

**INTERNATIONAL
CAMPAIGN
FOR WOMEN'S
RIGHT TO SAFE
ABORTION**

FROM: Marge Berer
International Coordinator
London, UK
E-mail: info@safeabortionwomensright.org
Web: www.safeabortionwomensright.org/join-the-campaign

TO: command.papers@gibraltar.gov.gi

RESPONSE TO:

GIBRALTAR – A COMMAND PAPER FOR A DRAFT BILL TO AMEND THE CRIMES ACT 2011 TO PERMIT ABORTION IN CERTAIN LIMITED CASES AS REQUIRED BY THE JURISPRUDENCE OF THE SUPREME COURT OF THE UNITED KINGDOM

<https://www.gibraltar.gov.gi/new/sites/default/files/press/2018/Press%20Releases/590-2018.pdf>

The following comments follow the order of the Command Paper and are a response to it. The paper also proposes an alternative text for the revised law that would be in line with the UK Supreme Court ruling (2018) as well as recommendations of the World Health Organization (2012 & 2015) and the UN Human Rights Committee (2018).

The Offences against the Person Act 1861 and its twin in Gibraltar law

This law is 150 years old. The Law Commission recommended that the Government abandon this law and write a new law relevant for today as regards offences against the person. For some strange reason they did not recommend deleting sections 58 and 59, which criminalise causing a miscarriage with any noxious substance, nor the section on adultery, both of which they said were not political.

However, every major international human rights body is recommending that the provision of safe abortion be removed from the criminal law, even if abortion is otherwise regulated. The most recent iteration of this is from the United Nations Human Rights Committee, 30 October 2018, as follows:

Para 4. Although States parties may adopt measures designed to regulate voluntary terminations of pregnancy, such measures must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the Covenant. Thus, restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardize their lives, subject them to physical or mental pain or suffering which violates article 7, discriminate against them or arbitrarily interfere with their privacy. States parties must provide safe, legal and effective access to abortion where the life and health of the pregnant woman or girl is at risk, and where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering, most notably where the pregnancy is the result of rape or incest, or is not viable. [8] In addition, States parties may not regulate pregnancy or abortion in all other cases in a manner that runs contrary to their duty to ensure that women and girls do not have to undertake unsafe abortions, and they should revise their abortion laws accordingly. [9] For example, they should not take measures such as criminalizing pregnancies by unmarried women or apply criminal sanctions against women and girls undergoing abortion [10] or against medical service providers assisting them in doing so, [my emphasis] since taking such measures compel women and girls to resort to unsafe abortion. States parties should not introduce new barriers and should remove existing barriers [11] that deny

effective access by women and girls to safe and legal abortion [12], including barriers caused as a result of the exercise of conscientious objection by individual medical providers. [13] States parties should also effectively protect the lives of women and girls against the mental and physical health risks associated with unsafe abortions. In particular, they should ensure access for women and men, and, especially, girls and boys, [14] to quality and evidence-based information and education about sexual and reproductive health [15] and to a wide range of affordable contraceptive methods, [16] and prevent the stigmatization of women and girls seeking abortion. [17] States parties should ensure the availability of, and effective access to, quality prenatal and post-abortion health care for women and girls, [18] in all circumstances, and on a confidential basis. [19]

FULL DOCUMENT:

https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/1_Global/CCPR_C_GC_36_8785_E.pdf

Therefore, your statement on page 10 that "Similar provisions [to the UK 1861 Act, Sections 58-59] are the international norm" is not in fact correct. While they may have been the norm until the second half of the 20th century, they derive from previous centuries when dangerous abortions were a real threat to a woman's life. The punishment they call for reflects that. And they were imposed on the global south in the 19th century by European colonial countries, across their colonies. Hence, these laws were written by only a few countries as long ago as 170 years ago. Today, more and more countries are removing abortion from their criminal law. This happened in Canada in 1988 by a Supreme Court decision and has happened most often since then in Europe (e.g. across Scandinavia, France, Belgium, Luxemburg) and across most of Australia. China has no law on abortion at all, let alone a criminal law.

