WOMEN'S RESOURCE & DEVELOPMENT AGENCY
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19th April 2017

*Abortion Consultation*
*Northern Ireland Office*
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**A New Legal Framework for Abortion Services in NI**
**Consultation Response**
**Women's Resource and Development Agency**

## Introduction:

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As WRDA is a regional organisation representing a diverse range of women across all of Northern Ireland, we believe it was fitting that we submit a response to this consultation. WRDA is a membership organisation and represents women at a local and international level and has a diverse membership including grassroots campaigns, community based women's groups, individuals, women's organisations, women's centres, national organisations and trade unions.

We also work with six other leading women's organisations in the Women's Regional Consortium to give a voice to women in disadvantaged and rural areas. Our partners include Women's Support Network (WSN), Northern Ireland Rural Women's Network (NIRWN) and Women's Centre Derry (WCD). WRDA staff are represented on a range of boards and organisations promoting a gender perspective including, but not limited to, areas of **Policy and Advocacy** through Women's Policy Group; Women's Budget Group; Rural Women's Policy Forum; Equality Coalition and various All Party Working Groups. We tackle **Health Inequalities**, through representing women on a wide range of Trust Boards and Forums and we represent women through **Leadership and Infrastructure Support** on the NICVA Executive, Government, Community and Voluntary Sector Joint Forum; Boards of NIRWN and NIWEP and more.

In line with the remit of WRDA, this consultation response will outline views on how to best implement legislation to create a mechanism for reproductive healthcare services that fully meets the needs of all women and pregnant people in Northern Ireland. The comments in this response are made with the expertise of WRDA as an organisation that represents a diverse range of women.

### 2.1 Early Terminations of Pregnancy

| **Question 1. Should the gestational limit for early terminations of pregnancy be:** | **Yes** | **No** |
|---|---|---|
| **Up to 12 weeks gestation (11 weeks + 6 days)** | | |
| **Up to 14 weeks gestation (13 weeks + 6 days)** | | |

**If neither, what alternative approach would you suggest?**

WRDA welcomes the recognition of the trauma women, girls and pregnant people who are victims of sexual violence and crime, as it is outlined in CEDAW recommendations that every person who becomes pregnant as a result of sexual crime should have the option to access an abortion. As this is difficult to legislate for without causing additional trauma for victims, it is widely accepted that a period of unrestricted access to abortion works best[1]. WRDA also welcomes the approach to avoid the requirement of having to declare or certify being the victim of a sexual crime as a precondition of accessing an abortion. WRDA supports a period of unrestricted access to abortion, as this is necessary in order to meet CEDAW recommendations to ensure all victims of sexual crime have access to abortion.

As outlined in the consultation document notes, early termination will meet the needs of the vast majority of care seekers (up to 90% of care seekers in England and Wales). However, WRDA does not believe that 14 weeks is a long enough period of unrestricted access to abortion. Evidence from Alliance for Choice, BPAS, the Abortion Support Network and many other sources, who regularly support victims of sexual crime, highlights that victims of sexual crimes can have complex reasons for being unable to access an abortion until the second trimester. Among these reasons, domestic abuse and coercive control can prevent victims from being able to access an abortion. WRDA believes that the timeframe of unrestricted access to abortion until the point of viability (currently 24 weeks in England and Wales) would be much more appropriate to ensure CEDAW recommendations are enacted. This will guarantee that no victims of sexual crime will be forced to travel to GB to access a termination.

In addition to this, very young people and menopausal women are more likely to not realise they are pregnant; especially in cases of rape or sexual assault. Disabled women also are more likely to be victims of domestic abuse and face additional barriers of being able to access support or healthcare. For these women, the best service that can be offered is, at minimum, an unrestricted limit of 24 weeks.

