Response ID ANON-YJP1-GGSC-8

Submitted to **A new legal framework for abortion services in Northern Ireland - Implementation of the legal duty under section 9 of the Northern Ireland (Executive Formation etc) Act 2019**
Submitted on **2019-12-16 17:05:29**

Introduction

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Section 1 - Legislative Changes

SECTION 2.1, Part 1 - Early terminations of pregnancy

Question 1a: Should the gestational limit for early terminations of pregnancy be up to 12 weeks gestation (11 weeks + 6 days)?

Not Answered

Question 1b: Should the gestational limit for early terminations of pregnancy be up to 14 weeks gestation (13 weeks + 6 days)?

Not Answered

If you answered no to 1a and 1b, what alternative would you suggest?:
Early Termination of Pregnancy and Sexual Crime
Pregnancy as a result of a sexual crime should always have the option of abortion. However, it is difficult to adequately legislate without causing further trauma to the victim, as the experience of the Isle of Man can attest to; where they attempted introducing a clause for rape and sexual crimes that was so difficult to meet that such victims continued to have to travel to GB (Isle of Man Government, 2017). Evidence from our partners such as BPAS and the Abortion Support Network (ASN) who regularly deal with victims of sexual crime attests to the complex reasons why someone might not be able to access an abortion until the second trimester. Unrestricted access works best in for pregnancy as a result of sexual crime, AfC therefore does not believe that 14 weeks is long enough to best serve everyone including the most vulnerable or marginalised.

Unrestricted early access to abortion services without any certification requirements is important and will meet the needs of around 90% of all women and pregnant people seeking abortions. However, inserting an additional and arbitrary gestational limit on abortion on request breaches the CEDAW recommendations referenced in the Statutory Insrument. Firstly it would breach the requirement for evidence-based protocols in Para. 85 (d) as it has no basis in medical recommendations or human rights recommendations, it would also breach Para. 85 (a) 2., by creating a sub-regulatory potential for criminalisation, it would breach Para. 59 by creating stigma around specific grounds and it could mean that those who failed to meet the time limits would be forced to travel, which would breach the greatest substance of the 2018 CEDAW Inquiry Report. (OHCHR CEDAW 2018)
AfC agree that restricting abortion access only to victims of sexual crime would be impossible to effectively regulate and has the potential to cause additional trauma to victims. Therefore unrestricted early access is the only way to satisfy the sexual crime element of the CEDAW recommendations. The law before decriminalisation was problematic as described in the IOM Consultation;

“There was also a provision for victims of rape, but only up to 12 weeks and only if the woman reported the assault to the police and signed an affidavit. Even then, an abortion would only be allowed if the doctors involved believed the woman, which could cause unnecessary distress.” (Isle of Man Govt. 2017).

The proposed limits of either 12 or 14 weeks are too restrictive to meet the needs of vulnerable women and pregnant people as the complexity of sexual abuse, domestic abuse, reproductive coercion or trauma could make it harder to access abortion services early in the pregnancy. Additionally, a higher number of young people and children access abortion at a later date, especially when it is due to a sexual crime, because of social stigma and fear of parents/community. Other marginalised groups such as lesbian and bisexual women, (Hodson et al 2018) trans men and non-binary people, (Hall et al., 2014) prisoners, migrants (Lara, Holt, Pena & Grossman) and disabled people, face greater levels of sexual violence and abuse, (Barrett, O'Day, Roche and Carlson, 2009) and also face greater challenges accessing healthcare when needed (Silvers, Francis, and Badesch, 2016)

We request unrestricted access to abortion up until the point of viability as outlined in the B section (currently 24 weeks in the rest of the UK), so as to ensure that no victim of a sexual crime, and especially that no-one with intersecting marginal positions will be forced to travel to GB for a termination.

Given the absence of criminal law from this point we believe this should be provided without certification by doctors. We accept that in cases that are closer to the upper gestational limit the medical professionals involved in the abortion care would need to verify the length of the pregnancy, but this does not need to be any

different to routine maternal healthcare dating technologies and with no additional certification.

Examples of ASN Clients presenting past 12 weeks gestation:

A migrant living in Ireland who recently lost her job and is ineligible for any benefits. She was 14 weeks when she contacted us. Her best friend is aware of the pregnancy and supportive.

“Please call me back, I am 12 weeks pregnant and I don’t have any money and I can’t have it done in Ireland.” We spoke to this client several times, but by the time she was able to arrange to travel over, she was over 14 weeks pregnant.

A woman who was pregnant despite having semi-regular periods. In fact, she was 17 weeks pregnant, which completely shook her, especially as she waited 2 weeks to get a dating scan. She has children already, but no passport, and we were able to give her advice on clinics and which airlines will let her fly with alternative forms of ID*.

A young woman told by a place in Ireland that she was 15 or 16 weeks but when she came over, she scanned over 18 weeks and there was no doctor at the clinic on that day to treat her.

"Please could you tell me the least expensive clinic where I am eligible for an abortion. I am 34 years old and 12 weeks 2 days pregnant… I already have children including a young baby and my partner abandoned us. I am also the sole carer for my terminally ill mother and can’t afford to pay a nurse for more than one day while I am gone.”

“I have just found out I am 12 weeks and two days pregnant and so I cannot have an abortion in Ireland. I had taken the medical abortion pills with my GP and this failed…No one else can know about this pregnancy.”

A woman who went to a rogue crisis pregnancy centre told her she was more than 12 weeks pregnant and to start taking ante natal vitamins. By the time she went to her GP to confirm several weeks later, having been 9 weeks along when she went to the rogue CPC, she was 12 weeks 2 days. Rogue agencies have delayed at least four ASN clients.

Below is a woman’s individual experience of the stress 14 week limits can cause at a proportionally higher rate to young women, pregnant people and children (as submitted to the Women and Equalities Committee Inquiry in 2018/19).

“I was 17. He was 18. We travelled to London and when I got to the clinic I was starving as we couldn't afford to spend any of the money on food. It all had to go on the abortion. I had a scan at the clinic and I couldn't look at the screen. The nurse then disappeared from the room and came back in with a doctor. They told me I was 5 weeks further along than I'd calculated. It was going to cost an extra £600 to have a termination as planned. I broke down in tears, I couldn't afford it. What would we do?

I wrote my parents a letter to tell them as I couldn't face it. My mum went mental. Why didn't I tell her? By this stage I was 14 weeks pregnant. My mum phoned the GP surgery and they could offer no advice. Eventually a receptionist gave us a page number of the yellow pages to look up but wouldn't tell us what we were looking for. We phoned Marie Stopes and got an appointment.

The journey, the return visit to the clinic, afterwards on the plane I was in so much pain. So much of it is now a blur. I put it down to how people who experience a huge trauma block it out of their mind. I was the same. I returned broken with no self-esteem, ashamed and absolutely lost. My parents were amazing. I am not sure what I would have done without them.”

Sources for this section:
Isle of Man Abortion reform Consultation response, https://consult.gov.im/office-of-the-clerk-of-tynwald/abortion-reform-bill-2017/
Shaw, D. and Norman, W.V., 2019. When there are no abortion laws: A case study of Canada. Best Practice & Research Clinical Obstetrics & Gynaecology.
CEDAW Inquiry Report on UK Abortion in NI 2018
https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/GBR/INT_CEDAW_ITB_GBR_8637_E.pdf
A systematic worldwide study (Hodson et al 2018 doi:10.1111/1471-0528.14449), including reports from the UK, found that there was a statistically significant higher rate of pregnancy in adolescent lesbians and bisexual women
Silvers, A., Francis, L.P. and Badesch, B., 2016. Reproductive rights and access to reproductive services for women with disabilities.
Barrett, K.A., O'Day, B., Roche, A. and Carlson, B.L., 2009. Intimate partner violence, health status, and health care access among women with disabilities.
Hall M, Chappell LC, Parnell BL, Seed PT, Bewley S (2014) Associations between Intimate Partner Violence and Termination of Pregnancy: A SystematicReview and Meta-Analysis. PLoS Med 11(1): e1001581. doi:10.1371/journal.pmed.1001581
Knowledge of abortion laws and services. Diana Lara, Kelsey Holt, Melanie Pena, Daniel Grossman. Journal of Immigrant and minority health.

