Command Papers Consultation

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**Comments on the Command Paper on Abortion from the British Society of Abortion Care Providers**

The British Society of Abortion Care Providers (BSACP) welcomes this opportunity to comment on Command Paper CO3/2018 published by the Government of Gibraltar on 27 September 2018. We have carefully read this Paper and take note of the UK Supreme Court judgment of 7 June 2018 ruling that the restrictive abortion law in Northern Ireland breaches women’s human rights (<https://www.supremecourt.uk/cases/docs/uksc-2017-0131-judgment.pdf>).

Background

BSACP can understand how Gibraltar, as a British Overseas Territory, might look toward the UK for a model for a revised abortion law, especially as it was the UK Supreme Court judgment of earlier this year that triggered the process. However, BSACP would ask the Government of Gibraltar to direct its attention much more widely than to the UK, in particular to its Crown Dependencies and to Europe.

The UK (and Finland) is out of step with the rest of Europe with regard to medical authorisation of early abortion (<http://srhr.org/abortion-policies/>). Most of Europe has abortion on request in the first trimester1. This type of policy is much more respectful of women, not subjecting them to any judgement and not ‘medicalising’ their healthcare needs.

BSACP would like to point out that the current situation in Gibraltar, with one of the most restrictive abortion laws in the world, does not mean that women living in Gibraltar do not face unwanted pregnancies and the difficult situation of trying to find appropriate healthcare in another jurisdiction. Restrictive abortion laws do not reduce the incidence of abortion, they force women into undergoing unsafe abortions. Liberalising abortion laws saves women’s lives2.

We would also point out that there are many differences in society now than when older abortion laws were drawn up. Nurses now play a fundamental role in delivering and often leading abortion services. Also, women now access abortion pills via the internet; this is not something that can be ignored and it certainly is likely to become more widespread3. Sometimes, the role of health services is to provide information and to take care of abortion complications.

The law in Gibraltar currently allows abortion to take place only if there is a risk to the life of the pregnant woman: in England and Wales in 2017 this ground comprised 107 out of a total of 189,859 abortions to residents i.e. 0.06% (<https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2017>). If this proportion is extrapolated to Gibraltar, currently 99.94% of abortions performed on women resident in Gibraltar are being ‘exported’. It is clinically impossible to determine whether or when a pregnant woman’s condition is going to progress from a risk of grave permanent injury to one of risk to life. Indeed, any waiting in this regard can in itself have a fatal outcome, as evidenced by the case of Savita Halappanavar while under the care of gynaecologists in Ireland (<http://cdn.thejournal.ie/media/2013/06/savita-halappanavar-hse-report.pdf>).

BSACP believes that abortion care is part of health care and should be decriminalised. Although this has not yet been achieved in Britain, we strongly approve of the progressive law that is about to be adopted by the Isle of Man – the Bill is back in the House of Keys on 30 October (<http://www.tynwald.org.im/business/bills/Bills/Abortion_Reform_Bill_2018.pdf>). We also draw attention to the fact that abortion has been decriminalised in Canada and in some Australian states. The Society is supporting efforts to similarly decriminalise abortion in the whole of the UK, including in Northern Ireland, where the Abortion Act 1967 does not apply. There is now evidence of widespread public and cross-party parliamentary support for decriminalisation4. A Bill designed to decriminalise abortion was presented in the UK Parliament yesterday by Diana Johnson MP and passed its First Reading with 208 votes in favour and 123 against (<https://www.independent.co.uk/news/uk/politics/abortion-northern-ireland-legalisation-mps-vote-bill-repeal-assembly-diana-johnson-a8597541.html>).

We are writing these comments on the assumption that decriminalisation of abortion will probably be unacceptable to the Government of Gibraltar at the present time. We would, however, point out that once an abortion law is in place it can often remain in place for decades and become outdated and not in keeping with modern medical practice. It is BSACP’s considered opinion that to retain criminal regulation of abortion in Gibraltar would mean that the law would be outdated from Day 1. Particularly as the intention is to retain the sentence of life imprisonment for those found guilty of procuring an abortion, we have seen in many countries the chilling effect this has on healthcare professionals with consequent reluctance to partake in abortion care and the resultant denial of vital healthcare to women. We note that the Isle of Man has reduced the maximum penalty to seven years in custody.

We will make our comments under the headings of the five sections of the proposed amendment to the Crimes Act 2011.

Section 163A

We would point out the logistical difficulties created by insisting that two doctors are signatories on the paperwork. Experience of this system in Britain, especially in the more recent era of nurses taking on a major role in abortion services, is that the two signature rule results in delays for women undergoing abortion. In order to reduce this barrier to access to healthcare, BSACP recommends that the proposed law in Gibraltar removes the requirement for two doctors’ signatures, in line with the conclusion of the House of Commons Science and Technology Committee (<https://publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045i.pdf>). The Government may want to consider requiring one doctor’s signature for gestations beyond 14 weeks, as in the Isle of Man Abortion Reform Bill.