Abortion to save the woman's life

On page 11, you state that abortion will remain available to save the pregnant woman's life. This is obviously very important. It is permitted in almost every country but it accounts for the least number of abortions, especially in countries where women are healthy and where maternal deaths in general are low due to good quality maternity care.

Risk to the woman's health and mental health

You say abortion will be permitted if there is a risk to the woman's mental health, in line with the UK Supreme Court's judgment. This raises the question of what "risk to mental health" means. The World Health Organization (WHO) definition of health is "A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." To be forced to carry an unintended/unwanted pregnancy to term because of the refusal of abortion must surely be seen as a threat to any woman's mental health and well-being. Yet you currently interpret this to cover only pregnancies resulting from rape or incest, which involve a wide spectrum of abuses. This is a very narrow interpretation, far too narrow, and we urge you to reconsider and revise this in line with practice in most countries that allow abortion on this ground.

You may be aware that in New Zealand, almost all abortions under the law since the late 1970s are permitted on the ground that refusal of abortion would create a risk to the woman's mental health. The current Prime Minister of New Zealand considers this too narrow and is planning to reform the law in the coming year, probably to permit most abortions at the woman's request.

In their 2012 guidance, the World Health Organization said: "Legal restrictions on abortion do not result in fewer abortions nor do they result in significant increases in birth rates. Conversely, laws and policies that facilitate access to safe abortion do not increase the rate or number of abortions. The principle effect is to shift previously clandestine, unsafe procedures to legal and safe ones. In Gibraltar, refusal of abortion forces women to go to other countries, e.g. Spain. Surely the point of your revised law should be to make travel to

other countries unnecessary. We therefore hope you will re-think the limits you wish to place in relation to this crucial legal ground.

Jumping to the top of page 12 for a minute, the phrase “certifications in respect of the potential ‘permanent grave injury’ to physical or mental health” appears. Is this actually the language you intend to use to describe risk to health or mental health? We urge you not to do so, for the same reasons as New Zealand has acknowledged.

Unwanted pregnancy is a common event. For most women, it happens only once, and then “lesson learned”. Where abortion is legal, i.e. across most of the developed world, women are not seeking abortions because they are a physical or mental wreck (see Bourne whose case involved the gang rape of a child). Many are due to contraceptive failure, or failure to use contraception. They occur among single women who are too young to get married, who may still be in school, or don’t have a steady partner, or they were at a party and the condom slipped off. There are also women with several children already, women with low pay and poor housing, women whose partner is violent, and so on, who cannot cope with another child. Girls and women move in and out of these various “stages” over the years. None deserves the punishment of having to carry an unwanted pregnancy to term, surely. Having sex is unfortunately not an indication of readiness or qualification for motherhood in today’s world (and it never was). Seeking abortion in these circumstances is the responsible thing to do. To have a baby one cannot look after is not good for the child, above all.

Fetal anomaly

As regards fetal anomaly, the allowance of abortion only for *fatal* fetal anomaly is definitely not the norm internationally. Indeed, it did not exist in abortion law until quite recently, when it was included in the 2017 law in Chile and has been proposed in Honduras, where abortion remains completely illegal, and in Poland, where it was proposed as a way of narrowing even further their current law, in which abortion for serious fetal anomaly is the only ground allowed in addition to saving the woman’s life. The population rejected this further restriction overwhelmingly.

In almost all other countries, serious fetal anomaly is the accepted ground for legal abortion. Limiting the law to fatal fetal anomaly is supported only by anti-abortion groups working across borders to reduce the number of abortions by whatever means they can find. Your addition of the following ground is presumably to take account of this:

“if the child were born, it would suffer from such physical or mental abnormalities as to be seriously disabled”.

