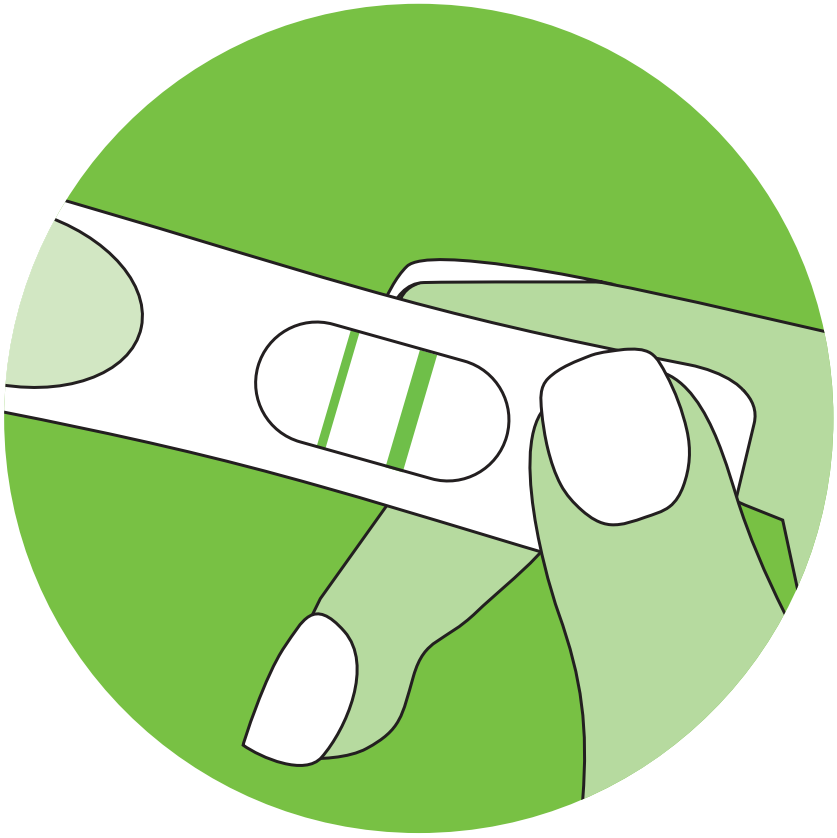
ENGENDER

OUR BODIES, OUR CHOICE:

THE CASE FOR A SCOTTISH APPROACH TO ABORTION



Close the Gap

AMNESTY INTERNATIONAL

RAPE CRISIS SCOTLAND

scottish women's aid

ZERO TOLERANCE

nus scotland national union of students

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Acknowlegements and notes

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1. INTRODUCTION

Women's reproductive rights incorporate the right to bodily autonomy and integrity, to reproductive choice and healthcare, and to legal, safe abortion. Access to safe abortion is fundamental to women's economic and social rights, to women's autonomy, employment, education and access to resources, and therefore to women's equality. Abortion is vital, routine healthcare that around one in three women will experience in her lifetime.[1] It is one of the safest and most frequent medical procedures used by women across the world, but laws and policies do not yet reflect this reality.[2]

In Scotland, we have a publicly funded and delivered abortion care service. Nonetheless, women's reproductive rights are currently undermined as a result of legal restrictions and service delivery issues that impede access to abortion. Women's right to choose is still predicated on the legal authorisation of two doctors, without which both women and health practitioners are subject to prosecution under the 1967 Abortion Act. Our organisations support women's bodily autonomy and the decriminalisation of abortion. We believe that abortion law in Scotland should be removed from the criminal justice system and provision should be regulated in line with all other healthcare. Women should have the legal right to choose with adequate information and support and without intimidation, coercion, harassment or stigmatisation.

The devolution of abortion law as part of the Scotland Act 2016 also provides Scotland with the opportunity to develop a Scottish approach to women's reproductive rights, incorporating improved, modernised and standardised service provision underpinned by a progressive devolved legal framework. Such a change to the legal framing of abortion should reflect international best practice and be developed following engagement with women, practitioners, and human rights and gender advocates in Scotland.

In the immediate term, the Scottish Government could address a number of issues that would improve Scotland's abortion care services. These relate to provision of late-term abortion, modernising approaches in line with technological advancement, and ensuring equality of access. As some of the barriers to accessing abortion in Scotland relate to geography and financial status,[3] as well as other protected equality characteristics, the need for such action is a matter of equality, as well as of women's rights.

[1] Purcell (2015) *The sociology of women's abortion experiences: recent research and future directions*
[2] World Health Organisation (2003) *Safe abortion: technical and policy guidance for health systems*
[3] There is geographical variation in service provision across health boards in Scotland.

This joint report from Engender, Amnesty Scotland, NUS Scotland, Close the Gap, Scottish Women's Aid, Rape Crisis Scotland and Zero Tolerance sets out women's international and domestic reproductive rights, including the case for decriminalisation, the implications of restricted access to abortion for women's equality and for diverse groups of women, current gaps in service provision in Scotland, and the political and social context in Scotland.

We make the case for action on some service delivery issues, but we also have a broader aim. We want to bring women's equality and rights into the heart of the public conversation about abortion in Scotland. Although the new powers over abortion that have transferred to Scotland do not require us to act in haste, they do open up an opportunity for us to think creatively about how we might better regulate women's reproductive healthcare.

2. WOMEN'S RIGHT TO ABORTION

Abortion rights are fundamental to women's rights to health, bodily integrity and safety and a range of social and economic rights that relate to equality between women and men. This section of the paper provides some context on these rights and considers these against the current legal framework in the UK.

2.1 Women's reproductive rights

Women's reproductive rights include basic rights around fertility and reproductive decision-making, and access to the information and healthcare services which enable this. This means the freedom and ability to decide if and when to have children and the right to high standards of sexual and reproductive health. At odds with this right to autonomous decision-making, however, is that women in Scotland currently have no legal right to end a pregnancy. That decision ultimately still sits with doctors, two of whom must authorise a woman's request for an abortion. Without the permission of two doctors, abortion is illegal everywhere in the UK[4] and both women and medical practitioners are subject to prosecution under the Abortion Act 1967.

This is despite the fact that jurisprudence from international human rights cases have consistently affirmed that abortion is a human right if continuing the pregnancy would endanger the life or health of the pregnant woman, if there is a severe fetal abnormality, or if the pregnancy is the result of rape or incest. The UN Human Rights Committee (HRC) established that laws restricting abortions for medical reasons ('therapeutic abortion') constitute a violation of the right to be free from torture or cruel, inhuman or degrading treatment (Article 7 of the ICCPR).[5]

While the HRC's rulings on therapeutic abortions can be seen as a baseline, there is a trend towards increasingly progressive global abortion laws. The UN Department of Economic and Social Affairs reports that, between 1996 and 2013, 56 countries amended laws to extend the grounds under which abortions can legally be provided.

This progression of abortion policies is supported and recommended by international human rights bodies. The Committee on the Elimination of Discrimination Against Women (CEDAW) has identified "laws that criminalise medical procedures only needed by women" as discriminatory and a failure of states' obligation to respect rights. According to the UN Office of High Commissioner for Human Rights (OHCHR), "states should remove legal provisions which penalise

[4] In Northern Ireland abortion is only legal when there is serious risk to the woman's life or health
[5] The UN International Covenant on Civil and Political Rights

women who have undergone abortion or medical practitioners who offer these services."[6] To remedy the discriminatory laws that restrict abortion and threaten women's right to health, the OHCHR recommends the decriminalisation of abortion. The UN Human Rights Committee strongly criticised the UK Government and Northern Ireland Executive on the failure to reform Northern Ireland's abortion law and on the criminal sanctions that apply.

2.2 Legal status quo in the UK

In contrast with almost all other European countries, abortion remains illegal in Scotland and the rest of the UK; there is no right to abortion recognised in UK law.[7] Contrary to popular belief, the 1967 Abortion Act, which only extends to England, Wales and Scotland, and excludes Northern Ireland,[8] did not legalise abortion, it simply provided a strict set of criteria under which the procedure would be permissible. All of the following conditions must be met:

- Approval must be obtained from two doctors that continuing the pregnancy would cause damage to the woman's physical or mental health
- The abortion must be carried out in a hospital or approved health facility
- Pregnancy gestation must not exceed 24 weeks (except in circumstances where continuing the pregnancy would endanger the life or health of the pregnant woman or in cases where there is a diagnosis of a serious foetal abnormality)

These criteria were established in the context of the 1960s, when women were dying from unsafe backstreet abortions and decades before modern abortifacient medication[9] was on the market. The 1967 Act is underpinned by the belief that sexual and reproductive health is an area of medical and state control. Women's rights to bodily autonomy and integrity, equality before the law, and reproductive health were not taken into consideration when the law was framed.

Although there has been significant social and medical progress since 1967, including the introduction of anti-discrimination law in the Sex Discrimination Act 1975, abortion policy remains outdated. The law no longer dictates that access to birth control pills be restricted to married women as it once did, yet to terminate a pregnancy the law still requires the legal permission of two doctors. Women's reproductive health and their right to terminate a pregnancy is legislated, restricted, second-guessed, and potentially criminalised, in a way that is entirely unique among medical procedures.

[6] OHCHR: http://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf
[7] Abortion is available on request throughout at least the first trimester in almost all European countries. https://www.womenonweb.org/en/media/inline/2012/9/13/abortionmap_2011-3.pdf
[8] In Northern Ireland abortion is legal if a woman's life is at risk or there is a permanent or serious risk to her health, but not in the cases of fatal fetal abnormalities, rape and incest.
[9] Abortifacient medication is classified as a substance that induces abortion

Within the current parameters, women and healthcare providers in Scotland can still be prosecuted if any of the conditions in the 1967 Abortion Act have not been met. Women must take abortifacient medication in a health facility rather than in their own home, in their own time. Women must attend multiple appointments so that individual doses of abortifacients can be administered, with the result that they can end up aborting the fetus during their journey home. This is particularly likely if they live in remote and rural areas, far from designated healthcare settings. This contrasts with other countries, including France and the USA, that allow the abortifacients Mifepristone and Misoprostol to be taken at home. The UK does allow this medication to be taken in the home but only following miscarriages, which demonstrates that it is perfectly safe but that there is an unwarranted distinction between the treatment of women with pregnancies that have ended through miscarriage or abortion.

