ONE

Introduction

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When people talk about the 'abortion question', what they generally mean is something like this: how should we balance the protection of unborn human life against the rights and interests of a pregnant woman to control her own body? Possibly, they also have in mind a further important (but analytically distinct) issue: how should law (criminal or otherwise) be deployed to enforce the answer given to the first question?

These are important moral and – for some – theological questions. However, this book does not engage directly with either of them. Rather, it aims to clear the waters, allowing them to be discussed in a way that is unmuddied by myths and misconceptions regarding matters of fact. In a debate where seemingly even the most basic empirical claims are disputed, the book offers a clear and succinct account of the relevant evidence. Where does public opinion stand with regard to the permissibility of abortion? What would be the likely impact of decriminalisation on women's health? Would it remove unnecessary restrictions on best clinical practice resulting in

the improvement of services, or would it rather amount to dangerous deregulation, removing essential safeguards against harmful practice? Would unqualified backstreet providers be left at liberty to offer unsafe services? Would it remain possible to punish those who cause women to lose wanted pregnancies through vicious assaults? And what lessons can we learn from the experience of other countries regarding the role played by criminal prohibitions on abortion and the likely impact of their removal?

While different people hold profoundly diverging views regarding the morality of abortion, the answers to these kinds of questions should not be a matter of moral disagreement. Rather, each can be answered through reference to robust clinical trials, well conducted observational studies, detailed consideration of demographic data, rigorous opinion polls, and careful analysis of relevant law. In the chapters to follow, the authors take on this work. They navigate a field in which high quality peer-reviewed studies, the findings of expert committees and data obtained from rigorous, representative opinion polls rub shoulders with ideologically driven pseudo-science, misleading lobbying literature, unsubstantiated media reports, personal anecdotes, and opinion data generated by 'push-polling'. All too frequently in public debate, claims that cite these various sources are wrongly offered up as if they have equivalent weight. Here, the authors sift and evaluate the evidence to offer a robust response to each of the questions discussed earlier, relying on the best available evidence. The aim is to ensure that readers are fully informed on these important questions of fact before they reach their own view on the moral issues at the heart of the abortion debate.

This introductory chapter begins by briefly explaining what is meant by the 'decriminalisation' of abortion, before outlining the relevant current law. It then moves on to offer an overview of trends in the incidence of abortion in the UK and how these have been shaped by broad demographic factors and sexual and reproductive health policy. Finally, the chapter considers

how reform might come about and what form it might take, before briefly introducing the five chapters to follow.

What do we mean by 'decriminalisation' of abortion?

In July 2019, *Time* magazine was forced to revise the headline that it had given to an earlier article, which had wrongly claimed that the Abortion Act 1967 had decriminalised abortion in England, Wales and Scotland (Haynes, 2019). The author of the original headline can, perhaps, be forgiven: he or she was far from alone in holding this mistaken belief. In a recent poll conducted by ICM, 69 per cent of the 2,002 people surveyed believed that abortion was currently 'completely legal if the woman requests it', with only 13 per cent identifying the correct legal position: that abortion is a 'criminal act unless certain strict conditions are met' (ICM, 2017).

For the purposes of this book, 'decriminalisation of abortion' is understood to mean the removal of those specific prohibitions that render abortion a criminal act, punishing the intentional ending of a pregnancy either by a woman herself or by a third party. Decriminalisation of abortion can be either partial (for example, where criminal penalties are removed only within a prescribed time period, say the first 24 weeks of pregnancy) or full (where no specific criminal prohibitions are retained at any stage of pregnancy).

We should also be clear about what 'decriminalisation' does not mean. Notably, following decriminalisation, the performance of abortions would not be exempt from criminal law: as will be described in Chapter Four, general criminal offences that apply to all medical treatment would continue to apply to non-consensual or dangerously negligent procedures. Nor does decriminalisation necessarily mean that there should be no specific regulation of abortion, merely that any such specific regulation should not be backed by criminal sanction. For example, while reporting of female genital mutilation is now mandatory in the UK, failure to report attracts not

a criminal sanction but a disciplinary one, enforced by the relevant professional regulatory organisation, such as the General Medical Council (section 5B, *Female Genital Mutilation Act* 2003). Likewise, when the Australian state of Victoria decriminalised abortion, it laid down specific requirements that must be met in order for an abortion to be performed after 24 weeks but backed them with a professional sanction, rather than a criminal one (see Chapter Six).

