Review of Abortion Law in Scotland

Expert Group Report

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Foreword

In the 2023-24 Programme for Government, the Scottish Government committed to undertaking a review of abortion law in Scotland ‘to identify potential proposals for reforms to ensure that abortion services are first and foremost a healthcare matter’.

Today abortions carried out in Scotland are regulated by a law passed in Westminster almost 60 years ago. The 1967 Act states that abortion can only be carried out legally if two doctors agree that a woman has grounds for terminating her pregnancy. Women in Scotland attempting to terminate their pregnancy without permission from two doctors can still be convicted of a criminal offence under common law criminal offences that date back hundreds of years.

Before 1967, abortion was illegal in the UK and, if discovered, could lead to a prison sentence for both the woman and her abortionist. Making abortion illegal does not prevent it. Before 1967 women in the UK knew that it was illegal, and they knew that they might die from having an abortion, yet they still did it. And it wasn’t just a few women, but thousands upon thousands every year. And they were women from all walks of life, rich and poor, married and single. The 1967 Act was a significant step for Parliament to allow abortion to take place at all. It brought an end to the widespread practice of illegal abortion that endangered women’s health and, sometimes, their lives, and so it was also a very positive step.

Today safe abortion is available throughout Scotland. It is a straightforward medical procedure that is a widely accepted part of our healthcare system. For some decades it has been regarded by the great majority of the public as an aspect of healthcare that should be available to women if it is in their best interests. The most recent British Social Attitudes Survey shows that 76% of people support allowing abortion if the woman does not want the child. In a recent study of healthcare professionals, more than 90% supported abortion being a woman’s choice and fewer than 9% of respondents felt that abortion should remain a legal issue. Most people in Scotland (including many healthcare providers), however, don’t know that abortion remains illegal except under the tightly controlled conditions of the 1967 Act.

Society has changed since 1967. The norm for women in the 1960s was marriage and children but in 2025, in contrast, one in five women choose not to have children. Medicine has changed. In 1967, it was felt that two - predominantly male - doctors, often one of them a psychiatrist, were needed to judge the mental fitness of women to have an abortion. In the 21st century, the paternalistic model of medicine has gone, replaced by a model aiming to put the patient at the centre of decisions. Most importantly, abortion care has changed. In 1967 all abortions were done surgically with women staying in hospital for up to a week after the procedure. In 2024, some 97% of abortions in Scotland were done using medical methods and the majority of those took place in the woman’s home.

There are no other medical conditions for which there is a law that proscribes exactly who can provide treatment, nor where it can occur. It is rightly assumed that registered healthcare practitioners who are appropriately trained and competent to perform the procedures will do them. In 2025 many medical procedures previously undertaken only by doctors are now routinely done by highly skilled nurses.

Reflecting these changes in medical practice, in recent years there have been changes, not in the Abortion Act itself, but in how it is implemented. The requirement for authorisation by two doctors remains, but in practice may be based on information conveyed to clinicians by other healthcare staff. The requirement that abortions must be performed by a doctor is interpreted to permit other appropriately trained nurses and midwives to carry out early medical abortion under the doctor's supervision.

In following the Scottish Government's instructions to ensure that 'abortion services are first and foremost a healthcare matter' an independent Expert Group comprising lawyers with expertise in medical/abortion law, clinicians responsible for delivering abortion services in Scotland and academics and representatives of women's groups representing the voice of 'lived experience' met monthly over the course of one full year. In reaching the recommendations presented in this report the Group took into account the complexities of the current law, examples of recently revised abortion laws from other countries, a wealth of evidence published in academic journals and other reliable sources and paid careful consideration to the views of around 50 stakeholders including many who believe that access to abortion in the UK should be more restrictive. It has been a complex process and in this report the Group presents the detailed justification for every recommendation that they make.

It is beyond time for the abortion law to catch up with the 21st century. While society and medicine have moved with the times, the abortion law has not. It is time for the Scottish Parliament to take a very positive step to modernise the abortion law for Scotland so that it reflects current practice and is fit for purpose.

Professor Anna Glasier OBE
Chair

1. Executive Summary

Abortion in Scotland is regulated by the 1967 Abortion Act. Before 1967, although abortion was illegal and could lead to a prison sentence for both the woman and the abortionist, thousands of women in the UK had an abortion each year and some of them died.

Clinical medicine has evolved significantly since 1967, as has the social and political context in which abortion is sought. This has changed the way that abortion is regarded and, most importantly, the way it is provided. In 1967, all legal abortions were done using a surgical procedure. In Scotland in 2024, 96.8% of abortions were medical abortions (using medicines), and 79.3% were early medical abortions carried out at home. Recognising the need for the law to be modernised and made fit for purpose, the Scottish Government's Programme for Government 2023-2024 committed to undertake a review of abortion law by the end of the parliamentary term (May 2026). The overall aim was to identify potential proposals for reforms to ensure that abortion services are first and foremost a healthcare matter.

An Expert Group was established comprising clinical, legal, academic and reproductive rights experts. The Group was tasked with reviewing the current law; considering whether any aspects of the existing law should be changed; if so, assessing the various options for reform; and providing recommendations on what a reformed legal framework could look like. The Scottish Government established the Group with the remit:

> "to provide recommendations to ensure that abortion services are first and foremost a healthcare matter and Scottish Ministers made clear their wish to ensure that patients in Scotland can continue to access abortions."[1]

The Group has carefully considered where it is appropriate to shift the regulation from abortion-specific criminal law to other, general provisions of healthcare law and clinical guidance. An overarching recommendation stemming from this review process is that a new Scottish Abortion Care guideline should be produced to ensure that best practice and patient safety remains at the core of service provision, following any changes to the legal framework.

The Expert Group structured its review around three key areas of Scotland's current abortion law: gestational limits and grounds; pathways to abortion care (including patient and provider pathways, data and reporting, and conscientious objection); and offences (including patient and provider offences and third-party offences).

For each topic, the Group began by reviewing the current law in Scotland. examining how the law operates in practice and the extent to which it aligns with the Group's agreed overarching principles, set out on page 26-27 of this report. The Group assessed the strengths and limitations of the current legal framework in relation to these principles and determined for each topic whether the existing law should remain in place or whether consideration of proposals for reform should be recommended.

[1] Scottish Government. (2024, August 21). Abortion Law Review Expert Group: Terms of reference.

The Group then considered stakeholder input. The Group recognises that abortion can be a polarising topic that attracts strongly held, sincere, and often competing views, which should be respected. The views of many organisations which campaign for restrictions to abortion in the UK were sought. In advance of each meeting around 50 organisations were contacted and invited to submit written evidence pertinent to the specific topic being discussed. The Group reviewed the perspectives put forward, and the quality and relevance of the supporting evidence presented. Alongside this stakeholder consultation, the Advisory Group of reproductive rights, women's and equalities organisations was convened to ensure that a concern for universal reproductive rights and gender equality was central to all stages of the Group's work, together with ensuring that the lived experience of pregnancy and abortion were represented throughout the process.

The Group also undertook a comparative review of international approaches to abortion law in order to identify instances of best practice focusing particularly on jurisdictions that had recently reformed or reviewed their abortion laws to treat abortion as a healthcare issue. These international examples were assessed both in terms of how they function in practice and how well they reflect the principles adopted by the Group.

Importantly, the Group sought and considered relevant evidence from peer-reviewed academic publications and other respected sources. Taking into account all the information and opinions gathered, the Group finally discussed potential models for legal reform. The manner of working and the justification for each of the recommendations made by the Group – and in some cases, alternative proposals offered – is presented in detail in the report.

The recommendations listed below reflect the Expert Group’s position throughout this process. The Group argues for a reformed abortion law that removes any oversight that has no medical justification and reflects the reality of current clinical practice where abortions are safely provided in the best interests of women. To this end, this report sets out 36 recommendations, among which the most significant are to remove the requirement for any grounds to be met and for two doctors to agree to an abortion before 24 weeks gestation, to enable any appropriately trained healthcare professional to provide an abortion, to amend the Grounds for an abortion over a 24 week gestational limit (while still requiring two doctors to agree), and to remove women from any criminal law relating to abortion. The evidence used to arrive at all the recommendations and the thinking behind them is laid out in detail in the appropriate section of the report.

The full list of recommendations are as follows:

Gestational Limits

1. The existing 24 week limit for most abortions should be retained.

2. Abortions after this gestational limit should be permitted under certain Grounds.

Grounds

3. No specified Grounds should be required to access abortion care up to 24 weeks gestation.

4. Decisions regarding abortions over 24 weeks gestation should be made in good faith by two healthcare professionals, who must agree that the abortion is appropriate, except in cases where an abortion is immediately necessary to save the life of the pregnant woman, in which case one healthcare professional may make a decision.

5. That Grounds for an abortion after 24 weeks' gestation are amended in an updated abortion Act to the following:

    1. An appropriately trained registered healthcare professional is authorised to provide an abortion for a person who is more than 24 weeks pregnant if –

        (a) the healthcare professional decides in good faith that performing the abortion is appropriate; and

        (b) the healthcare professional has agreed with one other registered healthcare professional that performing the abortion is appropriate

    2. In considering whether an abortion is appropriate, a registered healthcare professional should have regard to –

        (a) the gestational age of the fetus;
        (b) all relevant current and reasonably foreseeable medical circumstances of the patient and the fetus;
        (c) the patient's current and reasonably foreseeable physical, psychological and social circumstances.

    3. One appropriately trained registered healthcare professional may terminate a pregnancy without agreement from a second healthcare professional where they believe in good faith that an abortion is immediately necessary to save the life of the pregnant person.

    4. In the case of multiple pregnancy, anything done to terminate the pregnancy as regards one particular fetus is authorised only if that ground applies in relation to that particular fetus.

6. That no specific reference is made to sex-selective abortion within any updated abortion legislation.

Provision

7. Any appropriately trained registered healthcare professional should be able to provide abortion care at all gestations.

8. Healthcare professional should be defined in regulations, rather than in primary legislation.

Certification

9. The requirement for two doctors to certify an abortion before 24 weeks gestation should be removed.

10. Two healthcare professionals should agree that an abortion is appropriate after 24 weeks gestation, before proceeding with the abortion (except in emergencies).

11. There should be no formal certification requirements at any gestation, with decisions recorded in medical records.

Place

12. Legislation should not stipulate where an abortion should take place but should state that abortions must be provided by an NHS provider or a private provider registered with Healthcare Improvement Scotland.

13. Further consideration should be made by the Scottish Government on whether existing provisions to ensure private providers are regulated are sufficient. If deemed so, no abortion specific legislation should be required.

Counselling

14. Mandatory counselling should not be included in abortion legislation.

15. Clinical guidance, rather than legislation, should state that there should be timely access to counselling available for patients who wish to access it.

Mandatory Waiting Periods

16. Mandatory waiting periods should not be included in abortion legislation.

Conscientious Objection

The Group recommends that this provision should remain similar to the current legislation, with a number of amendments:

17. With regard to wording in section 4(1) of the Abortion Act which states that ‘no person shall be under any duty, whether by contract or by any statutory or other legal requirement to participate in any treatment authorised by this Act to which he has a conscientious objection’, the Group recommend that ‘by contract’ should be removed.

18. An inclusion of a duty on those with conscientious objections to refer patients on to somewhere they should be included in an updated conscientious objection clause.

Reporting and notification

19. The requirement to notify the Chief Medical Officer of an abortion should be removed.

20. The requirement to collect data should be included in any updated abortion legislation.

21. Any requirements on what data are to be collected should be in guidelines, not primary legislation.

Adults with Incapacity, Young People and Brain Stem Dead Patients

22. There should be no specific changes to primary legislation regarding adults with incapacity (AWI) or young people.

23. The courts should not be involved in authorising abortions for AWI.

24. The Mental Welfare Commission should ensure there are clearer pathways and guidance in future for helping ensure swift processes and support for AWI where an abortion is being considered.

25. There should be no specific additional requirements for young people.

26. There should be no specific additional requirements within abortion legislation for patients who are brain stem dead.

Positive Duty to Provide

27. The Scottish Government should include a duty to provide abortion services – or a 'right to abortion' – with said duty being on Scottish Ministers and Health Boards.

Offences in relation to women having abortions

28. There should be no offences for anyone ending their own pregnancy and any common law offences should be repealed.

Concealment of Birth

29. The Concealment of Birth (Scotland) Act 1809 should be repealed, and the crime of concealment should be repealed.

Offences in relation to healthcare staff

30. The common law offences for registered healthcare professionals who provide an abortion(s) outwith the terms of abortion legislation should be repealed.

31. The Scottish Government should consider how compliance with the provisions of revised abortion legislation will be enforced. The Group proposes two options relating to offences for healthcare staff:

    a) The Scottish Government may consider that existing law around healthcare, including the registration and regulation of healthcare professionals, is sufficient to appropriately enforce the law, and thus no specific statutory penalty should be created; or
    b) A new specific offence should be included for any healthcare professional who provides an abortion outwith the terms of the legislation. This should reflect provisions within The Abortion (Northern Ireland) (No. 2) Regulations 2020 where the maximum penalty is a fine, and prosecution should only be brought by, or with the consent of, the Lord Advocate

32. The Scottish Government should ensure that any new offences would not prevent innovation in contraceptive and abortion care, including the use of new medications, or the development of contragestives.

Abortions provided by someone who is not a registered healthcare professional

33. Any person who is not a 'healthcare professional' (as proposed by the Group and defined in Regulations) providing abortion services should be guilty of an offence. If this is already an offence the Group does not see any need for a separate offence to be created; however, if that is not the case, then a new offence should be created.

34. Any new offence should be carefully considered so as to avoid prosecuting anyone helping someone to access an abortion in good faith, such as a mother helping her daughter.

Procurement of abortion through fear, force, or fraud

35. The Group proposes two options in relation to coercion:

    (a) The Group's position is that existing offences would be likely to be sufficient to capture the most serious cases where coercion can be proven and that, given the complexity of coercion and the need to distinguish it from pressure or influence from others, it would realistically be difficult to prove in most cases. The Scottish Government could therefore decide that no new, specific offence is required.

    (b) However, if the Scottish Government decides that existing offences are not sufficient, a new specific criminal offence relating to reproductive coercion of all forms could be created. If this course of action is pursued, careful thought should be given as to how best to balance the offence in terms of policy goals and the experience of individual abuse survivors.

In either option, any clinical guidelines on abortion could provide recommendations to ensure all abortion providers have robust procedures in place to detect suspected coercion and support those involved.

Offences relating to ending a pregnancy without consent

36. The Scottish Government should consider if there should be an offence of a third party undertaking criminal acts against a pregnant woman which intentionally or recklessly causes the end of her pregnancy without her consent.

2. Abbreviations and Terms

2.1 Abbreviations

AAC	Advisory Appointment Committee
ACT	Australian Capital Territory
ARC	Antenatal Results and Choices
AWIA	Adults with Incapacity Act 2000
BAPM	British Association of Perinatal Medicine
BASHH	British Association of Sexual Health and HIV
BCOS	Bishop's Conference of Scotland
BMA	British Medical Association
BMFMS	British Maternal & Fetal Medicine Society
BPAS	British Pregnancy Advisory Service
BSACP	British Society of Abortion Care Providers
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CESCR	Committee on Economic, Social and Cultural Rights
CHI	Community Health Index
CMO	Chief Medical Officer
CO	Conscientious Objection
COPFS	Crown Office and Procurator Fiscal Service
CRC	Committee on the Rights of the Child
CRPD	Committee on the Rights of Persons with Disabilities
CRR	Centre for Reproductive Rights
CoSRH	College of Sexual and Reproductive Healthcare
DCMO	Deputy Chief Medical Officer

DDA	Disability Discrimination Act (1995)
DHSS	Department of Health and Social Security
ECHR	European Convention on Human Rights
EEA	European Economic Area
EMA	Early Medical Abortion
EMAH	Early Medical Abortion at Home
FFLM	Faculty of Forensic and Legal Medicine
FIGO	International Federation of Gynaecologists and Obstetricians
GMC	General Medical Council
GP	General Practitioner
HBs	Health Boards
HIS	Health Improvement Scotland
HSC	Health and Social Care
MHRA	Medicines and Healthcare products Regulatory Agency
MTOP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NICE	National Institute for Health and Care Excellence
NIPT	Non-Invasive Prenatal Testing
NMC	Nursing and Midwifery Council
PHS	Public Health Scotland
POMs	Prescription Only Medicines
RCGP	Royal College of General Practitioners
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists

RCPsych	Royal College of Psychiatrists
RPharmS	Royal Pharmaceutical Society of Scotland
SACP	Scottish Abortion Care Providers
SACHA	Shaping Abortion for Change study
SAAAC	South Australia Abortion Action Coalition
SALRI	South Australian Law Reform Institute
STOP	Surgical Termination of Pregnancy
SWA	Scottish Women's Aid
TOP	Termination of Pregnancy
VA	Vacuum Aspiration
VLRC	Victoria Law Reform Commission
WHO	World Health Organization
WHP	Women's Health Plan

2.2 Key Terms and Terminology

The "Group"

Throughout this report, the "Group" refers to the core members of the main Expert Group. Membership of that Group is set out on page 24-25 of this report.

Advisory Group

The Advisory Group refers to the group of reproductive rights, women's and equalities organisations who have provided direct input to the Expert Group through a representative. The full list of organisations represented on the Advisory Group is in Annex D.

Abortion

"Abortion" in this report refers to the intentional termination of a pregnancy and the associated treatment. This does not therefore include 'spontaneous' abortions, which are more commonly referred to as miscarriages, and associated treatment, and does not include treatment for ectopic pregnancy. The Expert Group uses the term "abortion" rather than "termination of pregnancy" (or TOP) in this report because it is widely understood by the public and in common use internationally.

Gestation

“Gestation” refers to the stage of the pregnancy and development of the fetus, usually measured in weeks from the date of the last menstrual period. The length of gestation in a healthy pregnancy varies but is commonly estimated to be around 40 weeks. This is divided into three periods called trimesters. The first trimester is from 0 weeks to week 12. The second trimester is from week 13 to week 27. The third trimester is from week 28 to birth.

Gestational Limit

“Gestational Limit” refers to the maximum gestation (or number of completed weeks of pregnancy) up to which a jurisdiction legally permits a woman to have an abortion.

Conscientious Objection

“Conscientious objection” refers to the circumstances where somebody decides not to provide or participate in the hands-on provision of a particular form of medical treatment – in this case abortion – because they do not agree with it. This may be due to religious beliefs or for any other reason. Most nations and states have some form of statutory or other protections in place that mean staff who have a conscientious objection cannot be required to provide abortion services.

Coercion (Reproductive Coercion)

“Coercion” refers to any form of behaviour that intentionally controls another person’s reproductive choices. These behaviours include forcing a person either to continue or to terminate a pregnancy.

Fetal Anomaly

“Fetal anomaly” or “congenital anomaly” refer to conditions which originate in a fetus before birth, including structural, and genetic anomalies such as neural tube defects, cleft palate, and Down’s Syndrome. Screening during pregnancy can detect some congenital anomalies before birth. Current abortion law in Scotland and across the UK permits abortion throughout pregnancy where there is a ‘substantial risk’ that the fetus or baby will not survive, or that the anomalies are significant enough to mean that the baby/child would be seriously disabled.

Fetus

“Fetus” is the medical term used for a pregnancy after the initial development of an embryo following conception. It becomes a baby (or neonate) at birth.

Medical Abortion

“Medical abortion” or Medical Termination of Pregnancy (MTOP) is an abortion which involves taking medication. This usually involves taking two sets of tablets (mifepristone and then misoprostol); the pregnancy is then passed.

Early Medical Abortion

“Early medical abortion” is a medical abortion which takes place during the first trimester of pregnancy. Early medical abortion at home (EMAH) refers to early medical abortions where one or both sets of tablets are taken, and the pregnancy is passed, outwith a healthcare setting. This may be at home, at a friend or partner’s home or in temporary accommodation depending on the patient’s individual circumstances.

Vacuum aspiration (VA)

“Vacuum aspiration” is a method of surgical abortion. It is a short outpatient procedure to end a pregnancy before 15 weeks, performed by a healthcare professional in a hospital or clinic, and uses gentle suction to remove the pregnancy from the uterus. Vacuum aspiration may also be used as a way to manage an incomplete miscarriage.

Surgical Abortion

“Surgical abortion” or “surgical termination of pregnancy (STOP)” normally involves removing the pregnancy (fetus) through the cervix using gentle suction (Vacuum aspiration).

2.3 Notes on Language

In this report we use a number of terms to refer to those who need and access abortion. We primarily use ‘woman’ or ‘women’ since the majority of individuals who access abortion are cisgender women and girls (women and girls whose gender identity corresponds with the sex they were assigned at birth) and abortion is a key issue for women’s equality. Additionally, much of the legal, health and research evidence which the Group reviewed refers only to cisgender women. However, we also use gender-neutral terms where appropriate, including ‘pregnant people’, and ‘patients’, in order to recognise that transgender men and boys, people who identify as non-binary or gender diverse, and intersex people may also need to access abortion. We wish to make clear that the issues we discuss are inclusive of all pregnant people who might wish to access an abortion

Down’s Syndrome terminology

It is generally accepted that both Down’s Syndrome (Trisomy 21) and Down Syndrome can be used interchangeably.

3. Introduction

The Abortion Act 1967 stands as a landmark moment in the history of reproductive rights in the UK and around the world. That Act, passed by the UK parliament and spearheaded by David Steel, the MP for Roxburgh, Selkirk, and Peebles, gave women a pathway to access abortion care legally and safely.

The law surrounding abortion profoundly shapes the lives of women. It determines the extent to which individuals can make autonomous, private decisions about what happens to their bodies and their future lives. It sets the terms of who needs to be involved in that decision and why. As such, the law reflects society's attitudes toward women and reproductive rights.

Moreover, the lack of legal abortion provision before the 1967 Act was passed certainly did not prevent abortions from taking place. Estimates of the number of abortions in the UK before 1967 ranged from around 10,000 to 250,000 illegal abortions taking place per year[2,3,4] with women at risk of death or permanent injury when those procedures went wrong. Indeed, by 1966, illegal abortion was the leading cause of avoidable maternal mortality.[5]

One of the most prominent campaigners for abortion law reform prior to 1967 refers to participants at a meeting she attended as part of the campaign for that Act:

> One after another of them…came up to me in the interval and said something like 'you know dear, I had an abortion, it was back in the 30s…Everybody you spoke to, if they hadn't had one themselves, or a daughter, they knew somebody who had. And many of them said, I looked after a friend, or my sister or somebody, when it went wrong.[6]

In Scotland, meanwhile, the common law which underpinned abortion provision saw significant differences in access to legal abortion care. Parliamentary debate at the time revealed that 1 in 50 pregnancies at that time were being legally terminated in Aberdeen, whereas in Glasgow that number was 1 in 3,750. In the 1960s, Sir Dugald Baird, Professor of Obstetrics and Gynaecology in Aberdeen, felt that the provision of legal abortion care in Aberdeen contributed to the low infant mortality and lower maternal mortality compared with other parts of Scotland. Aberdeen had an infant mortality rate comparable to the affluent south of England and a much-reduced incidence of women presenting as a result of septic abortion.[7,5]

The Abortion Act came into effect on 27 April 1968. Despite decades of ongoing debate between those against and in favour of legal abortion both in and outside

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[2] Dickens, B. M. (1966). Abortion and the law. Macmillan**;** Lane Committee (1974).
[3] Report of the Committee on the Working of the Abortion Act 1967 (The Lane Report) (Vol. 1, paragraph 506). Her Majesty's Stationery Office.
[4] Potts, M., Diggory, P., & Peel, J. (1977). Abortion.
[5] Ferris, P. (1966). The nameless. Hutchinson.
[6] Munday, D. (2023). Interview by Jane O'Neill. In S. Sheldon, M. Davis, J. O'Neill, & C. Parker, The Abortion Act 1967: A biography of UK law. Cambridge University Press.
[7] Baird, D. (1966). A fifth freedom? Eugenics Review, 58(4), 195–204.

parliamentary settings, today in Scotland, abortion is a common and safe procedure. Common, in that 18,710 women had an abortion in Scotland in 2024, and national statistics show that around one in three women in Britain will have an abortion during their lifetime.[8] This is in line with international estimates, which generally range between one in three women and one in four women.[9,10] And safe; national and international evidence shows that abortion performed in line with best practice is safe, and markedly safer than carrying a pregnancy to term. A study in the Obstetrics and Gynaecology journal found that pregnancy and childbirth was associated with a 14 times greater risk of death than abortion,[11] as well as higher overall morbidity linked to complications. Indeed, pregnancy and childbirth carries its own risks, both direct and indirect. In the UK and Ireland, the latest MBRRACE report for 2020-22 found a maternal mortality rate of 13.56 per 100,000 maternities.[12]

Clinical medicine has evolved significantly since 1967 and so has the social and political context in which abortion is sought. This has changed the way abortion is viewed and, importantly, the way it is provided in practice. In 1967, safe medical abortion did not exist, and abortion was a major surgical procedure, typically accompanied by up to a week's stay in hospital, with a significant risk of complications and, indeed, death.[13] In Scotland in 2024, 96.8% of all abortions were medical abortions (done using medicines rather than surgery), and 79.3% were early medical abortions at home (EMAH), in the first trimester.[14]

A growing emphasis on patient autonomy in healthcare provision has called into question many areas of legal involvement in abortion provision including, for example, the requirement that only doctors can provide abortion care, and that two doctors must certify an abortion at all gestations before it proceeds. These provisions were shaped by the medical, legal, social and political context of the Abortion Act 1967. For example, the requirement that two doctors must certify an abortion was created in a context in which doctors required legal protection from the potentially illegal act of providing an abortion outwith the provisions of the Act. It was also put in place in a context where one of the doctors who certified an abortion was often a psychiatrist, pointing to attitudes towards abortion at that time in which women were not deemed capable of making their own decisions. Social attitudes to abortion have changed significantly, and in today's clinical context women are – and should be – regarded as capable of making their own decisions about their bodies. It is clear that

[8] House of Commons Science and Technology Committee. (2007). Scientific developments relating to the Abortion Act 1967: Twelfth report of session 2006–07 (Vol. 1, HC 1045-I). The Stationery Office.
[9] Jones, R. K., & Jerman, J. (2017). Population group abortion rates and lifetime incidence of abortion: United States, 2008–2014. American Journal of Public Health, 107(12), 1904–1909.
[10] Chan, A., & Keane, R. J. (2004). Prevalence of induced abortion in a reproductive lifetime. American Journal of Epidemiology, *159*(5), 475–479.
[11] Raymond, E. G., & Grimes, D. A. (2012). The comparative safety of legal induced abortion and childbirth in the United States. Obstetrics & Gynecology, 119(2), 215–219.
[12] MBRRACE-UK. (2024). Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020–22. National Perinatal Epidemiology Unit, University of Oxford.
[13] The Lane Report recorded a maternal mortality rate of 9-126 deaths per 100,000 abortions (depending on which of the two surgical procedures then available were used) and an average length of hospital stay of 7.8 days in 1968. Volume 2, para 165.
[14] Public Health Scotland. (2024). Termination of pregnancy statistics: Year ending December 2024.

the Abortion Act is increasingly at odds with contemporary social attitudes and healthcare provision.[15]

The Scottish Government's Programme for Government 2023-2024 committed to undertake a review of abortion law by the end of the parliamentary term (May 2026), The overall aim of the review was to identify potential proposals for reforms to ensure that abortion services are first and foremost a healthcare matter.[16] As part of this review, the Minister for Public Health and Women's Health established a new Expert Group (hereafter the "Group") comprising clinical, legal, academic and reproductive rights experts. The Group was tasked with reviewing the current law; considering whether any aspects of the existing law should be changed; if so, assessing the various options for reform; and providing recommendations on what a reformed legal framework could look like.

There has been a recent increase in the number of women being investigated or prosecuted in England and Wales, suspected of inducing abortion at or beyond the legal gestation limits. This led to a vote in the House of Commons in June 2025 to remove women acting in relation to their own pregnancy from the criminal law related to abortion in those jurisdictions. The conversation around this change to the law has also progressed to discussion about wider reform of abortion law, including the decriminalisation of healthcare professionals involved in abortion care.

This follows substantive reform of Northern Ireland abortion law in 2019 and 2020 which began with the repeal of underlying criminal statute up to the point of viability via Westminster legislation, and the creation of regulations for legal abortion care provision by the Secretary of State for Northern Ireland. As a result of the law change, in the year ending March 2024, there were 2,792 abortions provided in Northern Ireland, compared to just 8 in the year ending March 2019.

Further, the work undertaken by the Group has taken place in the context of significant changes in abortion rights in many parts of the world.[17] Guided by a set of overarching principles, set out later in this introduction, the Group has considered very carefully and in detail, how the Scottish Government could ensure that access to abortion care is not only protected but improved through changes to the law. We have benefited from the input and expertise of a wide range of stakeholders in reaching the recommendations presented throughout this report. Our overarching goal is to ensure that abortion is seen primarily as a healthcare matter regulated by a law which is fit for purpose. We have aimed to balance the need to ensure patient safety whilst seeking to enhance the rights of everyone who requires access to these essential services.

3.1 Scope of the Review

The Group recognises that abortion can be a topic that may attract strongly held, sincere, and often competing views, which should be respected. The Group

[15] S Sheldon (2016) 'British Abortion Law: Speaking from the Past to Govern the Future' 79(2) Modern Law Review 283-316.
[16] Scottish Government. (2023). Programme for Government 2023 to 2024.
[17] Center for Reproductive Rights. The world's abortion laws.

benefited from a private seminar on the ethics of abortion, to provide helpful context on the perspectives that have been contributed throughout the review. However, the review itself does not cover the complex moral and ethical questions relating to abortion (such as when human life begins or concepts of personhood). Rather, the purpose of this review, and the remit of this group, was to consider the law and regulation of abortion as first and foremost a healthcare matter, similar to other equivalent healthcare services, and to make recommendations where the law could be improved. Within this, the importance of ensuring continued access to abortion was also recognised.

Further, the focus of this review is on the law on abortion and not on service provision. To provide an example, the Group did not discuss in detail the safety and practice of Early Medical Abortion at Home (EMAH), which was evaluated separately in 2023, alongside recommendations on how to improve provision and access to EMAH across Scotland.[18] However, the Group did consider how EMAH might be reflected within the law, taking into account the EMAH approval.[19] Some of the Group's discussions did cover aspects of service provision, where it was necessary to consider whether, and if so what, elements of service provision should be specified in legislation.

The Group was clear that their recommendations should not seek to deregulate abortion provision, which should remain subject to the same robust regulation that ensures the safety of other healthcare services. However, the Group have carefully considered where it is appropriate to shift that regulation from abortion-specific criminal law to other, general provisions of healthcare law and clinical guidance. An overarching recommendation stemming from this review process is that a new Scottish Abortion Care guideline should be produced to ensure that best practice and patient safety remains at the core of service provision, following any changes to the legal framework.

Much of the campaigning to modernise abortion law has focused on the decriminalisation of abortion, and discussions on offences (current offences and potential future models) have therefore formed a significant part of this review. However, at the start of this process, and as part of the terms of reference provided to the Group, it was considered important that all aspects of the current law relating to abortion should be covered. Decriminalisation of abortion alone, while a major step towards reproductive freedom in the UK, would not be sufficient to guarantee delivery of high-quality abortion care, as has been learned from other contexts globally. The Group certainly recognised that improvements to abortion care often originate from outwith the legal framework. However, it is fundamental that the regulatory framework itself should support excellent and high-quality abortion services for women and pregnant people in Scotland.

There were a number of reasons for expanding the scope of the review beyond just decriminalisation. These included aims of:

[18] Scottish Government. (2023, March 22). Telemedicine early medical abortion at home: Evaluation.
[19] Scottish Government. (2024, December 4). Updated approval on taking abortion medications outwith the hospital or clinic: CMO(2024)21.

- Modernising – ensuring the regulation of abortion recognises major shifts in clinical practice since 1967, alongside ongoing innovation in service provision, and is able to support evolving standards of clinical best practice.
- Removing unnecessary barriers that can cause difficulties for Health Boards and healthcare professional and create delays for patients accessing time-sensitive procedures.
- Understanding abortion as healthcare – to align with the Scottish Government's rights-based approach to healthcare, and to respect the review's terms of reference.

The review therefore included an in-depth analysis of the Abortion Act 1967. It examined the common law, noting that abortion provision outwith the terms of the Act may be considered a common law crime in Scotland. Additionally, the review considered other relevant laws to ensure appropriate controls and/or regulations around abortion services are recommended.

3.2 Ways of Working

The topics covered by the review include, but are not limited to: gestational limits, grounds under which abortion is permissible, patient and provider pathways (including, but not limited to, the places where abortion can be provided, who can provide abortions, and what legal requirements should exist for patients before they can get an abortion), data and reporting, conscientious objection, regulation, and offences, including patient and provider offences and third party offences. For each topic, the Group considered the current law, international examples, stakeholder views and evidence (the views of around 50 organisations were sought in advance of each meeting), and considered potential models for a reformed Scottish law before coming to an agreement on the model to be recommended. Further details on the process taken by the Group can be found in **Annex A.**

From the outset, the Group was clear that it would remain open to considering other issues based on input provided by stakeholders, and any additional topics that arose from the evidence that has been carefully considered. Feedback from stakeholders led to discussions on topics such as mandatory counselling, mandatory waiting periods, and the potential for specific offences around forced abortion or coercion.

3.3 Composition of the Expert Group

The membership of the Expert Group was carefully considered, with members selected to reflect a diverse range of expertise relevant to the healthcare focus of the review and its aim to develop recommendations that best serve the needs of those seeking and providing abortion care, while also considering the complexities of the matter. The composition of the Group has been criticised by a number of Pro-Life and Faith based groups for being 'unrepresentative'. When agreeing the membership, consideration was given to expertise in abortion law, medical law and provision of services in Scotland under the terms of the 1967 Act. The Group membership therefore focussed on experts and not 'representatives'. No core members of the Group specifically represent Pro-Life or anti-abortion organisations since the question of the morality or permissibility of abortion under the law was outside the remit of the review.

However, the Group has, from the start of the process, engaged with organisations and individuals representing a wide range of views, and has carefully considered submissions made by all stakeholders regarding the regulatory or legal status of abortion. Around 50 organisations were contacted in advance of each topic and invited to submit written evidence. The Group reviewed the perspectives put forward, and the quality and relevance of the supporting evidence

The membership of the core Group comprised:

- Professor Anna Glasier, Women's Health Champion and Expert Group Chair
- Professor Marion Bain, Deputy Chief Medical Officer, Representing the Chief Medical Officer
- Professor Sharon Cameron, Scottish Abortion Care Providers and consultant gynaecologist
- Dr Alastair Campbell, the Royal College of Obstetricians and Gynaecologists
- Rachael Clarke, British Pregnancy Advisory Service
- Dr Sinead Cook, College of Sexual and Reproductive Healthcare and Consultant in Sexual and Reproductive Health
- Professor Anne-Maree Farrell, Professor of Medical Jurisprudence at The University of Edinburgh
- Andrew Lothian, Law Society of Scotland, Health and Medical Law Sub-Committee
- Dr Lynsey Mitchell, Senior Lecturer in Scots Private Law, University of Strathclyde

- Dr Carrie Purcell, Research Fellow in Sexual and Reproductive Health, The Open University

- Professor Sally Sheldon, Professor of Law at the University of Bristol and expert in the UK’s abortion law

- Dr Sarah Wallage, Scottish Abortion Care Providers and Consultant in Sexual and Reproductive Health

- Jill Wood, representing the Advisory Group of reproductive rights, women's and equalities groups.