BSACP notes that at clause 1(a) the Government of Gibraltar has not yet decided what gestational limit it will put forward in the Bill in relation to what in Britain is ground C. BSACP also notes that the intention is to allow only first trimester abortions under the equivalent of ground C. In England and Wales, 10% of abortions take place beyond 13 weeks’ gestation. The reasons that abortions take place in the second trimester are complex but certainly not trivial5. BSACP recommends that this limit is kept at 24 weeks, in line with Great Britain. BSACP does not understand the reasoning behind the Government stating that a 24-week limit has been overtaken by scientific advances. There may be some confusion here with fetal viability which, in our opinion, needs to be disentangled from abortion law6.

BSACP notes that clauses 1(b) and 1(c) are worded identically to the Abortion Act 1967. With regard to clause 1(d) on fetal anomaly, BSACP recommends that the second option is adopted i.e. ‘if the child were born it would suffer from such physical or mental abnormalities as to be seriously disabled’. Requiring the fetal abnormality to be ‘fatal’ is very restrictive; there are many fetal anomalies that are very severe which may or may not be ultimately lethal.

Clause 3 not only requires that the premises in which abortions are performed to be approved by the Minister for Health, but that these be restricted to hospitals (in effect St Bernard’s Hospital). The Government should be open to allowing the abortion process (or parts of it) in other premises. The Government states in the Command Paper that it might sponsor women to have their abortion in a clinic or hospital in the UK or Spain. In England and Wales, only 28% of abortions are carried out in NHS hospitals. The proportion of abortions performed medically has now risen to 65% in England and Wales and to 83% in Scotland. Very few abortions need to take place in hospitals. Clause 4, by copying the wording of the 1990 amendment to the Abortion Act 1967, takes the women of Gibraltar back to an era before regimens for medical abortion existed. After much pressure over a period of nearly 30 years, approval for the use of misoprostol at home (which is evidence-based) has finally been achieved in Scotland, Wales and England (<https://www.rcog.org.uk/en/news/rcog-and-fsrh-statement-on-women-in-england-being-able-to-take-misoprostol-at-home/>). Classes of places where abortion can take place need to be defined much more widely than hospitals and clinics or mention of place taken out of the Bill altogether.

Section 163B

BSACP sees no problem with requiring notification of abortions, although it is arguable that statistical data should routinely be kept on all healthcare procedures; making it a legal requirement for abortion potentially stigmatises women and service providers.

Section 163C

This section allows conscientious objection to participation in abortion care. It should be mentioned in this section that this relates to direct ‘hands-on’ participation only, as laid down by the UK Supreme Court in 2014 in the Scottish midwives case (<https://www.supremecourt.uk/cases/docs/uksc-2013-0124-judgment.pdf>).

Section 163D

We have no comment to make on this section on selective reduction of multiple pregnancies.

Section 163E

We have no comment to make on this section on interpretation.

Buffer zones

We would like to mention another area of concern not covered in the draft legislation. BSACP is concerned about the ongoing intimidation and harassment of patients and staff outside facilities providing abortion services in the UK7. We are aware of 26 providers in England and Wales and 7 in Scotland who have been affected by protestors. BSACP supports proposals to establish ‘buffer zones’ outside clinics providing these services - zones in which anti-abortion activity cannot take place. BSACP notes that buffer zones have been incorporated into abortion laws in South Africa, the USA (Federal law and State-level in Colorado, Massachusetts and Montana), Canada (British Columbia, Ontario, Quebec and Newfoundland & Labrador) and Australia (Australian Capital Territory, New South Wales, Northern Territory, Queensland, Tasmania and Victoria). The Tasmanian 2013 model is well drafted. Unfortunately, the British Home Office concluded last month, after a consultation, that it would not back a national law allowing buffer zones (<https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2018-09-13/HCWS958>). The only buffer zone so far established in the UK is in Ealing (<https://www.ealing.gov.uk/info/201249/past_consultations_2018/2381/mattock_lane_safe_zone_consultation/1>) – achieved by the use of a local Public Space Protection Order.

BSACP is aware of anti-abortion picketers harassing women in a variety of different ways, including filming individuals approaching clinics which provide abortion services and giving women unsolicited ‘advice’ which is contrary to that provided by doctors and grossly erroneous information about clinical risks, such as linking abortion with breast cancer. It is likely that this type of anti-abortion activity would happen in Gibraltar should women be able to more readily access services on the island.

BSACP appreciates that there is a range of views on abortion, and that there must be opportunities for these diverse and strongly-held views to be heard. However, intimidating staff who are providing a necessary, lawful and Government-approved service, and approaching women accessing these services who may already feel vulnerable, are unacceptable ways to promote anti-abortion views.

This will be particularly important in Gibraltar due to the close-knit community. Women’s privacy must be protected as much as possible when they access abortion services.

Professor Sam Rowlands on behalf of BSACP

24 October 2018

References

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