

Abortion policy

FPA supports the reproductive rights of all people. We believe it is a pregnant persons right to choose whether or not they continue with a pregnancy.

A note on terminology

FPA is a pro-choice organisation which supports the reproductive rights and freedom of individuals. People who don't support the reproductive rights of pregnant people shouldn't be described as pro-life but rather as anti-choice.

What do we believe?

1. **Abortion is an essential part reproductive health. It should not be considered or implied to be a criminal act. We believe abortion should be removed from criminal law in all parts of the UK, and should be regulated as a healthcare procedure, with the final decision resting with the pregnant person.**
2. **Regulation of abortion should be in the best interests of pregnant people and abide by standards of best clinical care. It should trust pregnant people to decide what is best for them and allow healthcare professionals to practice without fear of punishment.**
3. **Pregnant people should be able to access an abortion through self-referral or with a referral from a GP. It's not necessary for two doctors to approve an abortion.**
4. **All pregnant people have the right to confidential, non-directive, accurate and up-to-date information about abortion.**
5. **All pregnant people seeking an abortion should be offered a choice of methods and procedures in a supportive and non-directive way, with all options fully explained.**
6. **Free, non-directive pregnancy counselling and post-abortion counselling should be accessible to everyone who wants or needs it.**
7. **Having taken the decision to end a pregnancy, pregnant people should be able to access abortion services promptly and without delay. We recommend that there should be a target waiting time of 72 hours after they have been referred for an abortion, and people should not have to wait longer than one week.**

8. All pregnant people should be able to access local NHS-funded abortion services appropriate for their stage of pregnancy, regardless of where they live in the UK.
9. When having an early medical abortion (EMA), a pregnant person should be able to choose where they take the second stage of medication, including at home if they wish and with easy access to ongoing medical support if required.
10. Nurses and midwives, with the appropriate qualifications and training, should be able to perform EMAs.
11. While we support the right to protest, we believe pregnant people have the right to access abortion and counselling services free from the threat of intimidation, harassment and assault.

Why do we believe this?

1. ***Abortion is an essential part of reproductive health. It should not be considered or implied to be a criminal act. Abortion should be removed from criminal law in all parts of the UK. Abortion is, and should continue to be, regulated as a healthcare procedure, with the final decision resting with the pregnant person.***
2. ***Regulation of abortion should be in the best interests of pregnant people and abide by standards of best clinical care. It should trust pregnant people to decide what is best for them and allow healthcare professionals to practice without fear of punishment.***
3. ***Pregnant people should be able to access an abortion through self-referral or with a referral from a GP. It is not necessary for two doctors to approve an abortion.***

In 1967, Parliament passed the [Abortion Act](#), with the aim of limiting the injury caused through illegal abortions. The Act applies to England, Wales and Scotland. It does not extend to Northern Ireland.

Rather than making abortion legal, the Act makes exceptions to the 1861 [Offences Against the Person Act](#), which made having or providing an abortion a crime carrying a potential life sentence. The Abortion Act means two doctors can legally authorise an abortion, as long as certain requirements are met. As a result, the decision to have an abortion does not legally lie with the individual, but with the doctors acting on their behalf.

If a pregnant person induces a miscarriage without this authorisation, they could face life imprisonment. A doctor who induces an abortion without authorisation may also face imprisonment. We believe no pregnant person or doctor should face legal threat for accessing or providing safe abortion care.

Rather than operating through this paternalistic framework which is increasingly out of step with the growing emphasis on patient autonomy elsewhere in medicine, FPA believe abortion should be decriminalised and services should be governed by the same regulatory and ethical frameworks as all other medical procedures.

Decriminalisation must extend to Northern Ireland. At present reproductive rights are covered by sections 58 and 59 of the [Offences Against the Person Act 1861](#) and section 25 of the [Criminal Justice Act \(Northern Ireland\) 1945](#).

As a result of this legislation, reproductive freedom in Northern Ireland is limited in all but the most exceptional circumstances. **Rape, incest and fatal foetal anomaly** are not circumstances in which a person can exercise their reproductive rights. What's more, section 5 of the [Criminal Law Act \(Northern Ireland\) 1967](#), creates the offence of withholding information if a person knows or believes an offence has been committed. This places healthcare professionals at risk of prosecution if they fail to disclose knowledge of an illegal abortion, thus breaching patient confidentiality.

The final decision regarding an abortion should rest with the pregnant person. Whilst we recognise many partners and fathers wish to be involved in the decision-making process, we don't believe a pregnant person should be forced to continue or to end a pregnancy against their wishes.

We fully support education regarding abortion as part of comprehensive relationships and sex education so all people are able to fully understand their options and partners are able to be supportive, whatever the outcome of a pregnancy.

