Response to Northern Ireland Office: A new legal framework for abortion services in Northern Ireland

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Introduction

Amnesty International UK (AIUK) is a national section of a global movement of over seven million supporters, members and activists. We represent more than 500,000 members, supporters, activists, and active groups across the United Kingdom, including thousands in Northern Ireland. Collectively, our vision is of a world in which every person enjoys all of the human rights enshrined in the Universal Declaration of Human Rights and other international human rights instruments. Our mission is to undertake research and action focused on preventing and ending grave abuses of these rights. We are independent of any government, political ideology, economic interest or religion.

Question 1: Should the gestational limit for early terminations of pregnancy be:

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?

Answer: Neither

People's ability to exercise their reproductive autonomy, control their reproductive lives and decide if, when and how to have children is essential to the full realization of human rights for women, girls and all people who can become pregnant.[1]

Human rights treaty bodies have consistently found that denying access to abortion or imposing barriers, such as arbitrary gestational limits, to such access undermines women's reproductive autonomy and violates their rights to privacy and equality, alongside their rights to life, health, and freedom from torture or ill-treatment.[2]

Women, girls and all pregnant people are the ones who should make decisions about their pregnancies. It should also be up to them to decide if they want third parties involved. Third parties have a role to play in the context of abortion – but it is not their role to determine the pregnant person's eligibility for abortion or to make decisions on their behalf or in their stead. Gestational limits such as those proposed can act as barrier to this healthcare.

A 12- or 14-week limit may not be sufficient to ensure access to abortion to all women, girls and pregnant persons who may need one, in particular those who are marginalised.

Women who are marginalised, including those who are victims of domestic abuse, and pregnant may take longer to present to services, either because of the logistics of accessing healthcare when living within a coercive relationship or because the violence has escalated during pregnancy and a continued pregnancy would put their safety at risk. Similarly, those who are victims of sexual crime such as rape and incest who may need additional time to come to terms with their trauma, realise they are pregnant and make a decision. The associated stigma around rape may also delay decision making.

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[1] While the majority of personal experiences with abortion relate to cisgender women and girls (that is, women and girls whose sense of personal identity and gender corresponds with the sex they are assigned at birth), intersex people, transgender men and boys, and people with other gender identities may have the reproductive capacity to become pregnant and may need and have abortions.

[2] See, e.g., *K.L. v Peru*, Human Rights Committee, Comm. No. 1153/2003, UN Doc. CCPR/C/85/D/1153/2003 (2005); *L.C. v. Peru*, CEDAW Committee, Comm. No. 22/2009, para. 8.15, UN Doc. CEDAW/C/50/D/22/2009 (2011).

While it could be argued that these cases can also be covered under the risk to health grounds, it must be recognised that drawing this arbitrary line has the capacity to cause harm to those who need these services most.

If, as presented, the regulations are to create a 12- or 14-week limit, then we would strongly urge the 14-week limit. However, longer than a 14-week limit is preferable to allow for women, girls and pregnant people in less advantaged situations to access services.

In addition, flexibility should be provided around access to abortion on request. Such provision would recognise that there may be challenging circumstances beyond the control of the woman or girl, which may have delayed her accessing the procedure within the time limit, and that she should not be denied access to the abortion she needs because of factors beyond her control.

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

If no, what alternative approach would you suggest?

Answer: No.

Requiring certification by a healthcare professional is clinically unnecessary and provides no additional safeguards for women or doctors.[3] The provision of medical and surgical treatments, including abortion, is heavily regulated. The independent regulators of the healthcare professions,[4] as well as the independent regulators of healthcare services,[5] ensure that all medical and surgical procedures, including abortions, are performed in safe, appropriate locations, by appropriately qualified professionals adhering to clinical best practice. Where practice falls outside of regulations, regulatory bodies retain the authority to take action against the individual or service responsible, for example by imposing restrictions on, or cancelling their registration. No additional form of oversight is necessary or justified in the case of abortion.

Further the certification requirement will deny autonomous-decision making to women, girls and pregnant people and will inevitably create delays, which in combination with a short time limit, may result in women in most marginalised situations not being able to access services on time.