3.4 Overarching Principles

The Scottish Government established the Group with the remit:

> "to provide recommendations to ensure that abortion services are first and foremost a healthcare matter and Scottish Ministers made clear their wish to ensure that patients in Scotland can continue to access abortions."[20]

The Group understands that abortion raises important moral questions upon which reasonable people have sincerely held, yet sometimes starkly opposed views. In recognising that abortion services should be treated 'first and foremost as a healthcare matter,' it does not deny these moral views. The Group notes that many other areas of healthcare practice likewise raise important moral and ethical issues. It believes that all healthcare provided in Scotland should be underpinned by a strong regard for medical ethics, human rights, equality law, and the principles set out in the Scottish Patient Rights Charter and the Scottish Government's Health and Social Care Standards.[21]

The Group interprets its terms of reference to require consideration of how abortion services should be regulated and delivered as part of a comprehensive and integrated health service designed to secure improvement in the physical and mental health of the people of Scotland. It notes that effective and timely fertility control is essential to health and wellbeing, and that abortion is a common procedure that has been offered within Scottish health services for many decades. It has worked to consider how best to ensure effective and proportionate regulation that supports the continued development of high quality, accessible abortion services, taking account of the best available national and international clinical evidence and guidelines, as well as the views of stakeholders.

These concerns have been integral to all aspects of the Group's work and underpin the recommendations to follow throughout this report. In addition to the overarching remit provided by Ministers, the Group established some overarching principles against which it has measured all potential models for reform. These principles are as follows:

1. **Supports equitable access to abortion care –** Does the potential model promote equal access to abortion as a means to improve healthcare outcomes for all, taking intersectionality into account?

2. **Advances gender equality –** Does the potential model situate abortion appropriately within wider structural gender equality aims?

3. **Positive impact on service delivery –** Does the potential model improve provision of, or access to, care for patients and abortion providers and avoid creating unnecessary barriers to future potential beneficial innovations in service delivery?

[20] Scottish Government. (2024, August 21). Abortion Law Review Expert Group: Terms of reference.
[21] Scottish Government. (2017). Health and social care standards: My support, my life.

4. **Complies with international human rights standards –** Does the potential model comply with various international human rights standards on abortion?

5. **Evidence-based –** Does the potential model have a strong evidence base, including clinical and academic evidence and consideration of stakeholder feedback?

These overarching principles guided the discussions carried out during the Group's review.

4. The current law on abortion in Scotland: An Overview

Abortion in Scotland is governed primarily by the Abortion Act 1967 (the "Act"), which also applies, in an amended form, in England and Wales.[22] Control over abortion law, and the Abortion Act 1967, has been devolved to the Scottish Parliament since 2016. The Act sets out the circumstances under which a termination of pregnancy may be lawfully carried out. Provided that the requirements of the Act are satisfied, a medical practitioner will not commit an offence under common law abortion offences in Scotland.

The Group's review began with consideration of the current law in Scotland, including the 1967 Act (as amended), Scottish common law, and relevant regulations and other relevant Acts. Understanding the legal framework and its interpretation in practice is important to assess whether the law remains fit for purpose and consistent with modern clinical practice and human rights standards.

4.1 Time Limits and Grounds for Abortion

The 1967 Act did not include a specific upper gestational time limit for abortions until 1990, when the Human Fertilisation and Embryology Act 1990 amended it.[23] The amendment introduced a 24-week gestational limit in section 1(1)(a) for abortions performed on the grounds of risk to the physical or mental health of the pregnant woman or her existing children of her family (Grounds C and D as set out below). This was the first time a formal statutory time limit applied in Scotland.

No upper time limit applies in relation to abortions carried out under the other statutory grounds.

4.2 Statutory Grounds for Abortion

Under section 1(1) of the Abortion Act, a pregnancy may be terminated lawfully where two registered medical practitioners are of the opinion, formed in good faith, that at least one of the following grounds applies:

> (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.

[22]UK Parliament. (1967). Abortion Act 1967.
[23] UK Parliament. (1990). Human Fertilisation and Embryology Act 1990.

Section 1(4) permits one medical practitioner to terminate a pregnancy where believed, in good faith, to be immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

The Abortion (Scotland) Regulations 1991[24] (as amended) further breaks these sections down into grounds used by clinicians to report abortions authorised under the Abortion Act. Reference to these grounds is made throughout this report.

- **Ground A:** That the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated.
- **Ground B**: That the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.
- **Ground C:** That the pregnancy has not exceeded 24 weeks and that continuing it would involve greater risk (than termination) of injury to the physical or mental health of the pregnant woman.
- **Ground D:** That the pregnancy has not exceeded 24 weeks and that continuing it would involve greater risk (than termination) of injury to the physical or mental health of the existing children of the family of the pregnant woman.
- **Ground E**: That there is a substantial risk that the child, if born, would suffer from such physical or mental abnormalities as to be seriously handicapped.
- **Ground F**: That the termination is necessary immediately to save the life of the pregnant woman.
- **Ground G**: That the termination is necessary immediately to prevent grave permanent injury to the physical or mental health of the pregnant woman.

4.3 Emergencies and Single-Doctor Authorisation

Under section 1(4) of the Act, a registered medical practitioner may carry out an abortion without the approval of a second doctor under Grounds F or G above in an emergency situation, where it is immediately necessary to save the woman's life or to prevent grave permanent injury to her health, recognising the need for urgent clinical discretion in critical situations.

4.4 Role of Healthcare Practitioners

Although the Act requires that abortions be carried out by a registered medical practitioner, in the case of Royal College of Nursing v DHSS [1981], the House of Lords (now the Supreme Court) confirmed that nurses may carry out parts of the abortion procedure, provided that they are acting under the direction of a doctor who retains overall responsibility.[25]

4.5 Places Where Abortions Can Lawfully Be Carried Out

[24]United Kingdom. (1991). The Abortion (Scotland) Regulations 1991 (S.I. 1991 No. 460 (S.41)).
[25]House of Lords. (1981). *Royal College of Nursing of the United Kingdom v Department of Health and Social Security* [1981] AC 800, [1981] 1 All ER 545 (HL).

Section 1(3) of the Act states that an abortion must be performed either in an NHS hospital or a place approved by the Scottish Ministers.

Under section 1(3A), a **"**class of place**"** may also be approved, allowing greater flexibility. This has been especially relevant in the context of early medical abortion at home and in other settings, where Scottish Ministers have approved certain homes and other locations as settings where abortion medication can be taken in certain circumstances[26].

4.6 Regulatory Requirements Under Section 2 of the Act

Section 2 of the Act requires Scottish Ministers to make regulations concerning:

- The certification process by the two doctors;
- The notification requirements to the Chief Medical Officer (CMO);
- And the confidentiality provisions regarding the sharing of information related to abortions.

These requirements are fulfilled through the Abortion (Scotland) Regulations 1991[27], amended in 2021. Under these regulations:

- Two doctors must complete and sign a standard form (the "green form") to confirm that the statutory grounds are met. This form must generally be completed before the procedure, except in emergencies, where it may be completed within 24 hours (and signed by only one doctor).
- A doctor must notify the CMO of all abortions carried out, providing their name and that of their employer and the number of abortions carried out within a monthly period. This notification must be submitted by the 15th day of the month following the procedure(s)[28].

Section 2(3) of the Act provides that anyone who wilfully contravenes or wilfully fails to comply with the requirements of those regulations will be subject to a fine if they are convicted.

In addition to the legislative requirements, Scottish Ministers issued a Direction to Health Boards in April 2022 under the National Health Service (Scotland) Act 1978, requiring Health Boards to submit abortion data to Public Health Scotland (PHS).[29] This data collection enables the publication of annual abortion statistics.[30]

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[26] Scottish Government. (2024, December 4). Abortion – Updated approval on taking abortion medications outwith the hospital or clinic: CMO(2024)21.

[27] The Act puts this obligation on the Secretary of State in respect of Scotland. The Secretary of State's functions have been devolved to the Scottish Ministers, so references to the "Secretary of State" are to be read as the "Scottish Ministers".

[28]Scottish Government. (2022, April 14). Notification of terminations of pregnancy to the Chief Medical Officer: CMO(2022)16.

[29] Scottish Government. (2022, April). Direction to Health Boards under the Abortion (Scotland) Regulations 1991 – Annex B.

[30] Public Health Scotland. (2025, May 27). Termination of pregnancy statistics: Year ending December 2024.

4.7 Conscientious Objection

Section 4 of the Act provides that no individual is obliged to participate in treatment authorised by the Act if they have a conscientious objection. This right does not apply in situations where participation is necessary to save the woman's life or prevent grave permanent injury.

This provision was tested in the case of Greater Glasgow Health Board v Doogan and Wood [2014] UKSC 68,[31] where two senior midwives objected to being involved in the supervision and delegation of duties to staff providing abortions. The UK Supreme Court ruled that the "conscience clause" applies only to those directly participating in the abortion procedure in a **"**hands-on" clinical capacity, i.e. "actually performing the tasks involved in the course of treatment". It was found to be unlikely that, in enacting the conscience clause, Parliament had in mind the host of ancillary, administrative and managerial tasks that might be associated with providing an abortion.

In any legal proceedings, the burden of proof of conscientious objection rests on the person claiming to rely on it. Subsection 3 states "In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon him by subsection (1) of this section". In Scotland, a sworn statement is generally sufficient.

4.8 Additional Provisions: Multiple Pregnancies and Visiting Forces

Section 5(2) of the Act sets out the circumstances in which a termination of one fetus can be carried out where a pregnant woman is carrying more than one fetus (i.e. twins, triplets, etc.). At least one of the grounds in section 1 of the Act must apply and, in cases where the termination is on grounds of a fetal anomaly diagnosis (section 1(1)(d) of the Act) then that diagnosis must apply in relation to the fetus being aborted.

Section 3 of the Act allows medical facilities under the control of visiting forces or international organisations to provide abortions on the same basis as NHS hospitals without needing to be approved by the Scottish Ministers, provided that (a) the medical practitioner providing the abortion has been appointed by that visiting forces or international organisation body and (b) the pregnant woman has a 'relevant association' with the body providing the abortion. It also excludes abortions carried out under this section from needing to comply with the record keeping and notification requirements under section 2 of the Act (i.e. visiting forces hospitals/ clinics are exempt from the requirements of the Abortion (Scotland) Regulations

[31] UK Supreme Court. (2014). *Doogan v Greater Glasgow and Clyde Health Board* [2014] UKSC 68, [2015] SC (UKSC) 32, [2015] SLT 25.

1991). To note, the Group is not aware of any such bodies seeking to provide abortions in Scotland.

4.9 Scots Common Law

The criminal law framework governing abortion in Scotland differs from that in England and Wales. In England and Wales, abortion is criminalised under the Offences Against the Person Act 1861 and the Infant Life (Preservation) Act 1929, with the 1967 Act providing exceptions. Scotland has no equivalent underlying statutory criminal offences, but abortion remains potentially a criminal offence under the common law offence of abortion, unless carried out under the terms of the Act, and people have been prosecuted under section 5(2) of the Abortion Act 1967. The scope and application of the common law offence is importantly unclear, contributing to increasing concerns in recent years regarding the potential for prosecutions in Scotland. Some have argued that abortion related prosecutions under section 5(2) of the Act is a misinterpretation of the law and therefore any reform must resolve this.[32]

4.10 Other Relevant Legislation

4.10.1 The Concealment of Birth (Scotland) Act 1809

The Concealment of Birth (Scotland) Act 1809 succeeded a law enacted in 1690, which was partly concerned with the abandonment of 'illegitimate' children. Section 2 of the Act provides that:

"And if, from and after the passing of this Act, any woman in Scotland shall conceal her being with child during the whole period of her pregnancy, and shall not call for and make use of help or assistance in the birth, and if the child be found dead or be amissing, the mother, being lawfully convicted thereof, shall be imprisoned for a period not exceeding two years in such common gaol or prison as the court before which she is tried shall direct and appoint."[33]

The equivalent offence in English law has been prosecuted in a small number of recent cases of unexplained late pregnancy loss or neonatal mortality.

This legislation does not directly relate to abortion, but it could potentially apply in cases where an unlawful abortion is suspected, as corresponding legislation in England and Wales has been where an abortion offence could not be proved – and indeed there have been prosecutions under this legislation in both Scotland and England in the past two decades. A Freedom of Information request (FOI) submitted to COPFS found that since 2003 there have been six charges brought forward to women suspected of concealing their pregnancy, where the child has been found dead or 'amissing'.

[32] Dr Mary Neal and Dr Johnathan Brown (2025). Scottish Government Abortion Law Review: Offences [unpublished stakeholder submission].
[33] United Kingdom. (1809). Concealment of Birth (Scotland) Act 1809, c. 14.

4.10.2 The Medicines Act 1968 and the Human Medicines Regulations 2012[34]

In addition to the restrictions imposed by the 1967 Act, which permits only a 'registered medical practitioner' to perform an abortion, mifepristone and misoprostol are classified as "prescription-only medicines" (POMs). POMs can only be dispensed with a valid prescription from a registered healthcare professional (e.g. doctor dentist, or certain nurses) and administered as per the practitioner's instructions. The way the abortion law is widely interpreted means that only doctors prescribe medications for medical abortions, not other professionals such as nurses, who may prescribe the same medications for use in miscarriage care

It is an offence to sell or supply prescription-only medicines without a valid prescription. Therefore, anyone in the UK sending/giving mifepristone or misoprostol to any patient without a valid prescription may be committing an offence regardless of the Abortion Act 1967 or the common law relating to abortion.

4.10.3 The Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002[35]

In the vast majority of cases patients will be expected to provide informed consent before having an abortion, as for other forms of medical treatment and subject to the same standards of information disclosure.[36]

However, in the rare cases where a pregnant patient does not have the capacity to consent to an abortion, it must be provided in line with the provisions of the Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002. While the 1967 Act does not make any explicit provision regarding consent, Regulation 4 of the 2002 Regulations specifies, subject to some exceptions, that an adult who is incapable in relation to a decision about an abortion can only have an abortion where a medical practitioner appointed by the Mental Welfare Commission, who is not the medical practitioner primarily responsible for any of the adult's medical treatment, certifies that–

"(a) the adult is incapable in relation to such a decision, and

(b) having regard to the likelihood of its safeguarding or promoting the adult's physical or mental health, the treatment should be carried out."

[34] The Human Medicines Regulations 2012: United Kingdom. (2012). The Human Medicines Regulations 2012 (S.I. 2012 No. 1916).
[35] Scottish Government. (2002). The Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002 (S.S.I. 2002 No. 275).
[36] UK Supreme Court. (2015). *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

4.11 Review of Current Law

There is a clear need for review of the current law. Ambiguity around the legal status of abortion in Scotland, international human rights standards, evolving clinical best practice, and related impacts on women's equality – particularly for marginalised groups - all point to the need for overdue modernisation of the abortion framework.

4.11.1 Clarity in the law

The complexity in the law (set out above) may lead to confusion for both patients and healthcare professionals providing abortion care services, hindering the ability of healthcare staff to act in the best interest of their patients. Clinicians in Scotland have attested to a growing concern over the potential exposure to criminal sanctions at work.[37] The recent increase of prosecutions under the Offences Against the Person Act 1861 in England and Wales (which does not apply in Scotland) has contributed to this, attracting considerable attention in the media and prompting RCOG 'guidance for healthcare professionals on involving the police following abortion and pregnancy loss'.[38]

This media attention also has potential to cause barriers to abortion care for patients. Awareness that abortion is criminalised in some circumstances in Scotland appears to be low.[39] While police investigation into abortion offences has been limited (albeit not non-existent) in 21st century Scotland, events in England and Wales, and globally, indicate the potential for increased investigations and prosecutions in Scotland. In these circumstances ambiguity in the law has the potential to cause anxiety and even harm for women seeking abortion care and for the clinicians offering it.

4.11.2 International human rights standards on abortion laws

International human rights bodies have firmly established that access to abortion is needed for the realisation of women's rights.[40] Legal frameworks that criminalise abortion, causing barriers to access, have drawn attention from numerous UN bodies and processes, including those directed at the UK.

The Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW Committee) has stated that: "legislation criminalising abortion should be amended"; that criminalising abortion is a form of gender-based violence; that laws requiring authorisation from two doctors (as is the case in Scotland) create barriers to access; and, jointly with Convention on the Rights of Persons with Disabilities, that

[37] Engender. (2024). Outdated, harmful and never in the public interest: The urgent need to modernise Scotland's abortion law and prevent prosecutions.
[38] Royal College of Obstetricians and Gynaecologists (RCOG). (n.d.). Involvement of the police and external agencies following abortion, pregnancy loss and unexpected delivery: Guidance for healthcare staff.
[39] Wellings, K., Scott, R. H., Sheldon, S., McCarthy, O., Palmer, M. J., Shawe, J., Meiksin, R., Lewandowska, M., Cameron, S. T., Reiter, J., French, R. S., SACHA Study Team. (2025). Attitudes towards the regulation and provision of abortion among healthcare professionals in Britain: Cross-sectional survey data from the SACHA Study. BMJ Sexual & Reproductive Health, 51 (2), 111–121.
[40] World Health Organization. (2023). Human rights and health [Fact sheet].

criminal provisions should be repealed to address the disproportionate impact of criminalisation on certain groups, including women living in rural areas and disabled people, with the CRPD specifically noting that concerns on disability discrimination could be addressed by decriminalising abortion. [41]

The Committee on Economic, Social and Cultural Rights (CESCR) has instructed states to liberalise any laws that impede access to sexual and reproductive rights, including laws that criminalise abortion. In its seventh periodic review of the UK's compliance with the UN Convention on Economic, Social and Cultural Rights, the Committee included a focus on access to abortion care, including the legislative framework across all jurisdictions of the UK. It concluded that the UK should be guided by the World Health Organisation's (WHO) 2022 guideline on abortion care, which recommends full decriminalisation of abortion.[42]

The Committee on the Rights of the Child (CRC) has emphasised that the criminalisation of sexual and reproductive health services harms adolescent girls in particular and urged states to "decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services."[43]

Special Rapporteurs (independent experts appointed by the UN Human Rights Council to examine and report on specific human rights issues) have further reinforced that the criminalisation of abortion does not align with international human rights law. The Special Rapporteur on the right to health emphasised that "decriminalization, coupled with appropriate regulation and the provision of accessible, safe abortion services, is the most expeditious method of fully protecting the right to health against third-party violations."[44] Similarly, the UN Working Group on Discrimination Against Women recommended states "decriminalize abortion, expand access to safe abortion services…and remove legal barriers to abortion in situations of crisis."[45]

4.11.3 Health standards and evolving clinical best practice

Scotland's abortion laws do not reflect modern clinical best practice and may act as a barrier to equality of access to health services. Bodies representing healthcare professionals are clear that the law needs to be modernised to bring it in line with the realities of current clinical practice, to support person-centred healthcare, to improve the rights of women, and to improve the efficiency of health service provision and access.

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[41] United Nations Committee on the Rights of Persons with Disabilities. (2017). Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland (CRPD/C/GBR/CO/1). United Nations.
[42] World Health Organization. (2022). Abortion care guideline.
[43] Committee on the Rights of the Child. (2013). General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), U.N. Doc. CRC/C/GC/15.
[44] Grover, A. (2011). Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (UN Doc. A/66/254, §28). United Nations.
[45] United Nations Human Rights Council, Working Group on Discrimination Against Women and Girls. (2021). Women's and girls' sexual and reproductive health rights in crisis (U.N. Doc. A/HRC/47/38).

All relevant professional health bodies in the UK support decriminalisation of abortion, including the British Medical Association (BMA), the Royal College of General Practitioners (RCGP), the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Nursing (RCN), the Royal College of Midwives (RCM), the Royal College of Psychiatrists (RCPsych), the Royal College of Anaesthetists (RCoA), the College of Sexual and Reproductive Healthcare (CoSRH), the Faculty of Public Health, the British Association of Sexual Health and HIV (BASHH), the British Society of Abortion Care Providers (BSACP), the Faculty of Forensic and Legal Medicine (FFLM), and the British Maternal and Fetal Medicine Society (BMFMS).

The Abortion Act 1967 sets out restrictions that can impede access to abortion, especially for those in rural areas and for groups that are marginalised within healthcare.[46] Since 1967, clinical practices, technology, cultural norms, progress towards gender equality, and the human rights landscape have evolved significantly. The Abortion Act is now prohibiting best practice with regards to where an abortion can take place, who can provide it and how. It can delay access to abortion, especially in rural areas, because of the third-party authorisation requirement ('two doctors' rule'), and/or place practitioners at risk of breaking the law while providing routine healthcare. It also contains outdated language.

The WHO recommends in its 2022 guideline that: governance of abortion should be removed from the criminal law; abortion should be fully decriminalised; and third-party authorisation requirements and other impediments to clinical best practice should be removed.[47]

4.11.4 Gender equality and stigmatisation of abortion

Abortion is routine healthcare that is accessed by around one in three women in Scotland in their lifetime. The framework of laws that govern abortion however, some of which is rooted in centuries-old law, has not kept pace with this reality. Instead, the parameters set out in the Abortion Act 1967 reflect sexist attitudes pervasive at the time, women's equality, and gender roles; women had very little control over reproductive choices, healthcare and many other aspects of their lives.

The Abortion Act requires two doctors to judge whether a woman's decision to have an abortion is legitimate within the restrictions set out by the Act. This approach is unique within Scotland's health system, out of step with increasing focus on patient autonomy within healthcare, and subjects individual decision-making to a level of oversight that has no medical justification. Exceptionalising abortion drives the ongoing stigmatisation that prevents improvements in access to services and contradicts the lived reality of abortion as a component of routine healthcare.

Access to safe and timely abortion is also essential for the realisation of rights to privacy, bodily integrity and autonomy. It underpins realisation of economic, social and cultural rights for women, girls and pregnant people, including access to

[46] House of Commons Science and Technology Committee. (2007). Scientific developments relating to the Abortion Act 1967 (Twelfth Report of Session 2006–07, HC 1045-I). The Stationery Office.
[47] World Health Organization. (2022). Abortion care guideline.

employment, training and education, adequate income and housing, household resources and financial security, and high standards of health and wellbeing.[48]

[48] Engender (2024)

5. Gestational Limits and Grounds

The Expert Group made an early decision that the complex and sensitive topics of upper gestational limits and grounds for abortion could not be considered in isolation from each other, and several meetings were subsequently devoted to considering them together.

The Group began by considering the current law and evaluating the extent to which it aligned with their overarching principles, relevant human rights standards, and robust international evidence regarding safety and best clinical practice. In addition to the views and evidence provided by the Advisory Group of reproductive rights, women's and equalities groups, the Group received 22 submissions on these topics, each of which was considered carefully. It was clear from these submissions that the issues of time limits and grounds were of great significance for many stakeholders. Further evidence was provided by Group members with experience of providing abortion and undertaking research in Scotland, offering insights into patient and provider perspectives, including the lived experience of people requesting abortion.

The Group considered several models for reform that had been implemented internationally. These were selected on the basis of deliberation within the Group, drawing on its own expertise, the advice of the Advisory Group, and suggestions in submissions made by stakeholders. The Group agreed to focus in particular on New Zealand and several Australian states – where laws have recently been modernised to, broadly speaking, reframe abortion as an issue of healthcare rather than criminal law. These jurisdictions recently moved away from provisions originally modelled closely on UK laws following a process of detailed consideration and consultation, with extensive relevant review documentation thus available. As the only UK country recently to have modernised its law, Northern Ireland was also considered in detail. Some European countries were also considered on the basis of stakeholder recommendations, which are provided in further detail within Annex B of this report.

5.1 Review of the Current Law

Section 1(1)(a) of the Act permits two doctors to authorise the termination of a pregnancy if it has not exceeded its 24th week (23 weeks and 6 days)[49] and if 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 her existing children. Since 1967, there has been a general trend towards a more liberal interpretation of Ground C and D[50] and the overwhelming majority of abortions in Scotland (more than 98%) are authorised on these grounds. While Ground C and D abortions are subject to a 24-week limit, most take place far earlier in pregnancy. In 2024, over 93% of abortions in Scotland were performed below 12 weeks' gestation, and over 99% took place before 20 weeks.[51] The rollout of EMAH has facilitated very early abortion, with 18% performed before 6 weeks in 2024. A far smaller number of

[49] High Court of Justice (Administrative Court). (2019). *British Pregnancy Advisory Service v Secretary of State for Health and Social Care* [2019] EWHC 1397 (Admin).
[50] Sheldon, S., Davis, G., O'Neill, J., & Parker, C. (2019). The Abortion Act (1967): A biography. Legal Studies, 39(1), 18–35.
[51] Public Health Scotland. (2024). Termination of pregnancy statistics – Year ending December 2023.

abortions are undertaken on the basis of Grounds A, B, E, F and G, where no upper gestational age limit applies. The majority of these are authorised under Ground E, with 280 cases in 2024 (Ground E refers to abortions performed because of fetal abnormality at any gestation). In Scotland in 2024, only 14 abortions occurred after 24 weeks (0.1% of the total), all 14 of these on the basis of Ground E.

The clinicians on the Group offered some insight into their experience of the Ground C and D patients who seek to access care at later gestations. The Group noted that there are very few abortions between 20-24 weeks gestation, with these patients tending to be particularly vulnerable with complex needs and having very strong indications that continuing the pregnancy would seriously impact their current or future mental health. The British Pregnancy Advisory Service (BPAS), Back Off Scotland, and Antenatal Results and Choices (ARC) supplied case studies of women requiring abortion care between 20 and 24 weeks. These included girls under the age of 16, young people in honour-based abuse situations and women with incapacity. BPAS provided case studies of some recent women treated over 20 weeks gestation, which include:

- A 16-year-old girl who found out she was pregnant at 23 weeks. Her family were anti-abortion so she had to ask her boyfriend's mother to take her to London for treatment at a BPAS clinic. She says that the '*fear and shame'* she suffered at that time made her contemplate suicide to escape the situation.

- A woman with addiction issues found out she was pregnant beyond 20 weeks. She was experiencing very poor mental health, complex addiction issues, and was struggling to leave her home. The woman had no support available from family or friends, and her ex-partner was on remand awaiting trial at the time of appointment.

- A woman who had recently received a long-term prison sentence made the decision not to continue her pregnancy which was over 20 weeks' at the time.

Drawing on experience and expertise within the Group and the input of the Advisory Group, the Group also discussed a range of problems regarding the implementation of current law. It was noted that meeting the formal requirements of the law, particularly the requirement for two doctors to sign-off an abortion, can contribute to delay with barriers to access likely to be experienced particularly by those living in rural communities.

A further concern was noted regarding those who present over the current legal limit for abortion, as there is currently no established pathway for them to access Ground A or ground B abortions where continuing the pregnancy poses a significant risk of grave permanent injury to their health, or to their life. Although these are primarily provision failings rather than legal concerns, the Group considered that the current wording of Ground A and B within the law may not be fit for purpose, and that any law must account not only for abortions currently provided in Scotland, but for the full breadth of need for abortion care in Scotland in line with the law, even where those women are currently treated further afield.

The current law was also widely felt to be out of line with the developments in clinical practice that had occurred since the late 1960s, when it was introduced.[52] It was also considered out of line with public opinion, with 76% of British adults believing that abortion should be allowed if a woman decides on her own she does not wish to have a child.[53,54] Internationally, 51 countries and 33 further jurisdictions permit abortion on a woman's request with no requirement for justification.[55] The grounds-based approach means that pregnant women need to justify their decision to access abortion care, in a way that patients do not need to do in other areas of medical practice. This is highly anomalous in light of the respect for patient autonomy that is a guiding principle in modern clinical practice,[56] which is widely recognised in clinical guidance. In the landmark Supreme Court decision in *Montgomery* (itself a Scottish case involving a pregnant woman's rights to make medical treatment decisions), Lords Kerr and Reed described a movement away ''from a model of the relationship between the doctor and the patient based upon medical paternalism" towards an approach that:

> "treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices."[57]

It is difficult to reconcile current abortion law with this more general approach to healthcare law.

However, some clinicians in the Group described finding value in a statutory ground in those rare cases where abortion care is sought at gestations beyond the 24 week limit, explaining that they can provide a useful template to support discussion with a patient and encourage uniformity in service provision over 24 weeks, contributing to equality of abortion access across Scotland.

5.2 Gestational Limits

5.2.1 International examples

The Group's review of the upper gestational time limit for abortion was aided by close consideration of a number of other jurisdictions (see Annex B). It noted wide variation on this issue, ranging from a small number of jurisdictions that have no time limits for abortion (including Canada, the Australian Capital Territory, and several US states), a 24 week upper limit in the Netherlands, 23 weeks in South Australia and Western Australia, 20 weeks in New Zealand, 18 weeks in Sweden, 16 weeks in France, 12 weeks in the Republic of Ireland, Germany and Italy, and a mixed model

[52] House of Commons Science and Technology Committee. (2007). Scientific developments relating to the Abortion Act 1967 (Twelfth Report of Session 2006–07, HC 1045-I). The Stationery Office.
[53] Chabdu, A. (2024, October 29). How are attitudes towards abortion in Britain changing? National Centre for Social Research.
[54] Gray, A., & Wellings, K. (2020). Is public opinion in support of decriminalisation? In S. Sheldon & K. Wellings (Eds.), Decriminalising abortion in the UK: What would it mean? (pp. 17–36). Policy Press.
[55] World Health Organization. (2018). Global Abortion Policies Database.
[56] General Medical Council. (2013). Good medical practice.
[57] UK Supreme Court. (2015). *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, para. 81.

using both 12 and 24 week limits in Northern Ireland. The Group noted that it can be misleading to consider gestational limits in the abstract and that the laws in these countries vary significantly in many respects. All make some provision for abortion, in more or less restricted circumstances, after the stated limit, and in all cases access to abortion is impacted by a range of other factors.

The Group also benefited from the input from a number of experts who brought experience of other jurisdictions. One common theme was that removing legal barriers to abortion care can help to facilitate access to services but is not enough on its own to deliver accessible, high-quality services. For example, the Australian Capital Territory has no gestational limits for legal abortion, however access to abortion services above 13 weeks gestation is limited. A further important example is provided by Canada, where abortion has been legal since 1988, when the Supreme Court decided in *R. v. Morgentaler* that a law that criminalised abortion in certain circumstances was unconstitutional.[58] This left Canada with no specific statutory framework for abortion, with abortion services subject to the same provincial healthcare regulatory rules and guidelines for physicians as other health procedures. This means that there are no specific grounds for abortion at any gestation, with decision making left to the patient and provider. However, almost four decades on, no province offers abortion on request beyond 24 weeks, some provinces only provide services up to 12 weeks, and medication for Early Medical Abortion was not approved until 2015.

5.2.2 Stakeholder views and evidence

While stakeholder submissions presented a wide range of perspectives on the appropriateness of the current 24-week gestational limit for abortion in Scotland, their views fell into three broad categories: those arguing that there was no need for an upper gestational limit, those arguing for a lower gestational limit (typically either 22, 20 or 12 weeks), and those arguing to retain the existing 24 week limit.

No gestational limit

Some stakeholders questioned the need for any upper gestational limit. Members of the Advisory Group of women's and reproductive health groups pointed to international examples of jurisdictions with no upper gestational limit. They further noted that:

- Gestational limits may create barriers to services that impact on the most vulnerable women, including disabled women, migrant women and young women, who may be deterred from accessing necessary healthcare. For example, disabled or young women may not realise they are pregnant until later or have less capacity for earlier decision making.
- Gestational age limits remove control over women's health and fertility from the woman and her medical team and place it in the hands of political decision-makers who are not best-placed to determine an individual woman's needs

[58] Supreme Court of Canada. (1988). *R. v. Morgentaler*, [1988] 1 S.C.R. 30.

- The WHO recommends against laws and other regulations that prohibit abortion based on gestational age limits
- The need for access to abortion at later gestations remains for small numbers of women, regardless of the law.
- Full decriminalisation of abortion and removal of time limits does not amount to deregulation. Abortion can be effectively regulated in other ways that ensure high standards of safe, high-quality care, which is better aligned with the goal of treating abortion as a matter of healthcare.
- There are other jurisdictions where no upper time limit exists and where abortion is provided safely and effectively, with no evidence of an increase in abortions or later abortions. While the abortion rate is not a concern for the Expert Group, as something that is impacted by numerous social and economic factors, it is a point of interest that speaks to concerns from some stakeholders. Canada, discussed further below, was cited as a particularly important international example here.

A submission from seven women's equality organisations[59] in Scotland emphasised the WHO position, which they suggested in line with the Group's remit to make abortion a healthcare matter and to empower women to make decisions for themselves. The WHO advocate against gestational time limits on grounds that they are associated with poor health outcomes, can cause delays to accessing abortion, have disproportionate impacts for learning disabled women, younger women, those in rural areas, women facing financial hardship and those with lower educational attainment, and are incompatible with requirements in international human rights law "to make abortion available when carrying a pregnancy to term would cause the woman substantial pain or suffering, regardless of pregnancy viability".[60]

It was also suggested that time limits for abortion contribute to abortion stigma and women's health inequalities. The statutory thresholds for gestational time limits ensure that ideological debates over women's bodies, the morality of abortion, and what is politically permissible are cyclically aired in parliament and the media.

Violence against women organisations argued that legal restrictions on time limits can have devastating impacts for women being coerced into keeping an unwanted pregnancy or prevented from accessing a timely abortion by an abusive partner. Survivors of sexual violence may not be aware of their pregnancy, experience clinical denial, or be unable to access abortion within the current gestational framework due to trauma. This may be particularly relevant for younger women, disabled women, women from certain cultural and faith backgrounds, LGBT people and women in rural or island areas.

A reduced gestational limit

A number of submissions – coming particularly from faith-based and Pro-Life groups – argued that the current 24-week time limit should be reduced. These submissions frequently raised ethical concerns about the morality of abortion and the moral status

[59] Close the Gap, Engender, Rape Crisis Scotland, Scottish Women's Aid, Scottish Women's Budget Group, Young Women's Movement, Zero Tolerance (2024) [Unpublished Stakeholder Submission]
[60] WHO (2022). Abortion Care Guideline

of the fetus, sometimes equating later abortion with infanticide. While the moral status of the fetus fell outwith the scope of the review, these submissions also voiced a number of opinions that fell within its terms of reference.

- Several submissions presented data showing that the risk of complications, including maternal mortality, increases significantly with gestational age. On this basis, they argued that high gestational limits can incentivise later abortions and thus expose women to greater health risks.
- The 24-week threshold, which is based on viability, was argued to have been overtaken by improvements in perinatal medicine and neonatal intensive care, with the result that some very premature babies born before 24 weeks gestation now survive. Some stakeholders cited the British Association of Perinatal Medicine (BAPM) Framework on Extreme Preterm Birth (2019)[61] reports that, with intensive medical treatment, survival rates of the babies that are well enough to receive treatment are approximately 30% at 22 weeks, 40% at 23 weeks, and 80% at 26 weeks. On this basis, a reduction in the upper time limit to 20 or 22 weeks was argued to be overdue. It should be noted, however, that on seeking evidence from the British Association of Perinatal Medicine, the Group was provided with information based on their latest cohort study which highlighted that these figures were skewed towards those babies already most likely to survive. Their data found that for women who went into labour between 22+0 and 22+6 weeks, only 5% of babies survived to discharge from neonatal care.[62]
- Recent advances in neuroscience and fetal imaging were cited in support of the claim that fetuses may be capable of experiencing pain from as early as 12 weeks' gestation. It was claimed that this supported a more radical reduction in the upper time limit to 12 weeks.[63] It should be noted, however, that the most recent review of evidence around fetal awareness from the Royal College of Obstetricians and Gynaecologists found that "the possibility of pain perception before 28 weeks is unlikely".[64]
- It was also suggested that a 12-week limit would better align Scotland with some other European countries, which have this legal limit.

Several stakeholders also raised arguments regarding the perceived inequity of allowing termination beyond 24 on the basis of a prenatal diagnosis of fetal anomaly, these arguments are considered below within the section on Grounds.

Retention of a 24-week limit

Finally, some submissions argued in favour of retaining the current 24-week upper gestational limit for most abortions. These submissions suggested that:

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[61] British Association of Perinatal Medicine. (2019). Perinatal management of extreme preterm birth before 27 weeks of gestation: A framework for practice.

[62] Smith, L. K., van Blankenstein, E., Fox, G., Seaton, S. E., Martínez-Jiménez, M., Petrou, S., & Battersby, C. (2023). Effect of national guidance on survival for babies born at 22 weeks' gestation in England and Wales: Population based cohort study. BMJ Medicine, 2, e000579.

[63] These submissions also sometimes suggested the need for use of fetal analgesia for abortions after 12 weeks, and this is considered further in Pathways below.

[64] Royal College of Obstetricians and Gynaecologists. (2022). Fetal awareness: Evidence review.

