on patients and staff. Am J Obstet Gynceol 135:235-238, 1979.

Previous induced abortion has been shown to be associated with clinically significant neurotic disturbances and affective disorders in subsequent pregnancy and it is postulated that this phenomenon may reflect a reactivation of mourning which was previously suppressed.[47,48]

[47] Kumar R., Robson K., Previous induced abortion and ante-natal depression in primiparae: preliminary report of a survey of mental health in pregnancy. Psychological Medicine 8(4): 711-5, 1978

[48] Kitamura et al. Psychological and social correlates of the onset of affective disorders among pregnant women. Psychological Medicine. 23: 967-975, 1993

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The needs of women facing unexpected pregnancy present a major challenge to society. It is generally agreed that Government has not yet found a coherent strategy to address the disturbing rise in the number of women seeking abortions in Britain. The establishment of the *Crisis Pregnancy Agency* heralds a new proactive approach in this regard. The Pro-Life Campaign's submission *Positively Protecting Life* hopes to contribute to the effort of finding ways to meet the real needs of women with unexpected pregnancies, in tandem with fostering a more caring and life-affirming culture, which respects the inherent dignity and value of each human life.

The Pro-Life Campaign
34 Upper Gardiner Street
Dublin 1
Tel. 01-8748090, Fax, 01-8748094
e-mail: prolife@indigo.ie
website:www.prolifecampaign.ie