Current law in the UK

What are the specific criminal prohibitions that punish the intentional ending of a pregnancy? These are to be found in a number of statutes and common law provisions, which together constitute the oldest extant statutory framework governing any specific medical procedure (Sheldon, 2016). The law differs in significant ways between England and Wales, Scotland and Northern Ireland.

The Offences Against the Person Act (1861)

The Offences Against the Person Act 1861 applies in England, Wales and Northern Ireland. It is a product of mid-Victorian Britain: in the memorable words of Sir James Munby, subsequently President of the Family Division of the High Court and a member of the Court of Appeal, it was passed at a time when 'our society was only on the brink of the beginnings of the modern world' (*Smeaton* 2002: para 332). While excluding the abortion provisions from its recent review of the Offences Against the Person Act, the Law Commission of England and Wales found generally that the statute was 'outdated' and 'notoriously difficult to understand and use', noting that it relies on 'archaic and obscure' language and that its offences are poorly defined and incoherently classified (Law Commission, 2015).

The Offences Against the Person Act creates two specific abortion offences: 'unlawful procurement of miscarriage'

(section 58) and supplying or procuring an instrument or 'poison or other noxious thing', knowing that it is intended to be used to procure a miscarriage (section 59). A third, related offence of concealment of birth allows a woman to be charged where infanticide or late abortion is suspected but cannot be proven. Apart from some minor changes in available sentences, these provisions have survived largely unaltered since 1861. While in many countries, women are exempt from prosecution for inducing the miscarriage of their own pregnancies, the Offences Against the Person Act offences apply to the pregnant woman who self-induces a miscarriage as well as to a third-party abortionist. They draw no distinction between abortions earlier and later in pregnancy, thus capturing any procedure that occurs after implantation (six to twelve days after fertilisation). Under section 58, both women and third parties face the harshest potential penalty for abortion foreseen in any European country (Nebel and Hurka, 2015): life imprisonment.

The Offences Against the Person Act makes no explicit provision for therapeutic abortion, leaving doctors potentially liable for the same offence as unqualified abortionists. However, a creative judicial interpretation of section 58, offered in the case of *Bourne*, provided that abortion would be lawful where performed by a doctor in order to 'preserve a woman's life', with this phrase interpreted broadly to include cases where a termination might prevent her from becoming 'a mental or physical wreck' (*Bourne* 1938: 619). Until October 2019, this highly ambiguous test remained the legal basis for the very small number of lawful abortions performed within Northern Ireland each year, where it was restrictively interpreted, particularly in more recent years (Women and Equalities Committee, 2019: para 12; Chapter Five). However, Northern Irish abortion law was found to breach human rights norms, with the Committee on the Elimination of Discrimination Against Women recommending that fundamental reform of the law was necessary to render it human rights compliant (CEDAW, 2018; see generally Chapter Five). In July 2019, Parliament voted by

an overwhelming majority for the government to introduce regulations to implement CEDAW's recommendations should the Northern Ireland Executive not be re-established by 21 October 2019. When this date passed with no change at Stormont, sections 58 and 59 were repealed for Northern Ireland and a moratorium was introduced on any prosecutions under them. At the time of going to press, the government is consulting on how abortion services should be introduced and regulated within Northern Ireland.

These offences are prosecuted infrequently. In recent years, section 58 appears to have been charged most often in cases where a wanted pregnancy is lost as the result of an assault on a pregnant woman or following the non-consensual administration of abortifacients (Sheldon, 2016). However, a small number of prosecutions have also been brought against women in England who have self-induced miscarriages very late in their pregnancies (for example, *Catt* 2013), and against women in Northern Ireland, who terminated early pregnancies using pills acquired on the internet (Women and Equalities Committee, 2019; Chapter Five).