- The 24-week limit reflects a long-established and workable balance between competing interests, which is well embedded in existing clinical practice. Later abortions are very rare and typically involve extremely complex or distressing cases, including serious fetal anomalies or significant changes in maternal health or dire social circumstances.
- The 24-week limit continues to reflect the best available scientific evidence on viability. While survival at 22 weeks is possible, it remains rare and is often accompanied by very severe, life-restricting impairments.
- Diagnostic procedures including detailed anomaly scans and genetic testing often cannot be completed until the second trimester, and results may not be available until close to the 24-week mark. Reducing the limit would disproportionately affect women facing these challenges and could result in rushed decision-making before all test results are available.
- The Group received a submission from Antenatal Results and Choices (ARC), a group with significant experience of supporting patients grappling with the results of prenatal tests. ARC advised that "many structural issues will be detected at the 18- 20^{+6} scan and will result in referrals for follow up testing. Results from genetic testing can take more than two weeks to be reported which means many will be close to the current 24-week deadline for most abortions. While Ground E currently allows for terminations to extend into the third trimester, doctors vary in their interpretation of the criteria of the ground and become much more cautious after 24 weeks. This means 24 weeks can act as a 'line in the sand' in many circumstances where what has been diagnosed is survivable or of uncertain prognosis… Any encroachment on the existing time limit will have a detrimental effect within the context of prenatal diagnosis. Therefore, if the recommendation is to retain time limits, ARC would strongly support retaining 24 weeks."[65]
- Reducing the upper gestational limit would also disproportionately affect vulnerable women, including those experiencing domestic abuse, mental health crises, or late recognition of pregnancy.

The introduction of a 24-week gestation limit onto the face of the Abortion Act had been motivated in part by a Royal College of Obstetricians and Gynaecologists (RCOG) working party report on neonatal survival rates[66]. While arguments for the reduction of the 24-week limit frequently cite further advances in neonatal care, this is not well supported by the clinical data. A very large US study has recently reported on the short-term survival outcomes of 124,345 infants born at or below 24 weeks gestation in the USA.[67] It found that survival rates for infants born before 24 weeks (47,295) and having completed 24 weeks (77,050) were 15.4% and 71.6%. A limitation of the study is that long-term outcomes are unknown. Further data from the British Association of Perinatal Medicine (BAPM) Framework on Extreme Preterm Birth (2019), reports that with intensive medical treatment, survival rates of the babies well enough to receive treatment are approximately 30% at 22 weeks, 40% at

[65] Antenatal Results and Choices (2024) [Unpublished stakeholder submission]
[66] Royal College of Obstetricians and Gynaecologists, British Paediatric Association, Royal College of General Practitioners, Royal College of Midwives, British Medical Association, & Department of Health and Social Security. (1985). Report on fetal viability and clinical practice.
[67] Qattea, I., Aly, H., Othman, H., Kattea, M. O., Alsabri, M., Hamzah, M., & Karnati, S. (2022). Survival of infants born at periviable gestation: The US national database. The Lancet Regional Health – Americas, 14, 100330.

23 weeks, and 80% at 26 weeks. However, the Framework also cites the extremely high risk of death or severe morbidity of neonates born before 24 weeks, even with the best available care. For this reason, the British Maternal & Fetal Medicine Society (BMFMS) has opposed a reduction in the upper time limit to 22 weeks, noting that although survival rates have improved since 1990, the majority of babies born before 24 weeks either do not survive or experience major morbidity, including severe disabilities requiring life-long care.

The Group acknowledged that the risks associated with abortion increase at later gestations. However, no evidence was found that increasing the upper gestational limit for abortion incentivises later presentation and abortion procedures. Canada – which currently has no upper gestational limit – currently has a lower abortion rate than Scotland.[68] Further, the evidence of the roll out of EMAH suggests that the most effective way to increase the proportion of abortions that occur at earlier gestations is to remove barriers to safe, effective services in pregnancy.

The Group also carefully considered the available evidence regarding the likelihood of perception of pain before 28 weeks gestation, noting significant disagreement in the scientific literature. It noted that while reflexive responses to stimuli may be observed earlier, these do not necessarily indicate conscious awareness or the experience of pain. The development of the key neurological processes in the capacity for pain perception typically occur after 28 weeks. The recent RCOG Fetal Evidence Review (December 2022) reviewed the literature from 2010 to assess whether developments in understanding of fetal awareness and pain should impact on clinical practice. The review concluded that the possibility of pain perception before 28 weeks is unlikely and therefore there is no basis for considering administration of analgesia or anaesthesia to a fetus before termination of pregnancy in the first or second trimester to prevent fetal perception of pain.[69]

Finally, while keen to learn from the experience of other countries, the Group did not accept consistency with the laws of other countries – for example, to align Scotland with a European or broader international norm – as an end in and of itself. Firstly, it is difficult to discern a meaningful 'norm' given the enormous variation that exists regarding gestational time limits in different national contexts. Secondly, the Group noted that the sensitivities of abortion have often translated into a reluctance to legislate on abortion, meaning that many abortion laws are – like those of Britain – very old. Nonetheless, Europe has been steadily following a wider international trend towards liberalisation of abortion laws, with 11 European states moving to permit abortion on request since 1994.[70] Thirdly and most importantly, in line with its terms of reference, rather than seeking to align Scots law with those of other countries, the Group understood its remit as making recommendations that would establish Scotland as a world leader, with robust, proportionate and effective abortion laws that are capable of supporting the world-class healthcare services that women in Scotland deserve.

[68] Abortion Rights Coalition of Canada. (2025, June 19). Statistics – Abortion in Canada.
[69] Royal College of Obstetricians and Gynaecologists. (2022). Fetal awareness: Evidence review.
[70] Mayall, K., Ajayi, L., & Gruer, C. (2025). Global progress in abortion law reform: A comparative legal analysis since the International Conference on Population and Development (1994–2023). Sexual and Reproductive Health Matters, 33(1), 1 15.

5.3 Grounds

5.3.1 International Examples

The Group's review of the appropriate grounds for abortion was aided by close consideration of a range of other jurisdictions. It noted that there is wide variation on this issue, ranging from virtually no provision for legal abortion to abortion on request, often within specific time limits.[71] In line with its terms of reference and overarching principles, the Group focused on those jurisdictions that frame abortion as an issue of healthcare rather than criminal law, allowing abortion on request at least within particular time limits. This is the case in some European countries, the Australian states, New Zealand, and in Northern Ireland. Where an upper gestational limit was retained, all of the jurisdictions considered made some provision for abortion to be permitted beyond it, and these grounds for later abortion were likewise the issue of close attention.

Northern Ireland has modernised its abortion laws in recent years, moving away from an almost complete prohibition of abortion, which had been widely criticised for violating human rights.[72,73,74] The Abortion (Northern Ireland) (No. 2) Regulations 2020 offer a tripartite model:

- until 12 weeks, abortion is available on request;
- from 12-24 weeks, abortion is available on grounds broadly equivalent to Ground C;
- after 24 weeks, abortion is available only on grounds broadly equivalent to Grounds A, B, E, F, and G.[75]

Other examples that set out specific grounds for abortion over a certain gestational limit were considered. For instance, in South Australia, abortions beyond 23 weeks are lawful only on grounds that likewise resemble those contained in the Abortion Act 1967.[76]

The Group also considered with interest a different model used in other Australian states. Under Victoria's Abortion Law Reform Act 2008, abortion is available on request until 24 weeks. After 24 weeks, it is allowed when a registered medical practitioner,

- reasonably believes that the abortion is appropriate in all the circumstances; and

[71] Center for Reproductive Rights. (n.d.). The world's abortion laws.
[72] Committee on the Elimination of Discrimination Against Women. (2018). Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women.
[73] UK Supreme Court. (2018). In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland) [2018] UKSC 27.
[74] House of Commons Women and Equalities Committee. (2019). Abortion law in Northern Ireland (Eighth Report of Session 2017–19, HC 1584).
[75] United Kingdom. (2020). The Abortion (Northern Ireland) Regulations 2020 (S.I. 2020 No. 345).
[76] Government of South Australia. (2021). Termination of Pregnancy Act 2021 (SA).

- has consulted at least one other registered medical practitioner who also reasonably believes that the abortion is appropriate in all the circumstances.

In considering whether the abortion is appropriate in all the circumstances, the medical practitioner must have regard both to all relevant medical circumstances, and the individual's current and future physical, psychological and social circumstances.

Western Australia and New Zealand have each adopted similar legal models, with a slightly lower upper time limit (23 weeks in Western Australia, 20 weeks in New Zealand). The New Zealand law also requires the health practitioner to consult with another qualified health practitioner, but provides for a slightly different set of factors to be taken into account, comprising:

- all relevant legal, professional and ethical standards to which the qualified health practitioner is subject;
- the person's physical health, mental health and overall wellbeing;
- the gestational age of the fetus.

The jurisdictions considered also made specific provision for abortions to be performed in 'emergency' situations, without meeting the formal requirements that might otherwise apply.

The Group benefited from the advice of experts with experience of these jurisdictions following reform. In particular, colleagues from New Zealand provided helpful insight to the Group regarding claims that there has been a significant increase in later stage abortions in New Zealand following amendments to the law on Grounds and Gestational age limits there. While there has been an increase in the number of abortions over 20 weeks, these represented less than 1% of the total number of abortions in 2023.[77] New Zealand's 2024 annual report on abortion notes that changes reflect the increased accessibility of in-person first-trimester abortions, as well as the availability of national and regional telehealth early medical abortion (EMA) services.[78] Colleagues from New Zealand reflected to the Group that prior to the change in legislation, it was extremely difficult for a woman to access an abortion over 20 weeks gestation despite there being very valid reasons for such a request – and that women are now able to access the services they absolutely need. Further, increasing access to abortion at all gestations has importantly led to the average gestation at the time of an abortion going down significantly to between 7-9 weeks, and 80.4% of abortions being carried out under 9 weeks in 2023,[79] compared to 64.5% in 2019.[80] The annual report also highlights significant improvements for those living in deprived areas, who also now access abortions at earlier gestations.

[77] Ministry of Health. (2024). Abortion Services Aotearoa New Zealand: Annual Report 2024. Ministry of Health. (pg.16)
[78] Ministry of Health. (2024). Abortion Services Aotearoa New Zealand: Annual Report 2024. Ministry of Health.
[79] As above, pg. 16
[80] Stats NZ. (2020, June 16). *Abortion statistics: Year ended December 2019*.

5.3.2 **Stakeholder Views and Evidence**

The British Social Attitudes survey reveals that, in 2024, 95% of British adults believed that abortion should be allowed if the woman's health is seriously endangered by a pregnancy and 89% where there is a strong chance of the baby having a serious health condition. A high but smaller proportion (76%) believe abortion should be allowed if the woman decides on her own she does not wish to have a child.[81] Submissions rather tended to focus on grounds C and D) and ground E. The Group carefully considered these submissions and their suggestions for reform.

Ground C (pregnancy less than 24 weeks involving greater risk of injury to physical or mental health)

Some submissions made by faith-based and Pro-Life groups expressed strong opposition to the existing grounds for abortion contained in the Abortion Act 1967. They argued that Grounds C and D are too broad and subjective, with Ground C effectively allowing abortion on request. Some submissions raised concerns about a cultural shift towards expressive individualism, whereby personal autonomy and choice are prioritised above other ethical and societal considerations. They argued that this has led to a situation where the legal framework does not reflect a balanced consideration of both maternal and fetal interests. On this basis, they called for restrictive amendment of the current Grounds C and D.

In contrast, some submissions noted that rigid or overly prescriptive criteria could lead to unjust outcomes, particularly for those facing complex medical, psychological, or social challenges. The ability to interpret the law in a way that reflects the nuances of individual cases was seen as a strength, rather than a weakness, of the current system.

Others argued that abortion should be permitted on request, and this should be explicitly stated in legislation, rather than being operationalised through broad interpretations of Ground C. They noted that current law is anachronistic and paternalistic, having failed to keep pace with broader shifts in medical practice towards shared decision-making and patient-centred care, and that it is impossible to reconcile with the emphasis on autonomy reflected in *Montgomery.*[82] Further, they argued that requiring two doctors to certify that a specific ground of the Abortion Act is met creates delay and barriers to access while providing no clinical benefit.

Women's organisations noted that the WHO "recommends against laws and other regulations that restrict abortion by grounds" due to physical and mental health risks for women; delays in accessing abortion; variable interpretation of grounds by healthcare providers; uncertainty about the law or how it should be applied; incompatibility with human rights law; particularly negative impact on women facing financial hardship and lower educational attainment; disproportionate impact on

[81] Chabdu, A. (2024, October 29). How are attitudes towards abortion in Britain changing? National Centre for Social Research.
[82] UK Supreme Court. (2015). *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, para. 81.

survivors of rape; the right to non-discrimination and equality in accessing sexual and reproductive health.[83]

Sex Selective abortion

Several submissions made by faith-based and Pro-Life groups raised concerns regarding sex-selective abortion, noting that the availability of early and accurate sex determination through non-invasive prenatal testing (NIPT) increases the risk of such practices occurring. Some submissions argued that, while the existing law does not explicitly permit abortion on the basis of sex, its ambiguity and the broad interpretation given to Ground C allows for such practices to occur. They cited anecdotal evidence and media investigations suggesting that some women may be pressured into terminating pregnancies based on the sex of the fetus, particularly in cultural contexts where there is a strong preference for male children. Some submissions referenced international agreements and declarations that call on states to eliminate practices such as prenatal sex selection and female infanticide, arguing that the UK should align domestic legislation with these commitments.[84] Some submissions pointed to legislative models in other jurisdictions, such as the Isle of Man, where abortion on the grounds of fetal sex is explicitly prohibited except in cases involving sex-linked genetic conditions. On this basis, they called for legal clarification or explicit prohibition of sex-selective abortion, or regulatory safeguards to prevent misuse of prenatal testing technologies.

A further submission on this issue came from Professor Maya Unnithan, who led a study on Pre-Natal Sex Selection among British minority ethnic South Asian families (Pakistani, Indian and Bangladeshi).[85] In line with Government data,[86] the study had concluded that sex-selective abortion is not widespread in the UK. It offered a rare insight into the views of the women in those communities, who overwhelmingly recommended that concerns regarding sex selection should not be used to justify restrictive abortion laws. The study rather recommended further education and funded specialist support services for women facing pressure to have male children in instances of closely spaced pregnancies, unwanted pregnancies and also cultural expectations.

Members of the Advisory Group, including Abortion Rights Scotland argued that women should have the right to make their own reproductive choices and are best placed to make pregnancy decisions based on their personal circumstances. These may include risk of violence and abuse. They also flagged the lack of evidence to suggest women seek abortion based on the sex of the fetus, that it would not be possible to police such an offence against sex selection in practice, and that arguments in favour can be prejudiced against ethnic minority communities and attempt to allocate rights to the fetus at the expense of women. Furthermore, they refuted arguments that legislating against sex selective abortion is positive for

[83] WHO. (2022). Abortion Care Guideline.
[84] Insofar as these submissions also raised concerns regarding coercion and the need for effective safeguarding, they are considered in more detail in Pathways below.
[85] Houghton, R., & Houghton, R. (2017). Re-visioning evidence: Reflections on the recent controversy around gender selective abortion in the UK. European Journal of Women's Studies, 24(3), 263–277.
[86] Department of Health and Social Care. (2023). Sex ratios at birth in the United Kingdom: 2017 to 2021. GOV.UK.

gender equality, noting that this merely punishes women for structural gender inequality and that efforts should be redirected towards tackling root causes.

Ground E (pregnancy at any gestation with substantial risk of serious 'handicap')

Many stakeholders – primarily faith-based and Pro-Life groups – raised particular concerns regarding the fetal anomaly ground of the Abortion Act (section 1(1)(d) or Ground E), arguing that it should be either removed altogether or made subject to the same upper gestational limit of 24 weeks as other abortions. In support, they argued that:

- The term 'seriously handicapped' in section 1(1)(d) of the Act is interpreted too broadly by doctors to permit abortions on the basis of conditions such as cleft lip/palate or club foot, and Down's Syndrome.
- The wording of Ground E is outdated and insensitive, reflecting the prevailing attitudes towards disabled people of the late 1960s.
- Ground E is discriminatory in allowing abortion (without gestational limit) following prenatal diagnosis of risk of serious fetal anomaly, when the termination of a fetus without a such an anomaly would not be permitted beyond 24 weeks.

The Group recognised that similar concerns regarding Ground E have also been raised by some disability rights campaigners, including Heidi Carter (née Crowter) in her recent court action.[87,88]

Other stakeholders criticised Ground E but disagreed that the appropriate solution was further restriction of the law. For example, the Advisory Group suggested that this issue would be best addressed through the full decriminalisation of abortion without gestational limit. It noted that the UN Committee on the Rights of Persons with Disabilities (CRPD) has recommended that '[w]omen's rights to reproductive and sexual autonomy should be respected without legalizing selective abortion on the ground of fetal deficiency.'[89]

A third group of submissions supported the retention of the current grounds-based approach. In particular, ARC drew on its experience of supporting women and couples grappling with diagnoses of fetal anomaly to set out the benefits of retaining the statutory framework currently offered by 'Ground E'. Without such a framework to guide clinical judgment, it was concerned that doctors involved in prenatal diagnostics or fetal medicine might distance themselves from discussing abortion. They also argued that individuals facing the decision to terminate a pregnancy following the diagnosis of a serious fetal anomaly can find comfort and reassurance in medical certification, which offers validation helping individuals to come to terms with a deeply distressing situation. For these individuals, ARC argued, a specific

[87] Court of Appeal (Civil Division). (2022). *Crowter v Secretary of State for Health and Social Care* [2022] EWCA Civ 1559.
[88] Don't Screen Us Out. (n.d.). Campaign for equality for people with Down's syndrome in the UK's abortion law.
[89] Committee on the Rights of Persons with Disabilities. (2017). Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland (CRPD/C/GBR/CO/1), para. 13.

statutory framework permitting later abortion can be experienced not as a barrier, but rather as important source of support and legitimacy.

The Group noted that the applicability of discrimination arguments in this context is not straightforward given that the fetus is not recognised as a legal person capable of experiencing discrimination, under Scots law.[90] While disabled people have a wide range of views regarding Ground E, the Group nonetheless noted that this includes many who find Ground E profoundly offensive.

The Group also considered a range of other evidence. It is the case that abortions are authorised on the basis of a prenatal diagnosis of Down's Syndrome (there were 58 such cases in 2024 under Ground E), including a small number that take place after 24 weeks (fewer than 5 over the six years from 2019 to 2024). The Group paid close attention to a letter written by fetal medicine specialists at the Royal College of Obstetricians and Gynaecologists (RCOG), opposing a proposal to lower the gestational limit for Down's Syndrome diagnosis to 24 weeks in English law,[91] and the detailed evidence provided by Professor Basky Thilaganathan for the RCOG in the Heidi Crowter case.[92]

This evidence noted that while Down's Syndrome can be diagnosed prenatally with a high level of accuracy, the same is not true for its likely severity in a specific future child. While many people diagnosed with Down's Syndrome enjoy a life expectancy of 50-60 years and a good quality of life, there is an increased risk of stillbirth or death in childhood and those who survive have symptoms that vary greatly in severity. A diagnosis of Down's Syndrome includes increased risk of specific heart problems, digestive system and neurological anomalies, which can have a significantly negative impact on life-expectancy and quality of life of the individual.[93,94]

The Group noted that during pregnancy women have the choice to access screening tests for Down's Syndrome at specific stages and that many (around 40%) choose not to access the test.[95] It further noted that diagnostic pathways for fetal anomaly can take time, meaning patients may be beyond 24 weeks gestation before getting a final diagnosis. For this reason, specialists have argued that patients need time to come to terms with a diagnosis and to make an informed decision on whether or not

[90] The UK Court of Appeal recently found that Ground E was not incompatible with Articles 8 and 14 of the European Convention of Human Rights, as a fetus has never been accepted as a legal person capable of holding rights under the Convention. *R (Crowter and ors)* v *Secretary of State for Health* [2021] EWHC 2536 (Admin); *Crowter* v *SSHSC* EWCA Civ [2022]
[91] Royal College of Obstetricians and Gynaecologists. (2024, May 10). Specialists in fetal medicine – concerns over amendments to alter abortion limits.
[92] High Court of Justice. (2021). *Crowter and others v Secretary of State for Health and Social Care* [2021] EWHC 2536 (Admin).
[93] Royal College of Obstetricians and Gynaecologists. (2024, May 10). Specialists in fetal medicine – concerns over amendments to alter abortion limits.
[94] Heinke, D., Isenburg, J. L., Stallings, E. B., Short, T. D., Le, M., Fisher, S., Shan, X., Kirby, R. S., Nguyen, H. H., Nestoridi, E., Nembhard, W. N., Romitti, P. A., Salemi, J. L., & Lupo, P. J.; National Birth Defects Prevention Network. (2023). Prevalence of structural birth defects among infants with Down syndrome, 2013–2017: A US population-based study. Birth Defects Research.
[95] Public Health Scotland. (2024). Pregnancy screening for Down's syndrome, Edwards' syndrome and Patau's syndrome in Scotland: 1 April 2019 to 31 March 2022.

they continue with the pregnancy; and those treating them need time to make a careful, case by case diagnosis.[96]

The Group noted that Ground E reflected a balance between the rights of pregnant women to make decisions regarding their future parenting, and an interest in protecting the developing fetus.[97] It recalled the comments made by the Court of Appeal in *Crowter* that the decision to end a pregnancy was "the right and personal responsibility of the woman, in accordance with the law", that she was "uniquely placed to make it".[98] It also recognised the complex professional judgments made in these cases.

5.4 Conclusions and Recommendations

The Group agreed unanimously that current Scottish abortion law is not fit for purpose and that alternative models should be considered. In particular, it agreed that the grounds-based model was anachronistic, paternalistic and failed to reflect best modern practice in abortion care. It agreed that legal recognition should be given to the woman's right to make their own decision regarding whether to continue or to end a pregnancy, and that abortion should become available on request, at least within gestational limits. Whilst recognising a significant shift in the formal legal position, this would serve to align Scottish abortion law with existing practice, which evidence suggests is broadly supported by the population.

5.4.1 Gestational Limits

Three options for gestational limits were identified by the Group as meriting further close discussion:

Model A: No Gestational Limit

The first model that the Group considered in detail would have no gestational limits. In practice, this would mean that abortion would be available on request throughout pregnancy, in the same way as other healthcare services. This did not mean abortion on demand at all gestations: as for other health procedures, abortion would become a matter of shared decision making between the woman and their healthcare professional with treatment not offered in circumstances where the latter believed it inappropriate. It was noted that the international evidence – including the examples of Canada and ACT – clearly suggests that removal of gestational limits would not result in a related increase in abortions or, specifically, in an increase in the incidence of later abortions. It was also noted that Scots law had not contained a statutory upper gestational limit for abortion until 1990, with no evidence of a higher incidence of later terminations before this time (or relative to England and Wales, where an upper limit had been incorporated into the law from the Infant Life (Preservation) Act 1929)[99].

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[96] High Court of Justice. (2021). *Crowter and others v Secretary of State for Health and Social Care* [2021] EWHC 2536 (Admin).
[97] Courts and Tribunals Judiciary. (2022). *Crowter v Secretary of State for Health and Social Care – Summary.*
[98] As above
[99] UK Government. (1929). Infant Life (Preservation) Act 1929, 19 & 20 Geo. 5 c.34.

Model A would have the advantage of fully reflecting respect for autonomy, treating abortion as a healthcare matter, and removing all legal barriers that might delay access to timely care. It would also align Scots law with the WHO recommendation to remove gestational limits and grounds, meaning patients do not need to justify their reasons for seeking abortion at any stage of pregnancy. Further, it would address the concerns regarding a specific exception permitting abortion for fetal anomaly, reflecting the suggestion of the Convention on the Rights of Persons with Disabilities (CRPD) that "[w]omen's rights to reproductive and sexual autonomy should be respected without legalizing selective abortion on the ground of fetal deficiency."[100] It was also felt that model A might help to reduce the stigma surrounding abortion, which the WHO has noted is a major barrier to safe abortion care. Finally, the Group noted that gestational limits disproportionately affect people with limited access to services, including rural, low-income or marginalised populations. The absence of an upper gestational limit would also support patients facing delayed diagnoses for serious fetal anomalies and avoid the pressures that might result in rushed decision making.

However, the WHO acknowledges that the architects of any legal reform must consider the sociopolitical context in which that reform takes place. Removing gestational time limits from the law would be a significant change and, as is clear from the submissions that the Group considered, later abortion raises particular concerns for many stakeholders. Further, while public opinion is broadly and consistently in favour of respecting women's rights to make abortion decisions, there is much less support for liberalising access to abortion after 24 weeks.[101] Regardless of the intention of the reform, removal of the upper time limit could be understood as heralding an increase in the incidence of later abortions, even if this concern is not supported by the existing international evidence.

Further, the Group noted that legal reform alone is not sufficient to address barriers to abortion care and stigma regarding abortion. Clinicians on the Group, as well as Antenatal Results and Choices, also noted that the removal of a statutory framework to guide decision making at later gestations where grounds are currently more restrictive might impact negatively on patients. This would also be the case if, for example, it resulted in an increased rate of conscientious objection.

For all these reasons, the elimination of a gestational limit is likely to face significant challenges and significant opposition, which could undermine broader reform efforts.

Model B: Retain the Existing 24 Week Limit

The second model that the Group considered would retain the 24-week gestational limit, with abortion available on request below 24 weeks and available beyond 24 weeks in more limited circumstances.

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[100] United Nations Committee on the Rights of Persons with Disabilities. (2017). Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland (CRPD/C/GBR/CO/1). United Nations.
[101] YouGov. (2023, June 28). Where does the British public stand on abortion in 2023?

Model B was considered to represent a significant advance in respect for the autonomy of patients up to 24 weeks. It would go some way to reflecting the dramatic advances made since 1967 with regard to the safety of abortion. It would also go some way to respecting the mandate that abortion should be treated as a matter of healthcare rather than criminal law, reflecting a broader trend in medical law to respect patient autonomy.

Model B would avoid some of the challenges identified with Model A. The 24 week - gestational limit is well established in the current law, as well as in healthcare settings, and is strongly supported by public opinion.[102] In making specific provision for abortion after 24 weeks, the new law might also retain a statutory framework to enable a healthcare-focussed, case-by-case approach in situations that are often complex and distressing, such as serious fetal anomaly or risks to the patient's life or health. In particular, Model B would protect the time required for patients facing a fetal anomaly diagnosis to make what can be incredibly difficult decisions, as emphasised by ARC.

Model C: Reduce the 24 Week Limit

The third model that the Group considered would be to reduce the gestational limit, with particular attention given to a suggested limit of 22 weeks, permitting abortion on request below this limit but above it only in certain, limited circumstances. Model C would respond to some degree to the concerns raised by faith-based and Pro-Life groups set out above, who argued that the current limit was out of line with recent clinical advances in viability.

While considered in detail, based on the evidence reviewed, the Group unanimously agreed that the balance of evidence did not support lowering the 24-week limit. This remains the most appropriate threshold, given that the survival rates of babies born at the extremes of viability remain very low, with serious morbidity risks very high. The Group noted that Model C would also serve to reduce access and create barriers, particularly for the most vulnerable groups of women. This would contravene the Group's terms of reference, as set by the Scottish Government, and its agreed overarching principles. It would also shorten the window for accessing services, leading to the potential for more rushed decision-making at a time of significant anxiety and distress for affected patients, who might also be denied the option of further testing. The Group also considered it likely that any restriction below that in place across the rest of the UK would likely result in some women travelling and paying privately to access care – making any such change particularly inequitable while not achieving its purported goals.

Recommendations

1. Based on all the evidence provided through stakeholder submissions to the Group, expert knowledge within the Group, and careful consideration of international examples:

[102] As above

2. The Group recommend that the existing 24 week limit for most abortions should be retained (model B).

3. The Group recommend that abortions after this gestational limit should be permitted under certain Grounds.

5.4.2 Grounds

Having decided to recommend that abortion be available on request before an upper gestational limit of 24 weeks, the Group then considered what provision should be made for the small number of cases where abortion is sought after this time. It noted that all of the international examples considered offered some provision for later abortion, and that no stakeholders argued for an absolute ban on abortions after a specific gestational limit, or criticised provision of abortions on Ground A, B or G (where necessary to save a pregnant woman's life or prevent grave permanent injury to her health).

Here, the Group considered two broad options, with the precise wording – covering who might lawfully provide abortion services – discussed below as part of the Group's deliberation on appropriate Pathways.

Grounds for abortion after 24 weeks

First, the Group considered retaining the current Grounds set out in section 1 of the Abortion Act 1967, subject to modernising the language. These grounds are well understood and embedded in clinical practice, offering a framework that clinicians use to support difficult and sensitive conversations with patients. While the statutory language of section 1(1)(d) (Ground E) was felt to be outdated and offensive, it was felt that this might be partially addressed through revising it to remove reference to 'risk' of 'suffering' a 'handicap' in favour of 'possibility' of 'having' an 'impairment'. It was noted that the Northern Ireland Regulations – which avoid the word 'handicap' – go some way to making these changes. However, retaining a specific fetal anomaly ground – however worded – on the face of statute law would continue to treat fetal anomaly as an exception to a general rule that a pregnancy must be continued, and delays associated with diagnosis after the 20-week scan may require more time for decision-making than would be possible within a 24 week limit. This would offer only a partial resolution of the issues raised by some disability rights campaigners, and in submissions made as part of this process.

For these reasons and considering its terms of reference and agreed overarching principles, the Group agreed that keeping the previous grounds, even if updated with more sensitive language, was not its preferred approach. It recognised, however, that abolition of this ground would leave women in difficult circumstances unable to make fully informed decisions about continuing their pregnancy after an antenatal diagnosis and was clinically likely to result in some women being forced to continue a pregnancy which ultimately resulted in stillbirth or neonatal death. As a result, the Group sought to consider alternative framings which would permit the uncontroversial health and life grounds, as well as other aspects of a woman's circumstances which could require access to later abortion.

It noted the advantages of the approach now adopted in New Zealand, and some Australian states. This retained a statutory framework for decision making for later terminations that offered both structure and flexibility, but removed a standalone ground for fetal anomaly, offering a fuller response to concerns that current law expresses a discriminatory message about the value of disabled people's lives.

The Group also noted that the current highly restrictive framework limited access to abortion for women and girls who had been the victims of sexual assault and rape, including girls under the age of 16 who had not been aware of their pregnancy until they were beyond the legal limit. The Group understands that current law would offer a basis for authorising abortion after 24 weeks in these circumstances. However, an important lack of clarity in the framing of the current law had resulted in a lack of clinical pathways for patients in these extreme circumstances, with the threat of criminalisation, meaning that many doctors were unable or unwilling to provide care. It noted that the adoption of a similar legal model has not resulted in any significant increase in the number of later abortions reported in Victoria, Western Australia, or New Zealand.[103]

As a result, the Group agreed to recommend the following wording for new grounds above 24 weeks gestation:

5. An appropriately trained registered healthcare professional is authorised to provide an abortion for a person who is more than 24 weeks pregnant if –

   (a) the healthcare professional decides in good faith that performing the abortion is appropriate; and

   (b) the healthcare professional has agreed with one other registered healthcare professional that performing the abortion is appropriate

6. In considering whether an abortion is appropriate, a registered healthcare professional should have regard to –

   (a) the gestational age of the fetus;
   (b) all relevant current and reasonably foreseeable medical circumstances of the patient and the fetus;
   (c) the patient's current and reasonably foreseeable physical, psychological and social circumstances.

7. One appropriately trained registered healthcare professional may terminate a pregnancy without agreement from a second healthcare professional where they believe in good faith that an abortion is immediately necessary to save the life of the pregnant person.

[103] Johnson, B. R. Jr., Keogh, L., & Norman, W. V. (2020). What would be the likely impact of decriminalisation on the incidence, timing, provision and safety of abortion? In S. Sheldon & K. Wellings (Eds.), Decriminalising abortion in the UK: What would it mean? (pp. 99–126). Policy Press.

8. In the case of multiple pregnancy, anything done to terminate the pregnancy as regards one particular fetus is authorised only if that ground applies in relation to that particular fetus.

Sex selective abortion

The Group agreed that it was unnecessary and potentially harmful to introduce a specific prohibition on sex selective abortion (SSA). It noted the lack of robust evidence that SSA takes place in Scotland. It believed that any prohibition would be unworkable in practice, requiring either intrusive and inappropriate questioning of all women regarding their motivation for seeking abortion, or racial profiling and additional questioning of a smaller proportion of women from ethnic communities where sex selective abortion is believed to be practiced. This would sit particularly uneasily within broader reform that recognised women's rights to access abortion on request within specific gestational limits. It was also noted that the end result of a denial of abortion care related to such concerns would be compelling a woman to continue a pregnancy she wanted to – or was being pressured to - end, posing serious risks to her mental and physical health, and increasing the likelihood of her seeking abortion outside the formal healthcare sector in a manner which could endanger her health. Finally, it was noted that the small amount of peer-reviewed research that has given voice to women in ethnic communities where SSA has historically been practiced found that they tend to support the eradication of SSA through further education and other initiatives rather than criminal prohibition.

Specific concerns had been raised regarding coercion in SSA. The Group agreed that any form of reproductive coercion (whether in favour of ending a wanted pregnancy or continuing an unwanted one) must be taken very seriously. The group further concluded that criminalisation of SSA would involve the possibility of criminalisation of women seeking abortions on these grounds – and that under no circumstances was it appropriate to criminalise a woman who was being subjected to coercive or controlling behaviour, or any other form of domestic abuse. This is considered in more detail in Pathways and Offences, below.

Recommendations

1. No specified Grounds are required to access abortion care up to 24 weeks gestation.

2. Decisions regarding abortions over 24 weeks gestation should be made in good faith by two healthcare professionals, who must agree that the abortion is appropriate, **except** in cases where an abortion is immediately necessary to save the life of the pregnant woman in which case one healthcare professional may make a decision.

3. That Grounds for an abortion after 24 weeks gestation are amended in an updated abortion Act to those set out on page 56-57 of this report.

4. That no specific reference is made to sex selective abortion within any updated abortion legislation.

6. Pathways

The topic of pathways considered how the law shapes the way abortion services are accessed in Scotland, and how providers are able to deliver them. The current law governs not just whether someone can access care (i.e. the grounds under which an abortion is allowed), but where an abortion can be performed and by whom. Currently only doctors can authorise and oversee abortions, and two doctors must sign off a request for an abortion before the procedure can go ahead. Legal requirements therefore impact many parts of the process.

This topic was a vital part of the review because the law is deeply embedded in clinical pathways and can act either to support safe and effective care - or, as has been raised throughout the process, can create delays and barriers that do not benefit patient safety. The Group approached this topic with a focus on ensuring that any new legal framework supports best current and future clinical practice and promotes patient safety.

The Pathways topic included a number of key areas, each of which may affect how accessible, timely, and person-centred abortion care can be provided in Scotland:

- Provision – who is legally permitted to provide abortion care.
- Place – where abortion can legally be provided.
- Conscientious Objection – the right of healthcare professionals to object to providing abortion care.
- Data and Reporting – what information is collected and how it is reported,
- Certification – the legal requirement for two doctors to certify that abortion grounds are met.
- Counselling – the role of counselling in abortion care
- Mandatory Waiting Periods – whether necessary or not
- Adults with Incapacity, Young People and Brain Stem Dead patients – how the law applies to complex and sensitive cases, including individuals who may be unable to consent.
- Positive Duty to Provide – whether there should be a legal duty on Health Boards or the Scottish Government to ensure abortion care is available.

These areas form the legal and clinical framework through which abortion care is accessed and provided. The Group's work on this topic aimed to ensure that any legal reform enables care that is in line with evolving best clinical practice, does not 'exceptionalise' abortion and is centred around the needs of those accessing care, while supporting healthcare professionals to provide safe, effective care without unnecessary legal barriers.

In discussing the above topics, the Group distinguished between issues that they felt should be covered in primary legislation and those that belong in clinical guidance. Recognising this distinction and the importance of issues which may not be in primary legislation, the Group discussed the need for the Government to commission a new and specific National Clinical Guideline for Scotland to accompany any new legislation, enabling abortion providers to follow best practice.

