EVENT OVERVIEW

This event took place in Glasgow in August 2017. It was organised to mark the 50th anniversary of the 1967 Abortion Act, which regulates abortion provision in Scotland, England and Wales. The event addressed what has been achieved regarding abortion provision, and what remains to be done, specifically in the Scottish context.

The event was timely, given not only the anniversary of the Act, but also the devolution of abortion law-making powers to Holyrood; the case which has recently been made for full decriminalisation of abortion in Scotland; the commitment from the Scottish Government to allow home use of abortion medication, and to support for women traveling from Northern Ireland (where access remains severely restricted); increasing infringements on reproductive rights stemming from the USA; and potential uncertainties raised by the United Kingdom’s departure from the European Union.

1. Past

Following an introduction to the day by Dr Carrie Purcell, the morning session began with a talk from Dr Rose Elliot (University of Glasgow) on historical perspectives on abortion in 20th Century Britain. Elliot noted several key points:

- Historically, abortion and miscarriage were not viewed as two separate medical issues
- Lack of clarity meant there was little understanding of how common either type of pregnancy loss actually was (meaning assumptions filled the gap)
- Medical view that working class women did not typically seek medical help for miscarriage (because such a common occurrence) so if they did seek help it would suggest criminal interference gone wrong
- These factors increased the appetite for medical/legal control over abortion from 1930s onward

Ann Henderson (Abortion Rights Scotland) presented the history of the campaign for legal abortion in Scotland, and noted:

- 1967 Act is the single most attacked piece of public health legislation in UK history
- Something that has slipped off the political agenda, although Scottish Greens, and now Labour (for the first time) do have a specific policy on abortion
- Risk that, because young people have not seen the impact of illegal abortion first hand, the significance of safe provision may seem less acute

Dr Gayle Davis (University of Edinburgh) discussed Scotland’s role in shaping the Abortion Act and noted that, prior to 1967, abortion was not regulated at a Britain-wide level. Davis pointed out that:

- Pre-1967 in Scotland, abortion was a common law offence, meaning doctors acting ‘in good faith’ could legally provide abortion, and ‘criminal intent’ had to be proven to prosecute them
- However most doctors were not aware of this and thus were not taking advantage of the flexibility of Scots’ law
- Leading gynaecologist Sir Dugald Baird fought to keep Scotland included in the Bill that became the 1967 Act to increase access to abortion services across Scotland
- The 1967 Act, developed by Scottish MP (now Lord) David Steel, deliberately tied together social and medical criteria for abortion, influenced by Baird’s clinical practice
2. Present: Abortion Stigma

In this session, Prof Lisa McDaid (University of Glasgow) introduced the issue of stigma drawing on two studies of women’s experiences with ‘late’ and ‘repeat’ abortion in Scotland, noting that:

- Abortion is highly stigmatised, despite being a very common medical procedure
- It is often framed negatively (e.g. in media), with distinctions made between ‘good’ and ‘bad’ reasons for seeking abortion
- Negative framings have also appeared in Scottish policy framings (e.g. ISD Scotland’s focus on ‘repeat’ abortion; policy drive to reduce incidence of second trimester abortions)
- Abortion stigma may be experienced most acutely by women who have undergone more than one, or relatively later abortions
- A more positive view of abortion should be promoted, with the procedure presented as essential (rather than exceptional) healthcare

This was followed by an overview of the My Body My Life exhibition from Dr Lesley Hoggart (Open University). Drawing on UK-wide research, Hoggart explained that, whilst many women feel shame around their abortion and internalise stigma, others resist and reject it. The interactive travelling exhibition thus:

- Aims to challenge abortion stigma by sharing women’s real-life reasons and experiences of abortion
- Presents these experiences in the accessible format of a pop-up shop (and accompanying booklet), enabling visitors to engage with a wide range of stories
- Offers the option for visitors to contribute their own stories, which many have so far done

3. Present: Perspectives on Abortion Provision

This session provided four diverse perspectives on abortion provision, beginning with Dr Fiona Bloomer (Ulster University). Reflecting on the Northern Irish context, Bloomer highlighted that:

- Given severe restrictions on provision, an average of just 37 legal abortions take place in Northern Ireland each year
- Guidelines for health professionals on the legal grounds for abortion remain so unclear that women have been denied abortions when they have, on review, met legal requirements
- Around 1,000 women per year travel to England for treatment which, until 2017, had to be entirely self-funded
- Pressure from activists has now resulted in free provision for NI women in England and Scotland, but travel remains a significant barrier
- Women are increasingly accessing abortion medications online (illegally), which they can then take at home
- Opposition to abortion continues to have cross-party political support (mirroring language of anti-abortion groups), despite public opinion in favour of legal change

Anne Johnston (NHS Lothian) provided an experienced nurse’s perspective on abortion care in Scotland, in which she noted that:

- The increased use of early medical abortion (EMA) has led to greater nurse involvement in provision
- Increased nursing involvement helps to reduce waiting periods and can improve access to contraception
- Despite nurses’ willingness to take on additional roles, the 1967 Act requires two doctors’ signatures to approve eligibility for abortion, significantly slowing the process
- Alongside a change in the law, accredited training for nurses working in abortion care could enable them to provide start-to-finish, holistic care (including counselling, treatment, contraception)