Section 2.1, Part 2 -Early terminations of pregnancy

Question 2: Should a limited form of certification by a healthcare professional be required for early terminations of pregnancy?

No

If no, what alternative approach would you suggest?:
Abortion care should be treated as part of sexual and reproductive health services to reduce stigma and an informed consent model should be used for care; women and pregnant people can come to this decision after a consultation with a healthcare professional and do not require ‘permission’ for access to care. There is a lack of scientific evidence for the requirement to ‘certify’ an abortion and therefore any legal requirement to do so would contravene Paragraph 85(d) of the CEDAW report.
■ Healthcare should be treated as a partnership with patients, there is no evidence to suggest that certification adds more rigour or safeguards for women and

pregnant people.
■ There should be no mandatory waiting period for access to services, rightly none has been suggested, however consideration should be given to the systematic 'built-in' waiting periods can occur because of non-pragmatic subsidiary legislation, NHS underfunding, lack of medical providers willing to give abortion care or via doctor appointment waiting period.

2.2 - Gestations beyond 12 or 14 weeks

Question 3a: Should the gestational time limit in circumstances where the continuance of the pregnancy would cause risk of injury to the physical or mental health of the pregnant woman or girl, or any existing children or her family, greater than the risk of terminating the pregnancy, be 21 weeks + 6 days gestation?

Not Answered

Question 3b: Should the gestational time limit in circumstances where the continuance of the pregnancy would cause risk of injury to the physical or mental health of the pregnant woman or girl, or any existing children or her family, greater than the risk of terminating the pregnancy, be 23 weeks + 6 days gestation?

Not Answered

If you answered 'no' to both of the above, what alternative provision do you suggest?:
The consultation document says very little about how the risk to physical or mental health would be assessed. It is possible that this criteria could be interpreted very conservatively by service providers and end up heavily restricting access to 2nd trimester abortions.
There is a body of evidence suggesting that doctors and other health professionals in Northern Ireland are not well trained in mental health (Participation and the Practice of Rights, 2018) and do not take women's mental health concerns seriously. For example, the report 'Women's Views on Health Service Provision in the Perinatal Period' (WRDA, 2019) contains feedback from women who experienced poor levels of care relating to perinatal mental health issues including a dismissive attitude from GPs with some feeling that GPs 'didn't really understand perinatal mental health, played down their concerns or asked unhelpful questions.' One participant in the focus groups remarked 'you'd have to have a complete breakdown in their office before they'd take you seriously' when discussing a commonly expressed view that GPs acted as 'gatekeepers' to mental health services.
AfC is concerned that access to abortion on the grounds of mental health could end up being severely restricted in practice despite the CEDAW requirement that the threshold should be lowered. Whilst the law in GB also makes provision only where continuing the pregnancy risks causing 'injury to the physical or mental health' of the woman or pregnant person, this ground also includes considerations of the person's social circumstances and risks to 'any existing children of her family'. It has therefore allowed for a broad application of the health grounds and ensured access up to 24 weeks in most if not all circumstances. AfC are seeking assurances that the NIO give that the application of health grounds in Northern Ireland will not lead to such restricted access that many people will continue to travel to GB. For example, if delays arise due to refusal of care, an ineffective medical abortion (i.e. pills not working) or being unaware of the pregnancy, or if someone experiences a sudden change of life circumstances such as loss of employment or a family member becoming ill or dying.

Sources used in this section:
Participation and the Practice of Rights (2019) 'Counselling - A Vital Tool: Equipping GPs With Mental Health Expertise'
https://www.pprproject.org/sites/default/files/documents/%23123GP%20Report%20FINAL_0.pdf

Gestation beyond 12/14 weeks
Due to the absence of anomaly testing at 12 weeks in Northern Ireland, many severe abnormalities are not detected until the 20 week scan, which may not happen until 21-22 weeks because of staff and clinic availability. If an abnormality is detected a referral can be made to the Foetal Medicine Unit for further scans and tests. Depending on appointment availability this could potentially take another week to 10 days (NOTE - some have experienced up to 10 days to get the first appointment and a further 10 days for the second because of consultants on annual leave). Following that appointment further specialist testing may be recommended such as an amniocentesis or NIPT which would require waiting for a further appointment and then the test results will take some time to come back. The test may need to be repeated if it doesn't work initially . Following this the pregnant person must be able to take whatever time they need to consider all the information they have and make a decision without being put under pressure by a deadline. Again we advocate that time limits are prohibitive to access.

2.3 - Fetal Abnormality

Question 4a: Should abortion without time limit be available for fetal abnormality where there is a substantial risk that the fetus would die in utero (in the womb) or shortly after birth?

Not Answered

Question 4b: Should abortion without time limit be available for fetal abnormality where there is a substantial risk that the fetus if born would suffer a severe impairment, including a mental or physical disability which is likely to significantly limit either the length or quality of the child's life?

Not Answered

If you answered 'no' to either or both of the above, what alternative provision do you suggest?:
It is important to remember that the CEDAW committee clearly requires access where the abnormality is 'severe' and not just 'fatal'. This will be important to those whose diagnosis brings with it difficult conversations about the odds of survival or the possibility of serious impact on length or quality of life. In the south of Ireland where only fatal anomalies are provided for, many families receiving devastating news are still having to travel due to the restrictive definition of 'fatal' contained within the regulations.
We have already talked about why it is important to provide access after 24 weeks in the previous question. When it comes to fetal anomaly these tend to be the most difficult, complex cases and it is important that families in that situation are not put under undue pressure when they are experiencing a terrible loss. We

have also noted that a very small number of abortion take place after this limit in GB; just 283 last year, and a number of these were families from Ireland north and south who had received a late diagnosis. With access to earlier screening and local abortion services, the number of post-24 week abortions could be reduced.
AfC believes that abortion should be available after the 24 week limit in both cases of fatal and serious foetal abnormality, as is required by the CEDAW committee.
In addition, AfC is guided by the principles of reproductive justice. This means that we do not look at abortion rights in isolation from the other inequalities that affect people's lives. Taking this approach means we are mindful of two issues when it comes to abortion and disability:
1. Disabled women and people who can become pregnant face particular barriers to getting the reproductive healthcare they need. There is a legacy of abusive reproductive policy aimed at disabled people such as forced sterilisation in many countries, including our own. It is vital that the autonomy of disabled people is respected and any barriers are removed. Disabled people's groups have recently spoken out against the co-option of their lives and identities by anti-choice campaigners, for example, Down's Syndrome Ireland publicly supported the 'yes' campaign in the referendum to repeal the 8th in the south.
2. Disability discrimination and lack of state support can impact on decisions about some pregnancies. Based on feedback from families we recognise the need for doctors and other healthcare professionals to be better educated on some conditions and provide families with access to balanced information about quality-of-life implications. For example, in Iceland with every diagnosis of Down's Syndrome the family is offered the opportunity to meet with a nurse who works in this field and to spend time with a family who have a child with the condition in order to get more holistic information about the positive and negative aspects of the diagnosis. We also call on the government to stop its horrific programme of cuts to the living allowances of children and adults with disabilities and to invest in support services. For genuine choice to be available to families we need a society where disabled people are valued and supported.