The Group first created a diagram of the current abortion pathway (Appendix C) to visually demonstrate the points at which the law currently directly impacts a patient's journey to accessing and receiving abortion care. In line with the overarching remit and principle to treat abortion as a healthcare matter, significant consideration was given to how abortion provision differs from other healthcare interventions, and whether these differences are medically justifiable.

6.1 Provision and Certification

6.1.1 The current law

The requirement that only doctors can provide abortion care, and that two doctors must certify an abortion at all gestations before it proceeds were, as discussed earlier, shaped by the medical, legal, social and political context of the Abortion Act 1967. Current models of healthcare emphasise patient-centred decision making, efficient service delivery and autonomy. With both shifts in workforce skills, and a huge shift to medical abortion provision, abortion care can be provided safely and effectively by a broader range of healthcare professionals, providing that they have been appropriately trained. Since 1967 there have been major changes to the role and responsibility of nurses and midwives in other areas of medicine, who now provide a wider range of tasks to meet the changing demands of a modern healthcare system.

The Group was clear that abortion provision is presently unnecessarily restricted by the legal requirement that it can only be provided (or at least overseen) by doctors. The Group noted that this requirement reflects the clinical context under which the legislation was originally drafted - when only surgical abortions were provided in a hospital. Clinical practice has changed radically, with medical abortion now overwhelmingly the most common method of abortion procedure, and one that can be safely provided by a number of healthcare professionals, including nurses and midwives. The Group also recognised that surgical abortion techniques, such as manual vacuum aspiration (MVA), can also be provided by other healthcare professionals with the appropriate skills and training. Midwives and nurses already deliver miscarriage care that involves that involves this same clinical procedure, and the Group noted that the distinction between this and abortion care has become increasingly illogical.[104]

The requirement for two doctors to certify that an abortion meets the legal grounds set out under the Abortion Act (the 'two-doctor rule'), can be a barrier to timely access, particularly in rural communities where it may be challenging to identify two doctors willing to sign the Certificate A (green) form. The Group felt that current certification requirements for abortions before the 24 week limit do not benefit the patient and increase workloads for providers. However, the Group also recognised that, for later stage abortions (after 24 weeks), the involvement of a second doctor is widely viewed by clinicians as valuable and supportive, particularly given the

[104] Sheldon, S., & Fletcher, J. (2017). Vacuum aspiration for induced abortion could be safely and legally performed by nurses and midwives. Journal of Family Planning and Reproductive Health Care, 43 (4), 260–264.

complexity of many of these decisions. In all areas of medicine, it is normal practice to discuss complex cases and difficult decisions with colleagues. The requirement can enable shared decision-making, professional reassurance, and clarity in interpreting the law.

6.1.2 International examples

With respect to the international examples, with the exception of Germany where only doctors can provide abortion, there is a clear preference towards expanding the range of healthcare professionals involved in abortion care, particularly for early medical abortion (see Appendix N). Nurses, midwives, nurse practitioners (and in Australia and Canada, pharmacists) are now able to provide or support abortion provision. In many of the jurisdictions considered, the ability to prescribe or administer abortion medication is not restricted solely to doctors, although in a number of cases this is limited to earlier gestations. There is a tendency then for laws to adopt a competence-based approach rather than defining provision by professional title.

The Group noted a similar trend in respect of the need for the number of practitioners required to agree the abortion with, in general, a need for two practitioners to discuss abortions only beyond a certain gestation, mostly 22 - 24 weeks (although 12 weeks in Ireland). In New Zealand the practitioners need not be in agreement. In the UK context, Northern Ireland allows doctors, nurses and midwives to act as medical professionals for the purpose of providing abortion. Certification and number of providers required vary by gestation and legal ground in Northern Ireland, with early abortions requiring one provider, and post-12-week abortions requiring one or two professionals depending on circumstances.

6.1.3 Stakeholder comments and Evidence Review

No stakeholder input specifically called for the retention of provisions that allow only doctor involvement, although a number of submissions argued that this ensures greater safety of abortion. This position, however, is not supported by international evidence, with the WHO's Abortion Care Guideline recommending that nurses, midwives, and other community health workers should provide early medical abortions, that midwives should provide vacuum aspiration, and that a wide range of healthcare professionals may be involved in provision in certain settings.[105]

With regards to the requirement for two doctors to certify an abortion, the Group reviewed a range of evidence that argues that two doctor certification is unnecessary and potentially harmful. The Advisory Group called for the removal of the requirement for two doctors to approve an abortion.

There is evidence that many doctors report discomfort with the need for two doctors to certify that one or more of the Abortion Act grounds are met, believing rather that the decision of whether or not to continue a pregnancy is one that properly belongs

[105] World Health Organization. (2022). Abortion care guideline.

to the pregnant woman, particularly at earlier gestations.[106] In some cases, doctors describe trying to conceal the need for legal certification from women, believing that they may find the legal requirements stigmatising.[107] Indeed, many women are unaware abortion remains a criminal offence unless one of the grounds of the Abortion Act is met.[108]

Considering the expanded scope of other healthcare professionals in providing abortion care, almost twenty years ago the House of Commons Science and Technology Committee report on Scientific Developments Relating to the Abortion Act 1967[109] concluded that, based on the evidence from existing service delivery, nurses and midwives were already significantly involved in abortion provision and should, with appropriate training be permitted to certify abortions, prescribe abortion medication and provide early surgical abortions. The committee found no evidence that these reforms would have any negative impact on patient safety or quality of care, and the restriction to permitting only doctors to provide abortion care does not reflect the realities of modern practice.[110]

The Shaping Abortion for Change (SACHA) study, the largest research project on abortion carried out to date within the UK, and funded by the UK's National Institute of Health Research published a paper in 2021 titled 'Attitudes towards the regulation and provision of abortion among healthcare professionals in Britain: cross-sectional survey data from the SACHA Study'.[111] This provides quantitative support for these views through a stratified cluster sample survey of healthcare professionals working in a range of healthcare services including abortion services. The survey found that 65.3% of healthcare professionals supported allowing nurses to prescribe abortion medication, with many respondents calling for nurse-led clinics that empower both nurses and midwives to prescribe abortion medication directly. Several free-text comments shared throughout the paper describe the current legislation as "archaic", and not reflective of current clinical practice especially in services that are already predominantly nurse or midwife led. A number of responses strongly supported repeal of the two doctor rule. Some respondents suggested that a single provider – whether that be a doctor, nurse or midwife – should be permitted to assess eligibility and provide care.

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[106] Wellings, K., Scott, R. H., Sheldon, S., McCarthy, O., Palmer, M. J., Shawe, J., Meiksin, R., Lewandowska, M., Cameron, S. T., Reiter, J., & French, R. S.; SACHA Study Team. (2025). Attitudes towards the regulation and provision of abortion among healthcare professionals in Britain: Cross-sectional survey data from the SACHA Study. BMJ Sexual & Reproductive Health, 51(2), 111–121.
[107] Lee, E., Sheldon, S., & Macvarish, J. (2018). The 1967 Abortion Act fifty years on: Abortion, medical authority and the law revisited. Social Science & Medicine, 212, 26–32.
[108] Wellings, K., French, R. S., Aronsson, A., Baraitser, P., Cameron, S., Free, C., Keogh, L., Lewandowska, M., Lohr, P., Meiksin, R., McCarthy, O., Murphy, C., Norman, W., Palmer, M., Reiter, J., Salaria, N., Scott, R., Shawe, J., Sheldon, S., & Wong, G. (2023). Evidence base to inform health service configuration for abortion provision: the SACHA (Shaping Abortion for Change) multi-component study. London School of Hygiene & Tropical Medicine.
[109] House of Commons Science and Technology Committee. (2007). Scientific developments relating to the Abortion Act 1967: Twelfth report of session 2006–07 (HC 1045). The Stationery Office.
[110] As above.
[111] Wellings, K., Scott, R. H., Sheldon, S., McCarthy, O., Palmer, M. J., Shawe, J., Meiksin, R., Lewandowska, M., Cameron, S. T., Reiter, J., & French, R. S.; SACHA Study Team. (2025). Attitudes towards the regulation and provision of abortion among healthcare professionals in Britain: Cross-sectional survey data from the SACHA Study. BMJ Sexual & Reproductive Health, 51(2), 111–121.

Kishen and Stedman (2020), writing in *The Role of Advanced Nurse Practitioners in the Availability of Abortion Services,*[112] provide further analysis. They demonstrated that outcomes of early abortions provided by non-doctor clinicians are equivalent in terms of safety and efficacy to those carried out by doctors and that advanced nurse-midwife practitioners are essential in meeting service demand, particularly as fewer doctors enter abortion care.

In a review[113] designed to assess the safety and effectiveness of abortion procedures, five studies (18,962 abortions), including one study from the USA, compared *surgical* abortion procedures administered by mid-level providers to those administered by doctors. Three studies (3,056 abortions), including one study in Sweden, assessed *medical* abortion procedures. There was no statistically significant difference in the risk of failure for medical abortions performed by mid-level providers compared with doctors. Observational data indicate that there may be a higher risk of abortion failure for surgical abortion procedures administered by mid-level providers, but the number of studies is small (and very few surgical abortions are done by any provider in Scotland). There were no statistically significant differences in the risk of complications for first trimester surgical abortions performed by mid-level providers compared with doctors.

The WHO further supports the expansion of abortion provision beyond doctors. In its guidance on 'Expanding Health Worker Roles for Safe Abortion in the First Trimester of Pregnancy', the WHO states that appropriately trained nurses, midwives and other healthcare professionals can safely provide first trimester abortion care, where referral systems for higher-level care are in place for any complications (as is the case within the Scottish health system). The WHO emphasises that "enhancing the role of non-medical practitioners may facilitate access to safe and timely healthcare where there are shortages of specialist medical practitioners".[114] Other human rights-based organisations support the WHO position, with the Human Rights Law Centre stating[115] that the two doctor rule treats women as incapable of making decisions about their bodies and should be excluded from South Australia's reformed abortion laws.

As outlined in the House of Commons Science and Technology Committee report, there were a number of reasons behind the introduction of the two doctor rule in 1967, including to provide legal defence for clinicians and to demonstrate the seriousness of the decision to terminate a pregnancy. Again, this points to the social attitudes towards abortion at the time in which the Act was passed. The report notes, supported by the clinical expertise on this Group, that today across the UK it is not uncommon that the two doctors signing the 'certificate A' form do not engage with the patient themselves. With the way that 'Ground C' is applied, it has been argued that any abortion under 24 weeks gestation would meet the required criteria, as

[112] Kishen, M., & Stedman, Y. (2010). The role of Advanced Nurse Practitioners in the availability of abortion services. Best Practice & Research Clinical Obstetrics & Gynaecology, 24(5), 569–578.
[113] Barnard, S., Kim, C., Park, M. H., & Ngo, T. D. (2015). Doctors or mid-level providers for abortion. Cochrane Database of Systematic Reviews, 2015(7), CD011242.
[114] World Health Organization. (2022). Family planning and comprehensive abortion care toolkit for the primary health care workforce.
[115] Human Rights Law Centre. (2022, December 19). Abortion as healthcare in law: Submission on the reform of South Australia's abortion laws.

continuing a pregnancy always has a greater physical health risk to a patient than an abortion.[116] With that in mind, a doctor would, in theory, always be able to make a decision 'in good faith' that at an abortion under 24 weeks, (accounting for more than 99.5% of abortions in Scotland in 2024) meets the criteria set out in the Abortion Act. As such, it appears to be the case that "the requirement for two signatures does not play a meaningful role in abortion practice".[117]

A number of major health bodies have called for the two doctor rule to be repealed. The RCOG states in its reforming abortion law position statement that the "requirement for two doctors' signatures to authorise an abortion should be removed, enabling abortion to be provided and regulated in line with other comparable forms of healthcare where the patient's autonomy is paramount and there is a process of informed consent."[118] Similarly, prior to their updated position statement calling for decriminalisation in 2024, the Royal College of Nursing published a Termination of Pregnancy Framework in 2013 which highlighted a consultation they had undertaken for submission to the Science and Technology Report. The RCN stated "ahead of its August 2007 submission to the Commons Science and Technology Committee inquiry…the RCN consulted with members working in termination of pregnancy services. Following this consultation, it was clear that for those who worked in this clinical field, the law required modernisation. The requirement for two doctors to agree that a woman meets the grounds of the Abortion Act 1967, and the prohibition on nurses and midwives prescribing early medical abortion drugs or performing early surgical termination of pregnancy were seen as outdated and in need of future consideration."[119]

The evidence makes clear that requiring two doctors' signatures deviates from standard medical practice for other health conditions including major surgery, where one relevantly trained healthcare professional is usually able to obtain informed consent and carry out procedures. The Group is aware that some stakeholder organisations, including some Pro-Life and Faith groups who submitted evidence to this review, argue that abortion should be treated differently to other healthcare matters, however this position cannot be justified with regard to the safety of modern abortion care, with no clinical evidence to suggest that it should be treated differently from other medical or surgical procedures that do not require the certification of two doctors. Further, it is clear that public opinion aligns with the view that "a woman should be able to terminate a pregnancy where she decides on her own that she does not want to have a child", as demonstrated in the 2024 NatCen British Social Attitudes survey, where 76% of respondents agreed.[120]

[116] Goodhart, C. B. (1968). G.M.C. and Abortion Act, 1967. British Medical Journal, 2 (5600), 298.
[117] House of Commons Science and Technology Committee. (2007). Scientific developments relating to the Abortion Act 1967: Twelfth report of session 2006–07 (HC 1045).
[118] Royal College of Obstetricians and Gynaecologists. (2023). Reforming abortion law.
[119] Royal College of Nursing (2013) Termination of Pregnancy: An RCN Nursing Framework.PUB 004 386
[120] National Centre for Social Research. (2023, September 21). Britain's attitudes towards moral issues have become much more liberal.

6.2 Place and Regulation

6.2.1 The current law

The Group noted the findings of the evaluation on Early Medical Abortion at Home (EMAH), published in 2023.[121] The report concluded that there was evidence of "the high effectiveness" of EMAH care in Scotland, as well as showing an incidence of complications which did not differ significantly from those associated with EMA undertaken in Scottish hospitals. This, alongside a high degree of acceptability to patients, and staff support for continuing the new model of care, "indicates that the benefits of the current flexible model outweigh any risks associated with not always having in person appointments."[122] It was not within the remit of this Group to consider the overall safety of EMAH, but given the outcomes of the evaluation and other clinical and international guidance pointing to the overall safety, the Group noted that the current approval in relation to EMAH and other forms of medical abortion outwith hospitals aligns with the overarching principles set out by the Group and that any consideration of the law on place should ensure that EMAH can continue to be offered.

However, the Group also observed that EMAH and other abortion treatment outwith a hospital is currently only permitted through Ministerial approval, as required under the Abortion Act 1967. The current law requires Scottish Ministers to approve each place, or class of places, where abortion care may be provided. While the Group agreed that it is appropriate for abortion care to be provided by healthcare services – either via the NHS or providers regulated by Healthcare Improvement Scotland, it noted that other comparable healthcare services do not require Ministerial approval. This legal requirement therefore 'exceptionalises' abortion, and the Group could identify no clinical justification for Ministerial sign-off to be necessary in approving providers. The Group did not consider there is clinical need for Scottish Ministers to approve the place of abortion provision as they do not approve it for any other health care, however complex. Furthermore, the Group raised concern that the current restrictions within the 1967 Act may limit innovation in service delivery – for instance the amount of time between licensing of early medical abortion and the agreement of Ministers to allow it at home despite standard practice around the world (20 years).

The Group's initial view held that, while the current legal framework has permitted the provision of EMAH, legal reform may be required to enable future innovation and to ensure consistency with how other healthcare services are regulated. The Group did note that any reformed legal framework should ensure that abortion care continues to be safe and patient-centred, without unnecessary barriers that prevent the future development of services in line with clinical best practice.

6.2.2 International examples

The international examples reviewed by the Group demonstrate a range of approaches to defining where an abortion may be provided, with many jurisdictions

[121] Scottish Government. (2023). Evaluation of telemedicine early medical abortion at home in Scotland.
[122] As above, conclusions

opting for models that align with broader healthcare regulation. A number of international models do distinguish between medical and surgical abortions, and some distinguish between early and later gestation procedures. It should be noted that while these examples focus on place, legislative frameworks should be considered alongside regulations on provision – often, for example, if a registered healthcare professional must provide the service, this would intrinsically have implications for where an abortion can be provided even if it is not included specifically in a law. In some countries a tiered approach is taken, changing the level of regulation required for what jurisdictions may determine to be more complex cases.

The international examples show that there remains an emphasis on ensuring that abortion is provided in clinically appropriate and regulated environments, including early medical abortion at home, but the legislative involvement does clearly vary and shows that many jurisdictions place abortion care within standard health service regulation.

6.2.3 Stakeholder comments and Evidence Review

With the increased use of EMAH, there have been renewed calls to reconsider the regulation of where abortions can be provided. The Group considered a number of views in stakeholder submissions on how and where abortion care should take place. While the submissions reflect the wide range of views, many of the concerns raised primarily focused on service delivery model rather than on any legal regulation of place.

In relation to EMAH, a number of stakeholder submissions from Pro-Life and Faith Groups raised concerns about potential reductions in oversight and accountability of abortion service providers and deterioration in the effective management of complications if they are not identified in a timely manner, particularly in relation to EMAH. Likewise, concern was expressed that telephone consultations jeopardised the ability of the provider to detect uncertainty and, importantly, coercion.

Restrictions on where abortion can be legally provided were argued by some Pro-Choice submissions and clinicians on the Group to be a barrier to access, particularly for patients in rural or island communities, those with disabilities and caring responsibilities, younger patients or those with coercive or abusive partners, for whom accessing in-person care may be unsafe. Drawing on a close assessment of relevant clinical evidence and human rights documents, the WHO has therefore called on states to remove unnecessary restrictions on abortion provision.[123]

There was broad agreement across submissions from all groups that abortion providers should be subject to appropriate oversight. However, most Pro-Choice stakeholders questioned whether Scottish Ministers should continue to retain responsibility for approving abortion providers or whether the role of approving providers could be transferred to an independent regulator, such as Healthcare Improvement Scotland (HIS), given that HIS already holds power to monitor registered private providers.

[123] World Health Organization. (2022). Abortion care guideline.

Pro-Choice stakeholders argued that abortion should continue to be regulated as a clinical procedure, but in a way that ensures it is in line with other procedures and regulated through existing professional organisations such as the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) and existing service regulators, such as HIS for any private providers.

There is strong evidence that medical abortion is safe and effective in a range of settings, including at home and community care centres. The WHO's 2022 abortion care guideline states that "Evidence has demonstrated that in gestational ages less than 12 weeks, pregnant persons can safely and effectively manage their own medical abortions using mifepristone and misoprostol in combination or misoprostol alone. Enabling this option can significantly improve access to safe, timely, affordable and person-centred abortion care."[124] This guidance notes the home as one example of where abortion can safely take place outwith a medical facility, and notes that "service delivery with minimal medical supervision can significantly improve access, particularly in restricted settings and crisis situations, as well as improve privacy, convenience and acceptability of the abortion process without compromising safety and effectiveness".[125] In support of this, the RCOG best practice guidance states that the "ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of clinical data presented by the patient".[126]

The National Institute for Health and Care Excellence (NICE) has also noted that early medical abortion at home (EMAH) is safe and should be offered to women as an option.[127] Subsequent to the NICE guidance, the Scottish evaluation into EMAH provided evidence for the safety of EMAH in Scotland up to 12 weeks gestation.[128]

6.3 Conscientious Objection

6.3.1 The current law

The Group noted that the current legal framework for conscientious objection in Scotland is generally well understood, broadly accepted and functions effectively in most circumstances. The existing provision under section 4 of the Abortion Act 1967 allows healthcare professionals to opt out of participating directly in abortion procedures if it conflicts with what the Group understand are deeply held moral or religious beliefs. It was felt important that clinicians are not required to deliver care that they do not feel able to provide in good conscience, and that the law recognises that moral complexity of abortion care for some healthcare professionals is likely to lead to an overall more comfortable service for patients.

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[124] World Health Organization. (2022). WHO recommendations on self-care interventions: Self-management of medical abortion – 2022 update (WHO/SRH/22.1).
[125] As above
[126] Royal College of Obstetricians and Gynaecologists. (2022). Best practice in abortion care.
[127] National Institute for Health and Care Excellence. (2019). Expulsion at home for early medical abortion (Evidence review G). NICE Guideline NG140.
[128] Scottish Government. (2023). Evaluation of telemedicine early medical abortion at home in Scotland.

That said, the Group also recognised the practical implications of conscientious objection for access to abortion care and for service delivery, particularly in relation to later stage abortion care where provision is already limited in Scotland. In these contexts, the impact of staff choosing to opt out of provision, and an unwillingness at a managerial level to tackle the issue and extent of conscientious objection has undoubtedly impacted the ability of patients to access the care they need in the country in which they live. The Group notes that with sufficient and accessible training for abortion care, these practical challenges can be manageable at individual Health Board levels through service design and staffing policies that ensure that patients are able to receive timely care.

One particular area of concern for the Group with regards to the current law on conscientious objection is the absence of a legal duty to refer – in other words a requirement for someone who conscientiously objects to refer an individual seeking abortion to someone else who can help them. While this does not currently cause widespread access issues due to self-referral models adopted by abortion providers within Health Boards, there may be instances, particularly in rural or island areas of Scotland, where patients visit a GP and face barriers to access if their local practitioner conscientiously objects.

Furthermore, it is not possible to predict how service design and delivery may change in the future. The Group therefore considers that this is an area that merits consideration.

6.3.2 International examples

Across all international jurisdictions, there is broad recognition of the right for clinicians to object on moral or religious grounds, with a number of countries attempting to balance this with patients' rights to access timely care.[129] Many jurisdictions, but not all, have therefore introduced a legal requirement to refer or provide information to patients seeking care. Notably, New Zealand's legislation includes specific guidance on the logistics of referral, requiring the clinician who objects to consider geography, timing and availability when directing patients to another service. It was noted that within the Scottish context, patients are already able to self-refer to abortion services. Consistently across all reviewed jurisdictions, conscientious objection does not apply in emergency situations where the life or health of the pregnant person is at risk.

6.3.3 Stakeholder views and evidence review

The Group recognises that conscientious objection remains a sensitive area of abortion care and abortion law, raising questions regarding how best to strike the balance between clinicians' individual moral autonomy and patients' ability to access healthcare services they require. As part of this review, the Group has considered a range of views and evidence regarding conscientious objection and how it ought to be retained or redefined within a future legal framework to protect this balance. This

[129] Chavkin, W., Leitman, L., & Polin, K. (2013). Conscientious objection and refusal to provide reproductive healthcare: A white paper examining prevalence, health consequences, and policy responses. Global Doctors for Choice.

topic was the subject of a significant amount of stakeholder comment, demonstrating the importance of ensuring that any amendment to conscientious objection law is considered carefully and decisions are made on the basis of not only empirical evidence, but with significant regard to the interests of those providing healthcare, and the patients accessing it.

Many stakeholder submissions emphasise that conscientious objection is not a matter of professional preference, but a fundamental expression of moral or religious belief. A number of Pro-Life stakeholder submissions emphasised the legal right to conscientious objection being anchored in Article 9 of the European Convention on Human Rights (ECHR),[130] which protects the freedom of thought, conscience and religion. Others have therefore argued that there is no need for a specific statutory provision in a revised abortion law, as rights of religious refusal of treatment are already protected under Article 9. Indeed, making statutory provision for abortion would perpetuate the exceptionalisation and stigmatisation of abortion care.

While there is a general interest for both patient and providers in not compelling individuals to provide care that conflicts with their moral values, there remains a need to ensure that conscientious objection does not impede access. This is clearly set out in the WHO abortion care guidelines.[131] Therefore, there are some exceptions to a conscientious objection clause to be considered.

There may be circumstances within the existing law under which the right to conscientiously object would obstruct safe provision. For example, in cases where a person is employed specifically to provide abortion services and proceeds subsequently to declare conscientious objection, there is a risk to sufficient and safe staffing levels. In her 2017 book titled 'Arguments about Abortion: Personhood, Morality and Law', Dr Kate Greasley therefore argues that "if safe abortion is to be accessible, then at the very least those who are employed for the sole purpose of carrying it out must be willing to do so."[132]

A number of Pro-Life and faith-based stakeholders advocated for an expansion of conscientious objection beyond direct participation in abortion and propose that with the expansion of medical abortion services, conscientious objection rights should be extended. They argue that *any* involvement in the process of abortion would make them "accomplices" to what they believe to be a fundamentally immoral procedure and places many professionals in an "invidious position".[133] It has been proposed within these stakeholder submissions that any future legal drafting of an updated Abortion Act should reflect section 38 of the Human Fertilisation and Embryology Act 1990 which states that "no person who has a conscientious objection to participating in any activity governed by this Act shall be under any duty however arising, to do so".[134]

[130] Council of Europe. (2021). European Convention on Human Rights.
[131] World Health Organization. (2022). Abortion care guideline.
[132] Greasley, K. (2017). Human equality and the significance of birth. In Arguments about abortion: Personhood, morality, and law (Chapter 8, pp. 181–200). Oxford University Press.
[133] Stakeholder submission to the Expert Group, November 2024, (Unpublished)
[134] United Kingdom. (1990). Human Fertilisation and Embryology Act 1990 (c. 37).

In the UK Supreme Court case, *Greater Glasgow Health Board v Doogan* [2014] UKSC 68 clarified the scope of conscientious objection under s 4 of the Abortion Act 1967. The court ruled that the right to conscientious objection is limited to direct, hands-on participation in abortion procedures. This means that tasks such as delegating, supervising, or supporting staff involved in abortions do not fall under the protection of conscientious objection. This decision has significant implications for the roles and responsibilities of senior healthcare staff.

One submission observed that the interpretation of the law as demonstrated in the Doogan case risks excluding capable individuals from the profession, particularly those whose conscientious beliefs were previously accommodated, leading them to leave their jobs or retrain. It is important to note that healthcare providers with an objection to abortion do not need to choose to specialise in this area of practice. The RCOG, for example, has an understanding with the Department of Health that if abortion care is one of the duties of a post that fact should be included in the job description and in the job advertisement.[135] The RCOG further advises trainees considering a career in Obstetrics and Gynaecology to discuss with the training director any concerns they may have about abortion before embarking on a training programme.[136] The CoSRH has a similar document, for both doctors and nurses training in the specialty.[137] All these advisory documents contain provision for individuals who have a 'change of heart' with regard to abortion care once in post. In practice, the clinicians in the Expert Group noted that it is rare for individuals to leave their clinical practice due to administrative tasks surrounding abortion care.

In the UK the General Medical Council, in *Personal Beliefs and Medical Practice* permits refusal to participate in the abortion procedure itself but not in pre- or post-abortion care, advice, or referrals.

In a recent study, the following actions were viewed as constituting 'no direct involvement in abortion': consultation/advice, booking women in, post abortion care. 'Partial involvement' involved the following: referring, supporting the woman through the process, medical practitioner agrees and signs form, supervising others, seeking second signature on form. 'Direct involvement' was understood as involving 'inducing the abortion, performing feticide, conducting labour and delivery and performing operation (e.g. curettage). While it was recognised that there was a reasonable allowance made to express a conscientious objection, there were some difficulties expressed by healthcare professionals in doing so in practice, particularly in relation to requirements set out in employment contracts.[138]

In the case of pregnant women seeking to access abortion services, the impact of healthcare professionals expressing a conscientious objection are a cause for

[135] Royal College of Obstetricians and Gynaecologists. (2024). Guidance for Advisory Appointment Committees (AAC) and RCOG representatives on AAC Panels: January 2024.
[136] Royal College of Obstetricians and Gynaecologists. (2024). Core Curriculum 2024 (Stages one–three): Definitive document, section 10.5.
[137] Faculty of Sexual and Reproductive Healthcare. (2017). Guidance for those undertaking or recertifying FSRH qualifications whose personal beliefs conflict with the provision of abortion or any method of contraception.
[138] Fleming, V., Frith, L., & Maxwell, C. (2024). Understanding the extent of and limitations to conscientious objection to abortion by health care practitioners: A hermeneutic study. PLOS ONE, 19(2), e0297170.

concern. One recent study drawing on empirical research findings in England showed that pregnant women experienced inconsistent communication and referral practices arising from the expression of a CO to abortion by healthcare professionals, with some left to navigate the system alone. In the circumstances, it was suggested that further reforms were required to ensure transparency in CO declarations and more seamless referral systems, which better balanced the rights of objectors with patients' rights to access abortion care.[139]

In R.R. v Poland, the European Court of Human Rights held that where healthcare professionals may have a right under domestic law to conscientious objection, "states are obliged to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals…does not prevent patients from obtaining access to services which they are entitled."[140]

It should also be noted that in a range of jurisdictions, such as Sweden, Finland and Iceland, CO on the part of healthcare professionals in public healthcare settings is not recognised under law.

A notable recent legal challenge to this position arose in the case of *Grimmark v Sweden* (Application no. 43726/17). In this case, the applicant complained under Article 9 (freedom of thought, conscience and religion) of the European Convention on Human Rights that, by prohibiting her work as a midwife, the Swedish authorities had interfered with her rights under Article 9 ECHR. The European Court of Human Rights found that the claim was 'ill-founded', and it was dismissed.

While there has been concern expressed by some academic commentators at the failure on the part of the Court to provide a more detailed analysis, other commentators have observed that the judgment strengthens the position that the refusal by healthcare professionals to carry out healthcare services, including abortion services, is not a human right.[141]

There is also debate on whether professionals who conscientiously object should be legally required to refer patients to another practitioner. At present, NHS contracts require anyone exercising their right to refusal under that section to make 'prompt referral to another provider of primary medical services who does not have such conscientious objections'.[142] According to the British Medical Association and General Medical Council guidelines, objectors should even, in some instances, arrange the appointment for the patient with a non-objecting doctor. Some submissions from Pro-Life organisations argue strongly against such a requirement, again arguing that making a referral amounts to facilitating an abortion and risks

[139] Self, B., Maxwell, C., & Fleming, V. (2023). The missing voices in the conscientious objection debate: British service users' experiences of conscientious objection to abortion. BMC Medical Ethics, 24, Article 65.
[140] European Court of Human Rights. (2011). *R.R. v. Poland*, Application no. 27617/04.
[141] Barke, N. (2020, April 6). Grimmark v. Sweden and Steen v. Sweden: No right for healthcare professionals to refuse to participate in abortion services, and framing strategies by anti-abortion actors. Strasbourg Observers.
[142] Scotland. (2004). The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004 (Scottish Statutory Instrument No. 115).

violating a conscientious objectors' moral judgement. Some stakeholders propose that referrals should only be made by a third party, such as the Health Board or a designated service, thereby protecting conscience without preventing care. In practice in Scotland, the vast majority of patients self-refer to an abortion service and it would therefore be for the Health Board organising the service to ensure that the patient has prompt access to a healthcare professional who does not conscientiously object. As such, within Scotland, it does not generally impact individuals' ability to access services. Even so, there is a significant amount of literature which accepts or proposes that referral, in circumstances where the first clinician has a conscientious objection, is necessary to avoid obstructing access to care. The WHO has long urged states to take steps to ensure that 'conscientious objection' does not undermine access to abortion in practice.

D.W. Brock, writing on conscientious refusal,[143] points to two further studies[144,145] that highlight how refusals to refer patients or the deliberate provision of misleading information—intended to deter or block access to abortion—can lead to delays in care. Under international human rights law, healthcare providers who object to abortion on conscience grounds are still required to refer patients elsewhere. This obligation is designed to prevent conscientious objection from becoming a barrier to abortion access. However, he notes that regulating conscientious objection is complex. In many countries, the law either does not address it or adopts what Brock describes as the "conventional compromise": allowing providers to object while attempting to regulate or limit the impact on women's health and rights. This compromise typically includes defining who may object (usually only those directly involved in care), what must be done in the event of an objection (often requiring a referral), and when objections are not allowed (such as in emergencies). Despite these legal frameworks, the studies show that such provisions are not always followed in practice. Professional medical organisations often support this compromise, emphasising that healthcare professionals must inform patients about the availability of abortion and refer them to another provider who can deliver the service.

6.4 Data and Reporting

6.4.1 The current law

The Group strongly valued the role of data collection in abortion care and noted the importance of the annual abortion data publications produced by Public Health Scotland (PHS). The Group recognised that these publications provide population-level overviews of abortion provision in Scotland, including information on gestation, method, age, area, deprivation category and more. This is helpful for understanding trends in service delivery, but also for monitoring and demonstrating the need for, and effectiveness of, abortion care in Scotland. The data also offer some insight into

[143] Brock, D. W. (2008). Conscientious refusal by physicians and pharmacists: Who is obligated to do what, and why? Theoretical Medicine and Bioethics, 29(3), 187–200.
[144] Fink, L. R., Stanhope, K. K., Rochat, R. W., & Bernal, O. A. (2016). "The fetus is my patient, too": Attitudes toward abortion and referral among physician conscientious objectors in Bogotá, Colombia. International Perspectives on Sexual and Reproductive Health, 42(2), 71–80.
[145] Homaifar, N., Freedman, L., & French, V. (2017). "She's on her own": A thematic analysis of clinicians' comments on abortion referral. Contraception, 95(5), 470–476.

accessibility of care and enable evidence-based decisions on improving abortion care along with other sexual health interventions, such as access to contraception. However, the Group did consider carefully whether the requirement for abortion data collection really does need to be included within legislation. Alongside this, as discussed earlier, the Group considered that the legal requirement to notify the Chief Medical Officer (CMO) of every abortion is clinically unnecessary. While other healthcare interventions are subject to standard data collection, abortion care is unique in the legal requirement for a statutory notification to the CMO. The Group felt that this requirement reinforced the idea of abortion being distinct from other forms of care, potentially adding stigma to a procedure that is routine and safe.

6.4.2 International examples

The international examples reviewed by the Group show variation in the legislative requirements for data collection and reporting of abortion data. All jurisdictions do appear to emphasise the importance of monitoring abortion services as part of a broader oversight of healthcare systems. While some jurisdictions do so through including reporting obligations directly in legislation, others rely on professional practice standards to guide data collection. Northern Ireland retains the requirement to notify the Chief Medical Officer within 14 days of performing an abortion.

6.4.3 Stakeholder comments and evidence review

A number of Pro-Life and Faith Groups stakeholders argued that a notification process should remain in place in order to monitor safety. Some feel that the current system is not as robust as it should be arguing that there should be a requirement to produce an annual report on the data collected which includes transparency about the grounds on which abortions are sought; and in the case of abortions on the grounds of disability, the conditions for which they are sought and detailed data on complications, Other Pro-Life organisations go further proposing ‘wide-ranging, connected, and longitudinal data to monitor health benefits, and risks of harm’ including harm to mental health, the effects on long term fertility and subsequent pregnancy outcomes.

PHS routinely collects and reports annually on abortion statistics including grounds and fetal anomaly.[146] With regard to complications of abortion, although not routinely published, the evaluation of EMAH was able to look at complication data and found that there were no indications of change in the low rate of serious complications before and after the introduction of EMAH.[147] Health Boards in Scotland are able to monitor complications using CHI numbers. In Scotland record linkage can be used to explore any long term effects which may be associated with abortion, but this is not done routinely. There are many publications that explored long term risks to, for example, fertility, pregnancy outcome and mental health, all of which are reassuring.[148]

[146] Public Health Scotland. (2024, May 28). Termination of pregnancy statistics: Year ending December 2023.
[147] Scottish Government. (2023). Evaluation of telemedicine early medical abortion at home in Scotland.
[148] Royal College of Obstetricians and Gynaecologists. (2011). The care of women requesting induced abortion: Evidence-based clinical guideline No. 7.

6.5 Counselling

In this report counselling is distinguished from information-giving and from the discussion which takes place in all medical consultations in which the health professional routinely discusses with the patient the risks and benefits of treatment as well as the alternatives. Clinicians on the group are clear that this forms part of every abortion consultation with clear and accurate information being given verbally as well as in a written leaflet and/or through an online video. The WHO notes “some individuals may wish to receive counselling before or after the abortion. Counselling is more than information provision but rather an interactive process through which someone voluntarily receives information, support and non-directive guidance… Counselling should always be voluntary.”[149]

6.5.1 The current law

The Group noted that there is no reference to counselling within the Abortion Act 1967, and that its provision is determined by clinical practice rather than by legislative requirements. Clinicians in the Group provided helpful insight on the current counselling pathways available in Scotland, noting that supportive, non-directive counselling is routinely offered to patients who request it or who are identified as potentially benefiting from it - either before or after the abortion.

