Women's sector submission to the Abortion Law Review Expert Group: Gestational time limits and grounds for abortion

November 2024

1. INTRODUCTION

Women's reproductive rights guarantee the freedom and ability to decide if and when to have children and access to the highest attainable standards of sexual and reproductive healthcare. However, women in Scotland currently have no legal right to end a pregnancy, and standards of abortion healthcare are subject to unnecessary legal restrictions and politicisation. This causes particular harm to marginalised and vulnerable women and pregnant people. These include women experiencing or at risk of domestic abuse, survivors of sexual violence, young women and girls, women from deprived areas or on low incomes, Black and minority ethnic women, migrant women and asylum seekers, disabled women, LGBT people, women from faith communities, women in rural and remote areas, and care-experienced women and girls.

The World Health Organisation has assessed global evidence and set out best practice guidelines on rights-based regulation of abortion. This includes detailed recommendations for states to their meet human rights obligations and to act in line with current evidence. **WHO guidance makes clear that abortion should be removed from the criminal law, should be available on request, and that time limits and grounds for abortion should not be determined by law**. This is in line with the Scottish Government's Terms of Reference for its Abortion Law Review, and the Expert Group's overarching principles.

The remit of the Abortion Law Reform Expert Group is "to identify potential proposals […] for reforms to ensure that abortion services are first and foremost a healthcare matter." The provision of all medical care is closely regulated using clinical and professional frameworks rather than specific criminal law. Following decriminalisation, abortion would continue to be regulated to the same standards as other medical and surgical procedures, including any necessary, evidence-based limits or restrictions.

Our view is that the Abortion Law Review process should therefore be closely focused on the removal of abortion from the criminal law and ensuring service provision is treated like all other aspects of healthcare. Our collective position is that **if women are to be empowered to decide for themselves, abortion must be removed from the reach of criminal law, the courts, policing, and the political system in the UK**.

As such, **we are strongly of the view that the Expert Group should not be developing specific recommendations for the retention of time limits or grounds for abortion in law**. We do not consider this to be in line with its guiding principles and we are concerned that there has been insufficient consultation on these matters.

We would strongly urge that decisions on the parameters of future service delivery should be determined via an evidence-led, rights-based process, involving a wide range of expertise and consultation. This should be led by the appropriate national clinical regulatory bodies, in line with all other healthcare, and as a subsequent step in the decriminalisation process.

2. INTERNATIONAL STANDARDS

2.1 The World Health Organisation

Best practice guidance from **the World Health Organisation is clear that regulation of abortion should be removed from the law.** On time limits and grounds for abortion, its abortion care guideline:

> 1a. "Recommend[s] against laws and other regulations that restrict abortion by grounds."
>
> 1b. "Recommend[s] that abortion be available on the request of the woman, girl or other pregnant person."
>
> 2. "Recommend[s] against laws and other regulations that prohibit abortion based on gestational age limits."

Development of these recommendations included systematic review of studies conducted in a range of countries including the UK. As set out on pages 26-29 of the guidelines, key factors in arguing against time limits and grounds include:

<u>Grounds-based approaches</u>

- Protecting women and girls from the physical and mental health risk associated with unsafe abortion
- Delay to accessing abortion
- Variable interpretation of grounds by healthcare providers
- Uncertainty about the law or how it should be applied
- Incompatibility with human rights law and/or WHO definitions of health and mental health
- Particularly negative impact on women facing financial hardship and lower educational attainment

- Disproportionate impact on women who seek abortion following rape
- The right to non-discrimination and equality in accessing sexual and reproductive health (SRH)

Gestational age limits

- A lack of evidential basis
- Delays to accessing abortion especially where provision is limited
- Association with poor health outcomes
- Disproportionate impact for learning disabled women, adolescents, younger women living further from clinics and women who need to travel for abortion, women facing financial hardship, women with lower educational attainment and unemployed women.
- International human rights requirement regarding non-discrimination and equality in provision of SRH and access to safe abortion.[1]

Specifically in the UK, the evolving landscape, with regard to the availability of abortion pills and rising investigations into suspected illegal abortions in England, has the potential to lead to increased unsafe abortions. Similarly, removing impediments to abortion – such as variable application of the grounds by GPs, or the intersectional impacts associated with time limits – would help to secure abortion access against any future attempts at regression. We should learn from the WHO's findings and seek to adhere to their guidelines in as far as possible.

2.2 International human rights standards

International human rights bodies have consistently recognised access to abortion as a fundamental component in the realisation of women's rights. The UN Committee on the Elimination of Discrimination against Women (CEDAW) has been explicit in its criticism of barriers to abortion access, including criminalisation. It has noted "[e]ven in countries in which abortion is legal, restrictive conditions […] often impede access".[2] As the WHO evidence sets out, time limits and grounds for abortion restrict access and discriminate against marginalised groups.