Prosecution is not a hypothetical but remote threat. We have recently seen several women in England and Northern Ireland prosecuted and sentenced after purchasing medication to procure their own abortion, or to assist someone else terminate their pregnancy. Abortifacient medication is now widely available online and women throughout the UK choose this option for a variety of reasons. While US president-elect Donald Trump's suggestion that women in the USA should be punished for having an abortion was widely condemned, here in Scotland under the 1967 Abortion Act women can indeed be prosecuted for terminating their own pregnancy.

3. ABORTION AND WOMEN'S INEQUALITY

Women's access to safe, legal abortion is a fundamental gender equality issue. In terms of health and safety, globally, an estimated 21.6 million unsafe abortions are performed each year, 47,000 women die attempting to access abortion and many thousands more suffer ill health as a result.[10] In terms of women's control over their fertility and reproductive choice, the social and economic implications of access to safe and legal abortion for women's equality are enormous. Women who experience multiple forms of discrimination face increased and particular barriers in realising their reproductive rights and accessing services.

3.1 Women's economic inequality

Access to birth control and abortion has enabled women's higher levels of educational attainment, increased the female employment rate, improved women's earnings potential, and reduced the gender pay gap. Abortion must therefore be understood as an economic issue. Without the ability to limit and time their pregnancies, women will always be disadvantaged in taking part in the formal labour market, which will necessarily increase their economic dependence on men.[11] Women's economic autonomy is critical to achieving gender equality, as it reduces their likelihood of living in poverty, reduces child poverty, and enables access to a more equal share in resources.

The economic costs of unwanted pregnancies and children are considerable both in terms of the financial cost of raising a child, and the economic and social opportunity costs for women. Research from the USA suggests that unplanned pregnancies and births can be detrimental to a woman's economic status and income, and can reduce the likelihood of labour market participation by 25%.[12]

Women's experiences of the labour market

The gender pay gap for women aged 40-49 is more than double that for women aged 30-39 (21.7% compared with 9.6%).[13] The main reason for this significant increase is women's greater propensity to have caring roles. Women still do the majority of unpaid childcare, and this is reflected in their experiences of entering and progressing in the labour market. After having children, a lack of flexible and quality part-time working means that many women find it difficult to balance work with family life. Many women have to opt for part-time work which is overwhelmingly concentrated in undervalued, low-paid jobs such as administration, retail and care. As a result, many women are working below their skill level in jobs

[10] World Health Organisation (2011) *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*
[11] Pollitt, K. (2014) *Pro: Reclaiming abortion rights*
[12] Chiquero, A. N. (2010) *The Labour Force Effects of Unplanned Childbearing*
[13] Close the Gap (2016) *Gender Pay Gap Statistics*

for which they are over-qualified. Reducing their hours in this way has an impact not just on women's pay but also their progression opportunities, and therefore their future earnings potential, and ultimately their pension.

Scotland's childcare costs are among the highest in the UK, which are among the highest in the world. Less than one-fifth (15%) of Scottish local authorities have sufficient childcare for parents who work full-time, and less than one in ten (9%) have enough childcare for parents who work outside of normal hours.[14] This lack of access is worsened for disabled children, older children and for children in rural areas,[15] and increases the risk of benefits sanctions for the increasing numbers of women who are required to undertake mandatory work activity under the UK Government's programme of 'welfare reform'.[16]

Specific groups of women such as lone parents and part-time working women in mixed-sex households are often forced out of the labour market by the prohibitively high cost of childcare. Spending time out of the labour market has a significantly negative impact on women's ability to re-enter at the same level. For every two years a woman is out of the labour market, her earnings fall by 10%.[17] While women's labour market inequality persists, and has such a stark impact on women's lives, careers, and the lives of their families, it's crucial that women have access to abortion and reproductive health services to ensure that they are able to make informed decisions about whether and when to have children.

Abortion and deprivation

There is a clear link between unplanned pregnancies, abortion rates, and areas of deprivation. Research shows abortion rates in Britain varying vastly between 18% and 76% depending on local authority area.[18] Deprived areas have both higher rates of pregnancy under aged 18 and lower rates of abortion. An audit of women presenting for abortions from 16 weeks onwards in Scotland in 2013-14, showed that 87% of women were from deprived areas.[19] There is a need to ensure that women in all areas of Scotland are under no expectation either to have an abortion or continue with a pregnancy, and that everyone is equally enabled to make timely and informed choices.

These statistics are driven by the fact that women in lower income groups typically take longer to confirm a suspected pregnancy and to decide whether to have an

[14] Family and Childcare Trust (2015) *Childcare Costs Survey 2015*
[15] The Daycare Trust and Children in Scotland (2011) *The Scottish Childcare Lottery*
[16] Engender (2016) *Securing Women's Future's: Using Scotland's new social security powers to close the gender equality gap*
[17] "Recession drives women back to the workforce", see:
http://www.nytimes.com/2009/09/19/business/19women.html?_r=0
[18] Joseph Rowntree Foundation (2004) A Matter of Choice? Explaining national variation in teenage abortion and motherhood
[19] Cameron et al. (2015) *Characteristics of women who present for abortion towards the end of the mid-trimester in Scotland: national audit 2013-14*

abortion than women in less deprived areas. It may be that this is shaped by knowledge of options and entitlements, and stigma or confidence around requesting them. Critically, women who are disadvantaged by income inequality will face additional barriers to access and are 'more vulnerable to the barrier of inadequate social support'.[20]

Research by Joseph Rowntree Foundation found that young women's decisions on whether or not to have an abortion are dependent on the economic and social context of their lives.[21] The perception of the opportunities available to women shapes their views about when is the best time to have children. Those women whose background and life experiences had given them a strong belief that they would go to university and have a career were those that chose to have an abortion rather than continue the pregnancy. Women who had been unemployed, experienced irregular employment, or whose lives were marked by other kinds of insecurity or instability were more likely to choose motherhood as a positive alternative. It concludes that policymakers should take account of the fact that young women's expectations regarding education and employment affect their decision-making around abortion.

Supply-side solutions which target individual women can only ever be part of the answer as they do not address the structural barriers to women's economic and labour market equality. However, there is clearly an argument to build women's aspirations around education and employment, particularly for those from deprived areas. The economic and social contexts of women's lives should not be the primary motivating factor in women's decision-making around abortion. The social security system, and state provision of services such as childcare and employability programmes should provide women with adequate economic and financial security so that they are able to make decisions on abortion, free from the constraints of poverty and inequality of opportunity.

3.2 Violence against women

Scotland's violence against women strategy, *Equally Safe*, recognises that women's inequality is both the cause and consequence of men's violence. It acknowledges that violence against women can only be prevented by advancing women's equality, and includes a substantive set of actions to reduce gendered inequalities in its primary prevention workstream.

As we have set out, access to abortion healthcare is linked to a number of domains of women's inequality, and thus is connected to women's experience of violence. There are also more specific connections between abortion and violence against women.

[20] Ostrach and Cheney (2014) *Navigating social and institutional obstacles: low-income women seeking abortion*
[21] Joseph Rowntree Foundation (2004) *A Matter of Choice? Explaining national variation in teenage abortion and motherhood*

Domestic abuse

Choosing to have or not have children is one of women's most basic—and contested—human rights, and like the other gendered roles women assume, that choice is commonly targeted by perpetrators of domestic abuse.

'Reproductive coercion' refers to the set of behaviours that extend coercive control into the reproductive domain. These include male partners' verbal threats and pressure to become pregnant (pregnancy coercion), direct interference with contraception (birth-control sabotage), inconsistent condom use, and threats and coercion related to pregnancy continuation or termination (control of pregnancy outcomes).[22]

Within the context of reproductive coercion, a positive pregnancy test could lead to an escalation of violence or threats (including death threats) in order to force a woman to terminate or continue with the pregnancy. The dynamics of reproductive coercion, or of coercive control more broadly, may mean that women struggle to attend medical appointments, make phone calls, or otherwise engage with healthcare providers. Women may also make decisions about termination later on in pregnancy. Given that termination of pregnancy must occur within specific time boundaries, this has the potential to severely impact women's ability to access appropriate abortion healthcare. It is clearly vital that practitioners providing abortion healthcare are sensitive to the implications of domestic abuse for women who are considering terminating a pregnancy, that they prioritise women's safety, and are able to link women with support and advocacy services.

In Scotland, health practitioners routinely ask women and men accessing certain types of healthcare if they have experienced child sexual abuse, and women are asked if they are experiencing domestic abuse. The settings in which routine enquiry operates include maternity, mental health, substance misuse, A&E, community nursing, and sexual health services.[23] In Wales, routine enquiry operates in all women's healthcare settings, including abortion healthcare.[24] It is not clear that all women accessing abortion healthcare in Scotland are asked about their experience of domestic abuse or sexual violence.

A recent study within one UK abortion clinic identified that 11% of women accessing the clinic had experienced physical abuse during the last year, and 4% had experienced sexual abuse during the last year. 4% of women seeking terminations had experienced physical abuse during their current pregnancy.[25] It is vital that routine enquiry forms part of the provision of abortion healthcare.