6.5.2 International examples

The majority of international examples reviewed do not mention counselling in their primary legislation, thereby not mandating counselling in advance of an abortion and leaving any counselling arrangements to service providers. For those who do specifically refer to counselling within legislation, a range of approaches are adopted. On one end of the spectrum, Germany’s model mandates compulsory counselling that emphasises the value of fetal life and is legally required before an abortion can be performed – although this model has been widely criticised internationally for compromising patient autonomy. In contrast, New Zealand and South Australia promote a non-directive, optional model that legally requires counselling to be available while respecting individual decision making on whether counselling is required.

6.5.3 Stakeholder views and evidence review

A number of the Pro-Life and Faith Groups advocated for formal pre-abortion counselling with concerns being raised around women who are uncertain of their decision to proceed with an abortion. The Group recognised that a few patients, following the routine consultation, who appear to be distressed or uncertain about their decision do require further discussion (and time), and all Health Boards in Scotland have a pathway to refer for counselling where this is clearly required or requested. Patients can also contact counselling services themselves if they do not wish to access this through a Health Board. The Group considered the evidence on decision-making. There is a significant amount of robust evidence that most patients seeking abortions are confident in their decision. A 2015 Scottish study entitled "Do

[149] World Health Organization. (2022). Abortion care guideline.

women seeking termination of pregnancy need pre-abortion counselling"[150] concluded that few women currently use pre-abortion counselling services in the setting under investigation, stating that they are already sure of their decision regarding termination of pregnancy and do not require additional support. Furthermore, the authors concluded that policies aimed at mandatory counselling are a waste of resources and contrary to women's wishes. They add that healthcare professionals working in abortion settings should, however, be aware of risk factors for poor psychological outcomes post-abortion so that they can specifically target counselling services to these women. A retrospective case note review was conducted in 2013 in Lothian[151] seeking to determine the proportion of women for whom a pregnancy was clearly unintended (based on the London Measure of Unintended Pregnancy score[152]). The authors concluded that almost all women requesting an induced abortion had a clearly unintended pregnancy, were certain of their decision and did not wish further counselling. They suggested that a simple self-completed questionnaire could identify those who may benefit from further discussion.

A number of the Pro-Life and Faith Groups advocated for a more formalised, national counselling process, one submission recommending that the abortion pathway should include counselling as standard, noting that this counselling should be provided by someone independent of the abortion service. One submission called for the Group to recommend that the Scottish Government introduce a centralised resource, accessible to all women, that comprehensively covers all available options including information on continuing with a pregnancy, adoption and accessing abortion services. Such an information resource is already in place on the NHS Inform website which provides detailed information on how to access abortion in Scotland, what is involved in the assessment, how abortions are performed, the risks and side effects and what happens after an abortion. NHS Inform also provides information on emotional support, mental well-being in the context of abortion as well as information on post-abortion contraception.[153]

While a small number of women may require additional emotional support after an abortion, most women who terminate a pregnancy do not experience mental health problems. A review of the evidence published in 2009[154] evaluated empirical research addressing the relationship between induced abortion and women's mental health. They concluded that the relative risk of mental health problems among adult women who have a single, legal, first-trimester abortion of an unwanted pregnancy is no greater than the risk among women who deliver an unwanted pregnancy. Evidence did not support the claim that observed associations between abortion and mental health problems are caused by abortion per se as opposed to other preexisting and co-occurring risk factors. Another more recent study set out to

[150] Baron, C., Cameron, S., & Johnstone, A. (2015). Do women seeking termination of pregnancy need pre-abortion counselling? BMJ Sexual & Reproductive Health, 41(3), 181–182.
[151] Cameron, S. T., Glasier, A.(2013). Identifying women in need of further discussion about the decision to have an abortion and eventual outcome: A retrospective review of case notes. European Journal of Contraception & Reproductive Health Care, 18(5), 370–373.
[152] Barrett, G., Smith, S. C., & Wellings, K. (2004). Conceptualisation, development, and evaluation of a measure of unplanned pregnancy. Journal of Epidemiology & Community Health, 58(5), 426–433.
[153] NHS inform. (2025). Abortion. NHS 24.
[154] Major, B., Appelbaum, M., Beckman, L., Dutton, M. A., Russo, N. F., & West, C. (2009). Abortion and mental health: Evaluating the evidence. American Psychologist, 64(9), 863–890.

determine the impact of abortion legislation on mental health during pregnancy and postpartum and assess whether pregnancy intention mediates associations.[155] Using longitudinal data from nurses in the USA in 2010–2017 (4,091 participants, 4,988 pregnancies) they quantified associations between restrictive abortion laws and stress, depression symptoms during and after pregnancy, and depression diagnoses after pregnancy. Restrictive abortion legislation was statistically associated with unintended pregnancies which were, in turn, associated with increased risks of stress and depression. The clinicians on the Expert Group agreed that while there may be a very small number of women who would benefit from support after an abortion this can be handled by existing services including UK-wide charities with specialist experience in this area for example 'AbortionTalk' a UK wide telephone-based service.

A number of Pro-Life and Faith Groups argued that including counselling as part of a standard abortion care pathway would improve opportunities to detect potential coercion. Reproductive coercion is defined as any form of behaviour that intentionally controls another person's reproductive choices.[156] These behaviours include sabotaging contraception, for example, by removing or damaging a condom, or throwing away oral contraceptives and forcing a person either to continue or to terminate a pregnancy. The incidence of reproductive coercion varies around the world but, while there are some data from the UK on coercion among women attending maternity services, there are no data relating to abortion. The clinicians on the Expert Group agreed that it is standard practice in Scotland to ask women seeking abortion whether they are sure of their decision, whether anyone else is aware of the pregnancy or abortion plans and whether they feel pressured to seek an abortion. However, in their experience, coercion to have an abortion is rare. The NICE guidance[157] emphasises the need, in the context of telephone consultations, to check that the person can speak privately and is seeking abortion voluntarily. Asking about coercion is also not standard practice in the antenatal consultation as part of the maternity care pathway.

Many national and international clinical bodies advise against mandatory counselling before abortion. The 2019 NICE guidelines explicitly state that women should not be required to undergo compulsory counselling, instead recommending that abortion providers should offer or refer patients for support only if they request it.[158] . Similarly, RCOG affirms in its Clinical Guideline that patients who are certain of their decision to proceed with an abortion should not be subjected to mandatory counselling (recommendation 6.3), noting that "most women who undergo induced abortion are certain of their decision",[159] but recommends that voluntary counselling and support pathways should be clearly accessible to those who do want them (recommendation 6.4). The WHO abortion care guidelines further support NICE and RCOG, with their

[155] McKetta, S., Chakraborty, P., Gimbrone, C., Soled, K. R. S., et al. (2024). Restrictive abortion legislation and adverse mental health during pregnancy and postpartum. Annals of Epidemiology, 92, 47–54.
[156] Moulton, J. E., Corona, M. I. V., Vaughan, C., & Bohren, M. A. (2021). Women's perceptions and experiences of reproductive coercion and abuse: A qualitative evidence synthesis. PLOS ONE, 16(12), e0261551.
[157] National Institute for Health and Care Excellence. (2019). Abortion care (NICE Guideline NG140).
[158] As above
[159] Royal College of Obstetricians and Gynaecologists. (2022). Best practice in abortion care.

Service Delivery Recommendation 5[160] on provision of counselling stating that counselling must be entered into freely and voluntarily, i.e. it should not be mandatory and the right to refuse when offered be respected. WHO also recommends that counselling should be made available and accessible to those who want to receive it, emphasising the need for person-centred counselling tailored to the needs to the individual.[161]

The Centre for Reproductive Rights published a fact sheet on counselling requirements in Central and Eastern Europe, referencing a number of international human rights bodies who oppose mandatory counselling including the CEDAW and the ICESCR. They state that "in and of themselves mandatory counselling and information requirements jeopardize women's human rights by forcing women to undergo counselling or receive information which they may not want and calling into question women's decision-making authority and agency."[162]

The range of evidence available upholds a position that is strongly against the imposition of mandatory counselling in Scotland. Much of the evidence supports robust, staff-led processes that can identify individuals who may benefit from counselling without mandating it for all, which can instead act as a barrier for those patients who are confident in their decision. Both NICE and RCOG highlight the importance of compassionate, patient-centred counselling that remains voluntary.

6.6 Mandatory Waiting Periods

Mandatory waiting periods – legal requirements that enforce a fixed period delay between a request for an abortion and the procedure itself – are implemented in a number of countries.

6.6.1 The current law

The Group noted that there is no reference to mandatory waiting periods in the Abortion Act 1967. The Group considered evidence on mandatory waiting periods, as set out in the evidence review section of this topic.

6.6.2 International examples

A mandatory reflection period to insist that a woman takes time before finalising a decision was abolished in France in 2022. In Germany there is a 3-day waiting period required after counselling. None of the other countries reviewed has a mandatory waiting period.

6.6.3 Stakeholder comments and evidence review

These mandatory waiting periods have been framed by their advocates as an opportunity to encourage reflection and to support informed decision making. A

[160] WHO (2022). Abortion Care Guideline.
[161] WHO (2022). Abortion Care Guideline.
[162] Center for Reproductive Rights. (2018). Abortion, women's mental health, and biased counselling in Central and Eastern Europe: Fact sheet.

number of Pro-Life and Faith Group stakeholder submissions emphasised the importance for patients not to feel rushed into making a decision on whether to proceed with an abortion, and the need for informed choice. The clinicians in the group made it clear that women requesting abortion are routinely offered more time to make a decision if they need it. They also pointed out that EMAH allows women to take the medication at home when it suits them, allowing them the choice to delay inducing the abortion if they so wish.

A number of clinical guidelines and international human rights standards view these waiting periods as unnecessary and potentially harmful. The National Institute for Health and Care Excellence (NICE), in its abortion care guideline NG140 (1.1.8)[163] states unequivocally that patients should not be required to undergo a compulsory period of reflection before having an abortion. Instead, providers should offer support and further decision-making time only if requested by the patient. This reflects an understanding that, as discussed earlier, people accessing abortion care are often already confident in their decision, and that imposed delays are not clinically justified. The Royal College of Obstetricians and Gynaecologists (RCOG) echoes this position[164], stating that delays caused by unnecessary processes can increase clinical risk and emotional distress without improving decision quality and highlighting that an abortion is safer the earlier it is provided[165] (although that is not to say that abortions provided at later gestations are unsafe). It would therefore be counterproductive to enforce waiting periods for patients who are certain of their decision. Both organisations, in short, suggest that enforced mandatory reflection does not add clinical value and may cause harm, with patients who are unsure offered additional time and support where it is wanted or needed.

The Centre for Reproductive Rights (CRR) offers a comprehensive critique of mandatory waiting periods in its 2015 fact sheet on "Mandatory Waiting Periods and Biased Counselling Requirements in Central and Eastern Europe".[166] The CRR outline several concerning consequences of mandatory waiting periods. Along with delays to care, they note that no evidence was found that waiting periods result in more “informed” decisions. In fact, many patients already experience emotional or logistical strain by the time they access services, viewing any additional forced wait as unnecessary and patronising. Importantly, the CRR also point to the potential of an increased risk of harm particularly for people in coercive relationships or facing unsafe living conditions. For these individuals, forced delays may increase their vulnerability and endanger their safety.

A number of international human rights bodies, including the CEDAW Committee[167] and the European Court of Human Rights[168] have criticised mandatory waiting periods as violations of women's rights to health, privacy, non-discrimination, and

[163] National Institute for Health and Care Excellence. (2019). Abortion care (NICE Guideline NG140): Recommendations – Service organisation.
[164] Royal College of Obstetricians and Gynaecologists. (2022). Best practice in abortion care.
[165] As above
[166] Center for Reproductive Rights. (2018). Abortion, women’s mental health, and biased counselling in Central and Eastern Europe: Fact sheet.
[167] Committee on the Elimination of Discrimination against Women. (2013). Concluding observations on the combined seventh and eighth periodic reports of Hungary (CEDAW/C/HUN/CO/7-8), para. 31(c). United Nations.
[168] European Court of Human Rights. (2007). *Tysiąc v. Poland*, No. 5410/03, para. 116.

autonomy. While it is clear that patients should be given time to make an informed decision, this objective can be met through voluntary reflection periods and tailored clinical care, without resorting to statutory delays.

6.7 Young People

The Group noted that there are no specific references to young people in the Abortion Act 1967. However, clinicians noted that with regards to EMAH, patients under 16 are under current guidance in Scotland expected to receive an in-person consultation and also to take their medications in hospital unless appropriate support is in place to enable them to take the medication at home.

6.8 Adults with Incapacity

As things stand, pregnant women in Scotland who are deemed to lack mental capacity can legally access abortion, but the process requires medical certification under section 47, Adults with Incapacity Act 2000 (AWIA), to confirm the treatment is in the person's best interests. In cases of abortion, regulations made under section 48 AWIA requires that an independent opinion be obtained from the Mental Welfare Commission and/or that a court order be obtained. Overall, it is designed to ensure that safeguards are in place to ensure decisions are made in the benefit of the individual.

The current law in this area is now considered outdated, particularly in light of the increased emphasis placed on the importance of adhering to a human rights approach as embodied in the UN Convention on the Rights of Persons with Disabilities.

This was recognised in the findings of the Independent Review of Mental Health and Incapacity Law in Scotland.[169] In its recommendations, the Review emphasised the need to facilitate reform that ensured that people assessed as lacking capacity have access to decision-making processes that align with their human rights. The Scottish Government has welcomed the recommendations, offered a detailed response, and reform is currently underway.

The Group supports a human rights-based approach to women deemed to lack capacity in terms of accessing abortion services. A more joined-up approach between mental capacity and abortion laws in Scotland would also assist in supporting a human rights-based approach which ensures access to timely and suitable abortions services for pregnant women deemed to lack capacity.

While recognising that it is important that suitable safeguards are put in place, a flexible case-by-case approach on an individual basis would also be welcomed, with support provided by independent advocates, and in circumstances where mandatory courts orders for accessing abortion services were not required.

6.9 Patients with Brain Stem Death

[169] Scott, J. (Chair). (2022). Scottish Mental Health Law Review: Final report. Scottish Government.

There is also no clear statutory framework in Scotland governing the provision of abortion where a pregnant patient is brain stem dead. As a result, providers are required to navigate these rare but complex cases using general legal principles.

How best to treat a pregnant woman who has been assessed as being brain stem dead raises a range of contested ethical and legal issues. While there have been some high-profile cases in this area in countries such as the United States, there is very little academic scholarship or case law in the UK on the issue.

In general terms, UK courts have recognised that the decision to withdraw life-sustaining treatment from a patient in a persistent vegetative state, for example, should be made in the best interests of the patient, even when they are unable to make decisions themselves. This may involve considering their quality of life and any previously expressed wishes. There is no requirement for court approval to be sought for withdrawal of life-sustaining treatment in these circumstances, provided that there is agreement as to what is in the best interests of the patient, in addition to ensuring any relevant mental capacity laws and professional guidance have been followed.

If the pregnant woman is assessed as brain stem dead in accordance with the Code,[170] then withdrawal of treatment may take place even if it results in the death of the fetus, without engaging the law on abortion. If no clinical diagnosis of brain stem death can be made in accordance with the Code, then a clinical assessment of what treatment is appropriate should be made on a case-by-case basis, based on the best interests of the pregnant woman. In individual circumstances, account may need to be taken as to whether the pregnant woman had made any relevant advance directives or had expressed specific values or beliefs in relation to the provision of such treatment. In the event that no agreement can be reached on what constitutes the pregnant woman's best interests, then recourse to the court may be necessary in the circumstances.

6.10 Positive Duty to Provide Abortion Services

The Group noted that there is currently no legal duty in Scotland requiring individual clinicians, Health Boards or the Scottish Government to provide abortion care, nor is there any legal obligation to ensure that abortion services are available across all gestations. The Abortion Act 1967 permits abortion on certain legal grounds, but the Group considered that this does not guarantee that services will be accessible. This is particularly relevant in Scotland for patients with complex needs or those requiring care at later gestations.

In practice, the Group considered that a lack of duty to provide may have contributed to variation in service delivery across Scotland, particularly in relation to abortions between 20 to 24 weeks' gestation. While abortion up to 24 weeks is legally permitted under the current legal framework, there is no routine access to care beyond 20 weeks within Scotland, except for cases of fetal anomaly, and most

[170] Academy of Medical Royal Colleges. (2025). Code of practice for the diagnosis and confirmation of death (Updated January 2025).

patients seeking abortion at later gestations under Ground C or D are currently referred to services in England.

A similar obligation is currently in place in the Northern Ireland context, where the Secretary of State for Northern Ireland is under a legal obligation to implement the recommendations of the CEDAW Report into abortion in Northern Ireland, including providing women with access to high-quality abortion and post-abortion care in all public health facilities. This obligation was cited by the Secretary of State in undertaking actions to commission services when the then-government declined to do so and was used by the Northern Ireland Human Rights Commissioner in their application to court regarding the failure to properly commission abortion services over an 18-month period between 2019 and 2021.[171] France has the right to access abortion written it's codified constitution, providing a means to challenge state failings to deliver accessible abortion care.

The Group decided that the lack of any statutory or regulatory requirement to ensure provision should be considered further.

6.11 Conclusions and Recommendations

6.11.1 Provision

The Group reviewed the evidence on the safety, effectiveness and acceptability of abortion care being provided by a wide range of healthcare professionals beyond doctors. Across the literature, and the international examples, there is consensus that abortion care can be safely and effectively delivered by a variety of professionals, including nurses and midwives, providing that they have the appropriate training. This is endorsed by WHO and reflected in recent reforms that have been carried out in a range of jurisdictions including a number of Australian States, New Zealand and Northern Ireland where a broader cadre of healthcare professionals now deliver and support abortion provision safely and effectively. The Group also noted midwives and nurses already provide clinically comparable care in Scotland, such as management of miscarriage, without legal restriction.

The Group agreed that, while abortions beyond 24 weeks gestation may require more complex decision making and therefore collaboration with other healthcare professionals, this does not necessarily require restriction to doctors. The crucial requirement is that any clinician providing abortion care at any gestation is appropriately trained and competent, in line with clinical standards that are in place to ensure safe provision in other areas of healthcare.

The Group therefore recommends that an updated abortion law should allow any appropriately trained healthcare professional to provide abortions. The definition should be set out in regulations, enabling it to be updated as practice, skills, and training frameworks develop. This ensures clinical flexibility and futureproofing, while still focusing on the overall safety of the procedure. It is noted that 'appropriately

[171] Northern Ireland Judiciary. (n.d.). Application by the NIHRC for judicial review: In the matter of the failure by the Secretary of State and others.

trained' would account for a range of scenarios and, for example, should allow a qualified nurse or midwife to provide vacuum aspiration (VA), but not necessarily other allied healthcare professionals.

Recommendations

1. Any **appropriately trained** registered healthcare professional should be able to provide abortion care at all gestations.

2. Healthcare professional should be defined in regulations, rather than in primary legislation.

6.11.2 Certification

On certification, the Group considered that the current legal requirement for two doctors to certify that the legal grounds for an abortion are met now functions predominately as an administrative barrier and adds little clinical value for abortions under 24 weeks gestation – and it is now at odds with modern medical practice and patient autonomy. Considered alongside the recommendation that there should be no legal grounds for abortions under 24 weeks gestation, there should be no requirement for two doctors to certify an abortion at those gestations. Stakeholders highlighted that no other comparable healthcare requires two doctors to sign-off before it can proceed, and that healthcare should be governed by clinical guidelines and patient consent rather than statutory certification. The RCOG and BMA have also reiterated support for the removal of certification requirements.

The Group appreciates that clinicians involved in later stage abortions, particularly those over 24 weeks, value consultation with other professionals when making what can sometimes be complex decisions. It is recommended that two healthcare professionals agree that an abortion would be appropriate after this gestational limit.

The Group considered the New Zealand model, whereby a consultation with a second professional is mandated before a later gestation termination can be authorised but agreement between the two is not required. However, given the particular complexity and sensitivity of these cases, it felt that there should be agreement between the two healthcare professionals that an abortion is appropriate in all the circumstances (except in an emergency). It is important to note that in line with current law this should not apply in emergency situations, and where an abortion is immediately necessary to save the life or prevent permanent grave injury to the patient, a healthcare professional should not be required to seek agreement from a second professional.

While two doctors must agree in these circumstances, the Group recommend that guidelines should set out what information should be recorded by providers in the patient's medical records rather than via formal statutory certification. Therefore, there should not be a need for Regulations to set out the information that must be recorded (as there is currently in the Abortion (Scotland) Regulation 1991). This is in line with provision of other healthcare services.

Recommendations

1. The requirement for two doctors to certify an abortion before 24 weeks gestation should be removed

2. Two healthcare professionals should agree that an abortion is appropriate after 24 weeks gestation, before proceeding with the abortion (except in emergencies).

3. There should be no formal certification requirements at any gestation, with decisions recorded in medical records

6.11.3 Place

At the time the Abortion Act came into force, the primary 'mischief' the bill was seeking to address was women resorting to illegal abortion as a result of lack of access to safe, legal abortion in the formal healthcare system. As noted in the introduction to this report, illegal abortion had – by the time the bill was passed – become the top cause of avoidable maternal mortality in the UK, with women often presenting with sepsis after procedures by illicit providers. The provision, therefore, of a requirement for licensed clinics and NHS hospitals was to protect women's health from the primary danger posed to it at that time.

In 2025, we are no longer in this position. Abortion is safe, largely accessible, and publicly funded. Women are able to present to hospitals for follow-up care where required. And most fundamentally, abortion is no longer a serious surgical procedure requiring a stay in hospital, but predominantly self-managed by women in their own homes via safe and effective medication.

At the same time, regulation and monitoring of healthcare services has progressed immeasurably since the 1960s. Non-hospital services need to be registered with Health Improvement Scotland, regular inspections and revalidation of medical and nursing professionals ensure that all healthcare is subject to the type of monitoring that the Abortion Act sought to introduce only for abortion care in 1967. The need for abortion-specific restrictions, therefore, is significantly less.

As a result of these developments, the Group agreed that there is no clinical reason to stipulate within legislation where abortions can take place, and therefore no need for Scottish Ministers to approve any place for abortions. Such matters should instead be covered in clinical guidelines, as for other healthcare procedures.

In order to tackle concerns around abortions taking place in unregulated premises, the Group consider that the law should stipulate organisations that abortion can be provided by – an NHS provider or a private provider registered with Healthcare

Improvement Scotland (HIS). The Group agreed that while HIS should regulate any private provider, this should only be specified in primary legislation if there are circumstances not covered by existing legislation (such as the provisions in National Health Service (Scotland) Act 1978 (as amended).

Recommendations

1. Legislation should not stipulate where an abortion should take place but should state that abortions must be provided by an NHS provider or a private provided registered with Healthcare Improvement Scotland.

2. Further consideration should be made by the Scottish Government on whether existing provisions to ensure private providers are regulated are sufficient. If deemed so, no abortion specific legislation should be required.

6.11.4 Counselling

Based on the variety of evidence and views submitted, the Group recognise the importance of ensuring that all patients accessing abortion services are offered the opportunity for counselling where required, noting that this should be person-centred and respectful of individual circumstances and preferences. The evidence highlights that while the majority of patients seeking an abortion are confident in their decision, a small proportion may benefit from additional support, and it is vital that this remains available.

Stakeholder submissions reflected this, with several organisations advocating for accurate, clear and supportive information to be provided to patients. Both NICE and RCOG have issued guidance that states that counselling should not be mandatory, but that it should be available for those who seek it. This is consistent with a rights-based approach to abortion care which prioritises informed choice, but also patient autonomy.

The Group carefully considered models, such as those adopted in New Zealand and South Australia where the offer of counselling is a legal requirement, while the decision to accept it remains with the patient. It is acknowledged that these models do ensure that support is available, without mandating and increasing barriers to care. However, the Group considers that existing service delivery pathways are the most appropriate mechanisms for ensuring that counselling can remain a core part of abortion care, without compromising access.

The Group concluded that counselling should indeed be routinely offered as part of best practice abortion care but managed through clinical guidance and standards rather than embedded in primary legislation. This approach allows for flexibility as service models evolve and avoids creating legal rigidity in what should ultimately be a matter of clinical judgement and patient preference. Concerns were raised that embedding a legal requirement to offer counselling could risk formalising care pathways that are then difficult to update over time.

Recommendations

1. The Group recommends that mandatory counselling should not be included in abortion legislation.

2. It is recommended that clinical guidance, rather than legislation, should state that there should be timely access to counselling available for patients who wish to access it.

6.11.5 Mandatory Waiting Periods

All the evidence suggests that the vast majority of women in Scotland are certain of their decision to have an abortion. For those who wish for more time to decide or further discussion, provision is made for that to happen. Mandatory waiting periods serve no clinical purpose but only delay the start of treatment. The Group therefore recommends that mandatory waiting periods before an abortion could take place should not be included in any potential legislation.

Recommendations

The Group recommends that mandatory waiting periods should not be included in abortion legislation.

6.11.6 Conscientious Objection

The Group considered conscientious objection thoroughly, acknowledging the overwhelming stakeholder view, including from clinical bodies, that the overall principle of conscientious objection should remain. The Group recognises the deeply held moral and religious views in the context of abortion, and the importance of the right to object for those who do not wish to provide these services. However, the Group equally acknowledge that careful thought must be given to the impact of conscientious objection on those seeking to access abortion services. The Group agreed that the principle of conscientious objection should remain in any reformed abortion law but wish to recommend ways that the right to object can be improved to align with current practice, and to ensure that unnecessary barriers are not put in place for patients.

With regard to wording in section 4(1) of the Abortion Act which states that ‘no person shall be under any duty, whether by contract or by any statutory or other legal requirement to participate in any treatment authorised by this Act to which he has a conscientious objection’, the Group considered that ‘by contract’ should be removed. This would restrict people applying for roles which make clear abortion treatment is a

significant/core part of the role and later identifying that they have a conscientious objection if they had not raised it during the recruitment process.

The inclusion of a duty on those with conscientious objections to refer patients on to somewhere they could be offered help with access to an abortion in an updated conscientious objection clause to more effectively balance the rights of individual healthcare professionals with the rights of women to access abortion care. This is in line with views of the professional organisations.

Recommendations

The Group recommends that this provision should remain similar to the current legislation, with a number of amendments:

1. With regard to wording in section 4(1) of the Abortion Act which states that 'no person shall be under any duty, whether by contract or by any statutory or other legal requirement to participate in any treatment authorised by this Act to which he has a conscientious objection', the Group recommend that 'by contract' should be removed.

2. An inclusion of a duty on those with conscientious objections to refer patients on to somewhere they should be included in an updated conscientious objection clause.

6.11.7 Data and Reporting

The Group felt that the requirement to notify the CMO of each abortion that takes place is anachronistic and serves no clinical purpose yet continues to exceptionalise and stigmatise abortion. It therefore recommends that there should be no statutory duty to notify the CMO or any other body about numbers of abortions.

However, the Group was clear that a comprehensive system of data collection is helpful for understanding trends in service delivery and for monitoring and demonstrating the need for and effectiveness of abortion care in Scotland. The data can enable improvements to service delivery and should continue to be gathered. The Group carefully considered whether this could be delivered through standard governance rather than legislation, but the Group would not wish to risk losing access to any data and felt that including a requirement for PHS to continue to collect data within primary legislation would safeguard the continuation of a wide range of accurate data

The Group agreed that PHS should continue to collect data on abortions and that there should be a requirement for this in primary legislation. However, legislation should not state what data should be collected, and this should be left to guidance. As is the case with other healthcare services where routine data are collected, the Group would not expect this to have any negative impacts on the data collection.

The Group carefully considered whether PHS should collect specific data on abortion complications but felt that any changes to how complications data is collected should

not be included within primary legislation, accounting for potential improvements in data collection systems and methods. It is recommended that the Scottish Government consider improving collection of complications data alongside Health Boards.

Recommendations

1. The requirement to notify the Chief Medical Officer of an abortion should be removed.

2. The requirement to collect data should be included in any updated abortion legislation.

3. Any requirements on what data are to be collected should be in guidelines, not primary legislation.

6.11.8 Adults with Incapacity, Young People and Brain Stem Dead patients

As things stand, pregnant women in Scotland who are deemed to lack mental capacity can legally access abortion, but the process requires medical certification under s 47, Adults with Incapacity Act 2000 (AWIA), to confirm the treatment is in the person's benefit. In cases of abortion, regulations made under s48 AWIA requires that an independent opinion be obtained from the Mental Welfare Commission and/or that a court order be obtained. Overall, it is designed to ensure that safeguards are in place to ensure decisions are made in the benefit of the individual and that they do not resist treatment.

The current law in this area is now considered outdated, particularly in light of the increased emphasis placed on the importance of adhering to a human rights approach as embodied in the UN Convention on the Rights of Persons with Disabilities.

This was recognised in the findings of the Independent Review of Mental Health and Incapacity Law in Scotland (Scott Review, 2022). In its recommendations, the Review emphasised the need to facilitate reform that ensured that people assessed as lacking capacity have access to decision-making processes that align with their human rights. The Scottish Government has welcomed the recommendations, offered a detailed response, and reform is currently underway.

The Group supports a human rights-based approach to women deemed to lack capacity in terms of accessing abortion services. A more joined-up approach between mental capacity and abortion laws in Scotland would also assist in supporting a human rights-based approach which ensures access to timely and suitable abortions services for pregnant women deemed to lack capacity.

While recognising that it is important that suitable safeguards are put in place, a flexible case-by-case approach on an individual basis would also be welcomed, with

support provided by independent advocates, and in circumstances where mandatory courts orders for accessing abortion services were not required.

How best to treat a pregnant woman who has been assessed as being brain stem dead raises a range of contested ethical and legal issues. While there have been some high-profile cases in this area in countries such as the United States, there is very little academic scholarship or case law in the UK on the issue.

In general terms, UK courts have recognised that the decision to withdraw life-sustaining treatment from a patient in a persistent vegetative state, for example, should be made in the best interests of the patient, even when they are unable to make decisions themselves. This may involve considering their quality of life and any previously expressed wishes. There is no requirement for court approval to be sought for withdrawal of life-sustaining treatment in these circumstances, provided that there is agreement as to what is in the best interests of the patient, in addition to ensuring any relevant mental capacity laws and professional guidance have been followed.

If the pregnant woman is assessed as brain stem dead in accordance with the Code, then withdrawal of treatment may take place even if it results in the death of the fetus. If no clinical diagnosis of brain stem death can be made in accordance with the Code, then a clinical assessment of what treatment is appropriate should be made on a case-by-case basis, based on the best interests of the pregnant woman. In individual circumstances, account may need to be taken as to whether the pregnant woman had made any relevant advance directives or had expressed specific values or beliefs in relation to the provision of such treatment. In the event that no agreement can be reached on what constitutes the pregnant woman's best interests, then recourse to the court may be necessary in the circumstances.

With regards to young people, the Group felt that it would be inappropriate to differentiate 'young people' within the law, and any additional safeguarding requirements could be considered as part of guidance.

Recommendations

1. There should be no specific changes to primary legislation regarding adults with incapacity (AWI) or young people and that Courts should not be involved in authorising abortions.

2. The Mental Welfare Commission should ensure there are clearer pathways and guidance in future for helping ensure swift processes and support for AWI where an abortion is being considered.

3. There should be no specific additional requirements for young people.

4. There should be no specific additional requirements within abortion legislation for patients who are brain stem dead.

6.11.9 Positive Duty to Provide Abortion Services

There is legislative precedent for creating duties in specific areas of health. For example, in the National Health Service 2006 Act, in relation to health research, education and training, workforce systems etc. The Group recommends that a positive duty on Ministers or health boards to provide abortion services in line with the law should be included in legislation.

It is recommended that the Scottish Government explore an amendment to the NHS (Scotland) Act 1978 to cover such a duty and ensure provision of abortion services is framed as part of a Health Board's role in providing healthcare. In discharging this duty, the Scottish Ministers must, in particular, facilitate or otherwise promote access to, and delivery of, abortion as a healthcare matter in Scotland.

It is recommended that the Scottish Government explore a duty to ensure sufficient staffing levels within the Health and Care (Staffing) (Scotland) Act 2019 and alongside a duty on Health Boards, that the Scottish Government should consider a duty placed on Scottish Ministers. The Group suggest that Scottish Ministers could, at least once every 10 years, publish a report describing the workforce arrangements and systems in place in the health service for access to, and delivery, of abortion as a healthcare matter in Scotland.

Recommendations

1. The Scottish Government should include a duty to provide abortion services – or a 'right to abortion' – with said duty being on Scottish Ministers and Health Boards.

6.12 A note on disposal of fetal remains

While not directly related to the law on abortion, the Group consider that the Scottish Government should take this opportunity to reconsider current guidance around the disposal of pregnancy remains following an induced abortion or pregnancy loss up to 24 weeks' gestation.

Currently in Scotland, guidance limits the options of disposal available to women, with a requirement that pregnancy remains of any gestation collected by healthcare professionals are subject to cremation or burial. This is despite the legal framework that a foetus is only a part of the woman, not a distinct entity in its own right.

Cremation is often associated with a ceremony and/or religious or spiritual ritual and takes place within a registered crematorium under the oversight of a Registrar, and while this may be the most appropriate choice for some women in these circumstances, for many it may be viewed as insensitive. Burial can be similarly emotionally taxing for women given the association with the loss of other family members or friends.

Because of the requirement for disposal to be via one of these options, a full consent form has to be undertaken with the woman during the consultation process which abortion providers report can be incredibly distressing, particularly at earlier gestations where if a woman had opted for EMAH as opposed to surgical or in-hospital EMA care there would be no such requirements. Current guidance also requires that pregnancy remains are required to be stored in a mortuary which, in light of other proposals in this paper around accessibility and provision of care, could limit where abortion can be provided in practice.

The Group consider that any legislation or guidance on this matter should reflect patient choice at its core and recognise that women experiencing pregnancy loss of any kind may not feel that cremation or burial is appropriate. The Group instead feel that the position in Scotland should reflect that of the 2024 Human Tissue Authority guidance applicable to England, Wales, and Northern Ireland, where cremation, burial, incineration or the return of the pregnancy remains to the woman when requested, are available options, and that women should also have the right to decline to discuss how their pregnancy remains are managed.

The Group therefore recommend a review on this matter, either within the ongoing process to review the law on abortion or separately, to ensure that patient choice is recentred at this stage of the pathway.

7. Offences

7.1 Review of the Current Law

The remit provided by the Scottish Government was to consider abortion as a healthcare matter. In order achieve this and to align abortion with other healthcare procedures, the Group believes that criminal sanctions against abortion should be removed unless they are deemed necessary and proportionate to achieve the goals of good healthcare regulation, which include ensuring safety, high standards of care, and respect for the rights of the patient. Decriminalisation does not mean deregulating abortion care nor removing all criminal offences that might apply to it. The Group explored the wider framework of legal and professional sanctions that relate to abortion to provide the Scottish Government with a full view of the landscape.

This topic includes consideration of offences that may be committed by women acting in relation to their own pregnancies, healthcare professionals who act outside regulatory frameworks or clinical guidelines, and unqualified providers. It also concerns criminal offences for individuals who end a woman's pregnancy through the use of fear, force, or fraud.

It is important to note that common law in Scotland has long held that the fetus is treated as a part of the woman's body, and not a separate legal person. Offences are therefore viewed through the prism of potential harm caused to the woman, rather than to the fetus or pregnancy itself. The Group does not recommend any alteration to this long-standing principle.

7.2 Abortion-specific law

Despite the 1967 Act providing a legal route for accessing abortion services, abortion remains potentially a common law crime in Scotland if performed outwith its provisions, posing potential legal risks for patients and providers. The Group notes that over the past 25 years, there have been investigations and prosecutions for abortion in Scotland.