The Infant Life (Preservation) Act (1929) and Criminal Justice Act NI (1945)

A second statute, the Infant Life (Preservation) Act 1929, applies in England and Wales. Its terms are replicated in section 25 of the Criminal Justice Act (Northern Ireland) 1945. These statutes prohibit the intentional destruction of 'the life of a child capable of being born alive … before it has an existence independent of its mother', unless this is done 'in good faith for the purpose only of preserving the life of the mother'. Each statute contains a rebuttable presumption that capacity for life is acquired at 28 weeks of gestation, reflecting the state of neonatal medicine in the 1920s. Subsequent advances mean that this presumption is today likely to be considered to have been rebutted, with viability accepted to be reached some weeks earlier (Science and Technology Committee, 2007; Chapter Two). Again, this

offence has been charged infrequently and then generally in the context of assaults against pregnant women. It overlaps with the offence of 'unlawful procurement of miscarriage' under section 58 of the Offences Against the Person Act, offering an alternative charge where pregnancy has reached an advanced gestation. These statutes also foresee a potential sanction of life imprisonment. They do not apply to Scotland, where abortion remains an offence at common law (Gordon, 1967; McKnorrie, 1985).

The 2019 reform of Northern Irish abortion law did not include repeal of section 25 of the Criminal Justice Act. As such, it remains a serious criminal offence to end the life of child 'capable of being born alive'.

The Abortion Act (1967)

The Abortion Act 1967 applies in England, Wales and Scotland but not in Northern Ireland. It exempts those who conform to its requirements from prosecution under the abortion offences described earlier. The Act is a product of the moral climate and clinical realities of the 1960s, when widespread backstreet abortions resulted in significant maternal mortality and morbidity (Birkett, 1939; Dickens, 1966; Lane, 1974a). Abortion was then a far riskier, more technically demanding, surgical procedure which required the skilled hand of a doctor and, on average, a stay of over one week in hospital (Chapter Three; Lane, 1974a: table D4; Lane, 1974b: table 5.1).

These clinical realities were reflected in the restrictions contained in the Abortion Act. The Act was intended to ensure 'that socially acceptable abortions should be carried out under the safest conditions attainable', 'with all proper skill and in hygienic conditions' (*RCN* 1981: 575 and 569). It provides that, in order to avoid a criminal offence, three conditions must be met. First, two doctors must certify in good faith that an abortion is justified on the basis of one or more of the four broad grounds set out under the Act:

a) continuance of the pregnancy would involve greater risk than termination to the physical or mental health of the pregnant woman or existing children of her family (subject to a 24-week limit);
b) termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;
c) continuance of the pregnancy would involve greater risk than would termination to the life of the pregnant woman; or
d) 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'.

In determining whether the first two conditions are met, the doctors may take account of the pregnant woman's 'actual or reasonably foreseeable environment' (section 1(2)).

Second, the abortion must be performed by a registered medical practitioner, meaning that a doctor must 'accept responsibility' for the procedure (*RCN* 1981: 569–70, 575, 577). And, third, it must be performed on NHS or other approved premises, with this requirement underpinning specific licensing requirements on non-NHS service providers (see Chapter Four). Since 1990, the government has had the power to license a broader 'class of places' – such as GPs' surgeries or women's homes – for the performance of abortions performed using medicines rather than surgery (see Chapter Three). In an emergency situation, the requirements for two signatures and for an abortion to be performed in NHS or approved premises do not apply (section 1(4)).

The Abortion Act also affords healthcare professionals a statutory right of 'conscientious objection', whereby they can refuse to participate in treatment authorised under the Act (section 4). Further, it requires the notification of all abortions certified and performed, underpinning the publication of detailed annual abortion statistics (section 2). The Abortion Act does not make any provision for informed consent,

counselling or safeguarding. Nor does it offer protection from intimidation or harassment of those accessing services, with the Court of Appeal having recently recognised that such conduct can cause 'significant emotional and psychological damage' to some (*Dulgheriu* 2019).

In sum, UK abortion law is very old. It is characterised by unclear and archaic language, overlapping offences and harsh sentences. The relevant offences are very rarely prosecuted. While the Abortion Act was intended to ensure that abortions were performed by appropriately skilled professionals in hygienic conditions, it was passed at a time of very different clinical realities and social mores. Further, the basis for important protections of those who access services are to be found not within this framework but in general provisions of law (see Chapter Four).