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[22] Miller, E. and J. Silverman (2010) *Reproductive coercion and partner violence: implications for clinical assessment of unintended pregnancy*

[23] http://www.gbv.scot.nhs.uk/national-gender-based-violence-and-health-programme/routine-enquiry

[24] Royal College of Nursing (2013) *Termination of pregnancy: An RCN nursing framework*

[25] Motta, S., Penn-Kekana, L., and S Bewley (2014) *Domestic violence in a UK abortion clinic: anonymous cross-sectional prevalence survey*

Rape

Women who become pregnant as a result of rape are more likely to terminate the pregnancy, sometimes as part of an ongoing pattern of abuse within a coercive relationship.[26] Limited access to late term abortions in Scotland is a particular issue for women who are pregnant as a result of rape (see details on late term abortions in section 4.1 below). Rape Crisis Scotland finds that it is not uncommon for women in these circumstances to delay confirming a pregnancy and to seek medical advice. Common psychological effects of rape include post-traumatic stress disorder, depression, and sleep disorders and eating disorders, all of which can make it more difficult for women to realise that they are pregnant and to seek medical advice.[27] This can mean that women in the most difficult of circumstances face having to travel to England to obtain a termination, as their pregnancy is too advanced to do so in Scotland. Developing access to late terminations in Scotland would reduce the additional stress and distress caused to women who are likely to already be experiencing mental health issues.

3.3 Multiple inequalities

Women, and men, who experience multiple forms of discrimination are likely to face increased and particular barriers in realising their reproductive rights and accessing services. These marginalised groups include young women, disabled women, minority ethnic women, refugee and asylum seeking women and transgender people. Issues related to reproductive health inequalities for these respective groups are set out below.

One overarching and highly topical issue faced by women who struggle to access safe abortion is the relative accessibility of illegal abortifacient medication online. Women resort to this course of action for a wide range of reasons, many of which relate to multiple inequalities. For instance, young women may be unable to confide in parents, women experiencing domestic abuse may need to hide their actions from an abusive partner, refugee and asylum seeking women may be unable or unaware of how to access NHS services, women from certain backgrounds may be pressured by the imperatives of faith or by stigma, and women in rural areas may be unable to take the needed time off from paid work or caring responsibilities to travel the required distances to access sanctioned methods of abortion. Given that abortifacient medication is now readily available online, those most in need of support are being pushed into a position where they risk prosecution by a needlessly onerous system. This reality adds weight to the arguments for decriminalisation and reform which are set out throughout this paper.

[26] McFarlane, J. (2007) *Pregnancy following partner rape: what we know and what we need to know*
[27] National Resource Centre on Violence Against Women (2011) T*he psychological consequences of sexual trauma*

Young women

Young women are the majority of those who present for abortion in Scotland. The abortion rate is highest amongst those between 20 and 24 years old, and the average age of women presenting for abortion at 16 weeks or more is 22 years old.[28] There is also a stark relationship between teenage abortion rates and levels of deprivation across Scotland. In 2012 around 30% of young women living in the most deprived areas of Scotland terminated a pregnancy, compared with 70% of young women from the most affluent parts of the country.[29] Research with pregnant young women indicates that economic circumstances, as well as views within the family and community, and perceived availability of services are key factors in shaping these decisions.[30]

This research, from the Centre for Research on Families and Relationships at Edinburgh University, showed that there are significant gaps in young people's knowledge about abortion, including basic information relating to women's rights, and when and how abortion is performed. It showed that young people's knowledge was not only limited, but often factually inaccurate. Many of the participants also identified stigma and taboo around abortion as a prevalent issue, and reported that discussion of abortion in schools was framed as a moral and abstract debate, as opposed to a healthcare issue related to sexual health and relationships. This was reflected in their discussion of abortion in terms of gender norms, ideals and stereotypes in relation to sexual behaviour. They expressed a desire for access to 'unbiased' information and viewed the lack of factual information provided by schools as problematic.[31]

Comprehensive sex and relationship education (SRE) is hugely important for young people and their ability to make informed decisions concerning their relationships and bodies. Evidence shows that quality SRE improves young people's knowledge around their rights and responsibilities, and their ability to make informed decisions about sex and relationships.[32] It is also vital in terms of addressing harmful gender stereotypes, and increased understanding of consent and violence, without which healthy relationships and equality for young women will be fundamentally undermined.

In 2013, the Scottish Parliament's Health and Sport Committee undertook an inquiry into teenage pregnancy. Evidence from respected organisations in the field of sexual health, including Brook, BMA Scotland, and Caledonia Youth, made strong

[28] NHS Information Services Division (2016) *Termination of pregnancy statistics: Year ending December 2015*
[29] Scottish Index of Multiple Deprivation (SIMD) 1 and SIMD5 respectively; cited in Scottish Parliament Information Centre (2013) *SPICe briefing: teenage pregnancy*
[30] Centre for Research on Families and Relationships (2015) *Young people's knowledge, beliefs and attitudes to abortion: an exploratory focus group study*
[31] Centre for Research on Families and Relationships (2015) *Young people's knowledge, beliefs and attitudes to abortion: an exploratory focus group study*
[32] UNFPA (2015) *Emerging evidence, lessons and practice in comprehensive sexuality education, a global review*

representations to the committee that SRE teaching across Scotland is patchy, inconsistent, and does not deliver the information young people need to effectively understand and manage personal and sexual relationships, including education that focuses exclusively on the 'biological'. NHS Health Scotland, Scotland's health improvement agency, was particularly critical, noting that: "although evidence clearly advocated the use of comprehensive sex and relationship education in educational settings, there was no obligation to 'do more than the bare minimum, mostly work around friendships and relationships, as demonstrated in the curriculum for excellence". Brook has previously recommended that abortion education "should include exploration of pregnancy prevention, pregnancy options and decision-making, and abortion."[33]

It is clear that lack of knowledge surrounding abortion provision in Scotland acts as a barrier to young people's ability to access their full range of legal options during pregnancy.[34] With anti-choice organisations, like Society for the Protection of Unborn Children (SPUC), offering misleading and medically inaccurate schools talks on pregnancy, including partial and harmful advice on abstinence, there is clearly a need to ensure that young people have access to adequate and balanced information, which reflects the realities of their lives. Young people need education and understanding not just of the ways their bodies change, but how to develop respect and confidence with regards to their decisions and autonomy. By continuing with non-statutory guidance, open to both interpretation and delivery, we are continuing to deny young people opportunities to have healthy relationships, and healthy attitudes towards sexual health, relationships, and others.

Despite the success of the Scottish Government's previous Teenage Pregnancy and Young Parent Strategy in helping to reduce the teenage pregnancy rate, there is clearly more to be done to improve young women's access to abortion and to young people's understanding of their reproductive rights. In line with the Scottish Government's Pregnancy and Parenthood in Young People Strategy 2016-2026, relationships, sexual health and parenthood education needs to be impartial and provided in a space without stigma. Improved SRE regarding pregnancy and abortion is also linked to reduced demand for later abortions.[35] We recommend that abortion education is carried out in line with strand two of the strategy: 'Giving young people more control around pregnancy.' Our organisations believe that factual abortion education, that informs students of their legal rights, should be a mandatory component of statutory sex and relationships education in Scottish schools.

[33] Brook (2013) *Abortion Education in the UK: Failing our young people?*
[34] ibid
[35] Purcell et al. (2014) *Access to and experience of later abortion: accounts from women in Scotland.* Many women presenting for abortion after 18 weeks did not recognise signs earlier, or were in denial about their pregnancy.

Disabled women

Access to abortion for disabled women in Scotland is shaped and potentially undermined by a range of particular issues. During a series of consultation events with disabled women with a wide range of impairments and conditions,[36] reproductive and maternity rights were strong themes to emerge. Women described infantalising treatment based on their gender within the healthcare system and experiences where doctors and other practitioners had made assumptions about their fertility, capacity and desire to parent. Many women related instances of negative comments from health professionals with regards to pregnancy and maternity, including assumptions that their pregnancies were unplanned or a bad idea. Women reported feeling pressured to terminate pregnancies (and to avoid becoming pregnant) and subsequent undue scrutiny from social work departments which led to fears that their children would be taken into care. Clearly, such experiences undermine disabled women's sexual and reproductive rights.

Disabled women's broader realities are also relevant. Many disabled women experience discrimination and stereotyping in the labour market on account of their gender,[37] and around half of disabled women experience domestic abuse in their lifetime, compared with one in four non-disabled women.[38] These issues are reflected in an average pay gap of 22% compared with non-disabled men, which is double that of the pay gap experienced by disabled men.[39] Many disabled women also report that partners control their access to social security benefits and that this increases the isolation that they experience due to lack of opportunities and barriers to full participation in society.[40]

All of these issues may be factors that undermine disabled women's reproductive rights. Unfortunately, however, our understanding of their experiences is extremely limited. The notification of abortion is mandated under the 1967 Abortion Act, but disability is not included amongst statutory data collection requirements. Research into disabled women's experiences of accessing abortion, as well as data collection on the incidence of abortion amongst disabled women is needed.

Abortion and disability also intersect with regards to the grounds under which termination of pregnancy is legal in the UK. In addition to lowering the time limit for most abortion to 24 weeks, the 1990 Human Fertilisation and Embryology Act also abolished an upper time limit in cases where 'there is substantial risk that of the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped'. This has caused controversy over recent years, with

[36] Engender, Inclusion Scotland and SDEF disabled women's discussion forums, 2013 - 2015
[37] ibid
[38] Women's Aid (2007) *Disabled women and domestic violence: Making the links*
[39] Equality and Human Rights Commission (2010) *How fair is Britain? The first triennial review*
[40] TUC and Women's Aid (2015) *Unequal, Trapped and Controlled: Women's experiences of financial abuse and potential implications for Universal Credit*

disability rights activists arguing that this provision devalues disabled people. Too often discussions around disability stem from the 'tragedy model of disability', which depicts disabled people primarily as victims of circumstance, who deserve to be pitied.[41] For instance, as above, such perceptions of disability feed into disabled women's experiences of accessing reproductive healthcare. It is essential that all women who must decide whether to terminate or continue with a pregnancy after a fetal anomaly has been identified are enabled to make informed decisions. Accurate information and support about different impairments, and appropriate input from healthcare professionals must be equally available to all. Underpinning this, protection for women who decide to terminate a pregnancy where there is fetal impairment must be maintained in Scotland.