However, that wording may entangle you in legal challenges as to what constitutes “seriously disabled”, something quite different from serious fetal anomaly – the one being a state or condition after birth and the other before birth. Abortion law should address itself to serious fetal anomaly before birth. We would strongly recommend that you follow the language of serious fetal anomaly, as in the British 1967 Act, which is considered to have the best possible language and approach for permitting this ground.

Where abortions can be carried out and by whom

This section on page 12 speaks of restrictions to ensure the woman’s safety. However, please note that abortion is one of the very safest clinical procedures that exists in health care. That is because the two main methods of abortion – (manual) vacuum aspiration and medical abortion – are simple, require a basic training but do not involve complex surgical or other procedures as they used to, prior to 1980 or so. Provision of medical abortion pills is managed by nurses and midwives across much of Europe, in many states in the USA, and recently in Canada. The World Health Organization (WHO) in fact recommends moving management of most abortions (in the first trimester) away from obstetrician-gynaecologists and away from

hospitals, and into primary care settings managed by GPs, nurses and midwives. See [Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception](#), 2015.

The outdated method of dilatation & curettage (D&C), for example, common in the 20th century, did require surgical skill and general anaesthesia, and therefore an overnight hospital stay. However, WHO has not recommended using D&C since long before the year 2003, when they published their first safe abortion guidance. See also: WHO's [Safe Abortion: Technical and Policy Guidance for Health Systems](#) (2012) which is due for updating next year.

There is only one surgical abortion method used in the second trimester, mostly after 20 weeks of pregnancy, dilatation & evacuation (D&E). This does need to take place in a hospital setting by a skilled gynaecologist. However, in Sweden for example, there are so few abortions after 18 weeks that it is impossible for any clinician to keep his/her skills up. So almost all second trimester abortions take place with medical abortion pills in a clinical setting. These too are managed by midwives and nurses, with back-up from a more senior person if and when required. Because of this, D&E is going out of use in many places.

It is important to understand that if early abortion is easily accessible, almost all abortions take place by 12-14 weeks, with exceptions. The minority that are later consist of: girls and others (such as older women who thought all that was over) who do not recognise they are pregnant for some time; rape victims who are ashamed and wait a long time before asking anyone for help; and those with fetal anomaly which is not diagnosed until the second trimester, often around 20+ weeks.

We believe it is important to make abortion as early as possible. Medical abortion pills can be used at less than 6 weeks, as soon as a woman misses her period and confirms she is pregnant. This should be encouraged and affects how and where abortion is provided.

Upper time limit

You note that the 1967 Abortion Act allows abortion up to 24 weeks. There is no time limit if the life of the woman is at risk or in cases where fetal anomaly has been diagnosed later than a 24-week limit would allow. We would strongly recommend you follow this as well. Only 1% of abortions in Britain take place after 20 weeks but they are all among the most vulnerable women, either with a late diagnosis of serious fetal anomaly, or those who have had a really difficult time asking for or finding help, or those whose life circumstances change suddenly (e.g. sudden loss of a job or a partner). Allowing abortion up to 24 weeks is not an encouragement to have a later abortion but only keeping a door open for those who didn't succeed earlier. The goal is always to encourage abortion to be as early as possible through education and accessible services that everyone knows how to find.

You say most respondents to your call for comments recommended an upper time limit of 10 to 14 weeks. We can only assume these were anti-abortion groups and individuals. No one who understands and supports the need for abortion would make such a recommendation. We strongly urge you to listen to those of us who speak for the reality of the lives of girls and women.

In both the short and long run, the problem with limiting yourself to 10-14 weeks is that you will force the minority of women to continue to travel outside of Gibraltar if they are beyond that point. If you want to meet women's and girls' needs, you must not be moved by people who wish abortion didn't exist and who propose laws to punish anyone who seeks an abortion.

One in four pregnancies worldwide ends in an induced abortion, legally or otherwise. Abortion is as old as history. It's a normal part of our lives, a consequence of unprotected sex, coercive sex, contraceptive failure and damaged pregnancy. No one has ever been able to prevent it, even with the threat of life in prison.