Other common law or statutory offences may apply to third parties who end a pregnancy without the pregnant woman's consent, or in a way which causes her harm. The most recent example of this is from July 2025 where a man was sentenced to ten years and six months imprisonment for assault to injury, sexual assault and procuring an abortion.[172] The abortion offence in this case involved administering abortion medication without the woman's knowledge or consent.

The Abortion (Scotland) Regulations 1991, as amended in 2021, impose additional obligations on practitioners, including mandatory notification to the Chief Medical Officer for each abortion. If practitioners fail to comply with these regulations, they could face professional sanctions. In addition, under section 2(3)[173] of the 1967 Act, failure to comply with the notification requirements can result in a fine.

[172] Judiciary of Scotland. (2025, July 7). *HMA v Stephen Doohan.*
[173] Legislation.gov.uk. (1967). Abortion Act 1967 (c. 87).

7.2.1 Regulation of healthcare providers

Abortion care is also subject to a far wider range of regulations governing healthcare professionals and medical practice, which stems from both common law and statute and includes sanctions for non-consensual or negligent procedures. Healthcare professionals involved in abortion services are also overseen by regulatory bodies such as the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC). Breaches of legal or ethical standards can lead to disciplinary actions, including suspension or removal from the professional register.

In Scotland, abortion providers are also regulated by Healthcare Improvement Scotland. Clinical guidance and standards for doctors are provided by the GMC as the statutory regulator of doctors' practice.[174,175]

Professional bodies, such as the Royal College of Obstetricians and Gynaecologists (RCOG), also issue best practice guidance for healthcare professionals.[176] These respond to evolving circumstances, as with the recent RCOG guidelines regarding police involvement following abortion or pregnancy loss.[177] Guidance from NICE and the Scottish Abortion Care Providers network is also used by abortion care providers in Scotland.

7.2.2 The Concealment of Birth (Scotland) Act 1809

The Concealment of Birth (Scotland) Act 1809[178] succeeded a law enacted in 1690,[179] which was concerned with the abandonment of 'illegitimate' children and cases where infanticide was suspected but could not be proven.[180,181]

The 1809 Act rules that concealing a birth is punishable with imprisonment. Section 2 of the Act provides that:

"And if, from and after the passing of this Act, any woman in Scotland shall conceal her being with child during the whole period of her pregnancy, and shall not call for and make use of help or assistance in the birth, and if the child be found dead or be amissing, the mother, being lawfully convicted thereof, shall be imprisoned for a period not exceeding two years in such common gaol or prison as the court before which she is tried shall direct and appoint."[182]

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[174] General Medical Council (2024) Good medical practice.
[175] Royal College of Obstetricians and Gynaecologists. (2011). The care of women requesting induced abortion (Evidence-based Clinical Guideline No. 7).
[176] RCOG (2022) Best practice in abortion care.
[177] Royal College of Obstetricians and Gynaecologists. (2024). Involvement of police following abortion and pregnancy loss.
[178] Legislation.gov.uk. (1809). Concealment of Birth (Scotland) Act 1809.
[179] 'Scotland Privy Council. (1690). Act anent murthering of children. Internet Archive.
[180] Gordon, G. H. (1967). The criminal law of Scotland. W. Green & Son.
[181] Harrower-Gray (2014) Scotland's hidden harlots and heroines: Women's role in Scottish society from 1690-1969. Pen & sword books Ltd.
[182] Legislation.gov.uk. (1809). Concealment of Birth (Scotland) Act 1809.

7.2.3 Medicines Act 1968 and the Human Medicines Regulations 2012

Under the Medicines Act 1968[183] and the Human Medicines Regulations 2012[184] mifepristone and misoprostol (the two medicines used to induce abortion) are classified as “prescription-only medicines” (POMs). POMs can only be dispensed with a valid prescription from a registered healthcare professional (e.g. doctor, dentist, or nurse) and administered as per the practitioner’s instructions.

It is an offence to sell or supply prescription-only medicines within the UK without a valid prescription. Therefore, anyone sending/giving mifepristone or misoprostol to any patient without a valid prescription may be committing an offence regardless of the Abortion Act 1967 or the common law relating to abortion.

7.2.4 Reproductive coercion

An important additional area of concern that was raised in many submissions by stakeholders concerned coercion. The Group notes that reproductive coercion encompasses both coerced pregnancies and coerced abortion. Those experiencing reproductive coercion often experience wider coercive, controlling or abusive behaviour.

A 2022 Freedom of Information response from the Scottish Government confirmed that while there is no specific offence of coercion to have an abortion, various existing offences can be used to prosecute coercive behaviour depending on the facts of the case.[185] Below is a summary of the existing legislation that is relevant to the consideration of coercion.

7.2.5 Domestic Abuse (Scotland) Act 2018

This Act introduced a specific offence of abusive behaviour towards a partner or ex-partner. Section 1 criminalises a course of behaviour that is abusive and likely to cause the victim physical or psychological harm.

Section 2 provides a non-exhaustive definition of abusive behaviour to include behaviour that is likely to have the effect of:

- Making the victim dependent or subordinate.
- Isolating the victim from friends, family, or support.
- Controlling, regulating, or monitoring the victim’s day-to-day activities.
- Frightening, humiliating, degrading, or punishing the victim.

Any offending behaviour under this Act would need to have formed part of a course of conduct that is abusive to the perpetrator’s partner or ex-partner and the course of conduct as a whole would have to be such that it would be likely to cause the victim to suffer physical or psychological harm (defined as including fear, alarm or distress)

[183] Legislation.gov.uk. (1968). Medicines Act 1968.
[184] Legislation.gov.uk. (2012). The Human Medicines Regulations 2012 (S.I. 2012/1916).
[185] As above

and the accused must be at least reckless as to whether their behaviour would likely to have this effect.

The Act sets out three conditions, all of which must be proven for a conviction:

- the accused engaged in a course of behaviour which was abusive of the accused's partner or ex-partner.
- a reasonable person would consider the course of behaviour to be likely to cause the partner/ex-partner to suffer physical or psychological harm.
- the accused either intended the course of behaviour to cause such harm or was reckless as to whether it would.

If a partner or ex-partner pressures or forces someone to terminate a pregnancy as part of a pattern of controlling or abusive behaviour, this could fall within the scope of the Act.[186]

7.2.6 Criminal Justice and Licensing (Scotland) Act 2010

Section 38 of this Act creates an offence of threatening or abusive behaviour likely to cause a reasonable person to suffer fear or alarm. This is a broad provision and can apply to a wide range of conduct, including threats or intimidation related to abortion decisions. If someone uses threatening or abusive behaviour to coerce a person into having an abortion, this could be prosecuted under this section.[187]

7.2.7 Abusive Behaviour and Sexual Harm (Scotland) Act 2016

Section 1 (2) of this Act defines an existing offence as aggravated when a partner or ex-partner commits an offence and:

> (a) the person intends to cause the partner or ex-partner to suffer physical or psychological harm, or
> (b) in the case only of an offence committed against the partner or ex-partner, the person is reckless as to causing the partner or ex-partner to suffer physical or psychological harm.

This Act contributes to the broader legal context of protecting individuals from abuse and harm.

7.2.8 Common Law and Other Offences

In addition to statutory provisions, common law offences such as assault or threats may be relevant. For example, if physical force or threats are used to compel someone to undergo an abortion, or if abortion medication is administered without consent, this could constitute assault or threats under common law to the woman involved.[188]

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[186] Scottish Parliament. (2018). Domestic Abuse (Scotland) Act 2018.
[187] Scottish Government. (2022). Freedom of Information request: FOI-202200273426.
[188] Judiciary of Scotland. (2025, July 7). *HMA v Stephen Doohan.*

Given the nature of the ending of a pregnancy through fear, force, or fraud – and the likely impact this will have on the woman – decisions on sentencing would likely be reflective of the significant level of harm involved, and in some circumstances, may involve aggravating factors.

7.3 Review of International Examples

The Group's review of offences for women seeking abortion and providers of abortion services was supported by consideration of several other jurisdictions, which are laid out in further detail in Annex B. In line with the Group's remit, particular attention was paid to jurisdictions that had moved to treat abortion as an issue of healthcare, along with other examples suggested by stakeholders. The international examples demonstrated some variation in how criminal law interacts with abortion care but displayed a notable trend towards reducing the use of criminal sanctions against women who have acted with regard to their own pregnancies.

The examples considered also show a shift away from the criminalisation of abortion as a general offence and toward a model where the criminal law is reserved for specific instances where abortion may be harmful to women: unqualified provision, coercion or breaches of clinical safeguards. While most jurisdictions maintained some criminal offences linked to abortion, these are typically narrow and proportionate, often do not include imprisonment as a penalty, and – importantly - do not focus on punishing providers or women acting in good faith, but on preventing unqualified providers or non-consensual procedures.

Canada represents the most fully decriminalised model, with no abortion-specific offences and care being regulated entirely through health law and professional standards. At the other end of the spectrum, Germany retains a detailed criminal code - abortions that are provided outside of prescribed conditions may lead to penalties for providers, and in some cases individuals who have acted with regard to their own pregnancies, though exemptions do apply. France maintains criminal offences for non-consensual abortions and procedures carried out beyond the legal gestational limit, or by unqualified providers.

Many recently revised legislative frameworks, including those in New Zealand, South Australia, Northern Ireland and Western Australia, explicitly protect women from any criminal liability and instead include offences targeted towards ensuring that only qualified health professionals provide abortion care. In South Australia, for example, unqualified provision of abortion is punishable by up to seven years' imprisonment.

With regard to coerced or non-consensual procedures, a number of jurisdictions include specific criminal offences. For example, in France, performing an abortion without the pregnant person's consent is punishable by up to five years' imprisonment and a substantial fine. Both Northern Ireland and New Zealand have offences designed to criminalise actions taken to cause the death of a fetus without the pregnant person's consent. New Zealand criminalises 'causing the death of a child who has not yet become a "human being" under the law' with a maximum sentence of 14 years, and Northern Ireland's "child destruction" offence carries a life sentence. In both cases, it is explicit that the woman would be exempt from any criminal offence.

It is clear from the examples reviewed that decriminalisation of abortion – especially for patients – does not lead to deregulation. Even in Canada, where there are no abortion specific offences, other healthcare regulation applies in certain circumstances, reflecting a system that does not exceptionalise abortion care but aims to protect patient safety in the same way as other healthcare services.

It is important to note that the Group focused predominately on abortion specific offences and therefore may not have considered, in depth, other healthcare law in international models that may interact with abortion care. In Scotland, there are a number of other pieces of relevant legislation or common law offences that have been considered alongside specific abortion legislation before forming recommendations on any specific offences within the Scottish legal context.

7.4 Stakeholder and evidence review

The Group heard various claims regarding public opinion on this issue. On the one hand, it was told that opinion is opposed to decriminalisation, with some of those making this claim referencing a poll conducted by Pro-Life groups via Whitestone Insight in 2024.[189] This poll found that 55 per cent of adults agree that it should remain illegal for a woman to abort a healthy baby after the current 24 week time limit. Only 16 per cent, fewer than one in six agreed that abortion should be fully decriminalised while 29 per cent said they preferred not to say or did not know. It is important to note that the full findings of this poll were never published, including the specific questions asked.

On the other hand, the Group reviewed other polling data,[190] which found that, in response to the question '*In events where women have had abortions outside the set rules (for example, by having an abortion without the consent of a doctor, or beyond the legal time limits), do you think they should or should not face criminal prosecution?'* 52 per cent of those polled agreed that women should not face prosecution, with 21 per cent disagreeing.

The Group notes the prevalence of push polling in this area, meaning that individual poll results needing to be treated with caution. Gray and Wellings (2020) explain that polling is an inexact science, and questions tend to have an 'acquiescence bias', a tendency on the part of respondents to agree with a statement on which they are asked to express a view (Lavrakas, 2008).[191] Nonetheless, the Group notes that the most authoritative survey of public opinion, the British Social Attitudes survey has found a strong and consistent trend towards a liberalisation of opinion regarding abortion.[192]

[189] Hymas, C. (2024, April 7).. Decriminalising abortion opposed by more than half the public, as MPs table reforms, The Telegraph.
[190] YouGov. (2023, June 28). Where does the British public stand on abortion in 2023?
[191] Lavrakas, P. J. (Ed.). (2008). Encyclopedia of survey research methods (Vols. 1–0). Sage Publications, Inc.
[192] Chabdu, A. (2024, October 29). How are attitudes towards abortion in Britain changing? National Centre for Social Research.

7.4.1 Criminal offences for women acting with regard to their own pregnancies

A recent amendment to remove women from the criminal law related to abortion in England and Wales was passed by the House of Commons in June 2025 with 379 votes in favour and 137 against. This brings the law in England and Wales into line with that of Northern Ireland on this issue, leaving Scotland as the only part of the UK where women remain liable to prosecution for ending their own pregnancies.

Views provided to the Group on the topic of criminal offences for the woman varied. Some stakeholders want to see women entirely removed from the criminal law relating to abortion, while others raised concerns about even this limited measure of decriminalisation.

As mentioned earlier in this report, all relevant major professional health bodies in the UK support decriminalisation of abortion, including the British Medical Association (BMA),[193] the Royal College of General Practitioners (RCGP),[194] the Royal College of Obstetricians and Gynaecologists (RCOG),[195] the Royal College of Nursing (RCN),[196] the Royal College of Midwives (RCM),[197] the Royal College of Psychiatrists (RCPsych), the Royal College of Anaesthetists (RCoA), the College of Sexual and Reproductive Healthcare (CoSRH),[198] the Faculty of Public Health, the British Society of Abortion Care Providers (BSACP), the British Maternal and Fetal Medicine Society (BMFMS),[199] the British Association of Sexual Health and HIV (BASHH), the Faculty of Forensic and Legal Medicine (FFLM)[200] and the International Federation of Gynaecologists and Obstetricians (FIGO). FIGO represents medical professionals in 132 countries and territories around the world.

The BMA notes that abortion is a safe procedure where major complications and mortality are rare at any gestation.[201] They point out that now most abortions are carried out in the first trimester using medicines, but when the 1967 Act was passed, abortion carried significant risks. As such they believe the law imposes restrictions which do not reflect the current evidence-base. The BMA also believe the law is not in line with the emphasis on patient autonomy found in other areas of medicine, where clinical decisions are made jointly between the patient and healthcare professional. Decisions made by patients and healthcare professionals are guided by regulations, professional standards and clinical guidelines which promote good

[193] British Medical Association. (2025). The removal of criminal sanctions for abortion: Position paper.
[194] Royal College of General Practitioners. (2019). RCGP UK-wide position on decriminalisation of abortion.
[195] Royal College of Obstetricians and Gynaecologists & Faculty of Sexual and Reproductive Healthcare. (2022). Joint statement on decriminalisation of abortion.
[196] Royal College of Nursing. (2024, December 3). RCN position on decriminalisation of abortion in England, Wales and Scotland.
[197] Royal College of Midwives. (2023). RCM position statement: Abortion.
[198] Royal College of Obstetricians and Gynaecologists & Faculty of Sexual and Reproductive Healthcare. (2022). Joint statement on decriminalisation of abortion.
[199] Royal College of Obstetricians and Gynaecologists. (2025). Multiagency call for urgent action by Parliament to protect women's essential reproductive rights.
[200] Royal College of Obstetricians and Gynaecologists. (2023). Reforming abortion law.
[201] British Medical Association. (2025). The removal of criminal sanctions for abortion: Position paper.

practice. The BMA encourage access to lawful, regulated services, but acknowledge for a range of reasons that patients are not always able to access these services and that criminalisation does not stop some individuals accessing abortion through unregulated routes.

The BMA supports the WHO view that criminalisation of abortion does not reduce the incidence of abortion and is more often associated with increased maternal mortality and morbidity, meaning women accessing abortion through unregulated channels is exposing them to serious harm.[202] Best practice guidance from the WHO is clear that regulation of abortion should be removed from the criminal law, recommending full decriminalisation of abortion.[203]

In their submission to the Group, the Royal Pharmaceutical Society of Scotland (RPharmS) suggested that a balanced approach is necessary when considering criminal offences for women regarding controlled medicines. RPharmS argued that it is crucial to address the risk of medicines being used safely and appropriately, while ensuring these medicines do not fall into the wrong hands and then misused – in a similar way to concerns about all prescription medications. RPharmS also advised that there could be consequences of introducing new offences that would deter individuals from seeking necessary medical support.

Members of the Advisory Group raised the concern that abortion is vital and routine healthcare and that keeping criminal offences for the woman would legitimise policing of individual reproductive decision making. Engender say that the legal framework stigmatises those who seek abortion[204,205] by requiring them to meet outdated and excessive procedural thresholds which unnecessarily infringe on their privacy when accessing routine healthcare.

The Advisory Group also noted international evidence that suggests the decriminalisation of those seeking abortion in law does not directly increase the incidence of abortion, gestational age at the time of abortion, sex selective abortion or compromise the safety of abortion.[206, 207]

In Australia, both in Victoria and South Australia, the incidence of abortion has been on a steady downward trend, unaffected by decriminalisation. In 2008, when Victoria decriminalised abortion, the incidence of abortion was 16.8 per 1,000 women aged 15-44. In 2017, this dropped to 12.2 per 1,000 women aged 15-44.[208]

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[202] World Health Organization. (2022). Abortion care guideline.
[203] As above
[204] Engender. (2024). Outdated, harmful and never in the public interest: The urgent need to modernise Scotland's abortion law and prevent prosecutions.
[205] Norris, A., Bessett, D., Steinberg, J. R., Kavanaugh, M. L., De Zordo, S., & Becker, D. (2011). Abortion stigma: A reconceptualization of constituents, causes, and consequences. Women's Health Issues, 21(3 Suppl), S49–S54.
[206] World Health Organization. (2022). Abortion care guideline.
[207] Boyd, S. (2020). Abortion and criminal law: Reframing the legal debate. In S. Sheldon & K. Wellings (Eds.), Decriminalising abortion in the UK: What would it mean? (Chapter 6). Bristol University Press.
[208] As above

The Roman Catholic Bishops' Conference of Scotland (BCOS) raised concerns that if abortion is removed from the criminal law, this could lead to an increase in abortions at later gestations, when a fetus could be born alive. The evidence from countries that have recently reformed their abortion laws does not support this concern. Evidence from Victoria, Australia suggests a downward trend in the number of abortions happening for 'maternal psychosocial reasons' above 20 weeks since decriminalisation. It is noted that a reason for this trend could be down to availability of services and the willingness of providers to provide abortions after 20 weeks, but that decriminalisation did not directly increase the incidence of abortion.[209]

The RCOG reports that most women make a decision and access abortion services quickly after finding out about a pregnancy that is unwanted. In 2024, 98.8% of abortions in Scotland were carried out below 18 weeks' gestation.[210] In 2020 and 2021 when non-urgent sexual and reproductive health services were seriously reduced due to the Covid pandemic allowing faster access to abortion care, 28.8% (in 2020[211]) and 32.2% (in 2021[212]) of abortions in Scotland were done before 6 weeks gestation. In 2023 and 2024 this percentage had fallen to 16.9% and 18.1% respectively as waiting times for abortion care rose.[213] In line with the Group's earlier conclusions, it believes that abortion should be available as early as possible - something which is likely to be supported by an improved legal framework - but also as late as necessary.

7.4.2 **Concealment of Birth**

Significant evidence was received from legal academics Mary Neal and Jonathan Brown, who laid out the issues with the Concealment of Birth (Scotland) Act 1809 which makes it an offence for a woman to "conceal" her pregnancy if she does not request help during childbirth and the child dies.

The Act was passed when there was a concern that pregnancies were being concealed in order to prevent it being discovered that a woman had become pregnant outside of marriage. In 1663, the courts in Scotland introduced an evidentiary presumption that 'where a woman had concealed her pregnancy and gave birth in secret, she had murdered the child born of that secret pregnancy'.[214] As a result, the Crown did not have to prove murder, of even that the child had been born alive – simply that the woman had been pregnant and concealed the birth.

That stigma (and therefore the concern which lay behind the Act) is an anachronism in modern Scotland. The Act however still criminalises women who may be in vulnerable situations and unable to disclose to their family or their partner they are pregnant because of, for example, domestic abuse, honour-based abuse, or where a woman, particularly a younger woman or girl, is genuinely unaware she is pregnant. Non-disclosure of a known pregnancy may be an active act or a form of denial,

[209] Sheldon, S. (2017). Abortion law reform in Victoria: Lessons for the UK. BMJ Sexual & Reproductive Health, 43(1), 25–28.
[210] Public Health Scotland. (2025). Termination of pregnancy statistics: Year ending December 2024.
[211] Public Health Scotland. (2021). Termination of pregnancy statistics: Year ending December 2020.
[212] Public Health Scotland. (2022). Termination of pregnancy statistics: Year ending December 2021.
[213] Public Health Scotland. (2024). Termination of pregnancy statistics: Year ending December 2023.
[214] Dr Mary Neal and Dr Johnathan Brown (2025), unpublished stakeholder submission.

sometimes arising from mental health conditions or from a learning disability. Similarly, under the 1809 Act, a woman who chooses to give birth without medical care (known as “free birthing”) may be criminalised, which prevents women from making decisions about their own bodies and their own care while pregnant.

Dr Neal and Dr Brown also raised an important concern that this law is inequitable in applying only to women. This creates a unique situation for women whereby the normal presumption of innocence has been apparently suspended, in that an inability to prove a different and more serious crime (murder of a child) has led to the creation of an offence (concealment of birth) that avoids the same evidentiary burden. Dr Neal and Dr Brown’s submission referred to archival research they had undertaken which indicates that between 1809 and 1900, there were more than 300 prosecutions of this statutory offence.[215]

It should be noted that this offence is distinct from that of failing to register a birth (an offence under s53 of the Registration of Births, Deaths and Marriages (Scotland) Act 1965, as well as any offence related to actions taken to end or contribute to ending the life of a living child, including homicide, culpable homicide, or neglect.

7.4.3 **Offences for providers**

Unlike other health services, abortion is commonly regulated to varying degrees through the criminal law in addition to regulation under general provisions of healthcare law. This has an impact on the rights of women and can have a chilling effect (e.g. suppression of actions due to fear of reprisals or penalties) on the provision of quality care. For this reason, the Group agreed that clear, accessible and rights-based law and policy must be part of ensuring a safe, accessible environment for the provision of abortion services. This is consistent with advice from the WHO, which recommends full decriminalisation of abortion, including for providers in their 2022 Abortion Care guidelines, stating that criminal penalties for abortion create barriers to safe care, violating human rights.[216]

Dr Neal and Dr Brown note that the prosecution of doctors is rare and limited to cases where they have acted outwith professional norms, more like a ‘backstreet’ provider. The majority of the examples cited are unreported, pre-date the 1967 Act, and frequently involve cases where the woman has died or been injured, insufficient consideration was given to patient safety, or where providers acted secretly or colluded in crime. One example was given from 1968, a year after the Act was introduced, where the doctor acted outwith the provisions of the Act. Conversely, it was explained that where physicians acted with a therapeutic motive, which could include ‘social’ considerations, if they were prosecuted for ‘procuring abortion’ they were acquitted if the evidence showed they had acted professionally and without a ‘mercenary motive’.

However, while prosecutions may be rare, the Advisory Group reported views from clinicians from across the UK, including in Scotland, who suggest increased public

[215] As above
[216] SRHR. (2022). Law & policy recommendation 1: Criminalization (2.2.1). In Abortion care guideline: Chapter 2 – Recommendations relating to regulation of abortion.

awareness of legal restrictions has led to a 'climate of fear' regarding processes within abortion care services and that prosecutions are contributing to these fears.[217] This was confirmed by the BMA, which suggested that criminal law may deter healthcare professionals from providing lawful abortion services, based on the current legal framework, and that this restricts services for women who require them.

A very different view was offered by Christian Action, Research and Education (CARE) for Scotland, who argued that any person involved in an abortion that is not lawful, should be considered as committing an offence, including healthcare professionals. They also suggested that in any future law on abortion, criminal proceedings should be brought only with the agreement of the Lord Advocate.

Other stakeholders made specific points regarding the need for robust regulation regarding abortion medication. The Royal Pharmaceutical Society (RPharmS) explained that it was important that providers have robust policies and procedures in place to ensure the safe and secure handling of all of the many medicines classified as hospital-only and prescription-only medicines (POM). Further to this the RPharmS believe the illegal distribution of these medicines can pose a significant risk to public health and undermine the healthcare system.

RPharmS added that professional standards for hospitals and approved places are within the remit of Healthcare Improvement Scotland (HIS) and pharmacists and pharmacy technicians employed in approved establishments and hospitals that are involved in the provision of abortion services are regulated by the General Pharmaceutical Council. RPharmS state that it is essential for these professional standards to be at the highest level to maintain safety and integrity of services.

The Medicines and Healthcare products Regulatory Agency (MHRA) confirmed that any person who sells or supplies a POM otherwise than in accordance with a prescription in breach of Regulation 214[218] of the Human Medicines Regulation 2012 commits an offence under Regulation 255(1)(a).[219] If the medicine is sold in an unlicensed generic version of a POM, then this may also constitute an offence of selling or supplying an unlicenced medicine under Regulation 46(1)[220] of the regulations.

The MHRA confirmed that the 2012 regulations are limited to conduct that takes place in the UK. As such, if a person sent abortion medication from, for example, France into the UK, they would commit no offence under UK law, however they may commit an offence in France. Prescriptions for POMs issued by a member state of the European Economic Area (EEA) can be legally dispensed in the UK if the prescriber is from a profession which is recognised as legally entitled to issue a prescription of that kind in the country in which the prescription is issued.

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[217] Engender (2024) Outdated, harmful and never in the public interest: The urgent need to modernise Scotland's abortion law and prevent prosecutions.
[218] UK Government. (2012). The Human Medicines Regulations 2012, Regulation 214. UK Statutory Instruments 2012 No. 1916.
[219] UK Government. (2012). The Human Medicines Regulations 2012, Regulation 255. UK Statutory Instruments 2012 No. 1916.
[220] UK Government. (2012). The Human Medicines Regulations 2012, Regulation 46. UK Statutory Instruments 2012 No. 1916.

Furthermore, the 2012 Regulations offer an exemption from the medicines importation prohibition in Regulation 17[221] where a person imports a medicinal product for administration to themselves or to any other person who is a member of that person's household. The Group recognises that the regulation of human medicines is reserved to Westminster, so did not consider this aspect of the legal landscape further.

The Group also considered existing professional sanctions that can be applied to healthcare professionals providing abortion services. The General Medical Council (GMC) regulates doctors in the UK and the Nursing and Midwifery Council (NMC) regulates nurses and midwives. The GMC[222] and the NMC[223] can investigate and sanction their respective professionals for misconduct, including issues related to abortion care if there is a breach of professional standards or ethical guidelines, which does not need to be a criminal offence. Both the GMC and the NMC have a range of sanctions depending on the seriousness of the action being investigated, including formal warnings, time limited restrictions to practice, suspension and removal from professional registers required to legally practice in the UK. The Group felt that it was beyond their remit to consider recommendations for changes to disciplinary sanctions and would not make any recommendation to further review or change how these sanctions operate within Scotland.

7.4.4 Procuring abortion through fear, force, or fraud

Multiple stakeholders raised concerns regarding women who may be forced into undergoing an abortion. These stakeholders asked that the Group should consider the topic of coercion, which was also discussed at some length in the counselling section under Pathways. Previous efforts in Westminster to reform the law related to the use of violence and misleading the woman as to the purpose of medication she was given were also discussed within the Group.[224]

The Group understands that there is no specific statutory offence in Scots law against coercing someone into having (or not having) an abortion. However, such behaviour may fall within the broader legal frameworks set out above, addressing domestic abuse, threatening or abusive behaviour, and common law offences such as assault and threats, depending on the circumstances.

A number of stakeholders suggested that a specific offence of coercion would be helpful, with ARCH (abortion care and recovery helpline, a project of SPUC Education and Research Trust) Trust stating that current laws criminalising domestic abuse require a pattern of incidents, and it also suggested there is inconsistency in how the police view complaints. The submission argued that coercion to end a pregnancy can happen in otherwise 'safe' relationships, not being recognised as criminal by the person who is displaying coercive behaviour or the victim themselves.

[221]UK Government. (2012). The Human Medicines Regulations 2012, Regulation 17 (as made). UK Statutory Instruments 2012 No. 1916.
[222] General Medical Council. Our sanctions – information for doctors under investigation.
[223] Nursing and Midwifery Council. Sanctions we can impose. Nursing and Midwifery Council.
[224] UK Parliament. (2017–2019). Abortion Bill (Bill 276).

The submission suggested that such an offence would provide an effective deterrent, but also a means of justice if coercion is identified after the abortion procedure. It also suggests that providers should be required to have adequate and effective procedures with support options for the patient if coercion is identified.

Another view provided to the Group suggested that a specific offence be created for criminal acts related to both physical or psychological coercion or deception, using the example of someone secretly adding abortion medication into the food or drink of a pregnant person.

Concerns were raised in some submissions on the number of patients feeling pressured into having an abortion, when they would have preferred to carry on the pregnancy. Evidence provided included a BBC commissioned poll in 2022 that found 15% of women aged 18-44 had experienced pressure to terminate a wanted pregnancy (with no question asked regarding how often this pressure had influenced their ultimate decision). [225] The same poll also found a significant incidence of women being coerced to conceive or to continue pregnancies.

A study produced by two self-described Pro-Life research centres in the United States of America was raised in one submission that found 61% of 226 women between the age of 41-45 had experienced pressure to end a pregnancy from people or circumstances.[226] From the sample, 38% of respondents reported pressure from male partners, 18% from other people such as friends or employers and 16% from family members. Unfortunately, it is not possible to disentangle in this study actions which would rise to the level of coercion from a broader sense of pressure. Abortion providers in the Expert Group noted that women rarely have one single reason for choosing abortion, but that wider circumstances including finances, relationships, and time of life often play a role in the choice to end a pregnancy which a woman may have, in other circumstances, opted to continue.

A number of national Women's Aid organisations across the UK and wider violence against women organisations in Scotland, including Rape Crisis Scotland are opposed to a new offence on reproductive coercion. They argued that the criminal justice system lacks the gender and domestic abuse expertise to safely manage violence against women, coercion, and trauma. They consider that a new offence – however well intended – has the potential to cause harm. These organisations cited research by McKenzie et al[227] which sets out many of the complexities for a truly trauma-informed response for both women forced to abort a pregnancy and women forced to parent. The Advisory Group of reproductive rights, women's and equalities organisations also oppose a new offence for reproductive coercion on grounds of gender equality and intersectionality, noting that experts in domestic abuse have shown such an offence would be unworkable in practice. They argued that there is a lack of intersectional gender competence across the criminal justice institutions, as

[225] BBC News. (2022, March 14). Reproductive coercion: 'I wasn't allowed to take my pill'.
[226] Reardon, D. C., & Longbons, T. (2023). Effects of pressure to abort on women's emotional responses and mental health. Cureus, 15(12), e45823.
[227] McKenzie, M., Humphreys, C., & Tarzia, L. (2024). Mothering in the aftermath of reproductive coercion and abuse. Violence Against Women. Advance online publication.

well as systemic sexism, racism, and other forms of discrimination, which would likely act as barriers to justice for women. The Centre for Reproductive Rights also advocate against new criminal offences related to abortion, including coercion, where existing law can be applied. Their concerns include the exceptionalising of abortion and the potential for new law to be used as a different means by which to 'police' women.

Importantly, Scottish Women's Aid (SWA), Scotland's national domestic abuse organisation, strongly oppose a new specific offence on abortion coercion. They are clear that the best and most trauma-informed intervention in abortion care would be a routine enquiry assessment that would be delivered by a trained healthcare professional. SWA believe that coerced abortion is already covered under Scottish legislation, such as the Domestic Abuse (Scotland) Act 2018, and correspondence between SWA and COPFS confirmed that such cases would be prosecuted in the High Court. SWA strongly believe that criminal offences would not bring justice for women, rather that, in line with existing criminal offences and the experience of abuse victims interacting with the police, the risks of further trauma far outweigh any potential benefits.

7.5 Conclusions and Recommendations

The Group heard from faith-based and anti-abortion groups that criminalisation acts as a deterrent. The evidence does not support this claim. The Group agrees with the WHO that restricting access to, or criminalising abortion does not prevent it occurring. When a pregnant woman is desperate to avoid childbearing, she will take desperate measures. Previously in this report, it was noted that abortion was commonplace before the 1967 Act, even when it carried the risk of imprisonment (and serious injury to health or death). When abortion is illegal, unsafe abortions happen and increase maternal mortality and morbidity. A US study that examined the association between state abortion policy contexts and maternal death found that states with a higher number of abortion-restricting policies had a 7% increase in total maternal mortality compared with states with more liberal policies during the years 2015-2018.[228] Since Roe v. Wade was overturned, concern has been expressed that restricting access to abortion in many US states will result in measurable increases in maternal mortality particularly among poor women and women of colour.[229] International data further suggests that a reduction in the incidence of abortion is more effectively achieved through improving access to effective contraception.[230, 231]

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[228] Vilda, D., Wallace, M. E., Daniel, C., Evans, M. G., Stoecker, C., & Theall, K. P. (2021). State Abortion Policies and Maternal Death in the United States, 2015–2018. American journal of public health, 111(9), 1696–1704.
[229] Williams, A. M., Kronk, C. A., Jimenez, R. H., & Watson, A. R. (2022). Associations between state policies, race, ethnicity and rurality, and maternal mortality and morbidity following the United States Supreme Court Dobbs v. Jackson Women's Health Organization ruling. British Journal of Anaesthesia, 129(6), e145–e147.

[230] Sedgh, G., Bearak, J., Singh, S., Bankole, A., Popinchalk, A., Ganatra, B., Rossier, C., Gerdts, C., Tunçalp, Ö., Johnson Jr, B. R., & Alkema, L. (2016). Abortion incidence between 1990 and 2014: Global, regional, and subregional levels and trends. The Lancet. Advance online publication.
[231] Foster, D. G. (2016). Unmet need for abortion and woman-centered contraceptive care. The Lancet, 388(10041), 216–217.

The Group therefore considered a framework that is protective of women and supportive of the provision of safe abortion care, rather than one designed to pursue what it believes to be the ultimately illusory goal of using criminal law to delay, deter, or limit the ability of women to access abortion care.

One concern raised by the Group was the limitations on innovation which had been in place as a result of the Abortion Act 1967 – such as preventing the home use of abortion medication (as was the case in much of the rest of the world) until the minister specifically approved it. As noted in the pathways section above, this was not seen as necessary for the safe provision of care in new legislation. The Group discussed potential future innovation in abortion care, specifically the use of contragestive medication - a type of fertility control that can prevent gestation, either by preventing implantation of a fertilized egg or by causing the uterine lining to shed soon after implantation.[232] The Group was keen to ensure that any offences laid out in new legislation did not restrict the innovation of care in this way.

7.5.1 Offences in relation to women having abortions

The Group discussed the position of those who act with regard to their own pregnancies. While recognising concerns expressed by some stakeholders that offences may provide some form of deterrent, there is a lack of evidence to support this position. Indeed, the WHO report that the legal status of abortion 'has no effect on a woman's likelihood of seeking abortion but it dramatically affects her access to safe abortion'.[233]

The WHO and numerous human rights bodies support full decriminalisation of abortion for the woman acting in relation to her own pregnancy. Chapter 1, section 1.3.1 of the WHO Abortion care guideline sets out the rationale[234] and Web Annex A of these guidelines lists the human rights principles and the statements that apply to abortion.

The Group agreed that imprisonment offers a particularly archaic and unjustifiable response to self-induced abortion, as there is no case for needing to protect the wider public from those seeking abortion. It was noted that criminal law represents the most onerous, intrusive and punitive of state powers and it is reasonable to assume that it should be invoked only where it offers a necessary and proportionate means to achieve an important objective, with the onus on those who would seek to deploy it to demonstrate that these criteria are met.[235],[236], [237]Moreover, any such demonstration should be subject to particularly robust scrutiny in the abortion context, given the significant considerations of gender equality, particularly for

[232] Cameron, S., Li, H. W. R., & Gemzell-Danielsson, K. (2023). Is contragestion the future? BMJ Sexual & Reproductive Health, 49(3), 145–147.
[233] World Health Organization. (2012). Safe abortion: Technical and policy guidance for health systems (2nd ed.).
[234] Chapter 1, section 1.3.1 of the WHO Abortion Care Guideline (2022)
[235] Jareborg, N. (2005). Criminalization as last resort. Ohio State Journal of Criminal Law, 2, 521–534.
[236] Ashworth, A. (2008). Conceptions of overcriminalization. Ohio State Journal of Criminal Law, 5, 407–422.
[237] Husak, D. (2008). Overcriminalisation: The limits of the criminal law. Oxford University Press.

marginalised groups of women, autonomy, and reproductive health that point powerfully in favour of liberal access to safe, legal services.

