Gibraltar Command Paper on Abortion

British Pregnancy Advisory Service Response

The British Pregnancy Advisory Service (BPAS) is a British reproductive healthcare charity that offers abortion care, contraception, STI testing, and pregnancy counselling to nearly 80,000 women each year via our clinics in Great Britain. We also treat women from Northern Ireland, Ireland, and Europe where their domestic laws prevent them accessing the care they need.

As part of our advocacy work to enable the women we treat to get the best possible care, we campaign for the decriminalisation of abortion. We do not believe there are circumstances where it is ever appropriate to imprison a woman for making a decision about her own pregnancy

Proposals

BPAS welcomes this Command Paper and the desire to ensure that abortion law in Gibraltar is in line with human rights legislation. Based on our experience providing abortion care under the Abortion Act 1967 from which this proposal is transcribed, we have a number of proposals, produced in support of the proposals of local pro-choice groups, to ensure that international standards are met and women in Gibraltar are better able to access the care they need.

These proposed changes would see the creation of abortion legislation similar to that of Ireland, the Isle of Man, France, and other European nations.

- **Decriminalisation of women.** There is no place in law for the continued criminalisation of women seeking to end their own pregnancies. It is out of step with most of Europe, with the USA, Canada, multiple states in America, and – most notably – with the new legislation being brought forward in Ireland. This would not mean abortion was available at any point – simply that women should not be jailed for ending their own pregnancies.
- **Abortion on request.** In order for abortion services to be timely, accessibly, and safe, the Government should seek, at least in earlier gestations, to fully decriminalise provision so as to allow women to request abortion care as they do any other type of healthcare – retaining existing medical law, regulation, and qualifications, but removing additional barriers to care. We would recommend that this how care should be provided up to the proposed time limit (10-14 weeks).
- **Women's health at later gestations.** Women may suffer from severe ill-health beyond 10-14 weeks which would not be provided for in the Act. To ensure that women's health is protected, abortion must be available beyond the proposed 10-14 week limit for women where continuation of the pregnancy would damage their mental or physical health.
- **Foetal anomaly.** We recommend the transcription of the wording of the 67 Act to allow women to make the best choices for their family without fear that a doctor will not consider their diagnosis sufficiently likely to result in neonatal death to warrant a therapeutic termination.
- **Forced abortion.** The UK Government is in the process of ratifying the Istanbul Convention on violence against women, which requires signatory states to criminalise forced abortion overseas. This Bill should criminalise those abortions that happen outside Gibraltar where a woman does not give her consent.

The need for reform

BPAS welcomes this Command Paper and the desire of the Gibraltarian Government to ensure that legislation is fully in line with the European Convention on Human Rights and Section 7 of the Constitution of Gibraltar.

Whilst some opponents to abortion law reform maintain that even in the event of a formal declaration of incompatibility of the law, no government is obliged to act, we strongly support the desire of the Gibraltarian Government to pro-actively engage with women's human rights and the international conventions which support them.

BPAS believes that reform of abortion law in Gibraltar is desperately needed. Under the current system, women are forced to travel across borders or to resort to illegal methods such as purchasing pills online which may prove damaging to their health if they then feel unable to present to healthcare professionals in the event of any complications.

Around the world the evidence is clear - outlawing abortion does not end abortion, it simply ends safe abortion.

Principles of abortion law

Abortion laws around the world are almost without exception more up to date than those which govern Gibraltarian (and UK) abortion provision. Based in the 1861 Offences Against the Person Act, these make abortion subject to the oldest criminal framework of any form of healthcare.

More modern laws, in line with developments by international bodies such as the World Health Organisation (WHO) and the United Nations Human Rights Commission (UNHRC) have focused increasingly on ensuring that abortion care is:

- Safe
- Accessible
- In line with international guidance
- Based on best medical practice

While the proposed changes in law ensure that abortions accessed in Gibraltar would be safe, they do not ensure that abortion would be accessible (in that they require two doctors to sign off, the proposed time limit is prohibitively early in the case of women's mental and physical health, and that women would be required to justify their need for an abortion into one of the categories provided), in line with international guidance (which has repeatedly called for the decriminalisation of women seeking abortion, whereas this command paper would retain a life sentence – the harshest penalty in the world), or based on best medical practice (as the restrictions around location and approval limit how procedures can be provided and have in other places, for instance, forced women to travel home whilst miscarrying.)

This submission therefore recommends some amendments to the existing Command Paper to better ensure that women are able to access the abortion care they need.