Minority ethnic women

In Scotland and the UK we know very little about minority ethnic (ME) women's experiences of accessing abortion and the barriers that women from different communities may face. There is research on teenage pregnancy and abortion among young ME women in England, which shows that young women of Bangladeshi, Pakistani and Black Caribbean ethnicity are less likely to terminate a pregnancy than teenagers from other ethnic groups.[42] However, this is based on survey rather than routine data and does not tell us anything about the situation in Scotland.

Research on late abortion commissioned by the Scottish Government shows a slight statistical difference by ethnicity in the decisions of women presenting for abortion after 16 weeks. ME women accounted for 2.3% of participants who proceeded to have an abortion compared with 6.5% of those who chose to continue with their pregnancy.[43] However, mandatory characteristics that are collected and reported to the Chief Medical Officer in Scotland do not include ethnicity and the annual report on termination of pregnancy statistics does therefore not include analysis on the grounds of race or ethnicity. Nor do we have a clear picture of ME women's access to wider maternity care services.

There are a number of factors that point to the need for this data collection. Minority ethnic women are overrepresented across poverty indicators and in terms of unemployment and underemployment.[44] Although there are large variations across communities, as a whole people from minority ethnic groups have lower household incomes and higher numbers of dependent children than white ethnic groups. Research to determine whether the termination rate for ME women corresponds with that of white ethnic populations in living in areas of deprivation would be a useful starting point in understanding potential barriers to access.

[41] The tragedy or charity model of disability stands in contrast with the social model of disability, which sees "disability" as a socially-created problem not attributed to individuals.
[42] NICE (2006); 25-30% of teenage pregnancies in these communities result in termination, as opposed to a rate of 35% for the teenage population as a whole.
[43] Purcell et al. (2014) Access to and experience of later abortion: accounts from women in Scotland
[44] Compared with both white women and ME men

It is also possible that community stigma in seeking out healthcare in some communities[45] may also apply to abortion. Young ME women report fear of bringing shame on their families, both for accessing sexual health services, including contraception and information, and as a reason for choosing abortion.[46] As a result they often wish to travel outside of their area to have an abortion and young women from certain communities prefer to consult GPs from a different ethnic community. Service providers report that young women from Muslim backgrounds tend to be under-represented in accessing advice and support services, and suggest that high rates of Pakistani and Bangladeshi young women presenting for abortion without the knowledge of family are linked to issues around contraception.[47] It is also worth noting that patterns of teenage fertility vary across Britain's ethnic communities. Among women of Pakistani, Caribbean and Bangladeshi origin the teenage fertility rate is higher than that of the white population, while among young women of Indian origin, the rate is lower than in the white population.[48] All of this shows that ME women from different communities will have particular concerns and needs, and points to the need for disaggregated data and research at the Scottish level.

Finally, at the UK level, women from minority ethnic backgrounds have often been the targets of efforts to restrict abortion through bans on sex-selection abortions. In February 2015, pro-life MPs in Westminster attempted to bring in a specific ban on sex-selective abortion, on the basis of attitudes within specific ME communities which favour male babies over female. However, legislation specifically banning sex-selective abortions is ineffective[49] and unnecessary and this attempt was defeated by campaigning, particularly from ME women's organisations. Research has shown that sex-selective abortions are not a widespread practice in Britain.[50] There would however, be a disproportionate impact on ME women if such legislation were to be introduced as stereotypical assumptions about women's motivations for termination may increase barriers to accessing abortion for ME women.

Refugee, migrant and asylum seeking women

In light of the above, it is unsurprising that there is also a complete lack of data relating to abortion and refugee and asylum seeking women in Scotland. It is likely, however, that the barriers that many of these women face in accessing healthcare will apply to reproductive health services. In broad terms, these include lack of

[45] NHS (2009) *Black and minority ethnic (BME): Positive practice guide*
[46] Government Office for London (2010) *Young people in London: Abortion and repeat abortion*
[47] University of Sheffield (2005) *An exploration of the teenage parenting experiences of black and minority ethnic young people in England*
[48] Office of National Statistics (2001) *Teenage births to ethnic minority women*
[49] In 2011 the UN Interagency Statement on Sex Selection concluded that laws banning sex-selective abortion are ineffective as they do not address underlying social and gender inequalities that result in son-preference.
[50] The Department of Health investigated the subject in 2015 and found "no substantiated concerns of gender abortions occurring in England, Wales and Scotland."

understanding of the healthcare system, including in terms of expectations and entitlements, linguistic barriers, and cultural stigma attached to seeking support. These issues often result in late treatment which endangers the health of migrants and asylum seekers, as well as that of the wider population. In Scotland, anecdotal evidence suggests that there is a lack of awareness amongst services, practitioners and refugee communities of asylum seekers' statutory rights to healthcare in Scotland.[51]

In terms of pregnancy and maternity care, research confirms that asylum seeking women experience worse outcomes in pregnancy and childbirth.[52] Research by Doctors of the World found that pregnant women and children are identified as being more susceptible to ill health and mortality than other vulnerable migrant groups and that 79% of pregnant migrant women were not accessing antenatal care.[53] Delays in accessing maternity care increases the likelihood of complications in childbirth and the Royal College of Obstetricians and Gynaecologists report that pregnant asylum seeking women are seven times more likely to develop complications and three times more likely to die during childbirth than the general population.[54]

There is also a high rate of post-natal depression among migrant women, which may be up to three times greater than native-born women, due to experiences prior or during pregnancy and less access to support networks.[55] In Glasgow, research conducted on access to maternity care for refused asylum seekers found that outcomes for women were constrained by interpreting standards, poor access to antenatal classes and English classes, and information provision, as well as the asylum process itself.[56]

Against this backdrop, access to abortion is therefore likely to be fraught with additional difficulties for refugee, migrant and asylum seeking women. Sexual violence, torture, trauma, human trafficking, homelessness and abuse have been part of many asylum seeking women's experiences of seeking sanctuary from persecution. Access to comprehensive reproductive healthcare at the earliest possible stage is clearly essential for these women, including for those carrying unwanted pregnancies as a result of rape. However, once in the UK, asylum seeking women's limited access to reproductive healthcare is compounded by dispersal policies that often see them placed far from existing support and advice networks and delay access and referral to much-needed services.[57]

[51] Scottish Refugee Council (2014) *Women and children first? Refused asylum seekers' access to and experiences of maternity care in Glasgow*
[52] Refugee Council and Maternity Action (2013) *When maternity doesn't matter: dispersing pregnant asylum seeking women*
[53] Doctors of the world (2015) *Experiences of pregnant migrant women receiving ante/peri and postnatal care in the UK*
[54] Still human still here (2013) *Response to the UK government consultation on migrant access to the NHS*
[55] ibid
[56] Scottish Refugee Council (2014) *Women and children first? Refused asylum seekers' access to and experiences of maternity care in Glasgow*
[57] Refugee Council and Maternity Action (2013) *When maternity doesn't matter: dispersing pregnant asylum seeking women*

Lesbian, bisexual, transgender and intersex people (LBTI people)

LBTI people are profoundly affected by issues referenced throughout this report, including appropriate reproductive healthcare, restrictions around abortion, the lack of comprehensive sex and relationships education (SRE), and access to contraception. Access to health services are fundamentally shaped by sexual orientation and gender identity, and by heteronormative assumptions and a lack of knowledge that pervade mainstream services.[58] All LBTI people that could become pregnant are at risk of unplanned pregnancy, or changed circumstances with regard to a planned pregnancy. Young lesbian and bisexual women are at least twice as likely to become pregnant as heterosexual peers, suggesting both discrimination and harassment on account of their sexual orientation, and marginalisation within SRE and reproductive care services.[59] Studies from the US show that bisexual women are significantly more likely to report rape, sexual assault and intimate partner violence than heterosexual women, with clear links to the need for access to safe abortion.[60]

Throughout this report we refer to women's reproductive rights, however people other than cisgender women also need access to safe abortion and related services. Restrictions to reproductive rights affect all gender identities, and access to abortion is an issue for trans men and non-binary people who can face severe barriers to realising their reproductive rights and to accessing appropriate health services. Health inequalities for trans people are relatively well-documented in Scotland, and trans-inclusive reproductive and sexual health services are sorely needed.[61] The 2012 Scottish Trans Health Conference found that lack of knowledge and understanding amongst healthcare professionals, stereotyping and lack of reliable information are amongst barriers to trans people's sexual and reproductive health. As with other marginalised groups, wider barriers to economic and social equality also have an impact on trans health inequalities, including widespread transphobia and discrimination,[62] high rates of unemployment and self-employment,[63] and non LGBTI-inclusive education.[64]

There is no specific data or research on the experiences of transgender people and gender minorities in need of abortion care in Scotland. However, as broader experiences of accessing healthcare and international examples demonstrate, challenges in accessing services and information will exist, and such research is

[58] Equality Network (2015) *The Scottish LGBT equality report.* 21% of LGBT survey respondents said they had personally experienced discrimination or less good treatment in Scotland's healthcare services
[59] IMPACT (2012) *Higher pregnancy rate for LGBT Youth,* drawing on "Not yet equal: the health of lesbian, gay, & bisexual youth in BC"
[60] National Centre for injury prevention and control (2010) *The National Intimate Partner and Sexual Violence Survey*
[61] Scottish Transgender Alliance (2012) *Scottish trans health conference report,* for further resources related to trans health see: http://www.scottishtrans.org/resources/
[62] Equality and Human Rights Commission (2016) *Trans research review*
[63] Scottish Transgender Alliance (2008) *Transgender experiences in Scotland*
[64] Time for Inclusive Education campaign, see: http://www.tiecampaign.co.uk/

needed. LGBTI rights movements have a long history of coalition-building and solidarity with the wider feminist movement and campaigns for sexual and reproductive rights. Movements for reproductive rights and LGBTI equality share goals around bodily autonomy, challenging gender norms and "the freedom of individuals to form families on their own terms".[65] Although we refer to women's reproductive rights throughout this report, we are also campaigning for a trans-inclusive model of abortion care in Scotland.