In considering this, the Group recognised in particular that those who might try to have an abortion outwith the terms of the law were often likely to be vulnerable and/or in a desperate situation, increasing the risk that criminalisation might deter them from seeking necessary medical help following any complications and put their health at greater risk. Even though it is extremely rare for women in Scotland to be prosecuted for offences relating to abortion or under the Concealment of Birth Act, the Group recognised that it was still a possibility, and cases have been brought forward in recent years.

Further, the recent increase in prosecutions in England and Wales demonstrates the need to future-proof this area of the law. Even the potential for prosecution or the process or prospect of facing questioning and investigation by the police could be very traumatic, even if this did not ultimately lead to any charges or prosecution. This is also the case for women who are ultimately found to have undertaken no action to end their pregnancy, but where suspicion has led to police involvement with cases involving premature labour or stillbirth. The Group is concerned by the recent guidance issued by the National Police Chiefs' Council regarding abortion and stillbirth.[238]

Until the law on abortion is reformed in Scotland, there is potential for police investigations that are extremely distressing for women. It is unclear whether the NPCC guidance would be adopted in Scotland, but methods recommended (including seizure of technological devices, and use of private medical records) have been roundly condemned by health and human rights bodies. Cases often take many years to go to court, as well as garnering significant media interest, causing demonstrable harm to women.[239]

The Group therefore agreed that neither imprisonment nor other legal sanctions were necessary or appropriate for individuals having an abortion under any circumstances. Given the lack of clarity under the common law, the Group believe it is necessary that any new legislation specifies this position.

Recommendations

1. There should be no offences for anyone ending their own pregnancy and any common law offences should be repealed.

[238] Academy of Medical Royal Colleges. (2025). A code of practice for the diagnosis and confirmation of death: 2025 update.
[239] Sheldon, S., & Lord, J. (2023, July 13). Care not criminalisation: Reform of British abortion law is long overdue. Journal of Medical Ethics. Advance online publication.

7.5.2 Concealment of Birth

The Group considered the evidence received regarding concealment of birth and was particularly concerned by evidence that its existence and use is discriminatory, creating a lesser evidentiary burden that relies on a historical assumption that a woman who has concealed the birth of a child who is now dead or missing is guilty of an offence. It noted the range of other offences that may be committed by someone who conceals a birth, which appear adequate to address any public health or administrative concerns arising from concealment (including failure to register a birth). It also considered the low levels of prosecutions under the law, with only one taking place in the last 20 years itself suggesting that the offence is poorly aligned with modern values.

The Group concluded that this offence is outdated, unnecessary, and risks criminalising women – and women alone – at their most vulnerable.

The Group therefore recommends repeal of the Concealment of Birth (Scotland) Act 1809 and abolition of the crime of concealment.

Recommendations

1. The Concealment of Birth (Scotland) Act 1809 should be repealed, and the crime of concealment should be repealed.

7.5.3 Healthcare Staff

The Group had concerns that maintaining criminal sanctions for healthcare professionals could lead to the continued 'chilling effect', stigmatisation and exceptionalisation of abortion, which can deter staff from working in abortion services.[240] It also noted that the general regulatory framework that governs healthcare in Scotland offers a range of other measures designed to address unsafe, inappropriate, or non-consensual practice, and that these measures are deemed sufficient to ensure patient safety and safeguarding in other areas of healthcare practice.

Clinicians on the Group emphasised that, in line with the Abortion Act 1967, staff who provide services in good faith should not face concerns about risks of prosecution. It was noted that, under the common law, staff would not be likely to be prosecuted in cases where they acted in good faith and any breach of the law was not deliberate, However, the complexity in the law could lead to uncertainty regarding the scope for prosecution among healthcare providers and among prosecutors. This in itself may have a chilling effect.

[240] de Londras, F., Cleeve, A., Rodriguez, M. I., Farrell, A., Furgalska, M., & Lavelanet, A. (2022). The impact of criminalisation on abortion-related outcomes: A synthesis of legal and health evidence. BMJ Global Health, 7(12), e010409.

The Group agreed that in the interests of clarity, any new legislation should remove common law abortion offences, and any offences should be set out specifically within a new act, if not adequately dealt with by existing legislation.

It was noted that, regardless of any criminal offences, there could still be potential for a complaint about a healthcare professional to be considered by either the General Medical Council (GMC)[241] or Nursing and Midwifery Council (NMC)[242] - as there is for issues arising in the context of other healthcare interventions. Both these bodies have powers to investigate and impose sanctions, up to and including deregistration where it is determined that a healthcare professional's misconduct was so serious that they are no longer fit to practise. However, the GMC indicated that they did not believe they were best placed to enforce any law around abortion that was not necessary for patient safety or clinical best practice (such as specific grounds for abortion, or time limits).

The Group therefore concluded that it should be an offence to provide an abortion outside the terms set out in the legislation, except when done in good faith to save the woman's life or prevent grave permanent injury to her mental or physical health. The Group considered that the most appropriate penalty for this would be similar to that set out in the Abortion (Northern Ireland) (No.2) Regulations 2020 – a fine, and where proceedings may be brought only by, or with the consent of, the Director of Public Prosecutions for Northern Ireland.

Recommendations

1. The common law offences for registered healthcare professionals who provide an abortion(s) outwith the terms of abortion legislation should be repealed.

2. The Scottish Government should consider how compliance with the provisions of revised abortion legislation will be enforced. The Group proposes two options relating to offences for healthcare staff:

a) The Scottish Government may consider that existing law around healthcare, including the registration and regulation of healthcare professionals, is sufficient to appropriately enforce the law, and thus no specific statutory penalty should be created; or

b) A new specific offence should be included for any healthcare professional who provides an abortion outwith the terms of the legislation. This should reflect provisions within The Abortion (Northern Ireland) (No. 2) Regulations 2020 where the maximum penalty is a fine, and prosecution should only be brought by, or with the consent of, the Lord Advocate

3. It is also recommended that the Scottish Government should ensure that any new offences would not prevent innovation in contraceptive and abortion care, including the use of new medications, or the development of contragestives.

[241] Medical Act 1983, c. 54.
[242] Nursing and Midwifery Order 2001, SI 2002/253.

7.5.4 Abortions provided by someone who is not a registered Healthcare Professional

The Group considered that it was important to ensure that abortions continue only to be provided by registered healthcare professionals who are appropriately trained to provide abortions. This was important to ensure that any change in law did not reduce the high clinical standards for provision of abortion care in Scotland.

The Group considered that any person who is not a 'healthcare professional' (as defined by the Group) who provides abortion services should be guilty of an offence under either existing or new legislation.

The Group notes that provision of abortion medications would already be restricted by the Medical Act 1983[243] and the Medicines Act 1968. In terms of surgical abortion, unqualified provision would likely be covered by the criminal law of assault. If this is already an offence the Group does not see any need for a separate offence to be created; however, if that is not the case, then a new offence should be created.

Recommendations

1. Any person who is not a 'healthcare professional' (as proposed by the Group and defined in Regulations) providing abortion services should be guilty of an offence. If this is already an offence the Group does not see any need for a separate offence to be created; however, if that is not the case, then a new offence should be created.

2. Any new offence should be carefully considered so as to avoid prosecuting anyone helping someone to access an abortion in good faith, such as a mother helping her daughter. Where someone, for example, provides abortion as a business, this should be an offence.

7.5.5 Procurement of abortion through fear, force, or fraud

The Group considered the existing offences which might apply in a case where someone was coerced, intimidated, or misled into having an abortion. While noting that at least one of these offences might apply in most cases where the acts were carried out by a partner or ex-partner, it was recognised that existing offences would not apply in all cases.

Reproductive coercion

“Reproductive coercion is ‘behaviour that interferes with the autonomous decision-making of a woman, with regard to reproductive health. It may take the form of birth

[243] Medical Act 1983

control sabotage, pregnancy coercion, or controlling the outcome of a pregnancy".[244] Academic literature suggests that this has been a neglected area of study within gender-based violence, and it is only now that Governments and other stakeholders are acknowledging the complex role such behaviour plays.[245]

While coercion in the context of abortion is important to acknowledge, studies on reproductive coercion suggest that it is far less common than other forms of reproductive coercion, including coercion to become pregnant or continue a pregnancy:

> Pregnancy promoting reproductive coercion (e.g. pressure to become or stay pregnant) is more common than pregnancy preventing abuse (e.g. abortion coercion). Yet the regulation and policy framework has developed with more attention on risks for those seeking abortion with little attention to the issues for maternity care.[246]

While some stakeholders suggested that coercion in the context of abortion should be explicitly criminalised, it is our recommendation that coerced abortion should not be singled out from the wider issue of reproductive coercion.

The Group acknowledged that this is an issue of significant importance to a range of stakeholders and suggests that the Scottish Government could consider this further in any future consultation. The Group identified **two** options for dealing with all forms reproductive coercion.

35. The Group's position is that existing offences would be likely to be sufficient to capture the most serious cases where coercion can be proven and that, given the complexity of coercion and the need to distinguish it from pressure or influence from others, it would realistically be difficult to prove in most cases. Feedback from Scottish Women's Aid raised serious concerns about the additional trauma to women of pursuing action without consent or a complaint from a victim and therefore, the Scottish Government could decide that no new offence is required.

36. However, if the Scottish Government decides that existing offences are not sufficient, a new specific criminal offence relating to reproductive coercion of all forms could be created. Given Scottish Women's Aid's position – if this course of action is pursued, careful thought should be given as to how best to balance the offence in terms of policy goals and the experience of individual abuse survivors.

Whilst the Group noted that Health Boards already have procedures in place to identify and support anyone who may be being coerced during pregnancy, it felt that an updated Scotland specific clinical abortion care guideline should cover coercion to seek to ensure all providers have robust procedures in place to detect signs of

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[244] Grace, K. T., & Anderson, J. C. (2016). Reproductive Coercion: A Systematic Review. Trauma, Violence, & Abuse, 19(4), 371-390. (Original work published 2018), 371.
[245] Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., Schoenwald, P., & Silverman, J. G. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. Contraception, 81(4), 316–322.
[246] Pam Lowe, (2023) 'Reproductive Coercion and Abuse: Key Issues for Safeguarding in Abortion, Contraception and Maternity Care Settings' Aston University, 3.

coercion and prevent abortions from proceeding in those circumstances. It also believes that reproductive coercion should be included in routine safeguarding training for healthcare professionals.[247]

Recommendations

The Group proposes two options in relation to coercion:

a) The Group's position is that existing offences would be likely to be sufficient to capture the most serious cases where coercion can be proven and that, given the complexity of coercion and the need to distinguish it from pressure or influence from others, it would realistically be difficult to prove in most cases. The Scottish Government could therefore decide that no new, specific offence is required.

b) However, if the Scottish Government decides that existing offences are not sufficient, a new specific criminal offence relating to reproductive coercion of all forms could be created. If this course of action is pursued, careful thought should be given as to how best to balance the offence in terms of policy goals and the experience of individual abuse survivors.

In either option, any clinical guidelines on abortion could provide recommendations to ensure all abortion providers have robust procedures in place to detect suspected coercion and support those involved.

7.5.6 Offence relating to ending a pregnancy without consent

The Group also considered carefully whether there should be a specific offence of ending a pregnancy without consent through illegal acts perpetrated against the pregnant woman. It should be noted that this section does not refer to the taking of appropriate consent in a healthcare setting, which the Group believes is appropriately governed by existing healthcare law or regulation.

In some cases, an individual might attack a woman either deliberately with the aim of ending her pregnancy or with reckless disregard as to the potential for pregnancy loss. Alternatively, they might deliberately administer abortifacient medication to a woman without her knowledge or consent, bringing about the end of her pregnancy, as in the recent case of HMA vs Doohan. Doohan pled guilty to an offence under the common law of procuring an abortion and was sentenced to ten years and six months imprisonment.[248]

Changes to the common law recommended by the Group would prevent future similar crimes being prosecuted under the law of procuring an abortion. Instead, they would be left to general common law offences such as assault or threats or

[247] Chamberlain, L., & Levenson, R. (2012). Addressing intimate partner violence, reproductive and sexual coercion: A guide for obstetric, gynecologic and reproductive health care settings (2nd ed.). Washington, DC: American College of Obstetricians and Gynecologists; San Francisco, CA: Futures Without Violence.
[248] Judiciary of Scotland. (2025, July 7). *HMA v Stephen Doohan.* High Court of Justiciary.

poisoning. The Group noted the importance of criminal law properly reflecting the harm done to a woman who has lost a wanted pregnancy.

Therefore, the Group recommends that the Scottish Government should consider further whether a specific, new offence should be created to fill the gap caused by repealing the common law offence, recognising that this should – if deemed necessary – be framed as a crime against the woman concerned and applicable only where acts are committed by a third party.

Recommendations

1. The Scottish Government should consider if there should be an offence of a third party undertaking criminal acts against a pregnant woman which intentionally or recklessly causes the end of her pregnancy without her consent.

8. Final Recommendations

Gestational Limits

1. The existing 24 week limit for most abortions should be retained.

2. Abortions after this gestational limit should be permitted under certain Grounds.

Grounds

3. No specified Grounds should be required to access abortion care up to 24 weeks gestation.

4. Decisions regarding abortions over 24 weeks gestation should be made in good faith by two healthcare professionals, who must agree that the abortion is appropriate, except in cases where an abortion is immediately necessary to save the life of the pregnant woman, in which case one healthcare professional may make a decision.

5. That Grounds for an abortion after 24 weeks' gestation are amended in an updated abortion Act to the following:

    1. An appropriately trained registered healthcare professional is authorised to provide an abortion for a person who is more than 24 weeks pregnant if –

        (c) the healthcare professional decides in good faith that performing the abortion is appropriate; and

        (d) the healthcare professional has agreed with one other registered healthcare professional that performing the abortion is appropriate

    2. In considering whether an abortion is appropriate, a registered healthcare professional should have regard to –

        (d) the gestational age of the fetus;
        (e) all relevant current and reasonably foreseeable medical circumstances of the patient and the fetus;
        (f) the patient's current and reasonably foreseeable physical, psychological and social circumstances.

    3. One appropriately trained registered healthcare professional may terminate a pregnancy without agreement from a second healthcare professional where they believe in good faith that an abortion is immediately necessary to save the life of the pregnant person.

    4. In the case of multiple pregnancy, anything done to terminate the pregnancy as regards one particular fetus is authorised only if that ground applies in relation to that particular fetus.

6. That no specific reference is made to sex-selective abortion within any updated abortion legislation.

Provision

7. Any appropriately trained registered healthcare professional should be able to provide abortion care at all gestations.

8. Healthcare professional should be defined in regulations, rather than in primary legislation.

Certification

9. The requirement for two doctors to certify an abortion before 24 weeks gestation should be removed.

10. Two healthcare professionals should agree that an abortion is appropriate after 24 weeks gestation, before proceeding with the abortion (except in emergencies).

11. There should be no formal certification requirements at any gestation, with decisions recorded in medical records.

Place

12. Legislation should not stipulate where an abortion should take place but should state that abortions must be provided by an NHS provider or a private provider registered with Healthcare Improvement Scotland.

13. Further consideration should be made by the Scottish Government on whether existing provisions to ensure private providers are regulated are sufficient. If deemed so, no abortion specific legislation should be required.

Counselling

14. Mandatory counselling should not be included in abortion legislation.

15. Clinical guidance, rather than legislation, should state that there should be timely access to counselling available for patients who wish to access it.

Mandatory Waiting Periods

16. Mandatory waiting periods should not be included in abortion legislation.

Conscientious Objection

17. The Group recommends that this provision should remain similar to the current legislation, with a number of amendments:

    1. With regard to wording in section 4(1) of the Abortion Act which states that ‘no person shall be under any duty, whether by contract or by any statutory

or other legal requirement to participate in any treatment authorised by this Act to which he has a conscientious objection', the Group recommend that 'by contract' should be removed.

2. An inclusion of a duty on those with conscientious objections to refer patients on to somewhere they should be included in an updated conscientious objection clause.

Reporting and notification

18. The requirement to notify the Chief Medical Officer of an abortion should be removed.

19. The requirement to collect data should be included in any updated abortion legislation.

20. Any requirements on what data are to be collected should be in guidelines, not primary legislation.

Adults with Incapacity, Young People and Brain Stem Dead Patients

21. There should be no specific changes to primary legislation regarding adults with incapacity (AWI) or young people.

22. The courts should not be involved in authorising abortions for AWI.

23. The Mental Welfare Commission should ensure there are clearer pathways and guidance in future for helping ensure swift processes and support for AWI where an abortion is being considered.

24. There should be no specific additional requirements for young people.

25. There should be no specific additional requirements within abortion legislation for patients who are brain stem dead.

Positive Duty to Provide

26. The Scottish Government should include a duty to provide abortion services – or a 'right to abortion' – with said duty being on Scottish Ministers and Health Boards.

Offences in relation to women having abortions

27. There should be no offences for anyone ending their own pregnancy and any common law offences should be repealed.

Concealment of Birth

28. The Concealment of Birth (Scotland) Act 1809 should be repealed, and the crime of concealment should be repealed.

Offences in relation to healthcare staff

29. The common law offences for registered healthcare professionals who provide an abortion(s) outwith the terms of abortion legislation should be repealed.

30. The Scottish Government should consider how compliance with the provisions of revised abortion legislation will be enforced. The Group proposes two options relating to offences for healthcare staff:

    1. The Scottish Government may consider that existing law around healthcare, including the registration and regulation of healthcare professionals, is sufficient to appropriately enforce the law, and thus no specific statutory penalty should be created; or

    2. A new specific offence should be included for any healthcare professional who provides an abortion outwith the terms of the legislation. This should reflect provisions within The Abortion (Northern Ireland) (No. 2) Regulations 2020 where the maximum penalty is a fine, and prosecution should only be brought by, or with the consent of, the Lord Advocate

31. The Scottish Government should ensure that any new offences would not prevent innovation in contraceptive and abortion care, including the use of new medications, or the development of contragestives.

Abortions provided by someone who is not a registered healthcare professional

32. Any person who is not a 'healthcare professional' (as proposed by the Group and defined in Regulations) providing abortion services should be guilty of an offence. If this is already an offence the Group does not see any need for a separate offence to be created; however, if that is not the case, then a new offence should be created.

33. Any new offence should be carefully considered so as to avoid prosecuting anyone helping someone to access an abortion in good faith, such as a mother helping her daughter. Where someone, for example, provides abortion as a business, this should be an offence.

Procurement of abortion through fear, force, or fraud

34. The Group proposes two options in relation to coercion:

    1. The Group’s position is that existing offences would be likely to be sufficient to capture the most serious cases where coercion can be proven and that, given the complexity of coercion and the need to distinguish it from pressure or influence from others, it would realistically be difficult to prove in most cases. The Scottish Government could therefore decide that no new, specific offence is required.

2. However, if the Scottish Government decides that existing offences are not sufficient, a new specific criminal offence relating to reproductive coercion of all forms could be created. If this course of action is pursued, careful thought should be given as to how best to balance the offence in terms of policy goals and the experience of individual abuse survivors.

35. In either option, any clinical guidelines on abortion could provide recommendations to ensure all abortion providers have robust procedures in place to detect suspected coercion and support those involved.

Offences relating to ending a pregnancy without consent

36. The Scottish Government should consider if there should be an offence of a third party undertaking criminal acts against a pregnant woman which intentionally or recklessly causes the end of her pregnancy without her consent.

9. Conclusion

The Expert Group has taken over a year to discuss the issues covered in this report and to identify potential proposals for reform to ensure that abortion services are first and foremost a healthcare matter. Throughout our deliberations we have aimed to balance the need to ensure patient safety whilst seeking to enhance the rights of everyone who requires access to these essential services. The discussions have been complex, and in some parts of the report we have detailed our thinking presenting a number of options for a particular recommendation together with the justification for our final decision. We have paid very careful attention to the published evidence which has led us to making our recommendations. Throughout the course of the meetings some members have changed their minds over certain subjects, a testament to the seriousness and thought with which the task was undertaken.

We have benefited greatly from the input and expertise of a wide range of stakeholders in reaching the recommendations presented throughout this report and we should like to thank everyone who has contributed. Some people reading the report will be disappointed with our recommendations. There will be some who feel that we have not gone far enough in reducing the regulation and the restrictions which surround abortion care, others will feel we have gone far too far. We trust that everyone reading the report will do so carefully and respectfully and put women with an unwanted pregnancy at the heart of their thinking.

Faced with the unwelcome news of an unwanted pregnancy women express a mixture of shock, dismay, embarrassment, even fear and many feel very alone, unable to speak to friends, relatives or even their partner. No woman takes the decision to have an abortion lightly. When they have made this decision, they deserve to be treated with compassion, given accurate information about abortion, and they also deserve to be treated quickly and efficiently. The Expert Group hopes that the Scottish Parliament, after reading this report, will seize the opportunity to change the law to ensure that this happens for the thousands of women in Scotland who seek abortion every year.

Members of the Expert Group were all deeply honoured to have been asked to be part of the process, and all have been thoroughly engaged every step of the way. We are proud to have been given the responsibility of making proposals for reform. We look forward to hearing the views of the Scottish Government.

Annex A

The Expert Group's Approach

The Expert Group agreed to structure its review around three key areas of Scotland's current abortion law: gestational limits and grounds, pathways to abortion care, and offences. This ensured a thorough review of the legal provisions that impact abortion services within Scotland. Each of these topics encompassed a number of related sub-topics:

Gestational Limits and Grounds

- Gestational limits for abortions currently under 'Ground C/D'
- Gestational limits for other abortions
- Grounds for abortions below a gestational limit
- Grounds for abortions permitted after a gestational limit

Pathways

- Who can provide abortions
- Where can abortions be provided
- Regulation of abortion providers
- Conscientious Objection
- Data and Reporting
- Counselling
- Waiting Periods

Offences

- Offences for a patient (including Concealment of Birth legislation)
- Offences for a provider (including unregulated providers and other third parties)
- Coercion and Forced Abortion

The governance structure that supported the review process - depicted in the diagram below at **figure 1** – enabled coordination between an Expert Group, an Advisory Group of reproductive rights, women's and equalities organisations, and a wide body of stakeholder organisations who were asked to provide written submissions on all aspects of the review. The Advisory Group, as noted in the diagram, was represented on the Expert Group. Its purpose was to ensure that a concern for universal reproductive rights and gender equality was central to all stages of the Group's work, together with ensuring that the lived experience of pregnancy and abortion were represented throughout the process.

The further body of wider stakeholder organisations who have contributed significantly to the review included Pro-Life and faith-based groups, campaign and advocacy groups, abortion and other service providers, academics, women's organisations, medical bodies, disability rights organisations and a range of other organisations that had registered interest in particular topics.

For each of the topics, the Group began by reviewing the current law in Scotland. This included examining how the law operates in practice and the extent to which it aligns with the Group's agreed overarching principles, which are set out on page 26-27 of this report. The Group assessed the strengths and limitations of the current legal framework in relation to these principles and determined for each topic, whether the existing law should remain in place or whether consideration of proposals for reform should be recommended.

The Group then considered stakeholder input. Around 50 organisations were contacted in advance of each topic and invited to submit written evidence. The Group reviewed the perspectives put forward, and the quality and relevance of the supporting evidence. Alongside the wide stakeholder consultation carried out by the Group, the Advisory Group of reproductive rights, women's and equalities organisations provided reproductive rights perspectives, equalities analysis and lived experience input. As noted, a representative of the Advisory Group sat directly on the Expert Group, ensuring that this input was integrated into discussions throughout the process. In addition, the Chair met a number of Pro-Life organisations to listen to their views and to discuss any additional concerns they wished to raise. Whilst the terms of the review precluded the removal or restriction of rights to access abortions, these groups have provided useful insights, which have assisted the Group by identifying specific points of concern, which were carefully discussed.

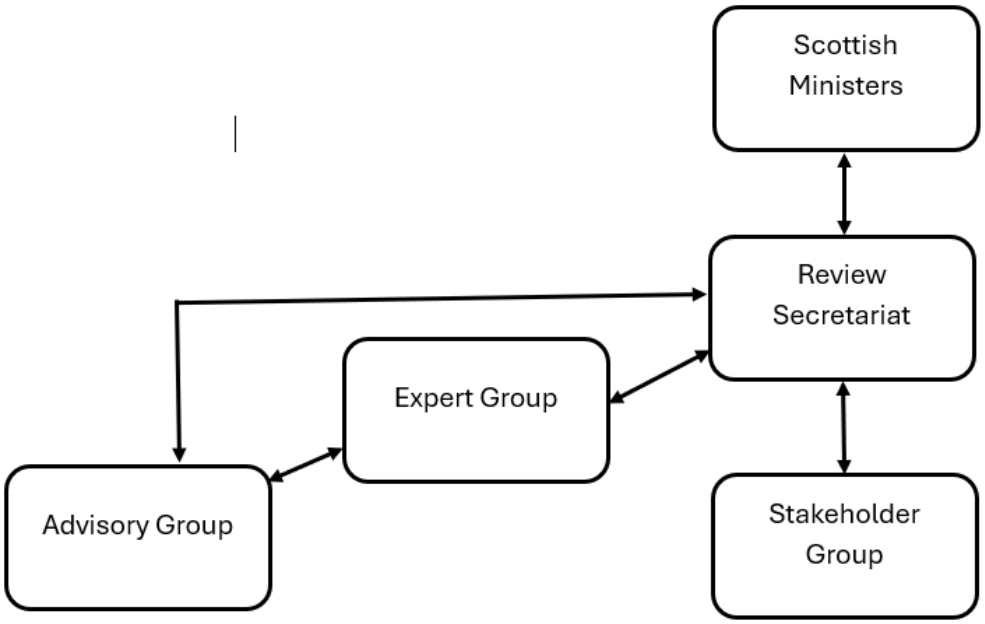
The Group also undertook a comparative review of international approaches to abortion law in order to identify instances of best practice. In line with its terms of reference, it focused particularly on jurisdictions that had recently reformed or reviewed their abortion laws to treat abortion as a healthcare issue, however it also considered a number of other jurisdictions suggested by stakeholders. These international models were assessed both in terms of how they function in practice and how well they reflect the principles adopted by the Group, and experts from relevant countries attended Group meetings to provide the Group with an understanding of how reforms may work in practice.

To bring together the full breadth of material submitted, the Group considered relevant additional evidence brought by the members of the Group. Using this evidence base, the Group then went on to engage in detailed discussion of potential models for legal reform. These discussions were iterative, utilising the expertise of the Group alongside the evidence base. Proposals were tested against the Group's overarching principles, considered in light of stakeholder and expert input, and examined for their practicality, coherence, and alignment with both the clinical situation in Scotland and international best practice. Where proposals raised legal, clinical, or practical complexities, further discussion and evidence-gathering was undertaken before reaching any recommendations.

This process was repeated for each of the three core topics and their associated sub-topics, ensuring a consistent and robust approach throughout. Every element of the Group's work has been conducted with a focus on evidence-based decision-making. The Group's methodology reflects a comprehensive approach to the complexities of this review, which are acknowledged by the Group. The process enabled careful and consistent exploration of the issues covered by this review,

close consideration of stakeholder views, and development of recommendations that are grounded in evidence and responsive to the needs of women and pregnant people in Scotland.

Figure 1. Governance Structure



Scottish Ministers commissioned the review and will consider report findings before consulting on proposals for reform.

The Review Secretariat is made up of Scottish Government Officials. The Review Secretariat liaises between the Expert Group, Advisory Group, Stakeholder Group and Scottish Ministers.

The Expert Group is chaired by Professor anna Glasier, the Scottish Government's Women's Health Champion. The Expert Group's core membership is academic, clinical and legal experts.

The Advisory Group is made up of women's and reproductive rights organisations. The Advisory Group advises the Expert Group on patient perspectives and lived experience. One representative of the Advisory Group sits on the Expert Group.

The Stakeholder Group is made up of all other stakeholders who provided written or verbal submissions to the Expert Group.

Annex B

International Examples

Gestational Limits and Grounds

Jurisdiction

South Australia

Gestational Limits and Grounds for Abortion

- Not more than 22 weeks and 6 days pregnant

No requirement for any grounds to be met for patients under 22 weeks and 6 days.

- More than 22 days and 6 weeks pregnant

Section 6 of the Termination of Pregnancy Act 2021 requires that (except in an emergency) two medical practitioners are of the view that:

I. the termination is necessary to save the life of the pregnant person or save another foetus; or
II. the continuance of the pregnancy would involve significant risk of injury to the physical or mental health of the pregnant person; or
III. there is a case, or significant risk, of serious foetal anomalies associated with the pregnancy.

A medical practitioner must consider all relevant medical circumstances, and professional standards that apply to the medical practitioner in relation to the performance of the termination. Section 9 of the Termination of Pregnancy Act 2021 sets out mandatory considerations for medical practitioners performing terminations after 22 weeks and 6 days.

The Act states that one medical practitioner may perform a termination on a person who is over 22 weeks and 6 days gestation in any circumstances in an “emergency”. An abortion may be performed on request (without needing to meet any grounds) Only a medical practitioner (the primary practitioner) is authorised to perform an abortion on a patient who is more than 23 weeks pregnant. The primary practitioner must consider whether performing the abortion is appropriate in all circumstances. In making a determination, the primary practitioner must take into account:

- all relevant medical circumstances
- current and future physical, psychological and social circumstances
- professional standards and guidelines commonly accepted by members of the medical profession in relation to the performance of the abortion.

The primary practitioner must also consult with at least one other medical practitioner who, having also taken into account the above considerations, reasonably believes that performing the abortion is appropriate in all the circumstances.

Legislation

Termination of Pregnancy Act 2021

Jurisdiction

New Zealand

Gestational Limits and Grounds for Abortion

- Before 20 Weeks

There are no clinical or statutory requirements for an abortion before 20 weeks' gestation - a qualified health practitioner can provide abortion services to a person who is not more than 20 weeks pregnant without needing clinical or any other evidence of appropriateness.

- After 20 Weeks

Statutory clinical requirements require to be met after 20 weeks' gestation - a qualified health practitioner may provide abortion services to an individual who is more than 20 weeks pregnant if they reasonably believe that the abortion is clinically appropriate in the circumstances. In considering whether the abortion is clinically appropriate in the circumstances, the qualified health practitioner must:

- consult at least one other qualified health practitioner
- have regard to:
- all relevant legal, professional and ethical standards to which the qualified health practitioner is subject
- the person's physical health, mental health and overall wellbeing
- the gestational age of the fetus.

Legislation

Abortion Legislation Act 2020 No 6, Public Act Contents – New Zealand Legislation

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Jurisdiction

Northern Ireland

Gestational Limits and Grounds for Abortion

- Up to 12 weeks

no grounds required

- Beyond 12 weeks and not exceeding 24 weeks

Two medical professionals must form an opinion in good faith that a pregnancy has not exceeded its 24th week; and continuance of the pregnancy would involve risk of injury to the physical or mental health of the pregnant person which is greater than if the pregnancy is terminated.

- Beyond 24 weeks

Where a registered medical professional is of the opinion that the termination is immediately necessary to save the life, or prevent grave permanent injury to the physical or mental health of the pregnant person;

Where two registered medical professionals are of the opinion that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman, or the continuance of the pregnancy would involve risk to the life of the pregnant woman which is greater than if the pregnancy were terminated;

Where two medical professionals are of the opinion that there is a substantial risk that the condition of the fetus is such that it is likely to die before, during or shortly after birth; if the fetus was to be born alive, it would suffer such physical or mental impairment to be seriously disabled.

Legislation

The Abortion (Northern Ireland) Regulations 2020 (legislation.gov.uk)

Jurisdiction

Australian Capital Territory

Gestational Limits and Grounds for Abortion

- All gestations

Abortion is lawful upon request from the patient at any gestational stage. Decisions regarding whether an abortion can be performed, the financial cost to the patient and the type of abortion available, is dependent on the patient's gestation and consultation with medical practitioners, who are regulated by health laws and their governing bodies.

Legislation

No specific Abortion law

Jurisdiction

Canada

Gestational Limits and Grounds for Abortion

- All gestations

Abortion services are subject to provincial healthcare regulatory rules and guidelines for physicians. No province offers abortion ‘on request’ beyond 24 weeks and some provinces only provide services up to 12 weeks, requiring patients to travel at later gestations. Since Canada has no legislation on abortion services, any termination required after 24 weeks is left to the discretion of the medical professional and the patient.

Legislation

No specific Abortion law

Jurisdiction

France

Gestational Limits and Grounds for Abortion

- Up to 14 Weeks

In France, abortion can be performed up to the end of the 14th week of pregnancy Abortion is performed on request.

The revised Article 34 of the constitution therefore provides a right to abortion, but only within the terms of the law.

Legislation

Are there any conditions for abortion? | ivg.gouv.fr

Law 2 March 2022 strengthening the right to abortion: deadline extended to 14 weeks | vie-publique.fr

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Jurisdiction

Germany

Gestational Limits and Grounds for Abortion

- Up to 12 Weeks

A pregnant woman requesting an abortion under 12 weeks of pregnancy will not be liable under Section 218 if she has undergone mandatory counselling at least three days before getting the abortion with a recognised pregnancy conflict counselling agency.

Abortion is permitted under 12 weeks gestation if the pregnancy was the result of sexual violence, such as rape.

- All gestations

Abortion is always allowed, regardless of the stage of the pregnancy, if it is medically necessary to ensure the pregnant woman's physical or mental health.

Legislation

German Criminal Code (Strafgesetzbuch – StGB)

Jurisdiction

Republic of Ireland

Gestational Limits and Grounds for Abortion

- Up to 12 weeks

No grounds subject to an examination by a medical practitioner

- Over 12 weeks

A termination of pregnancy may be carried out in exceptional circumstances, including risk to life/or serious harm of the pregnant person. Terminations under this ground can only happen before the fetus has reached 'viability' unless there is an immediate risk to the life, or of serious harm to the health, of the pregnant woman and an abortion is needed urgently to avert that risk.

Abortions are also allowed over 12 weeks in the case of fetal anomaly that is likely to lead to the death of fetus either before, or within 28 days of, birth.

Terminating a pregnancy when the foetus is affected by a non-fatal condition is only lawful in Ireland in the first 12 weeks

Legislation

Health (Regulation of Termination of Pregnancy) Act 2018

United States

The U.S. Supreme Court's decision in Roe v. Wade guaranteed the constitutional right to have an abortion in the U.S . The Supreme Court has now overturned Roe v. Wade with their decision in Dobbs v. Jackson Women's Health Organization . Roe being overturned means the constitutional right that was in place has been removed, and the states are no longer limited in what kinds of abortion restrictions they can pass. Some states have legal protections in place that will ensure that abortion remains legal there. Other states have banned or severely restricted abortion.

A full guide to abortion laws in the United States can be found here: State by State Guides to Abortion | U.S. Abortion Laws by Location (abortionfinder.org)

State

Alaska

Abortion Law

Abortion is legal at all stages of pregnancy in Alaska, and there are no specific grounds required to obtain an abortion.

Legal Reference

None

State

Colorado

Abortion Law

Abortion in Colorado is legal at all stages of pregnancy and in 2022, the Reproductive Health Equity Act was signed, which guarantees access to reproductive care and affirms the rights of pregnant women to continue or terminate a pregnancy. There are no specific term restrictions, meaning later stage abortion is permitted.

Legal Reference

Reproductive Health Equity Act | Colorado General Assembly

State

New Jersey

Abortion Law

New Jersey does not impose any gestational limits on abortion, meaning abortion is legal at all stages of pregnancy and there are no grounds required for abortion in New Jersey.

