Submission to Consultation on BCAP Broadcast Advertising Standards Code

Prepared by the Catholic Bishops' Conference of England and Wales and the Linacre Centre for Healthcare Ethics[1]

Introduction

We welcome the opportunity to contribute to the consultation on the draft BCAP Code, and will focus on two issues: the advertising of pregnancy/abortion advisory services, and the advertising of contraceptives.

Post-conception Pregnancy Advisory Services

We do not believe that services which offer or refer for abortion should be allowed to advertise on broadcast media. We also argue that even on its own terms the proposed rule 11.11 is defective.

(1) Reasons for opposing such broadcast advertisements on principle

Abortion is neither medicine nor a consumer product. Presenting it as either of these erodes respect for life, and is highly misleading and damaging to women, who may feel pressured into making a quick decision which can never be revoked.

The law in the UK does not permit abortion on demand, and there is no "right" to have an abortion. Abortion is illegal in the United Kingdom unless two doctors agree that the woman satisfies specific exemption criteria as laid out in the 1967 Abortion Act (as amended). To allow broadcast advertising of post-conception pregnancy advisory services which refer women for abortion would be to send a profoundly misleading message about the basis on which abortion is legally available.

Abortion, so often surrounded by euphemisms, is still, when seriously and honestly examined, the deliberate taking of an innocent human life. As such, it violates the rights of the unborn child – rights which coexist in harmony with

[1] This submission has been prepared on behalf of the Bishops' Conference of England and Wales and the Linacre Centre for Healthcare Ethics by Dr Helen Watt, the Director of the Centre, in collaboration with colleagues Stephen Barrie and Anthony McCarthy.

those of the mother – to security from deliberate, lethal attack.[2] Allowing broadcast advertising of abortion services would contribute to a further "normalisation" of abortion and its assimilation to a consumer service. This is counter-productive to the reduction of the number of abortions and STIs and it fails to promote habits and attitudes which effectively secure better sexual health and respect for life in the population, especially young adults. What is needed is the development and financing of a comprehensive programme aimed at reducing the abortion rate and promoting positive values of human life and relationships.

Moreover, to allow the advertising of abortion-referral services is, in effect, to allow the exploitative promotion of these services and is not in the interests of the health or psychological well-being of women.

Due to their access to substantial funding, both from private and from NHS sources, organisations that provide or arrange abortions are in practice likely to be the only pregnancy advisory services that will be able to afford to advertise on TV and Radio. Such organisations would seek to recoup their advertising costs both through charges to private patients and through charges to the NHS. Taxpayers would then be paying both for abortions on the NHS and for their promotion.

While sometimes treatment of the woman's own body (for example, removal of a cancerous womb or damaged fallopian tube) will sadly result in the death of her baby as an unintended side-effect, this is not an abortion. It is not the kind of intervention marketed by abortion advisory services. On the contrary, these services promote deliberate, elective abortion for entirely social reasons. The ending of a human life is presented as a simple lifestyle choice.

(2) Why on its own terms the proposed rule 11.11 is defective

The proposed rule 11.11 states that "Advertisements for post-conception pregnancy advice services must make clear in the advertisement if the service does not refer women directly for abortion".

Providing abortion referrals should not be seen as a central part of 'pregnancy advice', such that its absence is deemed worthy of specific comment. It is not abortion referral, but help with having a baby, that should be the central focus of pregnancy advice.

Many counselling centres help women to overcome problems associated with pregnancy, without recourse to aborting their children, and so reduce the number of women who see abortion as the only option. This is surely

[2] There is a vast literature supporting this view, including many works which do not appeal to religious presuppositions. For a very brief summary of non-religious arguments, see Watt H, Living Together: Pregnancy and Parenthood, in Institute of Ideas *Debating Matters* Series, *Abortion: Whose Right?* (London: Hodder & Stoughton 2002), available on-line at http://www.linacre.org/AbortionDrHelenWatt.htm.

admirable, particularly in a climate where so many people are rightly concerned about the vast scale on which abortion is occurring.

To present non-referring organisations with a mandatory warning is in effect to privilege abortion-referring organisations. It sidelines those who respect both the woman and her child. Without exposure to those who do not refer for abortion, women risk being given a misleading, euphemistic picture of what abortion involves, of a kind favoured by abortion providers. They also risk not being offered the practical support available from non-referring organisations for women who wish to continue with their pregnancies, but are in need of some assistance. This downgrades the psychological and physical welfare of pregnant women and leaves them vulnerable to exploitation.

The reason given for stating where a service does not refer is to reduce "delay in performing an abortion [because this] could result in medical complications"[3] No evidence is, however, offered to show that use of non-referring centres causes significant delays - assuming such delays are undesirable, rather than providing space to think and reflect.

A woman may *choose* to delay seeking an abortion while she explores other options - and during this period she may decide to keep her baby and avoid the trauma of abortion. Would that be an outcome to regret? The loss of one's child through abortion is permanent: to suggest that a woman should be helped to make this kind of choice without delay is to fail to acknowledge the gravity of this irrevocable decision.