We are calling on Scottish Government to:

- Encourage schools to strengthen education on reproductive rights and healthy relationships within SRE as part of a wider commitment to tackling abortion stigma in Scotland
- Mandate intersectional data collection on women presenting for and proceeding to abortion, whilst protecting anonymity with regards to public release
- Ensure that abortion care meets the needs of disabled women, ME women, refugee women and LBTI people, and explore the introduction of specialist services

[65] "Abortion clinics don't just serve straight women", see: http://www.advocate.com/commentary/2016/6/29/abortion-clinics-dont-just-serve-straight-women

4. SERVICES AND PRACTICE

The devolution of abortion law to the Scottish Parliament provides opportunities to review existing abortion care in Scotland. Health has been devolved to Scotland since 1999 and the Scottish Government is responsible for providing abortion services and support to women who access them. This is underpinned by Health Improvement Scotland's sexual health service standards on the termination of pregnancy. Under the service statement target that "women receive safe termination of pregnancy with minimal delay, followed by contraceptive advice and psychosocial support", a set of five criteria drive delivery of abortion care services in Scotland.[66] These include the target that "70% of women seeking the termination of pregnancy will undergo the procedure at 9 weeks gestation or earlier", which has contributed to the significant increase in women accessing earlier abortion in Scotland over recent years. However, certain notable gaps in the provision of services persist and opportunities related to technological advances are not reflected in Scotland's current approach.

4.1 Late term abortion

Critically, Scotland lags behind England in its provision of later-term abortions. Although the legal gestational limit for most abortion is 24 weeks in the UK, abortion for non-medical reasons[67] is not normally provided after 18-20 weeks in Scotland. Women who request an abortion for non-medical reasons beyond this point in their pregnancy must travel to England if they wish to proceed with the termination. In 2011 and 2013 respectively, 233 and 182 women had to travel to England in order to access safe, legal abortion.[68] The Scottish Government has commissioned research into later abortion and asked the Chief Medical Officer to produce a report on the subject, but has not yet taken action to rectify the inequality experienced by women in Scotland in this regard.

Implications of travel

Profound implications emanate from this inequality of access. Research with women attempting to access late-term abortion in Scotland found that the burden of travel constitutes a significant barrier to abortion for women in Scotland. Economic resources are an issue, with travel and accommodation costs often having to be

[66] NHS Quality Improvement Scotland (2008) Standards 2008: *Sexual health services;* "essential criteria" are 1) 70% of women seeking termination undergo the procedure at 9 weeks gestation or earlier; 2) A mechanism to ensure all women are offered, at the time of termination, a range of contraceptives; 3) 60% of women leave the facility with one of the more effective methods of contraception 4) Post termination of pregnancy counselling to provide psychological support is available within 4 weeks for women (and their partners) who request it; 5) The NHS board has an agreed referral mechanism in place (where services are not available locally) for women who require a termination of pregnancy up to the legal time limit.

[67] Medical reasons for abortion are grave risk to the life or health of the woman, or severe fetal anomalies.

[68] Cameron et al. (2015) *Characteristics of women who present for abortion towards the end of the mid-trimester in Scotland: national audit 2013-14 ; Cochrane and Cameron (2013) Attitudes of Scottish abortion care providers towards provision of abortion after 16 weeks' gestation within Scotland*

paid up front, and at short notice, therefore incurring higher rates. While these costs can be reclaimed from a woman's local NHS board, the process is complex, unclear and not well signposted. Some health boards will pay for a companion to accompany women on the journey, whilst others will not.[69] Women face further challenges in arranging childcare, which may have a cost attached to it, and securing time off work. Being able to do so at short notice is particularly difficult for women in low-autonomy or insecure work, or shift work where there is a greater need to explain absences to managers and colleagues.

In addition to financial implications, the obligation to travel often entails emotional, physical and practical challenges. These include disclosing information to more people than desired, including employers, and related anxiety over workplace rights. Women present for later abortion for a range of reasons that are outwith their control, including delayed recognition of pregnancy, changed life circumstances, delays around referral and appointment waiting times. Onerous travel on top of and as a result of these challenges only serves to compound them.

Furthermore, research shows that women in Scotland have to be assertive and remain committed to their choice in order to access later abortions.[70] Women found the travel to be distressing and stigmatising, and the lack of local access contributes to the taboo and perceptions of discrimination that surround abortion. Scotland's failure to provide later abortions also arguably breaches women's rights. The Centre for Reproductive Rights states that "ample jurisprudence from human rights bodies demonstrates [that] compelling women to undertake excessively cumbersome measures in their pursuit for legal abortion services constitutes human rights violations".[71]

Postcode lottery

Within this context, a considerable postcode lottery with regards to late term abortion also exists across Scotland's fourteen NHS boards. Gestational limits differ significantly in different parts of Scotland, from gestations of 16 weeks onwards, and the information women receive can vary depending on their individual GP.[72] One researcher found that the local gestational time limit for accessing services varied between 15 and 20 weeks, and was informed of a different local limit at every participating hospital.[73] This puts women under pressure to find a service, or make the choice between arranging and undertaking the demanding journey to England or continuing with an unwanted pregnancy. However, the reasons for this regional variation, including how informal local time limits are set, are unclear.

[69] BPAS in Scotland, meeting of women's organisations on the devolution of abortion law, December 2015
[70] Purcell et al. (2014) *Access to and experience of later abortion: accounts from women in Scotland*
[71] Centre for reproductive rights (2013) *Response to call for submissions in connection with the CEDAW general discussion on access to justice*
[72] Cochrane and Cameron (2013) *Attitudes of Scottish abortion care providers towards provision of abortion after 16 weeks' gestation within Scotland*
[73] Beynon-Jones (2011) *Timing is everything: The demarcation of 'later' abortions in Scotland*

Furthermore, protocol and administration of the necessitated travel process also varies across health boards, with financial implications for women. Women are not consistently informed that they are able to reclaim travel expenses and how to do so.[74] There is need for a mechanism to standardise not only gestational time limits across different areas of Scotland, but also the standard of care and support provided.

There is also a need to improve data collection with regards to later abortion in Scotland, subject to confidentiality controls around publication. Data on the number, circumstances and equality characteristics of women who present for abortion after 20 weeks of gestation are not reliable. In Scotland, we lack detail on the degree of variation across geographical health boards and also the subsequent decisions made by women seeking advice and support with regards to abortion.

Facilities and practitioners

Abortions for non-medical reasons are not provided after 16-20 weeks in Scotland, yet facilities exist to perform later-term abortions in the case of fetal anomaly or miscarriage. Women seeking later abortions report that this disparity creates an environment of moral judgement and made them feel discriminated against and stigmatised.[75] According to researchers Cochrane and Cameron, it is arguable that "every tertiary hospital maternity service in Scotland currently possesses the necessary nursing and medical skills in their existing workforce to provide a late medical abortion service". [76]

This begs a set of questions as to why these distinctions are drawn and what lies behind Scotland's lack of development in the field of later abortion provision. It remains unclear why Scotland's delivery of abortion services is more restrictive than other areas of Britain, with academic literature suggesting that religion, limited resources and 'institutional inertia' may all be factors.[77] Clearly, this needs to be better understood if women in Scotland are to access abortion on an equitable basis with women in other parts of Britain.

The issue of institutional inertia is highlighted by a survey of practitioners at a recent conference for abortion care providers in Scotland.[78] Only a quarter of those surveyed would be prepared to administer later-term abortion procedures, with lack of expertise, lack of physical facilities, lack of support from senior hospital management and nurses' unwillingness to participate in later abortions all cited

[74] Purcell et al. (2014) *Access to and experience of later abortion: accounts from women in Scotland*
[75] Cameron et al. (2015) *Characteristics of women who present for abortion towards the end of the mid-trimester in Scotland: national audit 2013-14*
[76] Cochrane and Cameron (2013) *Attitudes of Scottish abortion care providers towards provision of abortion after 16 weeks' gestation within Scotland*
[77] Pearson (2015) *Abortion in Scotland (Dissertation MSc in Equality and Human Rights, University of Glasgow)*
[78] Cochrane and Cameron (2013) *Attitudes of Scottish abortion care providers towards provision of abortion after 16 weeks' gestation within Scotland*

as perceived reasons for Scotland's dearth of services. In keeping with the sense of uncertainty and 'inertia', others felt that lack of capacity within NHS Scotland was not a real barrier to later term provision, given that the total number of Scottish residents treated in England is relatively small.

Research commissioned by the Scottish Government raised concerns that some frontline health practitioners in Scotland are not well informed with regards to gestational limits, which causes delays for women seeking abortion and contributes to anxiety around their decision-making.[79] The study found that GPs appeared "confused" or "unclear" regarding the gestational limit of their NHS board, with women receiving misinformation regarding the threshold. Having been told an inaccurately low time limit, they were subsequently given the correct information by their local abortion service. Clearly, this is not acceptable and could result in women proceeding with an unwanted pregnancy.