4. ***All pregnant people have the right to confidential, non-directive, accurate and up-to-date information about abortion.***
5. ***Pregnant people seeking an abortion should be offered a choice of methods and procedures in a supportive and non-directive way, with all options fully explained.***
6. ***Free, non-directive pregnancy counselling and post abortion counselling should be accessible to all individuals who want or need it.***



the sexual health charity

FPA provides the only non-directive pregnancy choices and post-abortion counselling service in Northern Ireland. The central principle is to enable pregnant people to make informed choices that are best for them, and we believe everyone should receive the same standard of care wherever they seek information and support.

We believe there should be a universal offer of free non-directive counselling for those who want or need it.

However, it should not be a mandatory element of the abortion pathway. The Royal College of Obstetricians and Gynaecologists [says](#), 'Women who are certain of their decision to have an abortion should **not** be subjected to compulsory counselling' however, 'healthcare staff caring for women requesting abortion should identify those who require more support in the decision-making process.'¹

In 2014, the young people's sexual health charity Brook undertook [research](#) on unregulated crisis pregnancy centres (CPCs). Information given by these centres is not subject to government regulations. In the UK they have a history of being funded by or affiliated with anti-choice groups. Brook's report found that misinformation was widespread.²

FPA believes that the NHS shouldn't signpost to CPCs and is in favour of clear, nondirective information and counselling, allowing pregnant people to make a fully informed decision, with appropriate support as required.

- 7. *Having taken the decision to end a pregnancy, pregnant people should be able to access abortion services promptly and without delay. We recommend that there should be a target waiting time of 72 hours after they have been referred for an abortion. People should not have to wait longer than one week.***
- 8. *All pregnant people should be able to access local NHS-funded abortion services appropriate for their stage of pregnancy.***

Despite being part of the UK, the 1967 Abortion Act only covers England, Scotland and Wales. This means pregnant people in Northern Ireland are unable to access local NHS funded abortion services. In fact, between 2016/17 only 13 abortions were carried out in Northern Ireland.³ At least 919 women travelled to England and Wales to access an abortion in 2017.⁴

Even in England, Scotland and Wales, people may need to travel to another area due to limited services where they live, which can cause delays in accessing an

¹ RCOG, [The Care of Women Requesting Induced Abortion \(Evidence-based Clinical Guideline No. 7\)](#), 2011

² Brook, [Highlighting misinformation, bias, and poor quality practice in independent pregnancy counselling centres in the UK](#), 2014

³ Department of Health (NI), [Northern Ireland termination of pregnancy statistics, 2016/17](#), January 2018

⁴ Department of Health, [Abortion Statistics, England and Wales: 2017](#), June 2018

abortion. EMA is, for example, the only method available for those living in North Wales, so those more than nine weeks pregnant have to travel to Liverpool to access an abortion.

The problem is greater when a person is seeking an abortion later in pregnancy, due to a limited number of clinics offering late-term abortions in the UK. In Scotland, the problem is even more pronounced. A 2017 study by Purcell et al found Scottish women seeking terminations for non-medical reasons from 18-20 weeks usually have to travel to England.⁵ This isn't a result of the law, but rather due to lack of trained clinicians and independent providers operating in the nation. This means that people from Scotland have to travel to England in later stages of pregnancy to access services, paying the costs. Although local NHS Boards offer reimbursement, many do not know that this is a possibility and the Purcell study found none of those interviewed knew how to claim.

Whilst the vast majority of abortions in England and Wales are paid for by the NHS and Department of Health statistics from 2017 show that the NHS funded 98% of abortions performed in England and Wales,⁴ private providers currently deliver the majority of late abortion services. The British Pregnancy Advice Service and Marie Stopes, for example, carry out almost 80% of abortions taking place between 20 weeks and 23 weeks and six days' gestation in England and Wales.⁶

In 2017 Westminster announced that people from Northern Ireland will be entitled to free abortions in England. The government also announced "hardship" grants for those who meet the financial criteria. Whilst this is welcome, it is neither a long-term solution nor a substitute for comprehensive reform of the law. What's more, people who do not qualify for the "hardship" grant are left out of pocket by having to fund the cost of traveling to England or Wales, as well as any accommodation that is required.

FPA believes that pregnant people who want to pay for a private abortion should always have the option if they wish. However, access to abortion shouldn't be limited by ability to pay and everyone should be able to access free abortion care locally through the NHS.

We believe the NHS should be offering abortion services with a more even geographic spread, so people do not have to travel so far from home.

The NHS should also prioritise training for healthcare professionals around later stages of pregnancy to ensure there are enough trained doctors to staff regional abortion services at this gestation. While we recognise the rights of healthcare workers to conscientiously object to participating in the process of abortion, we

⁵ Purcell C, et al, [Access to and Experience of Later Abortion: Accounts from Women in Scotland](#), Perspective of sexual and reproductive health, 2014

⁶ Department of Health, [Abortion Statistics, England and Wales: clinic data tables](#), June 2018

agree with the World Health Organisation [statement](#) that ‘that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women.’⁷

- 9. When having an early medical abortion (EMA), pregnant people should be able to choose where they take the second stage of medication. This should include taking the medication at home if they wish. People should have easy access to ongoing medical support if required.**

EMA involves taking two sets of tablets, firstly mifepristone and secondly misoprostol 24 to 48 hours apart in order to induce a miscarriage. It is available for the first 9 weeks of pregnancy.