Below is part of a testimony from one of our members who tried to access abortion for a foetal anomaly diagnosis and was unable to be treated even in Engliand:

"I found out during my 20 week scan that my baby had a condition that appeared to be incompatible with life. I was referred to the foetal medicine unit at the Royal hospital in Belfast for a second opinion.There were delays on this appointment due to specialists on annual leave so it wasn't until 10 days after we initially had the 20 week scan. That consultant said that he agreed with what had been seen at the previous scan however he advised us to have a follow up appointment the following week to have another opinion. Again, this follow up appointment was delayed and I wasn't seen for another 10 days. The consultant at that appointment was much more clear and firm in her diagnosis, said that our baby did have a condition that was incompatible with life and that she would be happy to sign off on a termination. However, as this was not the hospital that I was under I had to have a further appointment back at my own hospital to discuss the next steps. This was arranged for the following day. My husband and I discussed what we believed to be our options at length that evening and after many hours and tears we decided that the best option for us was to have a termination.
We got to our local hospital the following day and we told the consultant that we saw that we wanted to have a termination. She replied, "Well that's not going to happen." I told her that the consultant from the Royal that we had seen in the foetal medicine unit said we could have one here and the consultant said,"Well I have friends in the Royal and that doesn't happen." I asked her what our options were and she responded, "Well the pregnancy would continue as normal."
I was extremely upset and frustrated that we had been told one thing by one doctor who seemed to want to help us but couldn't yet a doctor that could help us didn't appear to want to. The consultant finally conceded, "Well you could go down the Marie Stopes route." …
We left that appointment distraught and frustrated because we felt that we had arrived at the heartbreaking decision to have a termination of a much-wanted baby, an option that we didn't want to have to take but felt it was the best option for us, only to have that option snatched away from us coldly and without compassion. Following that awful appointment, my husband and I talked and agreed that we would scrape together the money for the procedure and travel costs to England and have a termination there. This was extremely upsetting as I was terrified of travelling to a strange hospital in a strange town for a traumatic procedure and being separated from my support network of family and friends. I googled Marie Stopes England and rang the first number that came up. I said that I needed a termination. The person on the other end of the phone asked me how many weeks pregnant I was, I replied I was 23 weeks and 6 days. The person on the phone said, "I'm so sorry but we can't help you, the procedure has to be carried out before you are 24 weeks pregnant." I started to cry and hung up the phone."

2.4 - Risk to the woman or girl's life or risk of grave permanent injury

Question 5a: Do you agree that provision should be made for abortion without gestational time limit where there is a risk to the life of the woman or girl greater than if the pregnancy were terminated?

Not Answered

Question 5b: Do you agree that provision should be made for abortion without gestational time limit where termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman or girl?

Not Answered

If you answered 'no' to either or both of the above, what alternative provision do you suggest?:
In considering this issue of health in pregnancy, it is vital to acknowledge that pregnancy in itself can be unsafe and problematic for many women, girls and pregnant people. This is well-evidenced, with a study by Raymond and Grimes (2013) highlighting the key trends. The authors identified that in a study of 24,481 pregnancies: "Every complication was more common among women having live births than among those having abortions. The relative risks of morbidity (illness) with live birth compared with abortion were 1.3 for mental health conditions, 1.8 for urinary tract infection, 4.4 for postpartum hemorrhage, 5.2 for obstetric infections, 24 for hypertensive disorders of pregnancy, 25 for antepartum hemorrhage, and 26 for anemia. In a analysis of seven years of data in the USA the authors concluded that legal induced abortion is markedly safer than childbirth. The risk of death associated with childbirth is approximately 14 times higher than that with abortion. Similarly, the overall morbidity associated with childbirth exceeds that with abortion". As Pierson and Bloomer (2018) state the recognition of the higher risk of childbirth over abortion is often lacking in a consideration on abortion. Within this lies the assumption "that abortion is always in some way a traumatic event that must have physical and mental health consequences on those who have an abortion. Assuming abortion to be traumatic continues to position it as the worst possible outcome for any woman and attempts to scare-monger those women who may be considering abortion by questioning their future heath. However, in reality what contributes to ensure that abortion has negative health consequences is to make it illegal and / or inaccessible, forcing women to travel, and / or to access unregulated medication or unregulated abortion services."

Risk to life/ grave permanent injury

Recommendations on gestational limits on the provision of aboriton in cases of risk to life / grave permanent injury were not included in the CEDAW report. CEDAW did specifically state that abortion should be provided in cases of: 'threat to the pregnant woman's physical or mental health without conditionality of "long-term or permanent" effects' (para 85bi). Provision in cases of risk to life is accepted grounds without gestational limit worldwide, save for a small number of countries (Singh et al 2018).

González Vélez's (2012) research with providers determined that "The application of the health exception when a woman's mental health is affected is considered by providers as part of a comprehensive understanding of the concept of health. Women should make the decision about abortion when their health is at risk. The woman is the one who has to decide how much risk she is willing to assume and how much injury she is willing to accept."

On mental health grounds, the World Health Organisation advises that "The scope of mental health includes psychological distress or mental suffering caused by, for example, coerced or forced sexual acts and diagnosis of severe fetal impairment. A woman's social circumstances are also taken into account to assess health risk" (WHO, 2012).

Examples of this include Kenya, wherein there is danger to the pregnant person's "life or health" it is recommended that determination should be carried out by a trained health professional in consultation with the patient; no other health providers are required for this assessment. Thus mental health specialists such as psychiatrists are not required to be consulted on for such as assessment. (Cook et al, 2006; Centre for Reproductive Rights, 2013).

The Centre for Reproductive Rights, (2013) advises that "determining whether a pregnant woman meets the mental health indication for a lawful abortion is a multi-step process that requires careful consideration of the individual woman's circumstances". This includes consideration of:

The risk of future negative mental health outcomes. a. Is there reason to believe that continuation of the pregnancy would endanger the pregnant person's future mental health? (vulnerability, Bereavement, Termination of a significant intimate relationship, loss of employment; poverty, lack of social support). OR b. Are there pregnancy-related factors or adverse social circumstances that appear so distressing as to be likely to cause depression or another psychiatric illness? (Pregnancy resulting from rape or incest; Diagnosis of harmful foetal conditions; Adolescent pregnancy; Pregnancy outside of marriage).

Acute risk of suicide a. Does the patient have an immediate intent to harm themselves? b. Do they have a specific suicide plan in mind?
Current serious and/or chronic mental illness
Does the patient have a mental illness (e.g., depression, schizophrenia, or bipolar disorder)? b. If yes, does the patient feel they are able to parent a child? i. If the answer is no, then a termination of pregnancy on mental health grounds is permitted.

AFC response
Provision of abortion in cases of risk to life should be allowed without gestational limit.
On mental health grounds assessment should follow that recommended by the Centre for Reproductive Rights, that the determination should be made between the patient and a health professional; mental health specialists such as psychiatrists are not required to be consulted on for such as assessment.
Mental health grounds should allow for 3 broad grounds: risk of future negative mental health outcomes if the pregnancy continued; acute risk of suicide; current serious and/or chronic mental illness.