Numerous other UN bodies, agencies and special procedures have called on states to liberalise and repeal discriminatory abortion laws (see sections 2.1 and 3) and to decriminalise abortion. These include but are not limited to the Human Rights Committee, the Committee on Economic, Social and Cultural Rights (CESCR), the Committee on the Rights of the Child (CRC), the Committee on the Rights of Persons with Disabilities (CRPD), the Office of the High

[1] WHO (2022) Abortion care guideline. Available at: https://iris.who.int/bitstream/handle/10665/349316/9789240039483-eng.pdf?sequence=1

[2] CEDAW (1999) General Recommendation 24: Article 12 of the Convention (women and health) [A/54/38/Rev.1]. Available at: https://www.refworld.org/legal/general/cedaw/1999/en/11953

Commissioner for Human Rights (OHCHR), the Special Rapporteur on the Right to Health and the UN Working Group on the issue of discrimination against women in law and in practice.[3]

Removing time limits and grounds for abortion from the law is in line with international human rights standards.

3. GENDER EQUALITY AND INTERSECTIONALITY

The WHO guideline states that:

> "A human rights approach that advances gender equality is essential and must be applied in all contexts providing services to people seeking health care."

Access to abortion on request underpins realisation of economic, social and cultural rights for women, girls and pregnant people. These include safety and security, access to employment, training and education, adequate income and housing, household resources, financial security, and high standards of health and wellbeing. Non-discrimination and equality in accessing healthcare is also compromised by the current framework, which undermines women's health equality with men and has intersectional impacts. Indicative circumstances linking abortion and gender equality are set out below.

3.1 Structural gender inequality

Gender-based violence

Timely and accessible abortion care can be crucial for women experiencing domestic abuse and their children, and for survivors of sexual violence. Abusive partners routinely use control of women's sexual and reproductive choices as a powerful way to control and abuse. Failure to remove regulation of abortion from criminal law enables abusers and fails to protect victims. Legal restrictions on time limits can have devastating impacts for women being coerced into keeping an unwanted pregnancy or prevented from accessing a timely abortion by an abusive partner. Survivors of sexual violence may not be aware of their pregnancy, experience clinical denial, or be unable to access abortion within the current gestational framework due to trauma. This may be particularly relevant for younger women, disabled women, women from certain cultural and faith backgrounds, LGBT people and women in rural or remote areas.

Financial security

Access to abortion without restrictions is vital in preventing poverty, or deeper poverty, for women and their children. Social security entitlements in the UK are premised on women's reproductive choices, with the UK Government's 'two-child limit' restricting financial support to the first two children in a family.[4] The cumulative 29% increase in the abortion rate in Scotland

[3] Details at: Engender (2024) Outdated, harmful and never in the public interest: The urgent need to modernise Scotland's abortion law and prevent prosecutions. Available at: https://www.engender.org.uk/content/publications/ENGENDER--FINAL-DECRIM-REPORT---21-05-24.pdf

[4] House of Commons Library (2024) The impact of the two-child limit in Universal Credit. Available at: https://commonslibrary.parliament.uk/research-briefings/cbp-9301/

seen in 2022/23 has been linked to the cost of living crisis, with financial concerns frequently cited alongside requests for a termination. The abortion rate in the most deprived areas of Scotland is now twice that of the most affluent areas.[5]

Health

Good physical and mental health for women can depend on access to quality and timely abortion care. Entrenched gendered health inequalities, including in sexual and reproductive health, undermine women's access to income, wellbeing, security and safety. Healthcare in Scotland, and more broadly, is institutionally discriminatory against women, people of colour, LGBT people, disabled people and other marginalised groups. Providers, including GPs and others involved in abortion care, are trained in systems that are not gender competent or intersectional, and have historically not researched, invested in or understood women's health on an equitable basis with men's. Decision-making and treatment of women by some health professionals is influenced by unconscious bias, gender stereotyping and other gendered social norms.

Intersectionality

The WHO guideline identifies that time limits and grounds have intersectional impacts for:

- learning disabled women
- young women and girls
- women in remote and rural areas
- women facing financial hardship
- women with lower levels of educational attainment.

Intersectional evidence on access to abortion in Scotland is lacking. Based on what we **do** know about wider reproductive health inequalities, the current legal stipulations on time limits and grounds for abortion for may carry additional impacts for :

- Women with physical impairments
- LGBTI people
- Black and minority ethnic women
- Migrant women
- Asylum seeking women and others with insecure immigration status
- Women from faith-based communities
- Care-experienced women and girls
- Lone mothers
- Unpaid carers
- Other marginalised groups of women and girls.