We now turn to consider how abortion services have developed within this legal framework. How do abortion rates within the UK compare to those in other western nations? And how have they changed over time?

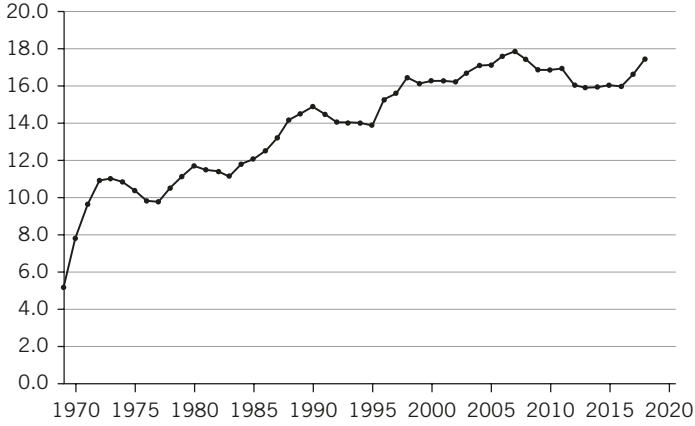
Reproductive and sexual health in the UK

Since the Abortion Act came into effect, abortion has become an increasingly widely accepted part of life (see Chapter Two). One in three women in the UK has an abortion in her lifetime and roughly one in five pregnancies end in abortion (Wellings et al, 2013). Around 200,000 abortions a year take place in England and Wales, with another 13,000 in Scotland. Roughly 5 per cent of the total are on non-resident women, although in recent years the vast majority of these have travelled from either the Republic of Ireland or Northern Ireland (DHSC, 2019a), meaning that this proportion is likely to decrease significantly in light of the recent liberalisation of the law in each of those places. Both the numbers of abortions carried out and rates per 1,000 women of reproductive age have fluctuated over time. Routinely collected statistics showed a sharp increase in

the reported abortion rate following the 1967 Abortion Act, which made it a criminal offence not to report abortions. As a result, for the first time, reliable statistics were available on the number of abortions carried out in Britain. What the official statistics showed unequivocally was the marked fall after the 1967 Act in infections and mortality resulting from illegal abortions (see Chapter Three).

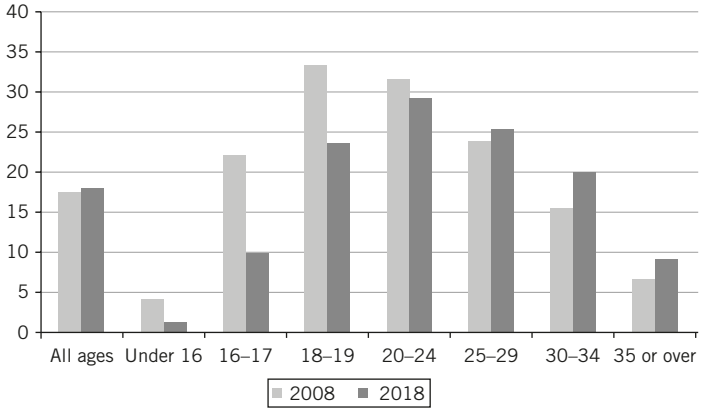
The rate of increase in reported abortions slowed from the early 1970s and actually fell from 1991 to 1995, possibly reflecting a more conservative attitude towards sexual behaviour generally in the era of widespread fear of AIDS and HIV transmission. Since the mid-1990s the abortion rate has been relatively stable in England and Wales (Figure 1.1), though there has been a very recent hike in the figures. In every 1,000 resident women of reproductive age, 17.4 had an abortion in 2018 compared with 16.7 in 2017, taking the rate back to its level in 2008 (DHSC, 2019a). Rates for Scotland remain

Figure 1.1: Age standardised abortion rate per 1,000 women aged 15–44, England and Wales, 1970 to 2018



Source: DHSC (2019a).