Sources for this section:

● Centre for Reproductive Rights (2013) Understanding the Mental Health Indication for Legal Abortion https://reproductiverights.org/sites/default/files/documents/Kenya%20Mental%20HealthAbortion%20Fact%20Sheet.pdf
● Cook, Rebecca et al., (2006).Legal Abortion for Mental Health Indications, 95 Int'l J. GynecoloGy & obstetrIcs 185, 188
● Susheela Singh,Lisa Remez,Gilda Sedgh,Lorraine Kwok and Tsuyoshi Onda (2018) Abortion Worldwide 2017: Uneven Progress and Unequal Access, Guttmacher Institute, https://www.guttmacher.org/report/abortion-worldwide-2017
● WHO (2012) safe abortIon: tecHnIcal and PolIcy GuIdance for Health 13 systems
● González Vélez, A.C., 2012. "The health exception": a means of expanding access to legal abortion. Reproductive health matters, 20(40), pp.22-29.
● Raymond, E.G. and Grimes, D.A., 2012. The comparative safety of legal induced abortion and childbirth in the United States. Obstetrics & Gynecology, 119(2), pp.215-219.
● Pierson C. and Bloomer F, (2018) Anti-abortion myths in political discourse. In: McQuarrie C, Pierson C, Bloomer F, Stettner, S (editors), Crossing Troubled Waters: Abortion in Ireland, Northern Ireland, and Prince Edward Island, Prince Edward Island: Prince Edward University Press

2.5 - Who can perform a termination

Question 6: Do you agree that a medical practitioner or any other registered healthcare professional should be able to provide terminations provided they are appropriately trained and competent to provide the treatment in accordance with their professional body's requirements and guidelines?

Not Answered

If you answered 'no', what alternative approach do you suggest?:
■ Abortion care should be treated like all other forms of sexual and reproductive healthcare and should be framed within an informed consent model.
■ Abortion care services in countries such as Sweden and Scotland are led by nurses and midwives, which may provide a better use of staffing resources (Bloomer et al, 2018).
■ Use of nursing and midwifery staff has been recommended in the NICE Guidelines, published in September 2019, and is recommended in World Health Organisation Guidance
■ There is a need for a change in medical, nursing and midwifery education to reflect the provision of abortion care as part of sexual and reproductive healthcare services.
■ Providers should be protected by their healthcare trust and union against any discrimination.
■ Conscientious commitment to providing services should be promoted as providing holistic care for women and pregnant people.
Without the constraints of the 1967 Abortion Act, there is now scope to develop a fully nurse-led early medical abortion service within SRH services in NI. A

flexible model of service delivery, whereby trained and competent health professionals could provide abortion treatment would be hugely advantageous in improving access and providing a cost-effective service. Nurses can also be trained to independently provide LARC, an important aspect of abortion care.

Sources for this section:

https://www.nice.org.uk/guidance/ng140/chapter/Recommendations

https://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf;jsessionid=DED576AC1D774759BE69069939CD0629?sequence=1

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6260173/

https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf?sequence=1

2.6, Part 1 - Where procedures can take place

Question 7: Do you agree that the model of service delivery for Northern Ireland should provide for flexibility on where abortion procedures can take place and be able to be developed within Northern Ireland?

Not Answered

If you answered 'no', what alternative approach do you suggest?:
■ Early medical and surgical abortion can be managed at a primary care facility level, which can include sexual and reproductive healthcare /family planning clinics, general practice surgeries.
■ Misoprostol has been cleared for home use in England, Scotland and Wales, providing more options for women and pregnant people to make decisions over their surroundings for the procedures
■ Telemedicine and home use of both mifepristone and misoprostol has proven both safe and effective in recent years in Northern Ireland and worldwide. This would provide good services to people in rural areas, where clinic facilities may not be readily available.
■ For patients with more complex needs, facilities should be scaled up appropriately e.g. those requiring general anaesthetic should be moved to a tertiary facility.
■ There should be buffer zones in place around facilities providing abortion services to ensure the safety of patients and staff.
■ There is a need for counselling services, both for people with unintended pregnancies and ambivalent feelings and also for people post-termination. These services should be endorsed by the healthcare trust to ensure quality of care for all patients.
■ Services should not come with barriers; a GP led model may lead to further problems due to waiting times for appointments.
■ NICE Guidelines recommend facilitating assessment within 1 week of request and termination services within 1 week of assessment.

Sources for this section:

https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf?sequence=1
https://www.bmj.com/content/357/bmj.j2011/peer-review
https://www.nice.org.uk/guidance/ng140/chapter/Recommendations
https://www.ncbi.nlm.nih.gov/pubmed/30869829

2.6, Part 2 - Where procedures can take place

Question 8: Do you agree that terminations after 22/24 weeks should only be undertaken by health and social care providers within acute sector hospitals?

Not Answered

If you answered 'no', what alternative approach do you suggest?:
Paragraph 85(d) of the CEDAW report requires that evidence-based protocols are adopted to enable the provision of legal abortions – this provision would contravene that recommendation.
There is no medical or social policy evidence available for including this restriction in law – it is safer and in the interests of people needing abortions that decisions about clinical safety and procedure are made at a medical regulatory level.
Crisis pregnancies are of such that the later the gestation, the greater the need for medical support and reassurance, it would work in opposition to compassionate medical provision to place barriers in the way of providing safe and effective medical care in the future, especially where there is no evidence to pregnancies at these later gestations to be for anything other than women and pregnant people in highly traumatic and stressful situations, both in terms of their health and their social circumstances.

2.7, Part 1 - Certification of opinion and notification requirements

Question 9a: Do you think that a process of certification by two healthcare professionals should be put in place for abortions after 12/14 weeks gestation in Northern Ireland?

No

Question 9b: Alternatively, do you think that a process of certification by only one healthcare professional is suitable in Northern Ireland for abortions after 12/14 weeks gestation?

No

If you answered 'no' to either or both of the above, what alternative provision do you suggest?:
There is no evidence for requiring more than one healthcare professional to certify a patient requiring abortion. Healthcare staff already work in multidisciplinary teams and requiring more than one staff member to certify is an unnecessary barrier.
Requiring more than one doctor may lead to an issue with conscientious objection and healthcare staff obstructing access to care.
Certification would undermine the government's commitment to providing safe, accessible abortion care – we know that the legal requirements put doctors off providing in Great Britain, and certification is an additional administration burden which is not required by clinical standards
AfC does not support certification specific to any abortion care. Certification treats abortion differently from other medical procedures and is potentially stigmatising. Although certification may be widely practised in other jurisdictions, many of these requirements are there due to social pressure rather than best medical practice and clinical evidence. There is no clinical evidence available to suggest certification assists with abortion services, in fact there is evidence to the contrary; often a certification process is unnecessary and can lead to delay. Patients undergoing abortion treatment should be counselled appropriately and consent should be obtained. Discussions and principles of informed consent should be documented in the medical records as it would for any other medical treatment.

Sources for this section
https://reproductiverights.org/sites/default/files/documents/GLP_Refusals_FS_Web.pdf
https://apps.who.int/iris/bitstream/10665/177628/1/WHO_RHR_15.11c_eng.pdf?ua=1

2.7, Part 2 - Certification of opinion and notification requirements

Question 10: Do you consider a notification process should be put in place in Northern Ireland to provide scrutiny of the services provided, as well as ensuring data is available to provide transparency around access to services?

Yes

If you answered 'no', what alternative approach do you suggest?:
AfC is clear that data collection on abortions performed is part of good governance and can provide assurance around ensuring everyone is able to access services. Ensuring that this data collection is mindful and inclusive of the needs and identities of trans men and non-binary individuals who may be accessing abortions is also essential for maintaining the accuracy of this data.
We would also assert however, that a notification process, should be in-line with notifications for other medical procedures and as with conscientious objection, it ought not be exceptionalised for abortion. Abortion is healthcare and should not require a distinct notification system from any other similar services such as vasectomies or miscarriage management.
The Data should also not be used to identify patients and should remain protected as all other medical data.