There is a parallel, in terms of access and delay, between advice centres and doctors who have a conscientious objection to abortion. In both cases, patients are in practice free to seek a second opinion, but nonetheless have valuable access to those offering life-affirming options. Many women who have had abortions have spoken of the 'conveyor belt' onto which they were pushed at an early stage, without being offered a chance to think further about a choice that did them serious harm.

Contraception for 10 – 16 year olds

We also have concerns relating to the advertising of condoms and other contraceptives, including to those under 16. It is profoundly inappropriate to advertise condoms to children, and around programmes that appeal particularly to children from the age of 10. Promoting use of condoms cannot be separated from promoting sex, and the sexualisation of the target audience, which will be extended in this case to children from 10 – 16 years old. The age of consent is 16 in England, Scotland and Wales. The BCAP should not encourage the sexualisation of children by promoting condom use, because such use does not in any way remove the moral or legal objections to sex involving children.

[3] BCAP consultation document 11.40.

While some may argue that condom promotion to underage children is a preventative measure, the failure rate for the first year of condom use is around 17.4%[4]. It should be noted that this failure rate is with reference to pregnancy, rather than STIs; since pregnancy can occur on only a few days a month, the failure rate for STI transmission may be much higher. In view of this, to promote condoms as 'safe sex' or as a reliable preventative measure is misleading and irresponsible. The only totally reliable 'safe' measure, which is compatible with respecting the dignity and innocence of children, is saving sex for marriage at some appropriate age.

The BCAP has said that its intention is to "normalise" condom use following the suggestions of the president of the Family Planning Association, Baroness Gould.[5] No arguments are offered in support of the claim that promotion of condoms will be effective in combating teenage pregnancy and STI rates; indeed the link is assumed with no supporting evidence at all.

Promoting condoms may, in fact, have an adverse impact through making sex more attractive to children, as the rate of STIs among young people in this country may seem to suggest. Even those who support condom use admit to frustration when it comes to reducing STIs in practice. As one writer commented: "condom use has gone up, but probably not enough to offset the increase in sexual partners".[6]

The BCAP, following Baroness Gould, proposes to bring the scheduling restriction for condoms "in line with advertisements for sanitary protection products"[7]. We would question the appropriateness of a comparison between condoms and sanitary products for the purpose of advertising regulations. Menstruation is not a moral issue, and sanitary products pose no problems apart from the usual considerations of taste and decency.

In contrast, condoms for children from 10 – 16 are being promoted for use in sexual intercourse, which is entirely inappropriate where one or both parties is a child. The analogy between condom promotion campaigns and promotion of "reduced risk" cigarettes may be instructive. Whereas young people are standardly advised to reduce risks of sex by using condoms, rather than abstain, health campaigns have tended to urge smokers to 'quit', rather than promoting 'reduced risk' cigarettes. One study found that "the unregulated promotion of "reduced risk" products threatens to undermine smoking

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[4] http://www.guttmacher.org/pubs/fb_contr_use.html [6th June 2009]
[5] BCAP consultation document 32.27.
[6] Adler MW, Sexual health – health of the nation, *Sexually Transmitted Infections* 2003; 79:85-87. See also Paton D, Random behaviour or rational choice? Family planning, teenage pregnancy and sexually transmitted infections, Sex *Education, Sexuality, Society and Learning* 2006; 6 (3): 281 – 308; Richens J et al., Condoms and seat belts: the parallels and the lessons, *Lancet* 2000; 355: 400-403.

[7] BCAP consultation document 32.27.

cessation (which is proven to save lives), cause former smokers to resume their addiction, and even attract young people to tobacco products." [8]

Such objections apply even more to some other forms of contraception, as many non-barrier methods may sometimes work, according to manufacturers, by preventing any embryo conceived from implanting in the womb. The morning-after pill, in particular, should be subject to the same advertising restrictions as surgical abortion.

Again, it is not clear that the morning-after pill reduces the rate of unintended pregnancy or recorded abortion at the population level,[9] even leaving aside its possible anti-implantation effect.

Conclusion

Our society is already failing young people by presenting an impoverished view of sex, too often entirely separated from any context of committed love and readiness for parenthood. It is very important that this process is not encouraged by a willingness to advertise services which have already done enormous damage to perceptions of sex in our society. In the many cases where respect for life, as well as sex and marriage, is at issue, the situation is still more serious, since not only the rights of young people are at stake, but those of any child they conceive. Respect for life, sex and parenthood are central to a healthy society, and advertising standards should reflect this.

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[8] The Lessons of "Light" and "Low Tar" Cigarettes: Without Effective Regulation, "Reduced Risk" Tobacco Products Threaten the Public Health, February 17, 2004. *Tobacco Control. Reports on Industry Activity from Outside UCSF*. Paper USREP http://repositories.cdlib.org/tc/reports/USREP)

[9] Raymond, EG et al, Population effect of increased access to emergency contraception pills: a systematic review, *Obstetrics and Gynecology* 2007; 109: 1, 181–188.