[1] Centre for Reproductive Rights – Law and Policy Guide: Rape and Incest https://reproductiverights.org/law-and-policy-guide-rape-and-incest

| Question 2. Should a limited form of certification by a healthcare professional be required for early terminations of pregnancy? | Yes | No |
|---|---|---|
| | | X |
| **If no, what alternative approach would you suggest?**<br><br>As abortion is decriminalised in Northern Ireland, it is unnecessary to abide by the conditions of the 1967 Abortion Act where two doctors have to certify that the woman or pregnant person has met the conditions of the act.<br><br>WRDA does not support certification as it treats abortion different from other medical procedures and can increase stigma. As there is no clinical evidence to suggest that certification assists with abortion services or provides safeguards for patients, certification could lead to unnecessary delays in accessing abortions. In addition, introducing unnecessary certifications may deter particular individuals, such as victims of sexual crime, from seeking care and support. Introducing conditions such as certifications may lead to delays and act as a deterrent.<br><br>Abortion should be considered a part of sexual and reproductive healthcare, therefore, an informed consent model should be applied. Women and pregnant people should be enabled to come to the decision of having an abortion after consulting with medical professionals, this should not require the 'permission' of medical professionals; women and pregnant people should be trusted to make the decision that is best for them. | | |

**2.2 Gestations beyond 12 or 14 weeks**

| Question 3: 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: | Yes | No |
|---|---|---|
| **21 weeks + 6 days gestation** | | |
| **23 weeks + 6 days gestation** | | |
| **If neither, what alternative approach would you suggest?**<br><br>WRDA would like to reference the Concluding Observations of the most recent CEDAW examination of the UK; whereby it was stated that the 'State Party should ensure that protections for women and girls be put on an equal footing with those elsewhere in the UK'. In order to ensure consistency of rights of women across the UK, this recommendation should also be considered in creating a legislative and medical framework for abortions in Northern Ireland. On that basis, a lower gestational time limit | | |

than England and Wales would be unacceptable in Northern Ireland as it would continue to force some women, girls and pregnant people to travel to access an abortion.

In order to meet the recommendation for equal footing of rights across the UK, WRDA believes, at the very minimum, terminations need to be available until at least 24 weeks, with the removal of time restrictions on terminations related to the grounds of physical or mental health. As is widely recognised, and acknowledged in the consultation document notes, it is likely that third trimester terminations will be an extremely low proportion of all terminations.

For those accessing an abortion after 20 weeks, it is highly likely that they are presenting later for care due to extremely complex reasons. Therefore, a time restriction is likely to increase the long term, permanent harm for this often very vulnerable group and further infringe upon their human rights. As the consultation document gives extremely limited detail on how physical or mental health would be assessed, this is very concerning. There is existing evidence of GPs and other healthcare providers not being well trained in mental health, dealing with those with existing disabilities or conditions, or taking women's mental health concerns seriously. Therefore, it is completely vital the assessment of physical or mental health is clearly set out, to ensure consistent, evidence-based practice across services in Northern Ireland.

Without this, it is possible that criteria could be interpreted very conservatively and inconsistently by service providers and this could lead to heavily restricted access to second trimester abortions. Furthermore, as domestic abuse and coercive control is not well understood by professionals here, and we have no legal protection against this crime, training is necessary to ensure care includes termination counselling where needed, alongside signposting to other services as appropriate. This is particularly prudent for victims of sexual crime, reproductive coercion, those with mental health issues, disabled people, those who are homeless or people with addiction or substance use issues.

To conclude on this point, WRDA believes that decisions regarding later terminations should be made between pregnant people in consultation with medical professionals (that are appropriately trained) to enable women, girls and pregnant people to make an informed choice. The majority of abortions in GB are following a diagnosis of a serious fetal abnormality happen before 24 weeks. Third trimester abortions are extremely rare and most families receiving this difficult news about a fetal abnormality decide whether or not to continue the pregnancy by 24 weeks. Under the current system, fetal anomaly screening takes place at the 20 week scan, with any detected abnormalities requiring a referral to the Fetal Medicine Unit; which can take a week to 10 days to secure an appointment. Further, specialist testing may be required which adds an additional amount of time to the wait for results. With all of this evidence, it is clear that a time limit of 21 weeks + 6 days cannot meet the needs of families in these circumstances and can lead to additional stress, trauma and in some cases, the violation of human rights. WRDA believes legislation in Northern Ireland should, at a minimum, equal the provisions in England and Wales.

**2.3 Fetal Abnormality**

| Question 4: Should abortion without time limit be available for fetal abnormality where there is a substantial risk that: | Yes | No |
|---|---|---|
| The fetus would die in utero (in the womb) or shortly after birth | X | |
| 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 | X | |

**If you answered 'no', what alternative approach would you suggest?**

WRDA would like to refer to comments made already in relation to question 3 on accessing terminations after 24 weeks. In addition, WRDA would like to note that experience from the Republic of Ireland shows that the definition of 'severe impairment' or 'fatal fetal abnormality' may not provide health professionals with the certainty that they need to perform terminations on the above grounds.