2.8 - Conscientious objection

Question 11: Do you agree that the proposed conscientious objection provision should reflect practice in the rest of the United Kingdom, covering participation in the whole course of treatment for the abortion, but not associated ancillary, administrative or managerial tasks?

Not Answered

If you answered 'no', what alternative approach do you suggest?:
AfC as a first principle believes that there should be no additional measures with regard to conscientious objection for providing abortion treatment beyond any other healthcare provision.
There is legal precedent in the United Kingdom with the case of 2 midwives in Scotland, (UK Supreme Court: Connie Wood/Mary Doogan Vs GGC 2014) that conscientious objection should cover only participation in the treatment for abortion and not associated ancillary, administrative or managerial tasks. It should also not be extended to any emergency or lifesaving healthcare and should be accompanied by the obligation to refer to someone who is willing to provide. There is also clear and robust guidance on conscientious objection from; General Medical Council, Nursing Midwifery Council and Royal College of Nursing.
The guidance from all is clear that conscientious objection cannot apply in an emergency situation where there is a risk to the life or if there is risk of serious deterioration in the health of a patient. The GMC guidance underlines that conscientious objection should not be used to discriminate against patients or to delay or obstruct access to care. RCN guidance is clear that midwives, nurses and nursing associates cannot refuse to care for a woman before or after an abortion procedure.
There have been a number of European Court of Human Rights cases, most notably in Poland and Italy, where a widespread and institutional refusal of care has created a need for women and pregnant people to have to travel outside of their country for abortion care.

"The European Committee of Social Rights (the 'Committee') has also addressed the obligations of European states to ensure that refusals of reproductive health care by medical professionals do not jeopardize women's access to care in three cases, all of which relate to lawful abortion services. In FAFCE v. Sweden42, the Committee held that there is no obligation on state parties to the European Social Charter43 (the 'Charter') to allow health care workers to refuse to provide abortion care on the grounds of conscience or religion. In IPPF-EN v. Italy 44 and CGIL v. Italy 45, the Committee specified that if, under its domestic law, a state party to the Charter chooses to allow medical professionals to refuse to provide legal abortion care, it must take effective measures to ensure that such refusals do not jeopardize women's timely and effective access."

In 2014 the European Committee of Social Rights also found, that Italy had violated women's right to health because Italian authorities had failed to establish effective measures that would ensure refusals of abortion care by medical professionals did not jeopardize women's access to legal abortion.

sources for this section
Centre for Reproductive Rights, 2018. "Addressing Medical Professionals' Refusals to Provide Abortion Care on Grounds of Conscience or Religion: European Human Rights Jurisprudence on State Obligations to Guarantee Women's Access to Legal Reproductive Health Care"

Underugga, V. & Sadler, M. (2019) The misrepresentation of conscientious objection as a new strategy of resistance to abortion decriminalisation https://tandfonline.com/doi/full/10.1080/26410397.2019.1610280

Question 12: Do you think any further protections or clarification regarding conscientious objection is required in the regulations?

Not Answered

If you answered 'yes', please suggest additional measures that would improve the regulations: :
Whilst AfC understands that medical bodies representing medical staff who have a conscientious objection to abortion have the right to be supported and more importantly women and pregnant people would receive a higher standard of care from medics who do not support their decision, we would also like to see support for those with a professional and conscientious commitment to providing abortion. At the very least there should be clarification of protections from discrimination by colleagues and from harassment and intimidation by protestors, anti-abortion groups or individuals. We would also welcome protection for staff from wider forms of harassment, such as malicious communications or defamation.
In Italy the impact on medics and its failure to properly address systemic refusal of care for abortions has been noted by the European Court of Human Rights, "medical professionals who are willing to provide abortion care face cumulative disadvantages in terms of workload, distribution of tasks, and career development opportunities, and that as a result the government had violated their rights to non-discrimination in employment and to dignity at work."

AfC are concerned that there is too much focus on the freedom of religion and not enough focus on a patient's right to be free FROM religion and religious dogma in a healthcare setting. The Convention for the Protection of Human Rights and Fundamental Freedoms recognizes:
Article 9. Freedom of thought, conscience and religion
1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.
2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.
International Human Rights Standards and Refusals of Abortion Care
A number of international human rights mechanisms have underlined that international human rights law and standards do not require states to allow medical professionals to refuse to provide legal reproductive health care, including abortion, on grounds of conscience or religion. (Centre for Reproductive Rights, 2018) Instead, they have repeatedly stated that where, as a matter of domestic law and policy, states choose to allow medical professionals to refuse to provide legal abortion care or other forms of reproductive health care on grounds of conscience or religion, they must establish and implement effective regulatory, oversight and enforcement frameworks so as to ensure that such refusals do not undermine or hinder women's access to legal reproductive health care in practice.
At a minimum this means that they must:
• Ensure the adequate availability and dispersal of willing providers.
• Prohibit institutional refusals of care.
• Establish effective referral systems.
• Disseminate information on legal entitlements to abortion care.
• Impose clear limits on the legality of refusals.
• Implement adequate monitoring, oversight, and enforcement mechanisms to ensure compliance with relevant regulations. (Centre for Reproductive Rights, 2018)
We would like to see training rolled out for all healthcare professionals on what conscientious objection actually entails and what the limits of it are in their professional practice. Recent interventions by some healthcare professionals in the media have bee extremely concerning, such as a GP speaking on BBC radio who stated that if a patient of his was seeking information on abortion care he would 'try to reason with her'. Doctors in NI currently receive no manadatory training on abortion care and as such a programme of work needs to be developed to accompany the new abortion regulations and services.

Sources for this section:
Centre for Reproductive Rights, 2018. "Addressing Medical Professionals' Refusals to Provide Abortion Care on Grounds of Conscience or Religion: European Human Rights Jurisprudence on State Obligations to Guarantee Women's Access to Legal Reproductive Health Care"
Underugga, V. & Sadler, M. (2019) The misrepresentation of conscientious objection as a new strategy of resistance to abortion decriminalisation https://tandfonline.com/doi/full/10.1080/26410397.2019.1610280

2.9 - Exclusion zones

Question 13: Do you agree that there should be provision for powers which allow for an exclusion or safe zone to be put in place?

Yes

If you answered 'no', what alternative approach do you suggest?:
The Government has an obligation to ensure access to safe abortion, which includes creating safe access zones to protect the mental and physical health of patients, medical staff, and the community at large. In jurisdictions without safe access (or 'buffer') zones, such as most parts of Great Britain and many parts of the US, patients and staff members are routinely harassed by anti-choice campaigners. This harassment has been shown to have a profoundly negative effect on both patients and providers, as well as the broader community. A large study of abortion patients and clinic staff in Great Britain found that people felt that anti-abortion protesters were invading their privacy and stigmatising their personal health decisions. Many reported that the presence of anti-choice protesters was the most stressful part of their abortion experience, while others reported feeling intimidated or threatened and fearing physical injury. In Canada, both patients and staff reported feeling harassed and distressed at the hands of anti-choice protestors.

In 2018, Ealing became the first municipal authority in the UK to introduce a Public Spaces Protection Order outside of an abortion clinic; those who violate this order are liable to criminal prosecution. The Government now has the opportunity to implement this model, which prioritises the well-being and safety of patients, in Northern Ireland. This solution already has cross-community political support within Northern Ireland. In 2017, the Belfast City Council passed a resolution condemning anti-abortion harassment and intimidation outside of reproductive health care clinics in the city. The implementation of safe access zones would recognise that people's medical decisions should be treated confidentially and with respect. However City Council legislation does not carry enough power in NI

to be effective and AfC believe UK-wide legislation is the only solution.