Figure 1.2: Abortion rate per 1,000 women by age, England and Wales, 2008 and 2018



Source: DHSC (2019a).

lower, while also hitting a ten year high in 2018, at 12.9 per 1,000 women (ISD, 2019).

Within the overall trends there are marked age differences (Figure 1.2). The abortion rate is highest among 20 to 24 year-olds and has changed less in this age group over the last decade, while rates among younger women have fallen year on year. The under-18 rate in 2018 of 8.1 per 1,000 women was less than half the 2008 rate of 18.9 per 1,000. Conversely, rates have been increasing among older women. The rate for women aged 35 and over was 9.2 per 1,000 in 2018, compared with 6.7 in 2008 (DHSC, 2019a). These same broad trends are visible in Scotland (ISD, 2019).

The majority of abortions are certified under the statutory ground of risk of harm to the mental or physical health of the pregnant woman. Only 2 per cent are the result of doctors deciding that there was a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped. Of abortions in England and Wales, 71 per cent were medically as opposed

to surgically induced in 2018, an increase on the 2017 figure of 66 per cent and almost double the proportion in 2008 (37 per cent). In Scotland, the figure was even higher: 86.1 per cent of abortions reported in 2018 were performed using medicines (ISD, 2019). An increasingly large proportion of abortions take place in the first trimester, with nine out of ten abortions carried out under 13 weeks. Since the advent of medical abortion, higher proportions of procedures have been carried out very early in the pregnancy: four out of five abortions were carried out under 10 weeks in 2018 (DHSC, 2019a; ISD, 2019). Contrary to the impression given in some media reports, late abortions are rare. Fewer than 2 per cent happen after 20 weeks, and these tend to be for particularly serious reasons (Nevill, 2017).

The abortion rate can be seen as an indicator of reproductive health. Strategic options for preventing unintended pregnancy occupy a continuum. At the start of the reproductive process they include methods of preventing ovulation by, for example, use of combined hormonal contraception. Where an egg has already been released, use of barrier methods of contraception and hormonal methods aimed at creating a hostile environment for the male sperm will prevent fertilisation. In the event that fertilisation has occurred, use of emergency contraception can prevent implantation. Finally, where an unintended pregnancy is already underway, medical or surgical methods of abortion can be used to end it. The earlier in this process that measures can be taken to prevent an unintended pregnancy, the better for the woman involved, the lower the costs to the NHS, and the lesser the scope for controversy. Any increase in abortion rates may reflect an unmet need for contraception.

Yet changes in the rates need also to be seen against the backcloth of recent demographic and social trends in Britain. There has been a progressive decrease over the past half century in age at onset of sexual activity, from a median of 20 for women born in the 1950s to a median of 16 for those born after 1990 (Wellings et al, 2013), and a parallel increase in the

average age at which childbearing begins, from 23 years in 1967 to 28.8 years in 2018 (ONS, 2019c). During the interval between these events, now averaging almost a decade and a half, women are single (defined as neither married nor cohabiting), sexually active and not wanting to conceive. The trend towards smaller families and the consequent need to space births and avoid further pregnancies following completion of childbearing has further led to an appreciable extension of the period during which women are potentially at risk of unintended pregnancy. Taking the average age of sexual initiation, 16 years, as the starting point and age 49 as the reproductive end-point, women now spend some 30 years of their lives avoiding unwanted pregnancy (ONS, 2019c).

Given these trends, it is surprising perhaps that the abortion rate in recent decades has remained relatively stable. In many respects, Britain can boast of being a success story in terms of national reproductive health and this is in large part due to contraception provision being free of charge under the NHS. While over half of pregnancies in Britain are planned, roughly one in six pregnancies are unplanned, and between a quarter and a third are categorised as ambivalent (Wellings et al, 2013). However, estimates from other high-income countries are higher. In France and the US, a third of pregnancies are estimated to be unplanned, two in five in Spain, and almost half in Japan (Wellings et al, 2013). Considerable success has also been achieved in relation to teenage conception. Conception rates for women aged under 18 years in England and Wales hit a record low in 2017 – declining by 60 per cent from 49.8 per 1,000 women in 1998 to 17.9 per 1,000 in 2017 (ONS, 2019a), the lowest rate recorded since comparable statistics were first produced in 1969. The fall in under 18 conceptions can be attributed to an increased time spent in education, investment in contraceptive services leading to improved uptake of reliable contraception, a change in social norms governing early motherhood, and investment in preventive programmes by successive governments, notably the Teenage

Pregnancy Strategy for England, 1999–2000 (ONS, 2016; Wellings et al, 2016).