Based on the experience of those in the Republic of Ireland, where only 'fatal' abnormalities are covered, many families receiving devastating news still have to travel outside of Ireland to access a termination due to the restrictive definition of 'fatal' within the regulations. Removing rigid definitions that do not encompass the full spectrum of health care issues is essential to providing best practice abortion care.

WRDA agrees that no limit should be placed on terminations on the grounds of severe or fatal fetal abnormality and that it is important to remember that CEDAW requires access to abortion where the abnormality is 'severe' and not just 'fatal'. This is significant for those who have received such a diagnosis that brings difficult conversations relating to the odds of survival or the possibility of serious impact on the length or quality of life. CEDAW recommendations also state that women, girls and pregnant people faced with such a diagnosis need sufficient time and support to reach an informed decision.

Families in this situation are experiencing the difficulty of grief and loss which can complicate decision making and require additional support through counselling and other relevant services. It has already been highlighted, in both the consultation document notes and this consultation response, that third trimester abortions are a very low proportion of all abortions, with these figures likely to be reduced as further diagnostic services are developed over time. WRDA believes it is necessary to develop specialist support provisions for these families, such as the models of support available in Iceland to ensure families can make an informed choice and feel support afterwards; regardless of the decision they make.

WRDA also recognises the separate issues of stigma around disability more generally; and particularly in relation to reproductive healthcare. Disabled women and people can become pregnant and face additional barriers in accessing the reproductive healthcare that they need. There is a legacy of abusive reproductive policies whereby disabled people have faced forced sterilisation. It is vital that disabled women and people are seen as respected, autonomous individuals and that barriers to reproductive healthcare are removed. Disabled people's groups have spoken out against the co-option of disabled

people's human rights, lives and identities by extreme anti-choice groups. For example, Down's Syndrome Ireland publically supported the 'yes' campaign in the referendum to repeal the eighth amendment in the Republic of Ireland.

When respecting reproductive justice as a human right, it is necessary that abortion rights are not viewed in isolation to the inequalities and barriers other people can face. Disability discrimination, stigma around disability and the further decreasing levels of state support for disabled people, can make it extremely difficult to make a decision around some pregnancies. Particularly for disabled pregnant people who get the diagnosis of a fetal disability, who may be unable to continue with a pregnancy due to a lack of support and through being one of the groups hardest hit by austerity[2]. WRDA believes that doctors and other healthcare professionals need to be better educated on the impact of different disabilities on the lives of individuals and provide families with balanced, evidence-based information about the quality of life implications. For example, every family that receives a Down's Syndrome diagnosis in Iceland is given evidence-based support and real life experiences from families with disabled children and meet with health professionals that work in this field. This approach helps remove some of the stigma associated with having a disabled child and allows families to make a truly informed choice.

This practise needs to be embedded into healthcare in Northern Ireland, to respect the autonomy of disabled pregnant people, remove some of the stigma associated with having a child who is disabled to ensure parents are able to make an informed choice that they are supported through; regardless of what that choice is. To further remove the stigma disabled women, pregnant people and disabled children face, WRDA believes the horrific programme of austerity cuts to the living allowances of disabled children and adults needs to end and appropriate investments into support services are necessary. The human rights of disabled people need to be fully recognised and respected, therefore, access to information and support is vital to ensure disabled women, children, pregnant people and their families can live their lives with dignity and as independently as possible. By incorporating this into reproductive healthcare, disabled people's lives, identities and human rights will no longer be co-opted by groups opposed to abortion and barriers for disabled people and their families making informed choices around reproductive healthcare will be removed.

[2] Disabled mothers with disabled children are set to lose 32% of their income by 2021 due to Austerity: https://wbg.org.uk/analysis/2018-wbg-briefing-disabled-women-and-austerity/

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

| Question 5: Do you agree that provision should be made for abortion without gestational time limit where: | Yes | No |
|---|---|---|
| There is a risk to the life of the woman or girl greater than if the pregnancy were terminated? | X | |
| Termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman or girl? | X | |

**If you answered 'no', what alternative approach would you suggest?**

WRDA believes that abortion should be available, without time limit, it cases where the pregnancy is a risk to the life or long term health and wellbeing of the woman, girl or pregnant person. Abortion must always be provided where there is a risk of grave permanent injury to a pregnant person's physical and/or mental health. This is accepted in almost every country in the world. It is vital that NI also includes the risk of grave permanent injury post-24 weeks; as without this provision, women, girls and pregnant people will still be forced to travel to GB for abortions. WRDA believes it would be totally unacceptable on human rights grounds to have people with severe physical or mental health risks having to travel for abortion care.