Legal Reference

NJ Legislature (state.nj.us)

State

New Mexico

Abortion Law

New Mexico does not impose any gestational limits on abortion, meaning abortion is legal at all stages of pregnancy and there are no grounds required for abortion in New Mexico.

Legal Reference

Reproductive and Gender-Affirming Health Care Freedom Act 2023

State

Oregon

Abortion Law

Oregon has no gestational limits or grounds required for abortion.

Legal Reference

Oregon Health Authority : Reproductive Health Equity Act : Reproductive and Sexual Health : State of Oregon

OR HB2002 | 2023 | Regular Session | LegiScan

State

Vermont

Abortion Law

Abortion in Vermont is legal at all stages of pregnancy with no gestational limits or grounds required.

Legal Reference

Constitution of the State of Vermont | Chapter 1, Article 22

State

Washington DC (District of Colombia)

Abortion Law

Abortion is legal in Washington DC at all stages of pregnancy and has some of the least restrictive laws in the United States,

There are no specific restrictions on later stage abortions and the decision to perform a later stage abortion is a choice made between the pregnant person and their healthcare provider. As such, there are also no grounds required to have an abortion.

Legal Reference

D.C. Law 24-254. Enhancing Reproductive Health Protections Amendment Act of 2022. | D.C. Law Library (dccouncil.gov)

Pathways

Where and Who can provide abortions

Jurisdiction

Australian Capital Territory

Legislation

Health Act 1993 and Regulation made under it

Where can abortions be provided

No restrictions on medical abortions. Surgical abortions to be provided in an approved medical facility, which is a place approved by the Health Minister.

Who can provide abortions

Medical abortion: doctor, nurse practitioner or other person prescribed by Regulation. “Authorised midwives” have been prescribed by Regulation.

Surgical abortion: doctor.

No requirement for dual sign-off.

Note that medical abortion is available in practice up to 9 weeks’ gestation.

Jurisdiction

South Australia

Legislation

Termination of Pregnancy Act 2021

Where can abortions be provided

Where an abortion is provided at more than 22 weeks and 6 days gestation, an abortion must be provided at a prescribed hospital.

Prescribed hospitals are set out in the Termination of Pregnancy Regulations 2022.

Who can provide abortions

Medical abortion: any registered health practitioner acting in the ordinary course of the practitioner's profession, provided they are authorised to prescribe the abortion

drugs under section 18 of the Controlled Substances Act 1984. Pharmacists can dispense abortion drugs.

A medical practitioner acting in the ordinary course of the practitioner's profession can provide an abortion on a person who is not more than 22 weeks and 6 days pregnant.

Where a person is more than 22 weeks and 6 days pregnant, a medical practitioner can provide an abortion provided they comply with the requirements of section 6 of the Termination of Pregnancy Act 2021.

A registered health practitioner may assist in an abortion.

Jurisdiction

Western Australia

Legislation

Abortion Legislation Reform Act 2023, which amended the Public Health Act 2016

Where can abortions be provided

No legislative requirements or restrictions.

Who can provide abortions

A medical practitioner is authorised to perform an abortion on a person who is not more than 23 weeks pregnant.

A prescribing practitioner may also provide an abortion (by prescribing, supplying or administering an abortion drug) up to 23 weeks' gestation. A "prescribing practitioner" means a person who is a member of a class of registered health practitioners that — (a) is authorised under the Medicines and Poisons Act 2014 to prescribe an abortion drug; and (b) is prescribed by the regulations for the purposes of this definition. We understand that this currently includes nurse practitioners or endorsed midwives but only up to 9 weeks' gestation.

A medical practitioner can provide an abortion after 23 weeks if — (a) after having regard to the matters referred to in subsection (2), they reasonably believe that performing the abortion is appropriate in all the circumstances; and (b) they have consulted with at least 1 other medical practitioner who, after having regard to the matters referred to in subsection (2), also reasonably believes that performing the abortion is appropriate in all the circumstances

The matters in subsection (2) are:
(a) all relevant medical circumstances;
(b) the person's current and future physical, psychological and social circumstances; and (c) the professional standards and guidelines commonly accepted by members

of the medical profession that apply to the medical practitioner in relation to the performance of the abortion.

The practitioner may take other factors into account too.

A medical practitioner can perform an abortion after 23 weeks gestation in order to save the pregnant person's life, without meeting the above requirements.

A pharmacist can dispense or supply abortion drugs in accordance with a prescription by a "directing practitioner".

A registered health practitioner in a relevant health profession (other than pharmacy) can perform an by supplying or administering an abortion drug provided it is under the direction of a directing practitioner.

A directing practitioner means—
(a) in relation to the performance of an abortion on a person who is not more than 23 weeks pregnant — a medical practitioner or prescribing practitioner; and
(b) in relation to the performance of an abortion on a person who is more than 23 weeks pregnant — a medical practitioner.

A registered health practitioner can assist with providing an abortion.

Jurisdiction

Canada (all provinces and territories)

Legislation

None.

Abortion services are subject to provincial / territorial healthcare rules and guidelines for physicians.

Where can abortions be provided

Some information is available from the Canada Public Health Agency: Abortion in Canada - Canada.ca

Who can provide abortions

No Data

Jurisdiction

France

Legislation

Public Health Code, a codification of public health laws, including on abortion.

There has been legislation passed that supports the right to abortion[249].

Where can abortions be provided

Medical abortion: hospital or other clinic, private clinic, sexual health clinic or health centre.

Surgical abortion: hospital or other clinic, certain authorised health centres.

For more information see: ivg.gouv.fr

Who can provide abortions

Medical abortion: doctor or midwife.
Surgical abortion: doctor or midwife.

Jurisdiction

Germany

Legislation

Section 218a [250]of the German Criminal Code (StGB)

Where can abortions be provided

No data

Who can provide abortions

A physician.

Jurisdiction

New Zealand

[249] Decree of 17 December 2023 about midwives performing abortions, Law of 2 March 2022 reinforcing the right to abortion, Decree of 19 February 2022 allowing wider access to medical abortion outwith hospitals and clinics, Decree of 30 December 2021 allowing, experimentally, midwives to perform abortions, Decree of 15 April 201 allowing surgical abortions by doctors in health centres, Law of 26 January 2016 allowing midwives to perform medical abortions and removing the 7 day reflection period and the need for a second appointment.
[250] Federal Ministry of Justice. (n.d.). German Criminal Code (Strafgesetzbuch – StGB) (Translation by Prof. Dr. Michael Bohlander; revised by Ute Reusch). Gesetze im Internet. (Accessed: 14 August 2025).

Legislation

Abortion Legislation Act 2020 No. 6

Where can abortions be provided

No Data

Who can provide abortions

Treatment must be provided by a qualified health practitioner (defined in the Health Practitioners Competence Assurance Act 2003 as a person who is, or deemed to be, registered with an authority as a practitioner of a particular health profession and who is acting in accordance with that Act)

One other qualified health practitioner must be consulted in cases where the pregnancy is over 20 weeks

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Jurisdiction

Northern Ireland

Legislation

Section 9 of the Northern Ireland (Executive Formation etc) Act 2019

Abortion (Northern Ireland) (no2) Regulations 2020

Abortion (Northern Ireland) Regulations 2021 and 2022

Where can abortions be provided

Medical and surgical at: a Health and Social Care (HSC) hospital; a clinic provided by a HSC trust for the purpose of carrying out abortion services (whether or not the clinic also provides other services); a premises used to provide primary medical services in accordance with arrangements under the Health and Personal Social Services (Northern Ireland) Order 1972 or at premises approved by the NI Department of Health
early medical abortion at home (EMAH) in certain circumstances.

Who can provide abortions

Registered medical professionals may perform terminations

"registered medical professional" means—
(a) a registered medical practitioner;
(b) a registered midwife;
(c) a registered nurse;

Terminations up to 12 weeks – 1 RMP

Terminations up to 24 weeks – risk of injury to physical or mental health of the woman – certification by 2 RMPs

No gestational limits – where immediate necessity – 1RMP

No gestational limit – risk to life/ grave permanent injury – certified by 2 RMPs

No gestational limit – fetal abnormality or death of fetus likely before, during or shortly after birth – 1 RMP

Abortion Requirements

Jurisdiction

Australian Capital Territory

Legislation

Health Act 1993 and Regulation made under it

Pre-abortion requirements

None

Post-abortion requirements

None

Reporting requirements

None in legislation.

Jurisdiction

South Australia

Legislation

Termination of Pregnancy Act 2021

Pre-abortion requirements

Except in an emergency, before performing a termination on a person, a registered health practitioner must provide all necessary information to the person about access to counselling, including publicly-funded counselling

Post-abortion requirements

None

Reporting requirements

An annual report is to be provided to Ministers each year, which is then to be laid in Parliament.

The report must contain:
(a) information in relation to each termination performed in the calendar year which must include the age of the pregnant person and the gestational age of the foetus at the time of the termination; and

(b) other information set out in regulations.

The Termination of Pregnancy Regulations 2022 require the following information to also be provided in the report:
(a) the number of terminations;
(b) the number of terminations that result in complications or adverse outcomes for the pregnant person;
(c) the different methods of terminations used and the number of terminations performed using each method;
(d) for a terminations after 22 weeks and 6 days —the circumstances under section 6(1) of the Act relating to the performance of the termination;
(e) the locations in the State of terminations performed and the regions of the State in which the persons ordinarily reside.

The 2022 Regulations also require hospitals and private day procedure centres to provide the numerous data on the patient, treatment and other data to the Department of Health (see Schedule 2 of the 2022 Regulations).

Jurisdiction

Western Australia

Legislation

Abortion Legislation Reform Act 2023, which amended the Public Health Act 2016

Pre-abortion requirements

None

Post-abortion requirements

The requirement for mandatory counselling was removed with effect from March 2024.
A statewide abortion care helpline is available[251].

Reporting requirements

The Public Health Act 2016 enables the Chief Health Officer to direct people (e.g. hospitals) to provide certain demographic or clinic information about abortions. The information can only be statistical or summary information and must not be capable of identifying individuals.

As at March 2024, the data to be provided by direction is as follows([252]):
- date of abortion
- age range of patient

[251] Information for patients - abortion services (health.wa.gov.au)
[252] Guide for notifying of abortion with E-form

- region of residence
- gestation
- reason for abortion (choice of 3 categories)
- method (medical or surgical)
- who submitted the notification
- category of abortion service provider (e.g. GP, public hospital, etc).

The Act sets out the purposes for which the data collected may be used.

Jurisdiction

Canada (all provinces and territories)

Legislation

None.

Abortion services are subject to provincial / territorial healthcare rules and guidelines for physicians.

Pre-abortion requirements

None

Post-abortion requirements

None

Reporting requirements

None

Jurisdiction

France

Legislation

Public Health Code, a codification of public health laws, including on abortion.

There has been legislation passed that supports the right to abortion[253].

[253] Decree of 17 December 2023 about midwives performing abortions, Law of 2 March 2022 reinforcing the right to abortion, Decree of 19 February 2022 allowing wider access to medical abortion outwith hospitals and clinics, Decree of 30 December 2021 allowing, experimentally, midwives to perform abortions, Decree of 15 April 201 allowing surgical abortions by doctors in health centres, Law of 26 January 2016 allowing midwives to perform medical abortions and removing the 7 day reflection period and the need for a second appointment.

Pre-abortion requirements

At an appointment (or two separate appointments) with a doctor or midwife, the patient must be given the opportunity to ask questions and be given information on their options, and then to confirm their choice.

Minor must attend a psycho-social consultation between getting the relevant information and making a decision. Such an appointment is optional for adults.

A mandatory reflection period before making a decision has been abolished.

Post-abortion requirements

None

Reporting requirements

None

Jurisdiction

Germany

Legislation

Section 218a[254] of the German Criminal Code (StGB)

Pre-abortion requirements

Counselling three days prior to the procedure, provided by a physician (who is not the one performing the abortion) and evidenced (sections 218a and 218b).

Where the abortion results from rape of the pregnant person, there are specific counselling requirements in section 219 of the German Criminal Code:

Post-abortion requirements

None

Reporting requirements

None

Jurisdiction

New Zealand

[254] German Criminal Code (Strafgesetzbuch – StGB) (gesetze-im-internet.de)

Legislation

Abortion Legislation Act 2020 No. 6

Pre-abortion requirements

A health practitioner must advise a woman of the availability of counselling services if the woman—
(a)
seeks advice or information about whether to continue or terminate a pregnancy; or
(b)
advises the health practitioner of the wish to terminate a pregnancy; or
(c)
has terminated a pregnancy.
(2)
A qualified health practitioner may not, as a condition of providing abortion services to a woman, require the woman to attend counselling before or after the provision of those services.

Post-abortion requirements

None

Reporting requirements

The Director-General of Health (DG) must:

a. Collect, collate, analyse, and publish information about the provision of:
i. Abortion services in New Zealand; and
ii. Counselling services in relation to, or in connection with, the provision of abortion services; and
b. Develop and publish standards for the services described in (a).

Abortion providers must notify the DG after the following services are provided by or through the provider:

a. A surgical abortion; or
b. A medicine is prescribed or administered for the purpose of inducing an abortion.

Notifications must include, in relation to the provision of the services referred to above:

a. The information specified in Schedule 2[38]; and
b. Such other information the DG may require.

In no case may the information provided under this provision include the name of the woman who the abortion service was provided.

Notifications must be given:

a. Not later than 1 month after the provision of the abortion service; and
b. In the form or manner required by the DG.

Jurisdiction

Northern Ireland

Legislation

Section 9 of the Northern Ireland (Executive Formation etc) Act 2019

Abortion (Northern Ireland) (no2) Regulations 2020

Abortion (Northern Ireland) Regulations 2021 and 2022

Pre-abortion requirements

Certification requirements that the grounds have been met by the RMP or RMPs Captain

Post-abortion requirements

None

Reporting requirements

Notification to CMO

A registered medical professional who terminates a pregnancy must give to the Chief Medical Officer of the Department of Health:
a. Notice of the termination; and
b. Such other information relating to the termination as is specified in the Schedule to the Regulation.

The notice and information must be given:
a. Within 14 days beginning with:
i. In a case where the termination is treatment with mifepristone, the date of that treatment; or
ii. In all other cases, the date on which the termination occurred; and
iii. In a sealed envelope or by email.

Conscientious Objection

Jurisdiction

Australian Capital Territory

Legislation

Health Act 1993 and Regulation made under it

Conscientious Objection

A doctor, nurse, nurse practitioner or other prescribed person (authorised midwife) may, on religious or other conscientious grounds refuse to provide any of the following services: (a) prescribe, supply or administer an abortifacient; (b) carry out or assist in carrying out a surgical abortion.

Conscientious objection is not available where a surgical abortion is required to save the life of a pregnant person, or where treatment is required in consequence of having an abortion.

If conscientiously objecting, the healthcare practitioner must inform the patient of that and either provide details of a healthcare professional or facility that they reasonably believe will provide the abortion service (without conscientiously objecting) or transfer the patient's care to that person/facility.

Jurisdiction

South Australia

Legislation

Termination of Pregnancy Act 2021

Conscientious Objection

Conscientious objection is available to a registered health practitioner who is asked to perform, assist or advise on a termination or to make a decision on whether a should be performed.

The practitioner must inform the patient of their conscientious objection as soon as practicable.

If the practitioner is asked to perform a termination or to advise the performance of a termination, the practitioner must, without delay— (a) give information to the person on how to locate or contact a medical practitioner who, in the first practitioner's reasonable belief, does not have a conscientious objection to the performance of the termination; or (b) transfer the person's care to— (i) another registered health practitioner who, in the first practitioner's reasonable belief, can provide the

requested service and does not have a conscientious objection to the performance of the termination; or (ii) a health service provider at which, in the first practitioner's reasonable belief, the requested service can be provided by another registered health practitioner who does not have a conscientious objection to the performance of the termination.

Jurisdiction

Western Australia

Legislation

Abortion Legislation Reform Act 2023, which amended the Public Health Act 2016

Conscientious Objection

Except in an emergency, a registered health practitioner (who has a conscientious objection to abortion has the right to refuse to do any of the following —

(a) perform an abortion on a person;
(b) assist in the performance of an abortion on a person;
(c) make a decision about the appropriateness of an abortion after 23 weeks' gestation;
(d) advise a person about the performance of an abortion on the person or another person.

The practitioner must inform the person of their conscientious objection immediately.

In the case of (a), (c), or (d), the practitioner must without delay transfer the patient's care to another registered health practitioner who, or another health facility which, in the refusing practitioner's reasonable belief, can provide the requested service; or immediately give the patient information, approved by the Chief Health Officer about how to locate or contact such a registered health practitioner or a facility.

Students have a right to conscientiously object to assisting with the performance of an abortion.

Jurisdiction

Canada (all provinces and territories)

Legislation

None.

Abortion services are subject to provincial / territorial healthcare rules and guidelines for physicians.

Conscientious Objection

None

Jurisdiction

France

Legislation

Public Health Code, a codification of public health laws, including on abortion.

There has been legislation passed that supports the right to abortion[255].

Conscientious Objection

A doctor is not obliged to perform an abortion but if they refuse to do so, they must inform the patient without delay and provide the name of practitioners/clinics who can provide the treatment. (Article L2212-8 and Article R4127-18 CSP)

The general right of doctors to refuse to provide treatment is subject to the exception of when treatment is required in an emergency.

Jurisdiction

Germany

Legislation

Section 218a [256]of the German Criminal Code (StGB)

Conscientious Objection

None

Jurisdiction

New Zealand

Legislation

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[255] Decree of 17 December 2023 about midwives performing abortions, Law of 2 March 2022 reinforcing the right to abortion, Decree of 19 February 2022 allowing wider access to medical abortion outwith hospitals and clinics, Decree of 30 December 2021 allowing, experimentally, midwives to perform abortions, Decree of 15 April 201 allowing surgical abortions by doctors in health centres, Law of 26 January 2016 allowing midwives to perform medical abortions and removing the 7 day reflection period and the need for a second appointment.

[256] Federal Ministry of Justice. (n.d.). German Criminal Code (Strafgesetzbuch – StGB) (Translation by Prof. Dr. Michael Bohlander; revised by Ute Reusch). Gesetze im Internet. (Accessed: 14 August 2025).

Abortion Legislation Act 2020 No. 6

Conscientious Objection

Section 14 of the 2020 Act - conscientious objection in terms of the provision or assistance in the provision of contraception, sterilisation, abortion and information or advisory services about whether to continue or terminate a pregnancy.

If the medical professional has a conscientious objection to providing, or assisting with providing an abortion, they must tell the patient at the earliest opportunity and give the patient details on how to access the contact details of another medical professional who is the closest provider (taking into consideration of the physical distance between the providers; the date and time that the patient makes the request; and the operating hours of the provider) of the service requested

It does not override a practitioner's duty to provide prompt and appropriate medical assistance to any person in an emergency

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Jurisdiction

Northern Ireland

Legislation

Section 9 of the Northern Ireland (Executive Formation etc) Act 2019

Abortion (Northern Ireland) (no2) Regulations 2020

Abortion (Northern Ireland) Regulations 2021 and 2022

Conscientious Objection

A person is not under a duty to participate in any treatment as set out in the regulations if they have a conscientious objection.

The regulations provide that that does not affect any duty to provide or assist in treatment which is necessary to save the life, or to prevent grave permanent injury to the physical or mental health, of the pregnant person.

Offences

Jurisdiction

Germany

Offence

Termination of pregnancy outside the legal exemptions set out in **section 218a StGB**.

Exceptions

set out in **section 218a StGB** of the German Criminal Code

Penalty

Up to three years of imprisonment or a fine for the person performing the abortion. (Section 218(1) StGB)

In especially serious cases, such as where the offender acts against the will of the pregnant woman or places the pregnant woman in danger of death or at risk of serious damage to health: Six months to five years of imprisonment. (Section 218(2) StGB)

If performed by the pregnant woman herself: Up to one year of imprisonment or a fine. (Section 218(3) StGB)

Legal Reference

Illegal Abortion **(Section 218 StGB)**

Jurisdiction

Germany

Offence

Whoever terminates a pregnancy in the cases under section 218a (2) or (3) without having received the written determination of a physician who is not performing the termination as to whether the conditions of section 218a (2) or (3) were met incurs a penalty, unless the act is subject to a penalty under section 218.

Whoever, in the capacity as a physician, despite knowing better, makes an incorrect determination as to the conditions of section 218a (2) or (3) for presentation in accordance with sentence 1 incurs a penalty, unless the act is subject to a penalty under section 218.

Exceptions

No exceptions noted

Penalty

Up to one year of imprisonment or a fine for the first offence above. (Section 218b(1) StGB)

Up to two years of imprisonment or a fine for the second offence above. (Section 218b(1) StGB)

The pregnant woman is not punishable. (Section 218b(1) StGB)

Legal Reference

Abortion Without Proper Medical Certification **(Section 218b StGB)**

Jurisdiction

Germany

Offence

Whoever terminates a pregnancy…

1. without having given the woman the opportunity to explain the reasons for requesting that the pregnancy be terminated,

2. without having given the pregnant woman medical advice about the significance of the procedure, in particular about the steps in the procedure, its after-effects, risks and possible physical or psychological consequences,

3. in the cases under section 218a (1) and (3) without having previously determined, on the basis of a medical examination, the length of the pregnancy or

4. despite having counselled the woman in accordance with section 219 in a case under section 218a (1)

…incurs a penalty, unless the act is subject to a penalty under section 218.

Exceptions

The pregnant woman does not incur a penalty. (Section 218c(2) StGB)

Penalty

Up to one year of imprisonment or a fine. (Section 218c(1) StGB)

Legal Reference

Breach of Medical Duties in connection with abortion **(Section 218c StGB)**

Jurisdiction

Germany

Offence

Putting on the market means or objects which are suited to terminating a pregnancy, with the intention of encouraging unlawful acts under section 218.

Exceptions

A woman obtaining substances for her own abortion is not punishable. *(Section 219b(2) StGB)*

Penalty

Up to two years of imprisonment or a fine. *(Section 219b(1) StGB)*
Means or objects relating to the offence may be confiscated. *(Section 219b(3) StGB)*

Legal Reference

Putting on market of substances used in abortion **(Section 219b StGB)**

Jurisdiction

France

Offence

Performing an abortion without the consent of the pregnant person.

Exceptions

No exceptions noted

Penalty

Five years of imprisonment and a €75,000 fine.

Legal Reference

Article L2222-1 of the Public Health Code, referring to Article 223-10 of the Criminal Code.

Jurisdiction

France

Offence

Performing an abortion under the following circumstances:

1. After the maximum gestation period for an abortion, except for medical reasons.

2. By a person who is not a doctor or midwife.

3. In a location/premises that do not meet legal requirements.

Exceptions

No exceptions noted

Penalty

Two years of imprisonment and a €30,000 fine.

Aggravated Penalty: If the offence is committed habitually, the penalty increases to five years of imprisonment and a €75,000 fine.

Attempts to commit the offence receive the same penalties.

Legal Reference

Article L2222-2 of the Public Health Code.

Jurisdiction

France

Offence

Performing an abortion following prenatal diagnosis without complying with procedures set down in law.

Exceptions

No exceptions noted

Penalty

Two years of imprisonment and a €30,000 fine.

Legal Reference

Article L2222-2 of the Public Health Code.

Jurisdiction

France

Offence

Supplying a pregnant person with the means to induce their own abortion.

Exceptions

The pregnant person is not considered an accomplice.

Penalty

Three years of imprisonment and a €45,000 fine.

Aggravated Penalty: If committed habitually, the penalty increases to five years of imprisonment and a €75,000 fine.

Legal Reference

Article L2222-2 of the Public Health Code.

Jurisdiction

Northern Ireland

Offence

A person who, by any means, intentionally terminates or procures the termination of the pregnancy of a woman otherwise than in accordance with regulations 3 to 8 of the Northern Ireland (Abortion (Northern Ireland) (No. 2) Regulations 2020 commits an offence.

Exceptions

This offence does not apply to the pregnant woman.

It does not apply where the act which caused the termination was done in good faith for the purpose only of saving the woman's life or preventing grave permanent injury to the woman's physical or mental health.

Penalty

Summary conviction to a fine up to level 5 on the standard scale.

Proceedings may be brought only by, or with the consent of, the Director of Public Prosecutions for Northern Ireland.

Legal Reference

The Abortion (Northern Ireland) (No. 2) Regulations 2020 established the legal framework for abortion in Northern Ireland and amended pre-existing offences. **Regulation 11, Abortion (Northern Ireland) (No. 2) Regulations 2020**.

Jurisdiction

Northern Ireland

Offence

A registered medical professional failing to comply with requirements in regulation 9 for certification under regulations 3 to 7.

Exceptions

No exceptions noted

Penalty

On summary conviction to a fine up to level 4 on the standard scale.

Proceedings may be brought only by, or with the consent of, the Director of Public Prosecutions for Northern Ireland.

Legal Reference

Regulation 9, Abortion (Northern Ireland) (No. 2) Regulations 2020.

Jurisdiction

Northern Ireland

Offence

A registered medical professional failing to comply with the requirements of regulation 10 concerning the notification of the Chief Medical Officer (CMO) of a termination.

Disclosure of any notice or information given to the CMO under regulation 10 except in accordance with paragraph (3) of that regulation.

Exceptions

No exceptions noted

Penalty

On summary conviction to a fine up to level 4 on the standard scale.

Proceedings may be brought only by, or with the consent of, the Director of Public Prosecutions for Northern Ireland.

Legal Reference

Regulation 10, Abortion (Northern Ireland) (No. 2) Regulations 2020.

Jurisdiction

Northern Ireland

Offence

It is an offence for any person who, with intent to destroy the life of a child then capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother. Evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be prima facie proof that she was at that time pregnant of a child then capable of being born alive.

Exceptions

This offence does not apply to the pregnant woman.

This offence does not apply to a registered medical professional, as defined in the Abortion (Northern Ireland) (No. 2) Regulations 2020, who terminated a pregnancy in accordance with regulations 3 to 8 of those Regulations.

Penalty

On indictment to penal servitude for life.

Proceedings may be brought only by, or with the consent of, the Director of Public Prosecutions for Northern Ireland.

Legal Reference

Criminal Justice Act (Northern Ireland) 1945

Jurisdiction

South Australia

Offence

An unqualified person who performs a termination on another person commits an offence. An “unqualified person” is a person who is not a registered health practitioner authorised under the Termination of Pregnancy Act 2021 to perform a termination.

An unqualified person who assists in the performance of a termination on another person commits an offence. An “unqualified person” is a person who is not a registered health practitioner acting in the ordinary course of the practitioner's profession.

Exceptions

No exceptions noted

Penalty

Maximum penalty: 7 years imprisonment and 5 years imprisonment, respectively.

Prosecution cannot be commenced without the Director of Public Prosecution's written consent.

Legal Reference

Section 14 of the Termination of Pregnancy Act 2021.

Termination of Pregnancy Act 2021 (SA)

Jurisdiction

South Australia

Offence

A person engaged or formerly engaged in connection with the operation of the Termination of Pregnancy Act 2021 must not publish information or data (however described) that identifies, or contains information tending to identify the name or address of a person who has sought or received a termination

Exceptions

No exceptions noted

Penalty

In the case of a natural person—$50 000 AUD

In the case of a body corporate—$120 000 AUD.

Legal Reference

Section 18 of the Termination of Pregnancy Act 2021.

Jurisdiction

South Australia

Offence

A person engaged or formerly engaged in connection with the operation of the Termination of Pregnancy Act 2021 must not disclose personal information relating to a person obtained while so engaged except to the extent that they may be authorised or required to disclose that information by (a) the Chief Executive or their employer, or (b) in the case of information obtained while working at an incorporated hospital or the South Australia Ambulance Service (SAAS) —by the hospital or SAAS. There are various exceptions where disclosure is permitted, set out in section 19(2). Information disclosed for one purpose under section 19(2) must not be used for any other purpose.

Exceptions

No exceptions noted

Penalty

Maximum penalty - $10,000 AUD.

Legal Reference

Section 19 of the Termination of Pregnancy Act 2021

Jurisdiction

Western Australia

Offence

An unqualified person who performs an abortion on another person commits an offence. Section 202MN of the Public Health Act 2016 sets out who is an “unqualified person”, distinguishing roles played in the performance of an abortion (e.g. prescription and supply of abortion drugs) and the gestation of the pregnant person.

Exceptions

No exceptions noted

Penalty

Imprisonment for up to 7 years.

Legal Reference

The Abortion Legislation Reform Act 2023 (Western Australia) amended the Public Health Act 2016.

Section 202MN of the Public Health Act 2016.

Jurisdiction

New Zealand

Offence

It is an offence for a person who is not a health practitioner to (a) procure, or attempt to procure, an abortion for a woman; or (b) perform, or attempts to perform, an abortion on a woman.

Exceptions

No exceptions noted

Penalty

Imprisonment for up to 5 years.

The offence does not apply to the pregnant woman.

Legal Reference

Section 183 of the Crimes Act 1961

Jurisdiction

New Zealand

Offence

It is an offence to cause the death of any child that has not become a human being in such a manner that he or she would have been guilty of murder if the child had become a human being, except where the death is caused by (a) a means employed in good faith to preserve the life of the child's mother; or (b) providing abortion services in accordance with section 10 or 11 of the Contraception, Sterilisation, and Abortion Act 1977.

Exceptions

No exceptions noted

Penalty

Imprisonment for up to 14 years.

Legal Reference

Section 182 of the Crimes Act 1961

Jurisdiction

New Zealand

Offence

It is an offence to cause the death of any child that has not become a human being in such a manner that he or she would have been guilty of murder if the child had become a human being, except where the death is caused by (a) a means employed in good faith to preserve the life of the child's mother; or (b) providing abortion services in accordance with section 10 or 11 of the Contraception, Sterilisation, and Abortion Act 1977.

Exceptions

No exceptions noted

Penalty

Imprisonment for up to 14 years.

Legal Reference

Section 182 of the Crimes Act 1961

Jurisdiction

Canada

Offence

In Canada, abortion services are subject to provincial / territorial healthcare rules and guidelines for physicians. There are therefore no abortion-specific offences.

Exceptions

None

Penalty

None

Legal Reference

None

Jurisdiction

Iceland

Offence

A woman who kills her foetus

Exceptions

If there are particularly strong extenuating circumstances, it may be decided that punishment is to be waived. Proceedings shall not be instituted if 2 years have elapsed since the commission of the offence. Unsuccessful attempts shall not result in punishment.

Penalty

Imprisoned for up to 2 years

Legal Reference

Terminations of Pregnancy Act 2019

Jurisdiction

Iceland

Offence

Any person who, with the mother's consent kills her foetus or provides her with assistance for an abortion.

Exceptions

No exceptions noted

Penalty

Imprisoned for up to 4 years. . In the case of a serious offence, and particularly if the offence is committed for gain or results in the death of, or serious damage to the health of, the mother, punishment of up to 8 years shall be applied. If the offence was committed without the mother's consent, the punishment shall take the form of imprisonment for a minimum of 2 years and up to 12 years.

Legal Reference

General_Penal_Code_sept.-2015.pdf

Jurisdiction

Iceland

Penalty

note, the offences for Healthcare Practitioners have not been set out in this example, and further review of the law in Iceland would need to be taken forward to confirm

Legal Reference

Healthcare Practitioners Act No. 34/2012,

Annex C

Direction to Health Boards on Data to be provided to Public Health Scotland

National Health Service (Scotland) Act 1978

Abortion (Information) (Scotland) Directions 2022

The Scottish Ministers give the following Directions in exercise of the powers conferred by sections 2(5) and 105(7) of the National Health Service (Scotland) Act 1978[257] and all other powers enabling them to do so.

Citation and commencement

1. These Directions may be cited as the Abortion (Information) (Scotland) Directions 2022 and come into force on 1 May 2022

Application

2. These Directions apply—

(1) where a pregnancy has been terminated in accordance with section 1 of the Abortion Act 1967, and

(2) in relation to terminations carried out on or after 1 May 2022.

Interpretation

3. In these Directions—

"PHS" means Public Health Scotland[258],

"termination" means a pregnancy which has been terminated in accordance with section 1 of the Abortion Act 1967.

Provision of information to PHS

4. Where a termination is carried out by a medical practitioner, the Health Board who employs the medical practitioner must provide the information specified in the schedule to PHS no later than 30 days after the day on which the termination is completed.

Rectification of inaccurate information

5. (1) Where a Health Board has identified that any information provided in accordance with paragraph 4 is inaccurate the Health Board must correct the inaccurate

[257] 1978 c. 29; section 2(5) was amended by section 66(1) and paragraph 19(1) of schedule 9 of the National Health Service and Community Care Act 1990 (c.19). The functions of the Secretary of State were transferred to the Scottish Ministers by virtue of section 53 of the Scotland Act 1998 (c. 46).
[258] Public Health Scotland is established by order by the Public Health Scotland Order, S.S.I. 2019/336.

information no later than 10 working days after the day on which the inaccurate information is identified.

(2) Where a Health Board receives notification from PHS that any information provided in accordance with paragraph 4 is inaccurate, the Health Board must correct the inaccurate information and provide the corrected information to PHS no later than 10 working days from the day the Board receives notification from PHS of the inaccurate information.

Maree Todd
Authorised to sign by the Scottish Ministers

St Andrew's House
Regent Road
Edinburgh
EH1 3DG

Schedule
Article 4
Information to be provided to PHS

1. The Community Health Index (CHI) number of the patient (where available)
2. Surname of the patient
3. Forename(s) of the patient
4. Patient's postcode
5. Date of birth of the patient
6. Ethnicity of the patient
7. Location (Name of Hospital) being the primary location where treatment was provided
8. Date of termination
9. Termination outcome
10. Statutory ground(s) for termination under the Abortion Act 1967
11. Specific indications for termination in either the patient or the fetus (where applicable)
12. If the termination was a selective reduction and (If it was a selective reduction), original number of fetuses and number of fetuses reduced to
13. Gestation of the patient's pregnancy in weeks
14. Method by which gestation has been estimated
15. Previous number of pregnancies of the patient and (if there have been previous pregnancies) numbers of previous live births, stillbirths, spontaneous abortions (miscarriages) and terminations of pregnancy
16. Surgical method used (where applicable)
17. Medical method used (where applicable)

18. Where antiprogesterone (e.g. Mifepristone) was taken (where applicable)
19. Where prostaglandin (e.g. Misoprostol) was taken (where applicable)
20. Second hospital (Treatment Centre) (if applicable)
21. Second treatment provided (if applicable)

Annex D

The Advisory Group

Membership of the Advisory Group consists of representatives from:

- Abortion Rights Scotland
- Back Off Scotland
- Close the Gap
- Engender
- Equality Network
- Humanist Society
- Scottish Trades Union Congress
- Scottish Women's Aid
- Young Women's Movement
- Zero Tolerance

Stakeholders Contacted for Views*

*This list represents organisations who were contacted for views, but did not all necessarily respond

- 40 Days for Life
- Alliance Defending Freedom (ADF)
- Antenatal Results and Choices (ARC)
- Arch Trust
- Dr Basky Thanaganathan
- British Medical Association (BMA)
- British Association of Perinatal Medicine
- British Maternal and Fetal Medicine Society
- CARE Scotland
- Catholic Parliamentary Office of the Bishops' Conference of Scotland
- Christian Medical Fellowship
- Church of Scotland
- Crown Office and Procurator Fiscal (COPFS)
- Don't Screen Us Out
- Down's Syndrome Association
- Dr Kate Greasley
- Evangelical Alliance
- General Medical Council
- Healthcare Improvement Scotland
- Humanist Society
- Dr Johnathan Brown
- Karma Nirvana
- March for Life UK
- Dr Martha Paynter
- Mental Welfare Commission
- Nursing & Midwifery Council
- Public Health Scotland

- Pro-life Students
- Professor Maya Unnithan
- Right to Life UK
- Royal College of General Practitioners
- Royal College of Midwives
- Royal College of Nurses
- Royal College of Paediatrics and Child Health
- Royal Pharmaceutical Society
- Scottish Association of Medical Directors
- Scottish Council on Human Bioethics
- Society for the Protection of Unborn Children
- Scottish Trades Union Congress
- Sisters of the Gospel of Life
- The Christian Institute
- World Health Organisation

The Expert Group also received presentations from representatives from several Australian States, New Zealand and Canada.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

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