Furthermore, whilst doctors in Scotland stressed women's autonomy in decision-making around abortion, they often went on to unconsciously contradict this position with regards to later abortion, appearing to see their intervention at that point as a justifiable exception.[80] This is despite the fact that 80% of abortion providers in Scotland support the expansion of provision up to the legal threshold of 24 weeks.[81]

We are calling on Scottish Government to:

- Develop capacity to perform non-medical abortions up to the legal 24 week gestational threshold in Scotland
- Establish a national framework to standardise access to abortion in Scotland, including the regional variations in gestational time limits
- Ensure that no woman is unable to access abortion due to lack of financial support

4.2 Modernise procedure

In 2016, abortion is an extremely safe and technically straightforward procedure. However, restrictions around process and access to abortion remain wedded to moral debates and the clinical context of the 1960s, and ignore many of the substantial technological developments that have taken place in the decades since.[82]

[79] Purcell et al. (2014) *Access to and experience of later abortion: accounts from women in Scotland*
[80] Beynon-Jones (2011) *Timing is everything: The demarcation of 'later' abortions in Scotland*
[81] Cameron et al. (2015) *Characteristics of women who present for abortion towards the end of the mid-trimester in Scotland: national audit 2013-14*
[82] Sheldon (2015) *Decriminalisation of abortion: an argument for modernisation*

Home terminations

The 1967 Act provides strict restrictions on where abortions may be carried out. Unlike women experiencing miscarriage, women choosing abortion are not permitted to take abortifacient medication at home in their own time. This means that women must attend multiple appointments at healthcare facilities and are unable to control the timing and circumstances around ending their pregnancy. In turn, this denies women clear potential advantages in terms of their wellbeing at what is often a very difficult time, and could influence their ultimate decision-making regarding abortion.

In the USA, France and Sweden, routine abortifacient medication can be administered by a pharmacy and taken at home. Scotland could choose to follow this path, or, as a step in the right direction, to allow women to take the second 'abortion pill'[83] at home, rather than returning to a hospital or clinic. Such flexibility would be beneficial to many women for a range of factors that include domestic abuse, parental involvement, and work and childcare commitments. It would be particularly pertinent for women in rural areas who can struggle to access designated clinics, both practically and financially. Provision for home terminations could be explored under Scotland's existing power to regulate the licensing of drugs.

Advances in contraception

Similarly, recent technological advances in contraception could reduce the incidence of the need for abortion services and offer women more control over their own bodies. The 'once-a-month' contraceptive pill, development of which has been in the pipeline for decades,[84] would be an option that 48% of sexually active women would consider as a replacement for their current contraceptive of choice.[85] Introduction of such a pill would also have a positive impact on the workload of medical practitioners.

However, this avenue of progress is currently blocked under the terms of the Abortion Act 1967. This is because the pill works at the point of implantation, to detach the fertilised egg from the womb lining, and implantation in the UK is the conceptual line between contraception and abortion. Section 5(2) of the 1967 Act makes clear that abortion *"done with intent to procure woman's miscarriage is unlawfully done unless authorised by section 1 of this Act"*. Therefore any use of the newer form of contraceptive is likely to be outwith the exceptions to the ban on abortion contained within the law. In Scotland this remains dealt with in the common law, and could be prosecuted as a common law criminal offence of abortion.

[83] The medical abortion procedure involves taking two sets of pills over two visits to a healthcare institution
[84] Sheldon (2015) *The regulatory cliff edge between contraception and abortion: the legal and moral significance of implantation*
[85] Survey of 1003 sexually active women between 16 and 45 by Censuswide; cited by BPAS at http://www.reproductivereview.org/index.php/rr/article/1711/

There is, however, an argument that this could be addressed in Scotland through existing powers to regulate the licensing of drugs. Alternatively, new powers over abortion law could be invoked to allow technological advances in contraception to develop. Under either approach, ending this prohibition on the development of safe contraception for which there is clear demand amongst women could constitute part of a progressive framework for reproductive rights in Scotland.

Nurse and midwife-led services

The current interpretation of the Act also prohibits the full development of nurse or midwife-led services that are widespread elsewhere and at the forefront of woman-centred maternity care. With advances in medical sciences, doctors are now taking a step back in the labour ward and maternity unit in relation to child birth. Units are increasingly led by midwives and nurses, with doctors on-call if required. However, nurses and midwives who can provide highly skilled, complex care in other fields are not permitted to provide straightforward abortion care. In 1967, abortion procedures may have been seen as uncommon, dangerous and complicated but medical advances have ensured that this is no longer the case.

In addition to the administration of abortifacient medication, studies from across the world have shown that nurses and midwives should be allowed to perform manual vacuum aspiration, which would expand early access to abortion care and reduce waiting times for women undergoing the procedure.[86] Since 2003, the World Health Organisation has been recommending that abortion care be provided at the 'lowest' appropriate level of the healthcare system and that vacuum aspiration can be provided by mid-level care providers, including nurses and midwives, in primary care facilities throughout the first trimester of pregnancy.[87] Scottish Government could explore the development of such a model of best practice for Scotland, as part of a package of improvements to abortion care services in Scotland.

We are calling on Scottish Government to:

- Regulate over the provision of medical abortion drugs to allow home terminations
- Work towards removing restrictions that block use of advances in contraception as a component of women's right to reproductive healthcare
- Develop nurse and midwife-led services that are able to provide manual vacuum aspiration and medical abortions

[86] Jejeebhoy et al (2011) *Can nurses perform MVA as safely and effectively as physicians: evidence from India;* Weitz et al (2013) *Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives and physician assistants under a California legal waiver*

[87] WHO (2003) *Safe abortion: technical and policy guidance for health systems*

4.3 Equal access to services

As set out above, women do not access abortion services on an equal basis in Scotland, in terms of both regional health boards and socioeconomic circumstances. Women's other equality characteristics are also highly likely to impact their ability to access services. With regards to a woman's residential address and age, data has been systematically collected over time, and it has been possible for analysts to monitor trends and to investigate drivers that shape women's understanding and experience of abortion. Aside from age and address, however, the only mandatory information recorded by the abortion provider is a woman's marital status and her obstetric history, including previous abortions.

Given the significant barriers to healthcare experienced by disabled women, LBTI people, refugee and asylum seeking women, and women from certain minority ethnic communities in Scotland, it is likely that access to safe abortion is also limited in particular ways for these groups. To develop our understanding of this and better enable all women to realise their reproductive rights, it will be vital to know where, when and how different groups of women are accessing abortion in Scotland. As above, a critical element in achieving equitable and accessible services will be building intersectional data about the incidence and experience of abortion for diverse groups of women in Scotland.

Best practice

In general terms, research also suggests that women's access to abortion is still shaped by the particular healthcare professionals they happen to encounter and that "significant effort is required for individuals to assert their candidacy for pregnancy or abortion services".[88] Clearly, not all women are equally equipped to make these assertions, due to a host of factors and experiences that include patriarchal culture, community background, faith or belief, mental or physical health, language, confidence and self-esteem. Women attempting to access later abortion in Scotland report that the extent to which they found services to be accessible and receptive to their needs was of vital importance.[89]

In addition to the postcode lottery which determines women's access to later abortion in Scotland, there appears to be a more general lottery related to attitudes amongst healthcare workers. Whilst this might not constitute a significant barrier to accessing abortion under 15 or 16 weeks, attitudes do shape women's experiences and may have an impact on future reproductive decision-making. Whilst many healthcare workers are providing excellent, non-judgemental abortion care, improved national guidelines to standardise the advice and support that women receive are urgently needed.

[88] Purcell et al. (2014) *Access to and experience of later abortion: accounts from women in Scotland*
[89] ibid

Stigma and the media

Commonplace stigma around abortion is perpetuated by the media and by a very small number of vocal anti-choice protesters. The media plays a significant role in shaping public perception of health issues, and its portrayal of abortion has been found to be extremely one-sided.

Analysis of the framing of abortion by print media in Scotland and the UK found that it is predominantly presented using negative language and lacks key perspectives, including those of women with experience of abortion services. Abortion is presented as inherently controversial, unusual and risky in "emotive and moralising" language, and is often linked to other stigmatised practices or experiences such as immigration, health tourism, binge drinking, promiscuity/casual sex, teenage pregnancy and rape.[90]

Abortion is not portrayed as a standard procedure that is routinely experienced by women across society. Rather, those who choose abortion are cast as a particular 'type' or 'subset', held up in contrast to 'normal' women, and judged and vilified as being irresponsible, selfish and immoral.

Negative media representations of abortion contribute significantly to the ongoing stigmatisation and taboo that surround abortion, and prevent women from talking about their experiences or seeking timely, routine support. This is reflected in the lack of knowledge and understanding demonstrated by young women, as highlighted in this paper, and has an impact on equality of access to reproductive healthcare, decision-making and abortion services.

Northern Irish women

The 1967 Abortion Act does not apply to Northern Ireland where abortion is still strictly prohibited by law. Women who self-induce an abortion (or help another to do so) are currently being prosecuted in Northern Ireland under the 1861 Offences Against the Persons Act where they can face maximum sentences of up to life in prison.

Women in Northern Ireland are still routinely denied access to NHS abortion services even in cases of rape, incest or fetal abnormality. To avoid self-induced abortions and possible prosecution, many women travel to Britain every year to terminate unwanted pregnancies. However, as they must pay for their procedure and travel expenses this journey is prohibitively costly for many women. Providing abortions for Northern Irish women on the NHS would allow a greater number to avoid the risk of prosecution and access quality healthcare services while terminating a pregnancy.

[90] Purcell, Hilton and McDaid (2014) *The stigmatisation of abortion: a qualitative analysis of print media in Great Britain in 2010*

The UN Human Rights Committee recently ruled that Northern Ireland's laws prohibiting and criminalising abortion constitute a human rights violation.[91] Without amending legislation, the Scottish Government could improve access to abortion by allowing women from Northern Ireland to access abortions free of charge on the NHS. With the situation in Northern Ireland having been clearly identified as a violation of human rights by the UN, it can be argued that Scotland has a moral obligation to assist Northern Irish women to realise their fundamental reproductive rights.