Beyond the fact that the mere presence of protestors serves as a source of intimidation of intimidation and stigma for many, it is important to note that many of the demonstrations that take place outside of abortion providing facilities are not contained to ‘peaceful’ protests. One study of abortion clinics in the United States found that only 6% of facilities had experienced ‘peaceful’ picketing alone. The overwhelming majority of facilities were subjected to a wide array of severely disruptive or even violent demonstrations such as abortion opponents falsely booking large numbers of ‘no-show’ appointments, clinics being invaded or blockaded by demonstrators, vandalism, death threats to staff members, and picketing physicians’ homes. Anti-abortion protestors in Great Britain have recently adopted many of the more aggressive tactics deployed by their American counterparts, including toting signs with grisly imagery, blocking clinic entrances or driveways, and engaging in ‘pavement counseling,’ a tactic in which protestors attempt to physically intercept arriving patients and ‘persuade’ them not to have an abortion. People’s right to express an opinion does not include a right to damage property, harass and threaten people, or physically obstruct the path of people attempting to access healthcare. Safe access zones are therefore required to ensure patients and staff members are able to freely and safely enter a healthcare facility.

Sources in this section:
Catherine Cozzarelli and Brenda Major, 'The Effects of Anti-Abortion Demonstrators and Pro-Choice Escorts on Women’s Psychological Responses to Abortion,' Journal of Social and Clinical Psychology 13, no. 4 (1994): 404–27.

Question 14: Do you consider there should also be a power to designate a separate zone where protest can take place under certain conditions?

No

If you answered ‘no’, what alternative approach do you suggest?:
• A safe zone only covers a specific area outside the clinic. A ‘separate zone’ where anti-abortion protest activity is allowed is everywhere else outside this zone.
• A separate zone is not standard in PSPOs in England – of the two PSPOs in place to address anti-abortion activity, one has a separate zone and one does not
• A separate zone will not placate anti-abortion activists who have made repeatedly clear that they want direct access to women as they enter clinics
• Given the history of attempts to police anti-abortion protests in Northern Ireland, a separate zone is likely to need constant enforcement to force protesters to abide by the rules – taking up policing time and causing distress to women who may still have to pass this zone.
• As the CEDAW report noted, anti-abortion protests have been persistently present in Northern Ireland for the duration that both abortion services and pregnancy options counselling has been provided in Belfast
• Anti-abortion protests in Northern Ireland have been more intimidating and physical than anywhere else in the UK, with a number of prosecutions for specific incidents in relation to activity outside clinics and the need for a persistent police presence. Despite these prosecutions, harassment of women continued unabated.
• The CEDAW report found that the UK was in violation of Convention articles 10 and 12 for “failing to protect women from harassment by anti-abortion protesters when seeking sexual reproductive health services and information.”
• As a result of this background, existing law is not enough to combat the issues of harassment and intimidation by anti-abortion protests and new legislation is needed
• PSPOs are an insufficient model to transpose into law. New, specific legislation is needed to introduce safe zones outside all premises that provide services without the need for prolonged delay and gathering of evidence about the harm done to women.

The PSPOs that have been put in place in England have taken at least a year to put in place despite evidence of daily harassment and intimidated
The bar for evidence in PSPO guidance excludes many clinics from protection – only around 10% of clinics with protests in England would meet the bar for intervention.
Lack of national provision of safe zones creates a postcode lottery for women
Local safe zones are expensive to introduce and uphold in court against the well-funded attacks of anti-choice groups – as evidenced by the court challenge of the Ealing PSPO where anti-choice protesters, including one paid to stand outside the clinic, are seeking to take the case to the Supreme Court.

CEDAW Inquiry Report 2018 https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/GBR/INT_CEDAW_ITB_GBR_8637_E.pdf.

Further Comments

Question 15: Have you any other comments you wish to make about the proposed new legal framework for abortion services in Northern Ireland?

Enter answer here:
Pregnancy as a result of sexual crime

● Although CEDAW recommends that this is dealt with as a separate issue, this consultation does not do this, which is an oversight.
● This is a cross-cutting issue as it also impacts on the stage of gestation at which termination may be sought, on the health implications for a person who has become pregnant as a result of sexual crime, and on other aspects of the law as it relates to accessibility.
● Regarding the term-limits, a person who has become pregnant as a result of sexual crime may present at any stage of pregnancy. This relates directly to the crime itself; sexual assault is traumatising and it is common for people to struggle to deal with the potential outcomes of such an assault until it becomes unavoidable or undeniable.
● While pregnancy as a result of rape is the most obvious form of sexual crime, reproductive coercion and coercive control is a form of criminal abuse all too common within relationships and can result in pregnancy which must be considered in this context.
● Tampering or interfering with contraception is a common method of coercive control and as a result the victim may not realise that they are pregnant until quite an advanced stage of gestation, believing they had used adequate protection and/or not being alerted by the absence of menstruation because of the nature of the contraception they were using. The BMJ Sexual & Reproductive Health reports that as many as 1 in 4 of the women who present at sexual health clinics have been victims of such reproductive coercion.

● Because such a pregnancy often occurs within a controlling or violent relationship, accessing abortion services may be especially difficult or even dangerous and as such the woman may present later in gestation because it has not been possible or safe for her to do so until that stage, or she has not been able to raise the funds within a financially controlling relationship.
● The narrative around domestic abuse and coercive control from anti-abortion campaigners tends to emphasise pressure to terminate a pregnancy that is wanted, in fact the evidence shows that reproductive coercion is very frequently reported by people who are seeking a termination, with 13% of women in violent relationships reporting that pregnancy had been “imposed” upon them (compared with 2% of those whose relationship was not reported as violent).
● A 2011 study by the Institute of Psychiatry at King’s College London found that 7% of pregnant women reported emotional and/or physical abuse at week 18 of their pregnancy
● Domestic Violence Charity Refuge reports that 20% of the women using their services are either pregnant or have recently given birth.
● Pregnancy is often an aggravating factor in domestic abuse as well as a means to control the pregnant person, with over one third of domestic abuse beginning or escalating during pregnancy - so much so that pregnant people are routinely asked whether they are safe in their domestic situation when they attend their first “booking in” appointment with maternity service.

Pregnancy for trans people

● This consultation, as well as the equality screening document released separately by the Northern Ireland Office, made no reference to trans patients and pregnant persons and their ability to access reproductive care.
● This presents significant issues for trans men and non-binary people - many of whom may require abortions at any point in their lives - given the language used throughout the documents; those who require abortions are referred to solely as ‘women’ rather than using a more inclusive term.
● This will not only put trans communities off responding to the consultation, but if this approach is maintained through the commissioning and development of services, will create significant barriers to trans people accessing abortion care.
● While cisgender women are likely to be the predominant demographic accessing any services developed from this legislation, it is important that the diversity of gender identities of those who may require abortions is respected and accommodated in any legislation or services developed.
● Access to abortion services can be a significant mental health emergency for a trans man or non-binary person who has become pregnant, as the heavily gendered nature of pregnancy may result in increased dysphoria or discomfort around their bodies and other people’s perceptions of their bodies.
● As a result, professionals working in the provision of abortion should be culturally competent on the language used within trans communities, should be comfortable supporting and affirming trans individuals as well as able to deal with the specific sensitivities around undergoing an abortion as a trans person.
● To ensure this is the case, proactive work to improve awareness across the health service will need to be undertaken, developing policies and procedures to support medical staff in their work with trans patients accessing reproductive care
● Trans communities are particularly at risk of homelessness and poverty as well as experiencing disproportionate rates of sexual and domestic violence. As a result, all the issues previously raised in this consultation response regarding access for those in poverty, the provision of local services, certification by medical professionals and term limits are particularly pertinent to ensure access for trans individuals..