Existing law

As the Command Paper notes, the law in Gibraltar is the same as underlies provision in England and Wales, and functionally the same as the law in Northern Ireland. Although in the 2011 Crimes Act, it is based on a piece of legislation passed in 1861 – long before women even had

the vote. It carries the harshest penalty in the world for a woman ending her own pregnancy at any stage – life in jail.

In some of the most conservative countries in the world whose human rights records leave much to be desired, the punishment for a woman ending her own pregnancy is less than that of Gibraltar. In Saudi Arabia, women are not criminalised. In Pakistan, a woman can be jailed for up to seven years. And in El Salvador, a woman can be jailed for between three and eight years.

That is to say that **contrary to the assertion of the Command paper, Gibraltar, alongside the UK, does have a draconian law in place. It is out of step with the western world and goes further than laws even in the most restrictive of abortion regimes.** Countries as diverse as France, the United States of America, Canada, several states in Australia, and even the strongly anti-abortion Poland do not criminalise women. Furthermore, the referendum in Ireland earlier in the year showed a 2/3rds majority of the public supported removing women entirely from the criminal law.

With regards to this legislation and its impact on the Article 3 rights of all citizens to be free from inhuman or degrading treatment, Lord Kerr's portion of the NIHCR Supreme Court ruling[1] said:

> *261. We need to be clear about what the current law requires of women in this context. It is not less than that they cede control of their bodies to the edict of legislation passed (in the case of the 1861 Act) more than 150 years ago and (in the case of the 1945 Act) almost 75 years ago. Binding the girls and women of Northern Ireland to that edict means that they may not assert their autonomy in their own country. They are forbidden to do to their own bodies that which they wish to do; they are prevented from arranging their lives in the way that they want; they are denied the chance to shape their future as they desire. If, as well as the curtailment on their autonomy which this involves, they are carrying a foetus with a fatal abnormality or have been the victims of rape or incest, they are condemned, because legislation enacted in another era has decreed it, to endure untold suffering and desolation. What is that, if it is not humiliation and debasement?*

There is no place in law for the continued criminalisation of women seeking to end their own pregnancies – and in legislation designed specifically to ensure that women's human rights are not breached, it should be clear that the existing law is patently draconian.

Shortcomings of the 1967 Abortion Act (and Command Paper proposals)

When passed in 1967, the Abortion Act was designed to protect women's health – yet in the 21st Century it prevents the provision of the best possible medical care for women.

As the largest abortion provider in England and Wales, BPAS are familiar with the operation of the 1967 Abortion Act in practice, as well as the issues it presents for women seeking to access care. Many of the issues that are present in the 1967 Act are often exacerbated in small and/or remote communities where care can be unduly restricted and women may be unable to access the care they need. These issues are likely to be further exacerbated in a territory like Gibraltar where healthcare professionals will need training and where the numbers of women seeking to access care would be relatively low.

[1] https://www.supremecourt.uk/cases/docs/uksc-2017-0131-judgment.pdf

The impact on operation and provision of services detailed below should make clear that **in order for abortion services to be timely, accessibly, and safe, the Government should seek, at least in earlier gestations, to fully decriminalise provision so as to allow women to request abortion care as they do any other type of healthcare** – retaining existing medical law, regulation, and qualifications, but removing additional barriers to care.

Two doctors' signatures. The Abortion Act requires that two doctors approve each request for a termination. This is a legal requirement which serves no clinical or safety purpose, and is separate to the process of obtaining informed consent, clinical assessment, and safeguarding. No other comparable medical procedure demands legal authorisation by doctors in addition to the normal requirements of obtaining informed consent. This requirement can cause delays for women. This can harm their health as abortion – while extremely safe – is safer the earlier it is performed. On occasion it can even force women to continue pregnancies against their will, seriously jeopardizing their health, as will be discussed below.

Home use of prescribed abortion pills. The framing of the law, duplicated in this Command Paper, has long prevented women in Great Britain being able to use medication for an early abortion at home in their own time, after it has been prescribed by a doctor, as women experiencing miscarriage are currently able to do. The requirement that women take the medication in clinics, surgeries, or hospital not only puts women at risk of miscarrying on their way home, but can also force women to attend multiple appointments – which can in some cases compel women to seek pills online.

Nurse-led care. The framing of the Act (and Command Paper) also prohibits the full development of nurse or midwife-led services, as is already the case in Sweden, Norway, and France, and that are now the model in delivering woman-centred maternity care. There is no reason why suitably qualified nurses and midwives could not perform surgical abortions if they wished to train in this area. Allowing those staff to offer this service would represent an important area of development, could reduce waiting times, and may often be preferred by women.