[5] Public Health Scotland (2022) Termination of pregnancy: year ending 2022. Available at: https://publichealthscotland.scot/media/19737/2023-05-30-terminations-2022-report.pdf

For example, disabled women have differing support needs when accessing abortion services, BME women face racialised injustices regarding perinatal healthcare, fertility and reproductive rights, LGBTI patients experience inequalities in sexual and reproductive healthcare (SRH) outcomes and face assumptions about their abortion care needs, and myriad barriers to good SRH compromise care for refugee and asylum-seeking women.

3.2 Stigma

Time limits and grounds for abortion contribute to abortion stigma and women's health inequalities. Scotland's current legal framework stigmatises those who seek abortion[6] by requiring women to meet outdated procedural thresholds when making decisions that are inherently personal. The current grounds for abortion force women to endure unnecessary infringements on their privacy in the delivery of routine healthcare. The statutory thresholds for gestational time limits ensure that ideological debates over women's bodies, the morality of abortion, and what is politically permissible are cyclically aired in parliament and the media.

This approach is unique within Scotland's health system and subjects women's life choices to a level of oversight and restriction that is not justifiable on medical grounds. It creates paternalistic and unequal power dynamics between doctors and women seeking abortion.

Making a legal exception of abortion is closely connected to ongoing stigma and stands at odds with women's lived reality of requiring access to abortion as routine healthcare. Ongoing regulation of time limits and grounds for abortion within the law would perpetuate abortion stigma and undermine progress towards health equality – and wider equality – for women. Reforming these restrictions would be in line with the Expert Group's remit and overarching principles on health, human rights, gender equality, intersectionality and service provision.

4. MAKING ABORTION FIRST AND FOREMOST A HEALTHCARE MATTER

The remit of the Abortion Law Reform Expert Group is "to identify potential proposals […] for reforms to ensure that abortion services are first and foremost a healthcare matter."

The Women's Health Champion expands on this in the Women's Health Plan final report:

> "The Expert Group [is] charged with reviewing the abortion law with the aim that abortion is seen as a health issue and managed in the same way as all other health issues with clinicians providing information on the risks, benefits and alternatives, empowering women to decide for themselves."

If women are to be empowered to decide for themselves, abortion must be removed from the reach of criminal law, the courts, policing, and the political system in the UK. They must have the choice to have an abortion if needed, in line with clinical guidelines and best practice in patient autonomy, without time limits or grounds for abortion stipulated within a legal framework.

[6] United Nation General Assembly (2011) Right of everyone to the enjoyment of the highest attainable standard of physical and mental health [A/66/254]. Available at: https://digitallibrary.un.org/record/710175?ln=en&v=pdf#files

4.1 Best practice in healthcare

The WHO guidelines set out best practice standards for abortion care. A human-rights based approach to abortion healthcare, which is consistent with the Expert Group's guiding principles, should underpin consideration of time limits and/or grounds for abortion, using the following parameters:

- Individuals' health and human rights
- Informed and voluntary decision-making
- Autonomy in decision-making
- Non-discrimination (including intersectional discrimination) and equality
- Confidentiality and privacy.[7]

This is in line with strategic aims, core principles and clinical guidance from health bodies currently involved in abortion regulation and best practice improvements to care in Scotland. These include:

- Healthcare Improvement Scotland: Strategic Priority 3 – place **the voices and rights of people and communities** at the heart of […] care[8]
- General Medical Council: Professional standards – **working in partnership with patients** and supporting them to make **informed decisions** about their care[9]
- RCOG: Guidance on providing acute care – Provision of care in an acute and/or critical situation can test a clinician's ability to engage in shared decision making […] However, [this] remains fundamental to providing safe care, upholding organisational values and **respecting patient autonomy**.[10]

A decriminalised regulatory framework for abortion in Scotland

The provision of all medical care is closely regulated using clinical and professional frameworks rather than specific criminal law. Following full decriminalisation, abortion would continue to be regulated to the same standards as other medical and surgical procedures, but would be removed from the parameters of the criminal law. Clinical and professional regulation would be carefully consulted upon and designed to ensure that an agreed set of principles and criteria were met.

---

[7] WHO (2022) Abortion care guideline. Available at: https://iris.who.int/bitstream/handle/10665/349316/9789240039483-eng.pdf?sequence=1

[8] Healthcare Improvement Scotland (2023) Leading quality health and care for Scotland: Our strategy 2023-2028. Available at: https://www.healthcareimprovementscotland.scot/publications/leading-quality-health-and-care-for-scotland-our-strategy-2023-2028/

[9] General Medical Council (2024) Good medical practice. Available at: https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-medical-practice

[10] RCOG (2021) Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology. Available at: https://www.rcog.org.uk/media/1e0jwloo/roles-and-responsibilities-of-the-consultant-workforce-report-may-2022-update.pdf

In addition to professional standards, data collection and other aspects of healthcare regulation, such a framework would include development of clinical guidance and governance. In turn, this would cover any necessary, evidence-based limits or restrictions.