Recently published NICE guideline on Abortion Care recommends a system of self-referral. A system of self-referral not only reduces the likelihood of delays but could improve women's experiences by allowing them to avoid stigma and negative attitudes when requesting an abortion.[6]

Under the new legislation, unlike other parts of the UK, abortion is decriminalised. Abortion is now a lawful medical procedure to be made available within Northern Ireland's healthcare system. Accordingly, the goal of maintaining quality abortion care will be best met through the established system of professional, regulatory and information-gathering mechanisms that ensure a high standard of care in all other areas of that healthcare system.

[3]Select Committee on Science and Technology. (2007). *Twelfth Report.* Retrieved from https://publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/104507.htm

[4] These include the Nursing and Midwifery Council, the General Medical Council, and the Pharmaceutical Society of Northern Ireland.

[5] In Northern Ireland, the Regulation and Quality Improvement Authority.

[6] NICE (2019) Abortion Care. Retrieved 27 November 2019, from https://www.nice.org.uk/guidance/ng140/chapter/Rationale-and-impact

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:

21 weeks + 6 days gestation

23 weeks + 6 days gestation

If neither, what alternative approach would you suggest?

Answer: 23 weeks + 6 days gestation at a minimum

International human rights standards require that women have a right to access abortion services for reasons of a risk to health at any stage of pregnancy, so it is absolutely necessary that this not be constrained by rigid gestational limits. While states are not prohibited in international human rights law from imposing reasonable restrictions on abortion services, such as gestational limits, such restrictions must not undermine women or girls' human rights. There must be flexibility in regulations in order to ensure that women and girls' human rights can be protected throughout pregnancy.

In many countries that provide access to safe and legal abortion, no gestational limits are imposed for abortions that avert a risk to health or life, in cases of severe or fatal foetal impairment, or where the pregnancy is the result of rape of incest. Furthermore, guidance around gestational limits for any grounds for accessing abortion would be better outlined in medical guidelines, rather than law. These are healthcare decisions medical professionals and pregnant women should make without arbitrary statutory restrictions.

This was underscored by experts presenting to the Joint Oireachtas Committee in Ireland when proposed legislation was consulted, who highlighted that viability cannot be defined arbitrarily based on gestational age, there are complex factors involved in determining the prospect of health and survival.[7] Such provisions in law will inevitably lead to greater risk to women's health and life through delay or denial of their access to abortion services. It would also force medical professionals to deliver a foetus in circumstances potentially conflicting with their clinical judgement, and indeed with medical ethics and best practice. Furthermore, no woman or girl or pregnant person must ever be subjected to coerced early delivery where alternative methods of abortion can be performed safely.

Finally, in practical terms, when an abortion is carried out for health reasons after the point of viability, this is in almost all circumstances a very much wanted pregnancy, and abortion is being accessed as a last resort to preserve a woman's health and sometimes her life. There are exceptions to this, of course, including in cases of rape where, due to trauma a woman or girl has not been able to present to services within the 12- or 14-week limit. This is no less of a health issue, and her access must be facilitated beyond the 12 or 14-weeks provided for. Access to abortion for rape survivors beyond 12 or 14-weeks is required by the international human rights framework.[8]

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[7] See Amnesty International Ireland, "Submission on the Health (Regulation of Termination of Pregnancy) Bill 2018", p. 7, available at: https://www.amnesty.ie/wp-content/uploads/2018/11/Amnesty-submission-on-Health-Regulation-of-Termination-of-Pregnancy-Bi....pdf

[8] See for example: CRC Concluding Observations: Argentina, UN Doc. CRC/C/ARG/CO/3-4 (2010) para. 59 ("The Committee recommends that the State party... Take urgent measures to reduce maternal deaths related to abortions, in particular ensuring that the provision on non-punishable abortion, especially for girls and women victims of rape, is known and

Question 4: 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

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

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

Answer: Yes, Yes

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

In some cases, women and girls may decide to terminate their pregnancies following a diagnosis of foetal impairment. As with all abortions, their decisions may be based on myriad factors including, their physical or mental health and wellbeing, the foetus' chance of survival, the options to treat and care for a child born with the anticipated health conditions etc. The decision whether to continue a pregnancy following a diagnosis of foetal impairment must lie with the pregnant person.