We are calling on Scottish Government to:

- Strengthen sexual health service standards to ensure that women presenting for abortion receive accurate advice and adequate support from all healthcare workers
- Mandate intersectional data collection on women presenting for and proceeding to abortion in Scotland
- Support women's rights to reproductive healthcare by waiving fees for women from Northern Ireland accessing abortion in Scotland

[91] In a case brought forward to the by the Centre for Reproductive Rights on behalf of Amanda Mellet

5. DECRIMINALISATION

The Office of the UN High Commissioner for Human Rights is not alone in its recommendation that abortion be removed from criminal law. Many campaigners in Scotland and the UK, including Abortion Rights, Lawyers for Choice, the Scottish Trades Union Congress (STUC) and the UK's largest independent provider of abortion healthcare, the British Pregnancy Advisory Service (BPAS), advocate for a 'woman's legal right to choose'.

5.1 The case for decriminalisation

Contrary to the claims of detractors, there is no evidence to suggest that the decriminalisation of abortion leads to an increase in later-term terminations. At present, 80% of terminations in Scotland take place before 12 weeks of gestation and less than 0.1% of all abortions take place after 24 weeks, mainly because of serious fetal anomaly which could not be confirmed at an earlier stage. The experience in jurisdictions where abortion has been removed from the criminal law has shown that women continue to choose abortion after 24 weeks only in exceptional circumstances. Regulatory frameworks govern the parameters of medical practice instead of legislation. In Scotland, this would be overseen by the British Medical Association and the National Institute for Health and Care Excellence.

The decriminalisation of abortion would require primary legislation passed by the Scottish Parliament, with the aim of removing abortion from the criminal law. The criminal law would still apply in circumstances where existing criminal offences are committed, such as assault or culpable and reckless conduct. It would also be necessary to retain a criminal element to capture situations where a woman was forced to undergo an unwanted abortion. A review of existing offences would therefore be required in order to ensure that the loss of a wanted pregnancy was captured. Equally, new legislation should ensure that women retain the right to abortion after 24 weeks gestation where the pregnant woman's life is at risk or there is risk of severe fetal anomaly.

In many respects the regulatory framework for medical practitioners would remain the same. If a procedure was undertaken in a way which was below the standard expected within the profession, a medical practitioner would be accountable to their regulator – whether the General Medical Council or the Nursing and Midwifery Council. Similarly, the patient would have recourse to the civil law for negligence and/or personal injury, in the same way as at present. This form of regulation would allow service provision to adapt with emerging technology and updates in medical research and guidelines.

Women who procure abortion should not be subject to prosecution for realising women's human rights, nor should those who assist them. Our organisations support

the view that abortion should be decriminalised and regulated like all other healthcare.

5.2 Current abortion law in Scotland

It is a crime to procure an abortion in Scotland. Unlike in England and Wales, however, this is not set out in the Offences Against The Person Act 1861, but in common law. In Scotland, it is settled law that any improper act *"by the mother or any other person calculated to destroy the fetus or cause its premature expulsion from the body of the mother constitutes a common law crime, that of abortion"*.[92] Prior to the Abortion Act 1967, the only exception to this was medical necessity, where the need to terminate the pregnancy was in the interests of the health of the mother. In these circumstances a doctor, using their own clinical judgment, could undertake a legal abortion.

The position was changed in 1967 with the passage of the Abortion Act. The Abortion Act allowed doctors to carry out abortions in additional specified circumstances without being at risk of criminal prosecution. However, it is important to remember that the 1967 Act was not designed to decriminalise abortion. In fact, there was no intention – at all – to remove the existing criminal offence of abortion. The purpose of the 1967 Act was simply to set out circumstances in which an abortion may be legally carried out.

The 1967 Act provided that:

"a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith"

The Act, as amended, then goes on to set out four statutory grounds on which an abortion may be performed. These are:

a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or

b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or

c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or

d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped

[92] Butterworths (1987) *The Laws of Scotland: Stair Memorial Encyclopaedia*

When deciding whether or not the continuance of a pregnancy would involve "risk of injury to health" for the purposes of (a) and (b) above doctors may take into account the pregnant woman's actual or reasonably foreseeable environment. Essentially, the 1967 Act provides a defence to doctors carrying out abortions.[93] It provides abortion if medically agreed to, but does not provide the right to abortion.

Until 1990 an abortion could be performed at any stage of pregnancy in Scotland, as opposed to in England and Wales where the time limit was contained within the Infant Life (Preservation) Act 1929. This discrepancy was addressed with the Human Fertilisation and Embryology Act 1990, which provided that the four defences under the 1967 Act are available until the end of the twenty-fourth week of pregnancy and thereafter only grounds (b) to (d) above are available. The latter provide grounds for termination up to the end of the pregnancy.

5.3 Requirement of approval from two doctors

As we have set out, abortion is still illegal throughout the UK but can be permitted when two doctors agree in good faith that a woman meets the criteria contained within the Abortion Act 1967. A woman has no right to abortion. Any request must be approved by two doctors, despite the reality that this decision is increasingly not based on medical factors. Nonetheless, the 1967 Act is "grounded in the assumption that doctors, rather than women, are best placed to decide whether an abortion is justified".[94] In practice, it is this requirement that criminalises abortion.

This need for two doctors to sign off an abortion is one of the most paternalistic aspects of the current 1967 Act and further undermines women's autonomy and reproductive decision-making. In many cases this is an entirely unnecessary, time-consuming hoop through which women must jump in order to make choices over their own body. It is also entirely out of step with the increasing emphasis of patient autonomy in other areas of medical treatment. It is a unique requirement amongst routine medical procedures, which gives power and privilege to doctors' opinions over the wishes of women regarding an unwanted pregnancy.

As above, the vast majority of abortions in the first trimester are carried out with the use of the 'abortion pill', nurses and midwives, who have equivalent levels of appropriate experience and skills, could be trained to undertake both medical and surgical abortions, and abortifacient medication could be issued by a registered pharmacist. The need for one doctor, never mind two, is unclear.

Conversely, support against the 'two doctors requirement' is clear-cut. Following a lengthy investigation, the Westminster Science and Technology Committee

[93] Ferguson, P. and C. McDiarmid (2009) *Scots Criminal Law: A Critical Analysis*
[94] *The Decriminalisation of Abortion: An Argument for Modernisation* : Sally Sheldon: Oxford Journal of Legal Studies 2015, pp1-32 at p12

recommended that it be removed, as it served no benefit. In their 2007 report on Medical Advances on Abortion, the Committee concluded, "the requirement for two signatures may be causing delays in access to abortion services and [their investigation] found no evidence of its value in terms of safety." Since 2007, the British Medical Association's policy has been to remove the requirement for approval from two doctors in the first trimester, so that abortion "is available on the same basis of informed consent as other treatments." As well as consideration of patient safety, this policy was passed on grounds that:

> "There will always be medical grounds to justify termination in the first trimester [...] the potential to create delays and unnecessary barriers to access [and the fact that] no other medical procedure requires the agreement of two medical practitioners, [make] abortion increasingly out of step with the emphasis on patient autonomy elsewhere in medicine."[95]

We are calling on Scottish Government to:

- Explore the decriminalisation of abortion and removal of the requirement for the 'two doctors rule' in Scotland to ensure women's legal right to choose

[95] British Medical Association (2014) *The law and ethics on abortion: BMA views*

6. THE SCOTTISH CONTEXT

In 2015, 12,082 terminations were performed in Scotland, representing a rate of 11.6 per 1000 women aged between 15 and 44.[96] This represents an overall decline of 14.9% since 2008. Of these, 98.3% were authorised under Ground C of the 1967 Abortion Act, which states that "the pregnancy has not exceeded its twenty-fourth week and that the continuation of the pregnancy would involve risk, greater than if the pregnancy was terminated, of injury to the physical or mental health of the pregnant woman."

In England and Wales abortion rates have been consistently higher than in Scotland, although there is no clear narrative as to why this is the case.[97] Given the issues we identify in this paper around access and attitudes, investigation into these statistics would constitute a useful research component of any further work commissioned by the Scottish Government or NHS Scotland. We set out the broad political and social contexts that form a backdrop to these statistics here.

6.1 Political context

In the past, a number of responsibilities relating to abortion were devolved to the Scottish Parliament. Abortion provision and care services, regulation, and the power to approve independent abortion providers have all been within Scottish Government's power under the devolution of health since 1999. The Scotland Act 2016 gives the Scottish Parliament the power to repeal or amend the Abortion Act 1967 in its application in Scotland. This means that, over time, the Scottish Government could choose to decriminalise abortion, to remove the requirement for two doctors' signatures, or to alter the legal gestational time limits that dictate current service provision.

In the last parliamentary term, the Scottish Government stated that its intention to protect current legal protections and entitlements, and stressed that gestational time limits should continue to be aligned across Great Britain. This commitment was reaffirmed in the Scottish National Party's (SNP) manifesto for the 2016 Holyrood elections. These are welcome interventions, which support the argument to provide later abortions in Scotland and to end the postcode lottery in accessing services within the country.

They do not, however, reflect the fact that there is an opportunity within the devolution of abortion law to develop a distinct Scottish approach to women's reproductive health and to strengthen women's rights. Historically, abortion and women's rights have been divisive issues. However, the high degree of public

[96] NHS Information Services Division (2016) *Termination of pregnancy statistics: Year ending December 2015*
[97] In 2015, the rate for England and Wales was 17 per 1000 women aged 15-44.

support for a woman's right to choose in Scotland[98] means that the Scottish Government can be bold in responding to recent developments, diverging from regressive aspects of UK political culture around reproductive rights, and creating a better environment for women seeking abortion in Scotland.