Research shows that the risks of continuing a pregnancy are often higher than the risks of an abortion. In addition, the risk of death from childbirth is 14 times higher than the risk of death from abortion. Finally, WRDA believe that the process of determining what a serious risk to mental health is should follow international best practice; such as guidance from organisations such as the World Health Organisation[3] or the Centre for Reproductive Rights[4].

**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? | Yes | No |
|---|---|---|
| | X | |

**If you answered 'no', what alternative approach do you suggest?**

WRDA agrees with the World Health Organisation and NICE guidelines that early medical abortions can be safely provided by nurses, midwives, auxiliary midwives and doctors. A multi-disciplinary approach to abortion provision will be the most appropriate for Northern Ireland. Abortion care should be treated like all other forms of sexual and reproductive healthcare and be framed within an informed consent model. Abortion care in countries such as Sweden and Scotland are led by nurses and midwives, which can lead to a more

[3] World Health Organization, Safe Abortion: Technical and Policy Guidance for Health Systems 92 (2d ed. 2012)
[4] Centre for Reproductive Rights: Law and Policy Guide: Life Exceptions https://reproductiverights.org/law-and-policy-guide-life-exceptions#footnote11_6z1lnsa

efficient use of staffing resources and can overcome any shortages of appropriately trained doctors.

Given the fact that nurses and midwives are currently trained to provide care in circumstances of miscarriage, it is appropriate that they are also trained to provide care relating to abortion. With this approach, it is likely that abortions will be more accessible, which is particularly important for people living in rural areas, those with disabilities and those with dependants. Creating an accessible service has been emphasised as essential in CEDAW recommendation. There is a need for a change in medical, nursing and midwifery education to reflect the provision on abortion care as a part of sexual and reproductive healthcare services.

Finally, WRDA believes that 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, girls and pregnant people.

**2.6 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?** | **Yes** | **No** |
|---|---|---|
| | X | |

**If you answered 'no', what alternative approach do you suggest?**

WRDA believes that in order to create an equitable and accessible service, it is essential to consider the realities of Northern Ireland. This includes, but is not limited to, rural inaccessibility, inadequate public transport, the centralisation of services across the region, women with high levels of caring responsibilities, long waiting lists to see GPs and the need to integrate abortion care into existing sexual and reproductive healthcare services.

Due to the above factors, it is necessary to adopt a flexible delivery model that includes independent sector providers working under NHS contracts alongside a NHS provision. It is inappropriate to restrict sexual and reproductive healthcare to NHS hospitals and abortion services should not be treated differently from these services. Through providing abortion care in NHS contracts alongside NHS provisions, it is necessary to implement a system where providers are regulated and supervised under clear legal regulations. In doing this, women, girls and pregnant people can trust the service and have the confidence that they will be treated professionally without further stigma. Whilst it is necessary for GPs to be required to provide referrals and information, women, girls and pregnant people need to be allowed to self-refer for treatment to ensure basic human rights obligations to be met.

Local family planning clinics and GP surgeries should provide access to early medical abortions (EMA). In rural areas, where service may be inaccessible or difficult to provide, access to EMA by telemedicine has been shown in many countries, such as the US and Australia, to work well. It is also essential that the legal framework includes a provision

enabling women, girls and pregnant people, to take either the second pill (in line with England and Wales) at home or to take BOTH pills at home – this flexibility can be important for women with children, caring responsibilities, disabled women, those in precarious working conditions and more. Misoprostol has been cleared for use at home in England, Scotland and Wales, providing more options for women and pregnant people to make decisions over their surroundings for their procedures. In addition, research has shown that home use of both mifepristone and misoprostol with online or telephone support, like the telemedicine mentioned above, has proven both safe and effective in many countries. This would provide additional accessibility to those who live rurally, are disabled, have dependents and so on.

For patients with additional or more complex needs, facilities should be scaled up appropriately, for example, those requiring general anaesthetic should be moved to a suitable facility. Additional support such as integrated counselling should be available both before and after the procedure. For consistency in care and standards, all of these services should be approved by the healthcare trust.