According to the British Medical Association, regulation of abortion once decriminalised would be determined by:

- The independent regulators of healthcare professionals, including the General Medical Council, the Nursing and Midwifery Council, and the General Pharmaceutical Council
- Healthcare Improvement Scotland
- The civil and criminal laws that apply to other aspects of healthcare.[11]

The development of regulations to replace the Abortion Act should involve input from a wide range of lived and learned expertise. If required, such a process would establish where governance of time limits and grounds would sit. A successor framework would bring together regulation currently sitting with the Abortion (Scotland) Regulations 1991 (aspects of provision), Healthcare Improvement Scotland (abortion providers), and RCOG and other professional bodies (clinical and best practice guidance for healthcare professionals). Careful sequencing would be required.

4.2 Later abortion services in Scotland

We are cognisant of difficulties in securing later abortion services in Scotland to the legal limit of 24 weeks. However, we do not believe that current staffing and culture across abortion care services should be a factor in determining what a rights-based abortion framework should look like, nor should we set limitations on working towards improved provision in the future. Healthcare staff today – both managers and providers - have been trained and operate within the confines of the Abortion Act. Social, cultural and professional norms shape the views and practice of many.

On the contrary, reforming the law such that abortion is "managed in the same way as all other health issues" would have a longer-term impact on how abortion is perceived across society, including within the health system. Removing time limits and grounds from the law is a critical part of ensuring that abortion is understood as rights-based healthcare provision and is destigmatised within the health system and society more broadly.

5. WOMEN'S ACCESS TO DECISION-MAKING

Women and pregnant people currently have some degree of clarity, transparency and access to decision-making with regards to abortion care. Women, and women's groups, can advocate for abortion rights with members elected to Scottish and UK Parliaments, and with other policy and

[11] BMA (2019) How will abortion be regulated in the United Kingdom if the criminal sanctions for abortion are removed? Available at: https://www.bma.org.uk/media/1141/bma-guidance-on-the-regulation-of-abortion-in-the-uk-2019.pdf

decisionmakers. It is important to consider any unintended consequences of removing this public scrutiny and for the Expert Group to explore any measures that could be recommended to maintain this.

However, vocal and influential anti-abortion lobbyists have the same access to decision-makers, as well as to constituencies of people that politicians fear alienating. These pressures influence politicians' behaviours, often despite personal views. In this way, abortion has been, and will continue to be, politicised if its regulation remains subject to political forces and individual legislators rather than healthcare experts. The current framework exposes women's reproductive rights and choices to much wider forces than best practices in healthcare. This approach is not replicated in any other area of healthcare.

Anti-abortion health professionals, who do not adopt a rights-based approach, may participate in the formation of a decriminalised abortion regime in Scotland, should its parameters and regulation be removed from the law. However, relevant healthcare regulators and professional bodies are governed by best practice principles and frameworks regarding health and human rights that political parties and actors are not. These include increasing focus on human rights-based approaches to healthcare, informed consent, confidentiality and privacy, and patient autonomy.

Abortion rights and women's organisations would continue to monitor any processes to create or amend regulations and guidance, to advocate for best practice, and to provide women with opportunities to make their voices heard. Progressive, rights-protecting clinicians and organisations within the health system would continue to argue for gold-standard improvements to abortion care.

Positive duty

We recommend that the Expert Group considers whether a positive duty to provide abortion, scheduled for discussion in 2025, could be useful in mitigating against potential regression on abortion care within healthcare decision-making structures. In doing so we recognise that positive duties to provide healthcare have not always guaranteed provision of services. This is the case with equality law, where public bodies' compliance with requirements of the public sector equality duty has been poor. Such duties do, however, provide recourse for scrutiny and accountability.

6. THE NEED FOR AMBITIOUS RECOMMENDATIONS

Finally, we highlight the danger of **not** including full decriminalisation as - at least - an option for Scottish Government to consider within the Expert Group's report. Our organisations have decades of experience participating in, responding to, and witnessing the evolution of Government reviews and working groups such as this one, including on healthcare issues. Once the recommendations have been considered by government, subject to public consultation and, where relevant, been scrutinised by the parliamentary system, they often deviate considerably from the carefully considered and nuanced proposals that were originally crafted. We are

particularly concerned that this issue will be subject to politicisation that dilutes focus on human rights and clinical best practice.

We therefore urge members of the group to be ambitious and resolute in recommending full decriminalisation of abortion, in line with international healthcare and human rights standards and the Expert Group's overarching principles on health, non-regression, human rights, gender equality, intersectionality, and quality services.

Close the Gap
Engender
Rape Crisis Scotland
Scottish Women's Aid
Scottish Women's Budget Group
Young Women's Movement