Sources for this section
Hall M, Chappell LC, Parnell BL, Seed PT, Bewley S (2014) Associations between Intimate Partner Violence and Termination of Pregnancy: A Systematic Review and Meta-Analysis. PLoS Med 11(1): e1001581. doi:10.1371/journal.pmed.1001581
Refuge (2017-2018) Performance Report, Domestic Violence and Pregnancy
https://www.refuge.org.uk/our-work/forms-of-violence-and-abuse/domestic-violence/domestic-violence-and-pregnancy/
Flach C, Leese M, Heron J, Evans J, Feder G, Sharp D, Howard L. Antenatal domestic violence maternal mental health and subsequent child behaviour: a cohort study. BJOG 2011;118:1383–1391.
NHS 2018 Domestic abuse in pregnancy: Your pregnancy and baby guide https://www.nhs.uk/conditions/pregnancy-and-baby/domestic-abuse-pregnant/
BMJ (2018) 1 in 4 women at sexual health clinics reports coercion over their reproductive lives
https://www.bmj.com/company/newsroom/1-in-4-women-at-sexual-health-clinics-reports-coercion-over-their-reproductive-lives/

Abortion as a workplace issue

It is unlawful for employers to treat pregnancy people less favourably on grounds that they are pregnant, for a reason relating relating to their pregnancy or because of an illness relating to their pregnancy. Maternity discrimination is that which relates to an employee’s maternity leave, whereby it is unlawful to treat a pregnant person less favourably because of time of exercising their right to leave in these circumstances.
At present the legislation in respect of both pregnancy and maternity discrimination makes no reference to abortion. It is the view of AfC that whether a pregnancy ends in birth, miscarriage or abortion, no woman or pregnant person should encounter less favourable treatment or discrimination from their employer at any point. In order to ensure that employers are aware of their responsibilities regarding potential abortion discrimination, the current equality legislation on pregnancy and maternity rights requires urgent amendment with a view to including abortion healthcare.

Anecdotal evidence reported to us by individuals and through discussion at a range of AfC workshops has highlighted the fact that a number of sizeable employers are present in Northern Ireland who hold demonstrably public anti choice views. These include schools based / education employers who retain exemption from the Fair Employment and Treatment Order Northern Ireland 1998.
The recent research study Abortion as a Workplace issue also highlights the fact that there is an onus on employers to ensure that women and pregnant people seeking and accesssing abortions do not encounter discrimination or negative workplace experiences relating to abortion (Bloomer et al, 2017).

This research found that people’s experience of abortion as a workplace issue ranged from stigma, isolation, lack of support to being unable to access leave or sick pay, especially in the case of precarious employment.
This study provides clear evidence that there is a need for newly developed workplace policies emanating from a comprehensive statutory and legal framework which encompasses abortion as an equality issue.

Sources for this section:
Bloomer, F., Devlin-Trew, J., Pierson, C., MacNamara, N. and Mackle, D., (2017) Abortion as a workplace issue: Trade union survey – North and South of Ireland, Dublin: UNITE the Union, Unison, Mandate Trade Union, the CWU Ireland, the GMB, Alliance for Choice, Trade Union Campaign to Repeal the 8th.
https://pure.ulster.ac.uk/en/publications/abortion-as-a-workplace-issue-a-trade-union-survey-north-amp-sout

Alliance for Choice Further information on Section 75 Screening

The purpose of Section 75 of the Northern Ireland Act is to ensure that the practices and policies of government and public authorities have equality of opportunity and good relations at their core. It is incumbent on public authorities to address inequalities and demonstrate the measurable positive impacts on the lives of people experiencing inequalities. The proper and effective use and application of Section 75 should improve the quality of life and access to services for all of the people of Northern Ireland.

The process of screening should also identify policies that are likely to have an impact on equality of opportunity and draw considerations of equality of opportunity into the policy making process. It is the duty of the public authority to commit to screening at the initial stage of the process. Screening is a key tool to enable public authorities to fulfil their statutory obligations and mainstream the Section 75 equality and good relations duties in to policy development.

Following the legislative changes that came into force on the 22nd October 2019, there is now an obligation to deliver the statutory duty in section 9 of the Northern Ireland Executive Formation Act. This requires the government to deliver, at minimum, service provision which is consistent with the recommendations in paragraphs 85 and 86 of the UN CEDAW Report, 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.

It is of the utmost concern therefore that Alliance for Choice note the resultant EQIA on religious and political grounds following the Section 75 screening process. It is not clear how this screening process was conducted given the conclusions reached. Had a thorough screening process been applied, the considerations for groups potentially affected by access to abortion provision could have been identified and addressed from the outset and at the initial stages of the process.

An obtuse and inappropriate application of Section 75 has now emerged whereby the provision of abortion services is being considered in light of political and religious barriers. It is the absence of fitting abortion provision in NI that has a discriminatory impact on women and pregnant people. Furthermore, given that abortion provision will, as with any other form of healthcare, be regulated accordingly it is impossible to see how it will impact on any religious freedoms or practices, individual or otherwise. Individuals also have the right to healthcare provision without interference from religion and/or religious organisations.

Abortion provision in NI will be a consensual service whereby individuals requiring abortion healthcare will provide their legal authority in order to undertake the procedure in a non-coercive environment. It is impossible to understand how that could possibly impact on or create an environment whereby the religious freedoms of individuals or organisations would be impacted or curtailed in any way.

The absence of fitting NI Abortion provision that is anything other than CEDAW compliant or does not fully consider the needs of a number of groups with protected characteristics that fall within the remit of Section 75, does give rise to concern.

These groups are as follows:
Women and pregnant people with one or more disabilities

Alliance for Choice are people with disabilities and have worked alongside people with disabilities for many years, including those seeking access to abortion healthcare. Women and pregnant people with disabilities face a myriad of challenges in relation to their sexual and reproductive health. Such services can lack measures to make them user-friendly and adaptable to various forms of disability. Various forms of control over sexual behaviour and reproduction, including coercive and involuntary sterilisation are used, often without informed consent.

Information and education, including on menstrual health, contraception, pregnancy, safe abortion and are often poorly provided, in formats that are inaccessible to women and pregnant people with various disabilities.

Attitudes towards the sexuality of women and pregnant people with disabilities mean that their sexual health needs are often ignored at a family and societal level; and given the link between disability and poverty, dealing with these needs becomes a major challenge for those who are economically dependent on others. Many of the disabled people we work alongside have reported that when it comes to their health, including their sexual health, they are often treated as a disability rather than a person. A distinct lack of a ‘person centred’ approach in order to cater for the nuanced and/or complicated needs of each disabled person prevails in the area of sexual healthcare for those with disabilities.

Abortion service provision in NI must:

ENSURE voluntary and informed choice for every woman and pregnant person with a disability regarding their sexuality and reproduction. It must respect, protect and fulfil their human rights. This includes their rights to non-discrimination, autonomy and self-determination. It should also include the right to the highest attainable standard of abortion healthcare, information and education.

ENSURE that abortion healthcare for women and pregnant people with disabilities is available and accessible without fear of discrimination or harassment. This includes safe access and egress to clinics and abortion service provider premises. Service providers must be trained on how to best serve the needs of women and people with disabilities, without discrimination, stigma and bias. This includes local access, no waiting period and telemedicine to ensure access for disabled people is maximised.

ENSURE comprehensive reproductive healthcare information and education for women and pregnant people with disabilities, including: sexuality, sexual health and pleasure; menstrual health; contraception; access to safe abortion services; the right to family planning, pregnancy and childbirth; sexual violence and harmful practices. Information channels must be adequate for various types of impairment to ensure that women and girls with disabilities can exercise informed consent.