With a history of strong stigma and mistrust around having an abortion in Northern Ireland, where the majority of care seekers have had to access an abortion without any social support, it is essential that stigma is widely addressed. For this reason, it could be beneficial to also provide outreach or mobile clinics as an options, where a GP referral is not a prerequisite of accessing treatment. All of the above suggestions should allow for a more flexible and accessible framework for abortion services in Northern Ireland that ensure women, girls and pregnant people are able to fully access this service whilst relieving the pressure on some service providers. NICE guidelines recommend facilitating an assessment within one week of the request and termination services within one week of assessment.

| **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?** | **Yes** | **No** |
|---|---|---|
| | | |

**If you answered 'no', what alternative approach do you suggest?**

WRDA recognises that terminations at this stage involve reduced grounds on which an abortion can take place alongside higher risk of complications for the patient. Therefore, WRDA believes any decisions regarding where a termination should take place after 24 weeks should be a clinical decision rather than a legally mandated restriction.

Legally stipulating the type of setting abortions can take place in through regulations is potentially stigmatising and could create an inequality with other types of sexual and reproductive care. Therefore, WRDA believes the legislation should remain flexible, while is it accepted that services in practice will focus on provision in acute sector NHS hospitals. Care should always be provided in a facility able to cater for complex needs and address any complications that may arise. All services should be available in NHS hospitals to ensure cost is not an additional barrier to accessing an abortion.

**2.7 Certification of opinion and notification requirements**

| **Question 9: 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?** | **Yes** | **No** |
|---|---|---|
| | | |
| **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?** | | |

**If you answered 'no' to either or both of the above, what alternative approach would you suggest?**

WRDA does not accept that certification is required at any stage. As the Executive Formation Act 2019 decriminalised abortion in Northern Ireland, certification is redundant, administratively burdensome, invasive and against the spirit of CEDAW recommendations which provide a clear roadmap to develop an appropriate legislative framework.

This is separate from ensuring all women, girls and pregnant people are given the opportunity to consult with medical professionals about their pregnancy and options for termination; which is essential to creating an informed choice and providing safe access to abortion. There is no clinical evidence available to suggest certification assists with abortion services or provides any safeguards for patients; in fact evidence suggests that it can lead to unnecessary delays.

If the government decides, against the suggestions from the women's sector, to introduce certification, this will make some women (especially rural) vulnerable to being refused care from doctors.

| **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** | **No** |
|---|---|---|
| | | |

**If you answered 'no', what alternative approach do you suggest?**

The notification process should be in line with other medical procedures and should support good governance and data collection. Abortion should not be treated as a special case; it is a form medical treatment just like any other medical procedure and should not require a distinct notification system. Notification requirements should not place undue burdens on abortion providers.

As with all medical procedures, WRDA believes only the minimum necessary information should be collected; in an anonymous way. With this in mind, relevant data collected may include the gestation, method of termination, broad age range of the care seeker and

potentially the health and social care trust area. This information will make it easier to understand barriers to access, and assist in developing appropriate services responding to specific identified needs.

It is worth looking to the US as an example of where exceptional notification processes for abortion have been used as a method of over-regulating the service providers in order to make it nearly impossible for them to function. This approach must be avoided and notification processes should be for data collection purposes only.

**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?** | **Yes** | **No** |
|---|---|---|
| | **X** | |

If you answered 'no', what alternative approach do you suggest?

WRDA believes that the provision for conscientious objection in Northern Ireland should be equal to the rest of the UK. This will ensure consistency in how health workers are treated and how care seekers can access treatment. By having consistency across the UK, it will create clarity for both providers and care seekers.

| **Question 12: Do you think any further protections or clarification regarding conscientious objection is required in the regulations?** | **Yes** | **No** |
|---|---|---|
| | | |

**If you answered 'yes', please suggest additional measures that would improve the regulations:**

WRDA believes that provision made in the professional codes of conduct of different professional bodies is sufficient and no additional protections are required specifically for Northern Ireland. However, staff who have a conscientious objection should be supported in the workplace, especially as those accessing an abortion deserve better than receiving treatment from those who do not support them or could increase stigma towards them. Further, protections created on the grounds of conscientious objection should also reflect the responsibilities of care providers towards their patients to ensure they can access the care they need.