Do you really want to continue to treat women like criminals, appointing gatekeepers who can turn them away, making it difficult for them to get help? We hope not. That is not at all in the spirit of the UK Supreme Court judgment, let alone the position of the UN Human Rights Committee or CEDAW. We understand Gibraltar has signed up to CEDAW?

Conscientious objectors

We believe conscientious objectors should not have to be involved in abortions. However, we also believe that they should not be able to stop women from having abortions within the terms of the law. There is only one good way to ensure this problem does not hurt providers or patients. That is, to ensure that there are enough people willing to provide abortion care that objectors do not have to do so. It also means objectors cannot be allowed to take up jobs that involve – or even *may* involve, e.g. as an emergency – doing an abortion or assisting with one. This can be taken care of via employment contracts which state either that abortion provision is part of the job, or that it is not. That is what they do in Sweden. There, the situation is crystal clear for everyone. It does mean, however, in Sweden, that no one can become an obstetrician-gynaecologist or a midwife in the public health system if they plan to be conscientious objectors to abortion. We agree. We say: you can't have your cake and eat it too.

Social and Health Care

This section of the Command Paper was unexpected, especially the paragraph on support mechanisms. To require women to say they have mental health problems in order to get an abortion, and in the next breath say that they must not be allowed to claim that these problems are related to their social and economic circumstances, is a convoluted way to make it impossible to have a legal abortion. If you think women will submit to “social services advice” (defined how precisely, and to what end?) or suddenly all agree to fostering or adoption of the child-to-be instead of abortion, you really need to think again. It won't happen. Even if foster parents and adoptive parents grew on trees, instead of being scarce, women are seeking abortion because they do not want to give birth to a child, for any reason. We strongly advise you to remove this paragraph altogether.

As regards access to contraception, yes, of course. We fully agree that this is part of what it means to provide comprehensive abortion care. But we would never agree that a condition of getting an abortion is a requirement to “accept” a contraceptive method.

As regards paragraph 3 on page 15, on clinical advice, we do not understand any of it, and hope you will revise it so as to make what it intends clear. If it means women should still be advised they can use emergency contraception to try and prevent pregnancy, we agree. If it means women seeking abortion need to be informed that there are two main methods of abortion and what they entail, that too we wholly support.

We hope you will add something about making training or abortion provision available in nursing, midwifery and medical schools, that you will confirm you will approve mifepristone and misoprostol for medical abortion and that you will ensure these pills are available from pharmacies (on prescription), and in general commit to implementing WHO's guidance on setting up services.

Penalty

We strongly urge you not to park this law in the 19th century, ignoring the pronouncements of WHO, the Human Rights Committee and CEDAW, among others, as well as almost 20 years of WHO's guidance and recommendations. Their pronouncements and guidance are based on the understanding that the right to life and health for women can only be achieved without discrimination if they have access to safe contraception and safe abortion – without punishment, without impassable barriers, and without gatekeepers whose main role is to say no, or to pick and choose who gets in the door and who does not.

If you actually want to continue to treat abortion as a major crime, if you intend to allow abortion only up to 10 or 12 weeks when you know that you will be discriminating against a vulnerable minority, and if you expect women to be at death's door or on the edge of a total mental breakdown before you are willing to allow them an abortion, then it is likely you will see only a few abortions a year in Gibraltar and most will continue to travel elsewhere. This is certainly what can be predicted from the draft law in the Command Paper.

However, with such a limited bill, is it possible you will actually not be complying with the UK Supreme Court judgment, by changing so little? Have you taken legal advice on this?

Recommendation of an Alternative Text

The following is a suggest wording for an alternative bill on abortion:

1. To permit abortion at the request of the pregnant girl/woman up to 14 (or 18 or 22) weeks of pregnancy.

Please note that Sweden permits abortion on request up to 18 weeks and Queensland, Australia has just passed a law allowing abortion on request up to 22 weeks of pregnancy. So 14 weeks now seems far more conservative. The bill tabled in Argentina in May 2018 allowed abortion on request up to 14 weeks with a long list of permissible legal grounds beyond that.