Framing the debate

Political debate around abortion in Westminster in recent decades has been largely instigated and heavily influenced by conservative politicians and like-minded commentators. As a result, the discourse has become steadily and increasingly focused on the foetus, to the exclusion of women and their rights. Key interventions at Westminster have been the legislative passage of the Human Fertilisation and Embryology (HFE) Act 1990 and the Human Fertilisation and Embryology Act 2008, which added to and amended the 1990 act.[99] Unsuccessful amendments to the HFE Act in 2008 included a free vote on the reduction of the time limit from 24 weeks, which was opposed by 304 votes to 233. These amendments, by Nadine Dorries MP, also attempted to insert language about the 'unborn child' into legislation.

However, this 'foetus-centred' discourse stands at odds with that of human rights. There is no international rights instrument that asserts that the foetus has human rights. The UN Convention on the Rights of the Child, and others, are unequivocal that human rights begin at birth.

The devolution of abortion law provides an opportunity to centre women's rights, and reproductive rights more widely, at the heart of a Scottish approach to abortion care. This would be consistent with Scottish Government's international human rights obligations, including those set out in the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Our organisations are calling on the Scottish Government to unequivocally support women's rights to bodily autonomy.

Cross-party support

In addition to the SNP's commitment to retain the current legislative framework, the Scottish Labour Party, the Scottish Green Party and the Scottish Liberal Democrats have also made clear their respective positions on abortion.[100] Scottish Labour and the Scottish Liberal Democrats would protect the current law, with Scottish Labour also committing to equal access to abortion services across Scotland, regardless of geography. The Scottish Green Party pledged support for the decriminalisation of abortion, to improve services and access across Scotland and to address inequalities for low-income and young women. The Scottish

[98] Abortion Rights Edinburgh (2015) *Abortion Poll,* see: http://survation.com/wp-content/uploads/2015/11/Final-ARE-Tables-1c0d8h4.pdf

[99] *The 1990 Act lowered gestational time limits from 28 weeks to 24, and the 2008 Act banned sex selection for social reasons and extended rights for same sex parents.*

[100] Engender (2016) *Gender edit: political party manifestos for Holyrood 2016*

Conservatives have not issued a position since the devolution of abortion law was confirmed, but party leader Ruth Davidson has declared her support for a woman's right to choose. This high degree of public positioning on abortion is welcome, particularly given that political parties tend to shy away from the issue and give elected representatives a free vote in related parliamentary decision-making.

Although not directly related to the Scottish context, the latest British Social Attitudes survey found only slim distinctions between supporters of different parties, with the exception of the Liberal Democrats. 82% of Liberal Democrat supporters support a woman's right to choose an abortion on request, compared with 57% of Conservative party supporters and 61% of Labour supporters.[101]

Commitments to gender equality and preventing violence against women

The devolution of abortion law presents a number of opportunities to advance gender equality in Scotland. As discussed, it could act as a catalyst to develop a concerted programme of work that addresses both existing issues with service provision and the anomalous criminalisation of abortion in Scotland. Such a programme of work could seek to develop a distinct Scottish approach to women's reproductive rights, which centres women's health and wellbeing and makes links across different strands of Scottish Government work. There are clear opportunities to make progress against existing Scottish Government gender equality strategies, including Equally Safe,[102] the strategic group on women and work, and broader goals to tackle sexism and women's economic and cultural inequality in Scotland. There are also opportunities to link in with the Scottish National Action Plan on Human Rights (SNAP) and rights-based approaches to mental and physical health across government.[103]

Development of such an approach should include input from women, women's organisations, human rights campaigners and health practitioners across Scotland, and time should be taken to ensure that the opportunity is maximised. An immediate starting point, however, must be the implementation of current legislation and the standardisation of services across Scotland.

6.2 Social context

Contrary to some perceptions, there is no evidence that Scotland is more conservative in its views towards abortion than other parts of Britain. In 2015, a Survation poll of 1084 people commissioned by Abortion Rights Edinburgh found

[101] British Attitudes Survey (2012) *British social attitudes 30,* see: http://www.bsa.natcen.ac.uk/latest-report/british-social-attitudes-30/personal-relationships/abortion.aspx
[102] Scottish Government (2016) *Equally Safe: Scotland's strategy for preventing and eradicating violence against women and girls*
[103] These include National Health and Wellbeing Outcomes, the Healthcare Quality Strategy for NHS Scotland and Getting It Right for Every Child.

that 75% of Scots support a women's right to choose.[104] Figures show that this includes a supportive rate of 74% in Glasgow, where it is often assumed that more anti-choice attitudes prevail. This is broadly in line with the most recent British Social Attitudes survey, which found that 62% of the British public support abortion on a woman's request.[105] Earlier polls have put public support for a women's right to choose as high as 83%.[106] In Scotland, 80% of adults think that it is unacceptable that women have to travel from Northern Ireland and pay for access to abortion which is available in other parts of the UK, with clear parallels with Scotland's lack of later term provision.

However, the social context of abortion remains a barrier to women's access. Despite the polls, abortion is still stigmatised in Scotland, which has an impact on women's ability to make decisions about their fertility and reproductive health. Historically, invoking the 'conscience clause' of the 1967 Abortion Act, under which health practitioners can be exempted from "participating in any treatment" related to abortion, has been widespread in Scotland, and contributed to both the emergence of geographical variations in provision and to the stigma that surrounds seeking abortion.[107]

The British Medical Association is clear that conscientious objection must not undermine the patient's "right to receive objective and non-judgemental medical advice and treatment", and that any health practitioner invoking the clause should inform patients and make arrangements for referral as quickly as possible.[108] However, whilst ultimately overturned by the Supreme Court, high-profile cases such as the 2014 legal challenge by Catholic midwives in Glasgow for exemption from delegating, supervising or supporting other staff involved in carrying out abortion procedures, continue to contribute to the stigmatisation of abortion in Scotland. A Scottish approach, with women's rights at its heart, could include a strategy to tackle the stigma attached to procuring abortion.

We are calling on Scottish Government to:

- Enshrine women's reproductive rights to safe abortion, access to appropriate services and bodily autonomy in a Scottish approach to abortion care
- Protect women's right to service provision against the 'conscientious objection' of auxiliary staff to supporting abortion care

[104] Abortion Rights Edinburgh (2015) Abortion Poll: "Abortion has been legally available to women on the NHS since 1967. Which of the following statements is closest to your opinion? a) abortion should remain legal and available in Scotland; b) the law should be changed to make abortion less available in Scotland; c) don't know

[105] The question was framed slightly differently: "Do you think the law should allow abortion when the woman decides on her own she does not wish to have the child?"

[106] GfK/ NOP poll (2007) see: http://www.abortionrights.org.uk/83-per-cent-support-a-womans-right-to-choose/

[107] Pearson (2015) *Abortion in Scotland (Dissertation MSc in Equality and Human Rights, University of Glasgow)*

[108] British Medical Association (2014) *The law and ethics on abortion: BMA views*

7. CONCLUSION AND RECOMMENDATIONS

Access to safe, legal abortion is a fundamental element of women's rights to bodily autonomy, and reproductive choice and health. It is also a key component in achieving economic and social equality for women in Scotland, including in terms of access to education and paid work, financial autonomy and the prevention of abuse. The right to abortion is a healthcare issue, an education issue and a broader equality issue, in terms of disability, race and ethnicity, immigration status, sexual orientation and gender identity.

The devolution of abortion law to the Scottish Parliament represents an opportunity to develop a progressive legal and operational framework in Scotland that places women's rights and wellbeing at its core. Our organisations believe that the Scottish Government can be bold in creating a distinctive approach to the provision of abortion services and abortion care. To this end, our recommendations include calls that could be enacted immediately under the current regulatory framework, alongside others that would make use of Scotland's newly devolved power over abortion law.

As a matter of priority within this, we are calling for the standardisation of access to services across NHS Health Boards, up to the legal threshold of 24 weeks mandated by the terms of the Abortion Act 1967. It is also critical that the Scottish Government adopt an intersectional approach to all ongoing and future work on abortion in Scotland, to ensure that all women are afforded the same reproductive rights. Finally, our organisations unequivocally support the decriminalisation of abortion and believe that the Scottish Government should make women's legal right to choose a reality.

We are calling on the Scottish Government to:

Women's rights

1. Enshrine women's reproductive rights to safe abortion, access to appropriate services and bodily autonomy in a Scottish approach to abortion care
2. Explore the decriminalisation of abortion and removal of the requirement for the 'two doctors rule' in Scotland to ensure women's legal right to choose
3. Protect women's right to service provision against the 'conscientious objection' of auxiliary staff to supporting abortion care
4. Support women's rights to reproductive healthcare by waiving fees for women from Northern Ireland accessing abortion in Scotland

Services

5. Establish a national framework to standardise access to abortion in Scotland, including the regional variations in gestational time limits
6. Develop capacity to perform non-medical abortions up to the legal 24 week gestational threshold in Scotland
7. Strengthen sexual health service standards to ensure that women presenting for abortion receive accurate advice and adequate support from all healthcare workers

Medical advances

8. Regulate over the provision of medical abortion drugs to allow home terminations
9. Work towards removing restrictions that block use of advances in contraception as a component of women's right to reproductive healthcare
10. Develop nurse and midwife-led services that are able to provide manual vacuum aspiration and medical abortions

Equality of access

11. Mandate intersectional data collection on women presenting for and proceeding to abortion, whilst protecting anonymity with regards to public release
12. Ensure that abortion care meets the needs of disabled women, ME women, refugee women and LBTI people, and explore the introduction of specialist services
13. Ensure that no woman is unable to access abortion due to lack of financial support
14. Encourage schools to strengthen education on reproductive rights and healthy relationships within SRE as part of a wider commitment to tackling abortion stigma in Scotland

Engender
1A Haddington Place
Edinburgh
EH7 4AE
0131 558 9596

info@engender.org.uk
www.engender.org.uk

Twitter: @EngenderScot
Facebook: /engender

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