Chilling effect on doctors. The fact that abortion continues to sit in the criminal law has a chilling effect on medical practice and doctors' willingness to authorise abortions, and the threat of prosecution that is unique to abortion can deter doctors from wanting to enter this fundamental area of women's healthcare. As a result, in Great Britain today as a result of the Act, the lack of clinicians willing or able to authorise and perform abortions means that women with complex medical conditions (who have to be treated in hospital) must continue pregnancies they do not want which can pose a risk to their health.

Conscientious objection. BPAS support the right to conscientious objection as laid out in the current law. It has the benefit of having strong and recent case law behind it (most recently, Greater Glasgow Health Board v Doogan before the Supreme Court in 2014), being well-understood, and enabling those with a moral, ethical, or religious conviction against providing abortion services to opt out of hands-on involvement. The current law effectively balances the rights of the healthcare professional to not provide abortion services with the right of the patient to access medical care. We are greatly opposed to any proposals to extend this right to include peripheral activities such as booking of appointments or management of staff, as this would have a sizeable impact on the ability of the health service to provide care. **We would recommend that if considering altering the conscientious objection provisions as laid out in the Command Paper, that the Government read the Doogan judgment[2] in full.**

[2] https://www.supremecourt.uk/cases/docs/uksc-2013-0124-judgment.pdf

Time Limit

The time limit for abortions in the UK remains at 24 weeks (excluding to save the life of the woman or in the case of severe or fatal foetal anomalies), and BPAS vehemently oppose any attempt to reduce this limit.

To be clear, there are no scientific advances since this time limit was created in 1990 which justify a time limit of 10-14 weeks. Given that pregnancy is measured from last menstrual period rather than the date of conception, a 10-week limit could mean that a woman with a long menstrual cycle may only have missed one period before being legally unable to access abortion services.

The earliest surviving premature baby was born at 21 weeks and 4 days. The Nuffield Council on Bioethics' guidelines on intensive care for extremely premature babies says that any intervention before 22 weeks is experimental and 'attempts to resuscitate should only take place within a clinical research study that has been assessed and approved by a research ethics committee and with informed parental consent'. There is no possible way in which a foetus 'born' at 14 weeks would survive.

Other countries in Europe have a limit comparable to this (10-14 weeks) for decriminalised or 'on request' abortions – that is, where a woman does not have to justify her decision or fit within legislative grounds for an abortion. Beyond this, grounds are largely comparable to those in the existing Command Paper – that continuation of the pregnancy would be harmful to mental or physical health, that there is a foetal abnormality, or that the woman's life is in danger.

Having a 10-14 week gestational limit for women's mental or physical health neglects to take into account the many reasons why women may present beyond this point – including that they were unaware of their pregnancy owing to contraceptive use which can make periods irregular and have side-effects which mimic pregnancy; that they have been misadvised about their fertility particularly with regard to menopause or breastfeeding and thus do not believe they can become pregnant; that they are young, scared, or unaware of what is happening to them; that they are traumatised as a result of sexual crime; or that they are in crisis situations where a previously wanted pregnancy is now not an option, such as having a partner who has died or an existing child with a newly-diagnosed serious illness.[3]

Women do not present late for simple reasons – they are often in vulnerable situations which would be immeasurably worsened by forcing them to continue with a pregnancy. **Abortion must be available beyond the proposed 10-14 week limit for women where continuation of the pregnancy would damage their mental or physical health.** This could reasonably be provided in the same manner as the grounds proposed in 163A(1)(a).

As a point of clarification, p10 of the Command Paper states that under current law there is a 28-week limit on the provision of abortion for the purpose of saving the life of the pregnant woman. This is not the case. S.161(2) makes clear that it is a defence to the crime of child destruction that the abortion was performed in good faith to save the life of the pregnant woman. We want to be clear that in no way should any provision seek to lessen this legislative protection.

[3] https://www.bpas.org/media/2027/late-abortion-report-v02.pdf

Decriminalisation

For the reasons outlined above, BPAS have campaigned extensively in the UK to decriminalise abortion – allowing care to be grounded in medical law and regulations rather than in abortion-specific legislation. Specifically, we believe that women should not face criminal sanction for ending their own pregnancy, and healthcare professionals should not be penalised for providing care in this field.

This belief is shared by the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Faculty of Sexual and Reproductive Health, the British Medical Association, and a large number of women's rights organisations.

The **UN Committee on the Elimination of Discrimination Against Women** told the UK government in February 2018 that abortion law in Northern Ireland breached UK citizens' human rights – saying that the breaches are "grave and systematic". They called on the UK government directly to repeal s.58 of the Offences Against the Person Act 1861 – decriminalising abortion. This call was also raised by the **UN Committee on the Rights of the Child** in 2016. These calls would not be satisfied simply by transcribing the Abortion Act into law as the underlying punishment would remain in place.