2. To permit abortion up to 24 weeks of pregnancy if:

a) there is a risk to the health or mental health of the woman greater than if the pregnancy was terminated, taking into account the woman's social and economic circumstances and those of her existing children.

b) the pregnancy is a result of rape or sexual abuse.

The importance of taking into account the girls' and woman's social and economic circumstances and the circumstances of her existing children is one of the most important strengths of the British 1967 Act.

3. To permit abortion at any stage if the woman's life is at risk from continuing the pregnancy, or if there is a risk of serious fetal anomaly.

4. A health professional should sign the form for recording abortion details to signal their approval in good faith that the woman's reason(s) for abortion are within the law. A health professional should be trusted to do so.

5. Appointments for abortion should be booked to take place no longer than a week after an abortion is first requested, and preferably less. A central booking service could be considered to distribute appointments across available providers equitably, as in Scotland.

5. Training in provision of abortion methods approved by the World Health Organization will be offered in medical, nursing and midwifery schools. Pharmacy students will also be taught about safe and effective use of medical abortion pills, so that they are able to answer questions and give information. These pills should be available from pharmacies on prescription.

6. Provision for abortions will be made at primary care level to meet expected need up to 14 weeks of pregnancy. A choice of abortion method should be offered. Routine ultrasound is not required by WHO.

a) Manual vacuum aspiration and vacuum aspiration can be provided by GPs, nurses and midwives at primary care level who have been trained to do so up to 14 weeks of pregnancy, e.g. in GP practices, or by midwives, or by nurses in family planning clinics.

b) Medical abortion pills can also be provided by GPs, nurses and midwives who have been trained to do so, with the woman instructed on how to use the pills. Pills can be used at home

up to 10 weeks of pregnancy. Some doctors are pushing the envelope on this and finding that women can use the pills safely at home until 14 weeks. But this is not yet an official recommendation.

c) A helpline should be set up providing 24-hour support in case women have any concerns or questions during or after the abortion.

d) Post-abortion care should be available in an appropriate hospital gynaecology clinic in case of complications. It is unlikely that this will be needed except rarely.

e) Use of a contraceptive method should be discussed in person before the abortion and a method provided at that time or just after the abortion, as appropriate. Women should not, however, be required to accept a method, nor a specific method

f) A follow-up phone call should be made to the woman to check she is not experiencing complications, and a reminder about obtaining or using contraception given. She should be advised that if she has symptoms or signs of continuing pregnancy, or signs of complications, she should return to the clinic for a check-up. Routine check-up in the absence of perceived problems should not be required. Most women know when they are still pregnant.

One or more additional doses of misoprostol should be recommended to complete an incomplete abortion.

7. Second trimester abortions should take place in a hospital outpatient clinic, with medical abortions managed by a trained nurse or midwife and D&E by a trained clinician.

There should be a list of primary care clinics and hospitals where abortion services are provided, available on the internet and through GPs and family planning clinics. Employment contracts to work in those clinics should stipulate that provision of abortion care is part of the job description.

8. Conscientious objection to abortion is permitted and must be declared in writing. Anyone with a conscientious objection may not be offered a position in a clinic where they would be (or even may be, such as in an emergency) involved in abortion. This protects both patients' and clinicians' rights.

9. Guidelines for abortion providers should be issued, based on WHO guidance.

10. Cost of abortion will be paid for by ... the State if possible as with contraception as an essential reproductive health care service.

11. Data on all abortions should be recorded, including the woman's age, number of weeks pregnant at abortion, abortion method, cadre of provider, any complications. Data should be completely anonymous and restricted use only for monitoring the quality of care of the service, ensuring abortions are as early as possible, using approved methods and with very low complication rates.

12. Only the consent of the girl/woman seeking an abortion is required.

Signed,



International Coordinator
London, UK

E-mail: info@safeabortionwomensright.org