In addition to this, it is essential that there is also support for those with a conscientious commitment to providing abortion care. For example, protection from discrimination and targeted harassment from colleagues, anti-abortion groups or individuals. Whilst conscientious objection often refers to the freedom of religion, consideration needs to be given to the freedom from religion when trying to access healthcare. Training for healthcare professionals on conscientious objection and its limits should be mandatory; especially as recent interviews from some GPs have suggested that the doctor should "try

| to reason with her". This would be going beyond the realm of conscientious objection and it is vital that a woman, girl or pregnant person is still able to access an abortion, without stigma, judgement or delay. |
|---|

**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** | **No** |
|---|---|---|
| | **X** | |

**If you answered 'no', what alternative approach do you suggest?**

Protesters outside of clinics and healthcare facilities are extremely distressing and a large invasion of the private life of a woman/pregnant people seeking an abortion and their families. Protesters further enhance the extreme stigma surrounding abortion and they have no place in anyone's healthcare experience.

Given past experiences in NI through the Marie Stopes Clinic, Brook clinic and the Family Planning Association, protesters were so distressing to those accessing healthcare that a volunteer clinic escort service was required for patients; with many patients and escorts facing verbal abuse, harassment, threats and, on occasion, physical assault.

For some leaving maternity hospitals, they are leaving without their babies and face being re-traumatised by protesters who attack each woman to looks to them as one who is of a child-bearing age. These protesters seek to humiliate these women, and further stigmatise them, this should not be tolerated nor enabled.

For context on Northern Ireland, Belfast City Council supported a motion calling for exclusion zones to reproductive healthcare facilities in 2017 and this gained cross-party support; including the DUP.

| **Question 14: Do you consider there should also be a power to designate a separate zone where protest can take place under certain conditions?** | **Yes** | **No** |
|---|---|---|
| | | **X** |

If you answered 'no', what alternative approach do you suggest?

Protesters should not be allowed to insert themselves into the private lives of those seeking abortions. Given the extremely negative experiences of those in the Republic of Ireland being greeted outside of maternity hospitals with white coffins by protesters, or those in the US being followed home by protesters, it is unsafe to suggest protesters can create a zone outside of the exclusion zone to protest. There is no other healthcare service where protesters are provided with zones to protest, why should this invasion of privacy be supported when it is related to reproductive health?

WRDA supports the freedom of opinion and expression, but protests of this kind involve threatening individuals making an extremely private decision in a public setting; this

should be described as harassment and abuse rather than protest. This sort of protest should be condemned and banned from being near any healthcare facility in Northern Ireland.

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

- WRDA believes it is necessary to deliver on all CEDAW recommendations to achieve full sexual and reproductive rights in Northern Ireland. For too long, women, girls and pregnant people have faced archaic laws, impossible barriers and immense stigma when it comes to abortion. Too many people have had to travel or continue with unwanted/forced pregnancies due to the 1861 Offence against the Person Act and it is a relief to the women, girls and pregnant people of Northern Ireland that abortion has finally been decriminalised. With all of this in mind, it is absolutely crucial that the new abortion framework in Northern Ireland is fit for purpose and fully accessible to all who need to access an abortion. We would like to address/suggest the following:

- **Addressing remaining criminal provisions/ Section 25 Criminal Justice (Northern Ireland) Act 1945**: It will be necessary for the new regulations to repeal s.25 of the Criminal Justice (Northern Ireland) Act 1945, in order to comply with s.9(1) of the NI (EF) Act 2019 read with paragraph 85(a to c) of the CEDAW report.

- **Non-discrimination in accessing services:**

    - *Trans Men and Non-Binary People:* Throughout the consultation document, as well as the equality screening itself, those who may require access to abortions are referred to solely as 'women and girls', leading to the exclusion of many transgender men and non-binary individuals and the potential exclusion of those groups in any services developed. While the majority of those accessing abortion will identify as women and girls, these services nevertheless must be accessible to all, especially considering the acute mental health impacts of pregnancy on many transgender men and non-binary people. The exclusion of those whose legal documents, physiology and/or expression may be gendered differently from the specific wording of the legislation will lead to the creation of barriers to accessing abortion services. Therefore, the legislative framework - as well as any services developed from that framework - must be inclusive and mindful of those experiences directly in the language used, and be developed in collaboration with trans civil society organisations to ensure all needs can be met within these services.

    - *Lesbian and Bisexual (L&B) Women*: 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 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 specially a recommendation of CEDAW which must be complied with, and the L&B women are more likely to need access in this circumstance, the introduction of abortion care will positively impact L&B women.