Campaigners and legislators in Northern Ireland have been clear that they do not support the extension of the Abortion Act 1967 but instead want to see Westminster repeal and reform the relevant sections of the Offences Against the Person Act 1861[4].

In recent weeks, a bill to decriminalise abortion in England, Wales, and Northern Ireland passed its first legislative hurdle in the UK Parliament with a sizeable majority and cross-party support.

In line with the proposals of the UN CEDAW Committee, BPAS calls for the pregnant woman to be removed from the criminal law entirely.

This legislation has the option to allow women to access abortion care in a modern way which is in line with the vast majority of western countries – rather than simply transcribing a law that was passed primarily to prevent women from being harmed by unscrupulous practitioners when abortion required a 5-day stay in hospital. Medical advancements mean that the same kinds of restriction are simply no longer needed, and indeed prevent the best care being provided.

The architect of the original 1967 Act, Lord Steel of Aikwood, has made clear that even he believes that the 1967 Act is now in need of updating to decriminalise abortion[5].

BPAS therefore recommend that the initial period up to the proposed time limit (10-14 weeks) is available upon request of a pregnant woman.

Other provisions

Foetal anomaly. We would support the retention of the second set of wording – that transcribed from the 1967 Act. The diagnosis of fatal foetal abnormality is complex, and given the potential penalty doctors are often reluctant to firmly declare that a woman meets certain grounds. If this was constrained only to 'fatal foetal abnormality' this could exclude from treatment women with

[4] https://www.bpas.org/about-our-charity/press-office/press-releases/letter-signed-by-170-calls-for-ni-abortion-law-reform/
[5] https://www.independent.co.uk/voices/abortion-act-northern-ireland-law-referendum-a8020826.html

diagnoses of exceptionally severe genetic conditions such as Edwards' or Patau Syndrome. Forcing women to continue their pregnancy to term in these situations is cruel and unnecessary – especially given that these were wanted pregnancies for which the parents will already be grieving.

Istanbul Convention. The United Kingdom government is in the process of passing legislation to allow it to ratify the Istanbul Convention. This Convention is designed to take action against violence against women and domestic violence. Article 39 of the Convention requires signatories to criminalise forced abortion not only in their own country but around the world.

The UK Government's initial proposal on this Article has been to propose extending the equivalent of s.152 of the Crimes Act 2011 to have extra-territorial jurisdiction. The impact of this would be to criminalise every abortion that a British woman has whilst abroad in a country with a restrictive abortion regime, whether it is consensual or not.

Given the Gibraltar Parliament will be debating this bill in the near future, we believe it is an ideal opportunity to extend the application of s.151 and s.152 where it is performed outside Gibraltar without the pregnant woman's consent.

Involvement of doctors. We would like to draw the Government's attention to the ruling in *Royal College of Nursing v Department of Health and Social Security (1981)*[6] which found that nurses are, under the 1967 Act, able to participating in the pregnancy termination as long as the registered medical practitioner remains in charge. In Great Britain that has long been interpreted so as to mean that the medical practitioner does not have to be on the premises, but that they are responsible for approving the abortion and method of treatment. We would want to ensure that if the Command Paper is not amended so as to allow for decriminalisation, that this finding is written into healthcare guidance.

Location of treatment. The Command Paper outlines that 'invasive' treatment (by which we assume is meant a surgical abortion as opposed to a medical abortion) must only be performed in a hospital. Clinically speaking, for early terminations (certainly using Vacuum Aspiration with local anaesthetic up to between 12 and 14 weeks of pregnancy), a hospital is not necessary. Vacuum Aspirations are simple procedures that take about 5-10 minutes and which could be performed in any doctor's surgery or clinic where IUCDs are fitted or cervical smear tests are performed – without the added pressure on gynaecology wards and staff.

Clinical advice. As a point of accuracy, we feel it is also important to note that Emergency Contraception (the morning after pill) is not an abortifacient as per p15 of the Command Paper. The 2002 High Court case *Smeaton v Secretary of State for Health* found that pre-implantation methods of contraception were not covered by abortion law[7]. Information about medical termination should be available in the same places and at the same time as surgical termination in order to allow women to make an informed choice about their options for treatment.

Contact
Rachael Clarke
Public Affairs and Advocacy Manager | British Pregnancy Advisory Service
+44 20 7061 3379 | +44 7985 351751
rachael.clarke@bpas.org

[6] https://www.bailii.org/uk/cases/UKHL/1980/10.html
[7] https://www.bailii.org/ew/cases/EWHC/Admin/2002/610.html