The risks of EMA are extremely low and, with the right support, it isn’t medically necessary for a pregnant person to take the second part of treatment, misoprostol in a medical setting.

However, unless performed in an emergency, section 1 (3) Abortion Act states that all abortions must take place in an NHS hospital or a place approved by the Secretary of State.⁸ FPA believes this isn’t necessary.

In October 2017, Scotland's Chief Medical Officer, Dr Catherin Calderwood, wrote to all health boards to say the drug misoprostol had been approved for the “second stage of early medical abortion treatment in a patients home in certain circumstances”.⁹ In June 2018 the Welsh government also issued guidance to health boards to allow for the home use of misoprostol.¹⁰ In August 2018 the UK Government also announced that “Women in England will be allowed to take the second of 2 early medical abortion pills in their own home”.¹¹

FPA supports these steps, and believes that provided they are given the right advice and medical support is available, pregnant people should be able to choose where an abortion takes place.

- 10. Nurses and midwives, with the appropriate qualifications and training, should be able to perform early medical abortions.**

2014 [guidance](#) issued by the Department of Health clarified that, under the 1967 Abortion Act, a doctor only needs to approve and begin a termination.¹² The rest

⁷ WHO, [Safe abortion: technical and policy guidance for health systems](#) (second edition), 2012

⁸ Section 1 was amended by s.37(2) of the Human Fertilisation and Embryology Act 1990 to insert subsection (3A), which extends the power under s.1(3) to enable approval for a class of places.

⁹ Letter from Chief Medical Officer, [ABORTION – IMPROVEMENT TO EXISTING SERVICES – APPROVAL FOR MISOPROSTOL TO BE TAKEN AT HOME](#), October 2017

¹⁰ BBC News, [Women allowed to take abortion pill at home in Wales](#), June 2018

¹¹ Department of Health and Social Care, [Government confirms plans to approve the home-use of early abortion pills](#), 2018

¹² DH, [Guidance in Relation to Requirements of the Abortion ACT 1967](#), May 2014

of the procedure can then be carried out by nurses or midwives. This followed the Royal College of Nursing's call for a change in the law to allow nurses to fully provide abortions induced by drugs. A spokesman for the Department of Health said nurses and midwives can 'administer abortion drugs' if doctors remain 'in charge throughout'.

FPA believes that appropriately trained nurses and midwives should be able to perform EMAs independently. By increasing the number of trained staff, access to EMA will improve and delays will be reduced. This is particularly important, given that the British Medical Association (BMA) states EMA is 'medically safer' than abortion that takes place after 9 weeks of gestation.¹³

11. *While we support the right to protest, we believe pregnant people have the right to access abortion and counselling services free from the threat of intimidation, harassment and assault.*

In the UK, there's been an increase in anti-choice groups protesting outside of clinics. This frequently involves displaying images of aborted fetuses, the distribution of leaflets containing misinformation about abortion and challenging and following service users and their family and friends as they enter and leave health services.

Anti-choice protestors have gathered daily outside FPA's office in Belfast for the past 20 years and people using our pregnancy choices and post-abortion counselling service have reported feeling distress, anger and frustration. To date, not one service user has said they found the presence of protestors helpful or supportive.

Whilst we support the freedom of speech of anti-abortion protestors, we believe the space outside of a clinic is not the appropriate location to oppose abortion provision and services users and staff should be protected.

FPA believe the UK government should do more to protect people seeking an abortion from reproductive harassment and bullying, by establishing safe zones outside care clinics and pregnancy counselling centres.

12. *As part of relationships and sex education / relationships and sexuality education at school, all young people should learn about pregnancy choices and be given consistent, evidence-based information about abortion, adoption and becoming a parent.*

Abortion is often only presented as a moral or ethical issue in school lessons, for example in religious studies. We believe that while young people should be given a safe space to explore how they feel about different pregnancy choices, they should always be in a position to make informed choices about pregnancy and

¹³ BMA, [Law and ethics of abortion: BMA views](#), November 2014 (Updated November 2017)

abortion. Evidence-based, non-biased information should be a part of a compulsory relationships and sex education curriculum in all schools.

Further resources

- [FPA Policy Statement: Relationships and Sex Education](#)
- [FPA and Brooks' guidance on decision-making support within the integrated care pathway for women considering or seeking an abortion](#)
- [FPA's abortion factsheet](#)

Additional reading

- ['The Law and Ethics of Abortion', the British Medical Association's view](#)
- ['Safe abortion: technical and policy guidance for health systems', World Health Organisation](#)
- ['The Care of Women Requesting Induced Abortion', Royal College of Obstetricians and Gynaecologists clinical guidance](#)