Although most would probably consider abortion to be the least desirable of preventive options, sexual health policy in Britain supports its provision as part of the repertoire of strategies to reduce unintended births. Almost all abortions in Scotland, England and Wales are funded by the NHS. Whereas in Scotland, almost all are provided within the NHS, in England and Wales, the majority – 72 per cent – take place in the independent sector. Recognition that abortion provision is a key plank of reproductive health service provision in Britain has been reflected in successive policy documents (DH, 2013; PHE, 2015). Though not always escaping controversy, such guidance accepts the critical role of legal abortion in protecting the health and wellbeing of women who conceive unintentionally.

How might decriminalisation of abortion come about in the UK and what would it look like?

Full or partial decriminalisation of abortion in the UK would recognise the important role that abortion has come to play in reproductive health policy. It would require reform of some or all of the laws described earlier, passed by the relevant Parliament. In the case of England and Wales, this would be Westminster. For Scotland, abortion is a devolved matter so any reform is a matter for Holyrood. Abortion is also a devolved issue in Northern Ireland so, similarly, it would generally fall to Stormont to legislate. However, as noted earlier in the chapter, with the Northern Irish Assembly suspended since early 2017 and abortion law in Northern Ireland found to breach human rights norms, the UK Parliament recently voted to decriminalise abortion in Northern Ireland (see further Chapter Five).

The fact that decriminalisation necessarily requires a process of statutory reform means that national Parliaments are free to

shape a new law in whichever way they see fit (and this will also be true for Stormont, if and when an Executive is re-established). Important issues to be considered in this process include whether:

- to decriminalise abortion throughout pregnancy or just within certain gestational limits;
- to introduce specific new offences to prohibit non-consensual abortion; to revise existing offences that might do this work; or whether existing criminal law offences of assault and poisoning already offer sufficient protection (see Chapter Four);
- to retain specific statutory provision for conscientious objection and, if so, whether to include a statutory duty to ensure that women's timely access to services is not thereby impeded;
- to retain notification requirements;
- to make statutory provision for 'safe zones' around clinics, as has been done in some Australian jurisdictions, rather than leaving it to individual local authorities to apply for Public Space Protection Orders (*Dulgheriu* 2019).

One possible model of reform was foreseen in a Ten Minute Rule Bill, proposed by a cross-party group of MPs led by Diana Johnson (Abortion Bill 2017–19, HC Bill 276). This foresaw the repeal of sections 58–60 of the Offences Against the Person Act and the replacement of the existing abortion offences with two new offences that prohibited non-consensual abortion and abortion after 24 weeks. It retained provision for notification of abortions and protection for conscientious objection rights. Northern Ireland, where criminal prohibitions have been repealed, offers another model that might be extended elsewhere in the UK. Still other possibilities are offered by a number of Australian states that have recently decriminalised abortion, often removing offences modelled on those of UK law, and by Canada (see Chapter Six).

Content of the book

The rest of this book sets out the evidence that should inform debate regarding the repeal of specific criminal prohibitions against abortion. First, it explores the extent to which UK public opinion supports decriminalisation through a close analysis of available polling data (Chapter Two). It then moves on to assess the likely consequences for women's health of removing the legal restrictions imposed under the current criminal law framework (Chapter Three). This is followed by a legal analysis of whether decriminalisation is liable to result in a dangerous deregulation of services (Chapter Four). Given that the law there has evolved along different lines, Northern Ireland is treated separately, with Chapter Five exploring the impact of previous criminal abortion laws and the likely effects of their removal in the region. Finally, Chapter Six considers how the experience of other countries can inform our understanding of the potential consequences of decriminalisation of abortion, with a particular focus on two case studies that are frequently discussed in decriminalisation debates: Canada and Australia.