ADDRESS the intersectional discrimination women and pregnant people with disabilities face in relation to their sexual health and service provision including on the grounds of socio-economic status, geographical residence, gender identity, sexual orientation, race, colour and religion. Ensure the availability and accessibility of information and quality services for women and pregnant people with disabilities in particularly vulnerable situations, such as gender based

violence. Ensure that protection and services for women and pregnant people with disabilities in fragile contexts are designed according to their needs and rights without negative assumptions around the capacity of those with disabilities.

ALLOCATE financial and budgetary resources to address the needs of women and pregnant people with disabilities. Allocate funds specifically to provide respectful, rights-based, comprehensive sexual and reproductive education for women and people with disabilities, including those with intellectual disabilities. Allocate funds to provide social protection frameworks for the elimination of GBV, sexual violence and harmful practices. Ensure financial resources and means to achieve protections for women and people with disabilities, including at preventive and primary healthcare levels. This should also include training of health care providers on disability inclusion.

ESTABLISH partnerships and collaborations among governmental and non-governmental organisations, professional bodies, law making and enforcement bodies, disabled people's organisations and civil society organisations to address the needs of women and people with disabilities with their leadership and meaningful.

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Lesbian and Bisexual (L&B) Women and Pregnant People

The equality screening does not highlight any particular impact on Lesbian or Bisexual women. This is concerning from a few angles;

Firstly the CEDAW report particularly highlights the need to provide abortion care where there pregnancy is a result of a sexual crime. Lesbian and Bisexual women are more likely to experience sexual violence than their heterosexual counterparts, and consequently a pregnancy as a result of a sexual crime. The Guttmacher Institute (Sexual Orientation and Exposure to Violence Among U.S. Patients Undergoing Abortion Rachel K. Jones) found in a 2018 US study of people who had had an abortion, 15% of Lesbians said their pregnancy was because of forced sex compared to 1% of heterosexuals and 3% of bisexuals. Bisexuals (9%, 7%) and Lesbians (33%, 35%) were also more likely to report that the man who impregnated them had physically or sexually abused them, compared to 4%/ 2% of heterosexuals.

It is likely that there are similar trends consistently identified in international research in the UK, as ONS and other research highlights that L&B women experience proportionately higher levels of sexual crime and domestic abuse. Given that access to abortion in cases of sexual crime is a recommendation of CEDAW which must be complied with and L&B women are more likely to need access in this circumstance, the introduction of abortion care will positively impact L&B women particularly those pregnant as a result of sexual crime.

A systematic worldwide study (Hodson et al 2018 doi:10.1111/1471-0528.14449), including reports from the UK, found that there was a statistically significant higher rate of pregnancy in adolescent lesbians and bisexual women. This was particularly found in bisexual adolescents where the rate was twice that found in the heterosexual adolescent cohorts. One study, included in the systematic review, on bisexual adolescents reported higher rates of unwanted pregnancy and termination.

It is currently unclear as to why there is a higher rate of pregnancies in teenage L&B women than their heterosexual peers and the reasons need to be established. Higher rates of pregnancy in L&B adolescents might follow their being more adventurous or sexually active in general, more forced or unplanned sex without contraception, or if they experiment with heterosexuality to persuade themselves that they are heterosexual. L&B teenagers are more likely to experience an unplanned pregnancy, which some will choose to terminate. This higher rate of L&B teen pregnancy also highlights the need for more comprehensive sex and relationship education, which is also recommended by the CEDAW report.

UK wide research has highlighted consistent barriers in relation to accessing healthcare, especially around heteronormative assumptions. All reproductive healthcare services, including abortion services, must resist heteronormative assumptions and ensure their provision is suable for all. There is consistent evidence of inequalities affecting L and B young women, including increased risk of teenage conception and worse mental health.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/723557/improving_health_and_wellbeing_LBWSW.pdf

Pregnancy for trans people

This consultation, as well as the equality screening document released separately by the Northern Ireland Office, made no reference to trans patients and pregnant persons and their ability to access reproductive care.

This presents significant issues for trans men and non-binary people - many of whom may require abortions at any point in their lives - given the language used throughout the documents; those who require abortions are referred to solely as 'women' rather than using a more inclusive term. This will not only put trans communities off responding to the consultation, but if this approach is maintained through the commissioning and development of services, will create significant barriers to trans people accessing abortion care

While cisgender women are likely to be the predominant demographic accessing any services developed from this legislation, it is important that the diversity of gender identities of those who may require abortions is respected and accommodated in any legislation or service delivery.

Access to abortion services can be a significant mental health emergency for a trans man or non-binary person who has become pregnant, as the heavily gendered nature of pregnancy may result in increased dysphoria or discomfort around their bodies and other people's perceptions of their bodies.

As a result, professionals working in the provision of abortion should be culturally competent on the language used within trans communities, should be comfortable supporting and affirming trans individuals as well as able to deal with the specific sensitivities around undergoing an abortion as a trans person. To ensure this is the case, proactive work to improve awareness across the health service will need to be undertaken such as developing policies and procedures to support medical staff in their work with trans patients accessing reproductive care.

Trans communities are particularly at risk of homelessness and poverty as well as experiencing disproportionate rates of sexual and domestic violence. As a result, all the issues previously raised in this consultation response regarding access for those in poverty, the provision of local services, certification by medical professionals and term limits are particularly pertinent to ensure access for trans individuals.

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Migrant Women and Pregnant People

Migrant Women and pregnant people are some of the most marginalised people in Northern Ireland society and face significant barriers when it comes to accessing healthcare, including reproductive and abortion healthcare.

Many women worldwide migrate in order to flee violence, improve their socio-economic status and seek improved healthcare and education services. It is imperative that these women and pregnant people do not face exclusionary barriers once in their destination countries. This includes access to sexual health and reproductive healthcare including abortion which can be considerably more difficult for a number of reasons.

Migrant women and pregnant people are not a homogeneous group with the same set of circumstances. For example, the legal status of those migrant people seeking healthcare, including abortion can and will differ, with a varying degree of preclusions around access to healthcare depending on their legal status. Forcible displacements, the fear of deportation, a hostile environment, no fixed abode, providing information which could be shared between statutory organisations and potentially impact their legal status and accessing services/information in an unfamiliar environment are among the practical barriers that migrant women and pregnant people have faced when it comes to accessing healthcare provision including abortion.

They have also described barriers associated with stigma and emotional connections stemming from family and societal relationships following migration. Migrant women and pregnant people have reported how feelings such as 'respecting family wishes' and a 'sense of duty' intensify when they leave their place of birth and can manifest as post-displacement stressors directly impacting their decisions around reproductive healthcare.

Many countries have laws that grant rights to migrant women and pregnant people but at the same time they restrict migrant access to healthcare, especially if they do not have legal permits including residency permits. Laws and lengthy administrative waiting periods operate in a manner that effectively denies the right to undocumented women to access reproductive healthcare effectively.

Practical and societal barriers for migrant women and pregnant people must be removed and mitigated against if NI abortion provison is to be fit for purpose. This includes an easy to access service with language barriers considered and help and assistance to navigate abortion services. Providing widely available reproductive healthcare information and education in order to overcome lack of knowledge of abortion laws, rights and services reported by migrant women and pregnant people is also necessary.

Such discrimination can also effect women in the most vulnerable circumstances such as those who have been victims of human trafficking and violence, including sexual violence. Not only can they face this at the hands of traffickers but also can face lengthy waits for legal abortions and be treated differently when it comes to service provision.

As with anyone with a protected characteristic, there is a need to ensure those dealing with service provision are fully trained in respect of the needs of migrant women and pregnant people.

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SECTION 3 - SUPPLEMENTARY INFORMATION