Dr Audrey Brown (NHS Greater Glasgow / Chair of Scottish Abortion Care Providers’ network) reflected on her experience as a doctor working in abortion provision. Brown noted that:

- Low uptake of specialist abortion training among medical students (3500 have registered for specialist O&G modules since launched by RCOG, only 30 have completed the abortion modules)
- Much of this low uptake could be attributed to so-called ‘conscientious objection’, as allowed for in the 1967 Act
- General Medical Council guidance (2008) stipulates that doctors seeing women pre- or post-abortion treatment have no legal or ethical right to refuse to provide care (the right to object applies only to conducting the procedure itself)
- Access to abortion in Scotland may be negatively impacted by increasing opt-out by trainees

Note: The strength of activism in Northern Ireland has since led to the publication of a report by the United Nations’ monitoring committee for the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), which states that the ongoing absence of safe, legal abortion in Northern Ireland constitutes violence that may amount to torture or cruel, inhuman or degrading treatment.

Jane Fisher (Antenatal Results and Choices) discussed issues specific to a diagnosis of a fetal anomaly, highlighting that:

- Antenatal screening options (including the now-standard 20-week fetal anomaly scan) are increasingly being provided by the NHS
- Private sector screening is a booming, as more new tests become available, but there is need for clarity about whether tests offer diagnosis or just an indication
- Additional resources are necessary to support women and couples who receive an anomaly diagnosis - a painful, life-changing moment for them
- Support should cover the decision to continue or terminate the pregnancy, and include a choice of termination method (i.e. medication or surgery)
- Terminations for fetal anomaly are only about 1-2% of all terminations in Scotland
- ARC now has on-the-ground presence in Scotland (in shape of new ARC Coordinator for Scotland)
4. Future

The afternoon session opened with Dr Mary Neal (University of Strathclyde), who described the potential options open to the Scottish Government following the recent devolution of law-making powers to the Scottish Parliament. Neal identified these as follows:

• Leave the 1967 Act in place, i.e. keep the law as it is
• Repeal the 1967 Act and revert to the pre-existing common law arrangement
• Repeal the 1967 Act and replace it with something else – which would be required for full decriminalisation
• The latter would also require legislation in Scotland to remove the common law crime of abortion

Dr Jeni Harden (University of Edinburgh) addressed home self-management of early abortion. Harden noted that:

• Early medical abortions (EMA) in first 9 weeks of pregnancy account for the vast majority of abortions in Scotland
• However, interpretation of the 1967 Act has required women to be in approved clinical settings to take abortion medications, which must be taken 1-2 days apart
• This has meant that, even though they already have the option to return home to pass the pregnancy, women must re-attend clinics 1-2 days later to take that second medication
• The stipulation has resulted in some women experiencing the distress of significant cramping and bleeding while travelling home
• Despite this, women who had this experience said they were glad of the option to complete the process in the privacy and comfort of their own home, and many saw travelling in discomfort as a necessary "evil"
• They also described the importance of having accurate, realistic information from abortion services, to prepare them for what to expect, and the essential role of telephone support from nursing staff

NOTE: the Scottish Government have since approved the option for home use of misoprostol (the second of two medications required for early medical abortion) under nine weeks of pregnancy.

Ann Furedi (British Pregnancy Advisory Service) concluded the day’s presentations with a focus on guiding principles for future abortion provision and regulation in Scotland, and the UK more widely. Furedi emphasised that:

• Modern democratic society relies on the full participation of women. To do so, women must be able to control their fertility
• Contraception alone is insufficient, and abortion is a necessary back-up. Both forms of birth control aim to make childbearing a deliberate act – a decision made by the woman
• The law needs to reflect that abortion is a medical procedure (which needs regulation) AND a moral decision (which does not, and which women can be trusted to make for themselves)
• The decision-making should be a private, personal matter
• Abortion should be decriminalised, and regulated within the basket of health legislation that applies to related procedures in obstetrics & gynaecology (e.g. management of miscarriage)

5. Round Table: Where next for abortion in Scotland, and how do we get there?

The day concluded with a discussion led by Emma Ritch (Engender), with participants Lisa McDaid, Audrey Brown, Ann Furedi, Fiona Bloomer, and Mary Stewart of the Scottish Government. With input from the floor, the discussion identified four key points of action for the future of abortion provision in Scotland, namely:

• To challenge abortion stigma – with inclusion in comprehensive sex and relationships education, social media and public awareness campaigns, and positive portrayals of women’s abortion experiences
• To reform the current abortion law, with at least the removal of the need for two doctors’ signatures, and at best full decriminalisation
• To continue to develop provision so that nurses can provide all aspects of abortion care, and more medical students receive basic training in medical components of abortion care and the learning opportunities it can offer
• To continue to press for improved access to abortion services in Scotland, including self-referral for abortion, and provision within Scotland of abortion at later gestations

Want to know more?
Details on The Abortion Act at 50: Still Disputed Ground event and speakers can be found here.

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To find out more about the work of the MRC/CSO Social and Public Health Sciences Unit, visit www.glasgow.ac.uk/sphsu

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