- *Adolescent Bisexuals and Lesbians:* A systematic worldwide study (Hodson et al 2018), 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. 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 relationships education, which is also recommended by the CEDAW report, as well as ensuring that measures are put in place to make abortion services accessible to lesbian and bisexual pregnant people. This raises further concerns on the need for adolescents being able to access abortion care without the consent of guardians.

- *Minority Ethnics, Migrants, Asylum Seekers and Refugees:* Ensuring equal access to abortion services for racialised groups, especially migrants (documented or undocumented) and asylum seekers, is essential for fulfilling the NIO's duty under Section 75. Many migrants, asylum seekers and racialised groups struggle to access mainstream healthcare services due to issues with ID, documentation, and/or for fear of the 'hostile environment' policy enforced by the UK government. These issues need to be considered by the NIO and an awareness of the needs of these groups needs to be established. We would recommend engagement with with migrant/refugee groups to ensure equal access to abortion and that all barriers are removed for these groups.

- *Disabled People*: For disabled people, accessing healthcare often raises issues regarding the lack of agency afforded to them in the decision-making process. Often, ableism is rife in healthcare services, with many disabled people accessing care being treated as though they don't have autonomy over

their own bodies. This intersects with how society views disabled people, in an infantilising and dehumanising way, creating unconscious bias amongst healthcare providers and a lack of cultural competency leading to barriers to accessing care. Given the widespread issues experienced by disabled individuals in accessing care in mainstream healthcare services, it cannot simply be assumed that these individuals will be able to access abortion services - it must be guaranteed in the language of the legislative framework and in any guidelines provided to healthcare practitioners. Issues regarding legal capacity and supported decision-making for people with learning disabilities also needs to be urgently addressed.

- *People with Dependants*: Many of those currently seeking abortions abroad find themselves struggling to cover the costs of childcare and/or making alternative arrangements for their dependants. It is absolutely essential that the barriers people with dependants face are considered and overcome in the creation of a new abortion framework; including providing localised services across Northern Ireland (including telemedicine), alongside support with alternative care arrangements for dependants.

- *Minors Accessing Abortions*: For under 18s, especially for those in abusive or dangerous living situations, access to abortion can be lifesaving. Access to this lifesaving care can be called into question due to a lack of agency provided to young people in those kinds of situations. There has been no information provided in the NIO's equality screening or consultation documentation as to what measures will be put in place to ensure confidentiality and access to services for minors who are in abusive or dangerous situations, which - if handled poorly - could put young people's lives at risk. We recommend that the NIO carefully researches and considers the impact of any abortion provision on minors.

- **Developing Integrated Sexual and Reproductive Health Services:**

This consultation on a new legal framework for abortion services in Northern Ireland should be seen as a unique opportunity to develop a fully integrated sexual and reproductive health service. This would be in line with CEDAW recommendations that note '*women attested to difficulties in obtaining modern forms of contraception, inter alia, emergency (morning after pill), oral, long term and permanent. Testimonies revealed that women were refused sterilisation if deemed too young or unmarried, including pharmacists' reluctance to dispense or provide information about emergency contraception'* (CEDAW 2018, para 46).

By removing barriers to contraception, the numbers of unplanned or unwanted pregnancies will fall. Despite this, cuts to the public health budget have affected access to contraceptives across the UK. With the introduction of abortion in Northern Ireland, this is the ideal opportunity to seek greater resources for integrated sexual and reproductive health services as a whole across Northern Ireland.

- **Relationships and Sexuality Education (RSE):**

RSE in schools across Northern Ireland is largely dominated by religious and anti-abortion organisations. The current provision of RSE is failing children across all of Northern Ireland, who are taught faith-based RSE[5]. RSE should teach children about abuse, consent, boundaries, contraception and respect. It should move beyond heteronormative views of relationships and this should be standardised across Northern Ireland. It is critical that age-appropriate RSE is developed with a factual information on sexual and reproductive rights. This is crucial to ensure women and girls are able to fully understand, enjoy and exercise their rights while contributing to addressing other issues such as violence against women, girls and gender non-conforming people. RSE should not be taught by external, anti-abortion or religious groups and it should be standardised, and regulated, across all schools in Northern Ireland.

[5] Faith-based RSE in Northern Ireland includes Love for Life and the Evangelical Alliance. Read more here: https://www.eauk.org/news-and-views/inspiring-choice