In October 2019, Sarah Ewart, supported by Amnesty International, won her legal challenge to NI abortion law. The Belfast High Court ruled that laws prohibiting abortion in cases of fatal foetal impairment are incompatible with the UK's human rights obligations under the European Convention on Human Rights. It is important to note that UN human rights treaty bodies have not limited their calls for access to abortion to cases in which foetal impairments are such that stillbirth or death immediately after birth is a virtual certainty. The UN Committee on the Elimination of Discrimination against Women has called on the Irish government to legalise access to abortion in cases of "severe impairment of the foetus"[9], as it had in its concluding observations on other countries.[10] This has also been raised during the review of Ireland's human rights record by the UN Committee on the Rights of the Child which criticised Ireland's criminalisation of abortion including in cases of "severe foetal impairment".[11] Severe foetal impairments can lead to a high degree of suffering after birth, and many women and couples opt for an abortion for altruistic reasons.[12]

enforced by the medical profession without intervention by the courts and at their own request"); CESCR Concluding Observations: Peru, UN Doc. E/C.12/PER/CO/2-4 (2012) para. 21 ("it recommends that the criminal code be amended so that consensual sexual relations between adolescents are no longer considered as a criminal offence and that abortion in case of pregnancy as a result of rape is not penalized."); CESCR Concluding Observations: Kenya, UN Doc. E/C.12/KEN/CO/1 (2008), para. 33 ("The Committee recommends that the State party ensure affordable access for everyone, including adolescents, to comprehensive family planning services, contraceptives and safe abortion services, especially in rural and deprived urban areas, by... decriminalizing abortion in certain situations, including rape and incest."); HRC Concluding Observations: Guatemala, UN Doc. CCPR/C/GTM/CO/3 (2012), para. 20 ("The State party should, pursuant to article 3 of its Constitution, include

[9] Concluding observations on the combined sixth and seventh periodic reports of Ireland, UN Doc. CEDAW/C/IRL/CO/6-7 (2017) para. 43.

[10] In its July 2014 concluding observations on Peru, for example, the CEDAW Committee recommended that the state "[e]xtend the grounds for legalization of abortion to cases of rape, incest and severe foetal impairment." CEDAW Concluding Observations: Peru, UN Doc. CEDAW/C/PER/CO/7-8 (2014) para. 36(a); CEDAW Concluding Observations: Chile, UN Doc. CEDAW/C/CHL/CO/5-6 (2012) para. 34.

[11] UN Committee on the Rights of the Child, Concluding observations on the combined third and fourth periodic reports of Ireland UN Doc. CRC/C/IRL/CO/3-4 (2016) para. 57.

[12] See the story of Laoise's mother in Amnesty International, She is not a criminal: The impact of Ireland's abortion law (EUR 29/1597/2015) 58-59.

We strongly urge that access to abortion is available in circumstances where there are severe or fatal foetal impairment diagnoses. Access can and should be addressed through a broad health ground, which is not restricted by a gestational limit. A pregnant person's right to health must always be at the centre of and inform medical decisions on terminating a pregnancy. We suggest that access to abortion in cases of severe and fatal foetal diagnoses are included under the risk to pregnant person's health as proposed under question 5.

It should be noted that laws or regulations that allow for abortion on grounds of fetal impairment do not implicate a violation of Convention on Rights of Persons with Disabilities (CRPD) article 10 on the right to life, given that the foetus is not a rights-holder under international human rights law. Rights enshrined in the CRPD and general international human rights law apply from birth.

States must also take comprehensive measures to address the underlying structural and social causes of stigma and discrimination against persons with disabilities. The language used in this question of 'abnormality' may in itself reinforce stigma around disability, we would encourage use of the term 'impairment' as an alternative. However, it is essential that states do so in a manner that does not violate women's human rights by removing or limiting access to abortion in cases of severe and fatal foetal impairments, exposing women, including women with disabilities, to risks to their life and physical, mental, social and emotional health and wellbeing.

We take this opportunity to highlight important steps that States should take to address the underlying structural and social barriers to realizing the rights of people with disabilities without jeopardizing women's rights, and these steps will have a direct impact on combating disability-related stigma. To this end, States should:

- Ensure that children with disabilities and their families have access to appropriate information, support, and services within their local community, in line with State obligations under the CRPD, to ensure that people with disabilities can live with dignity and exercise their rights. States also must allocate sufficient funding to support services.
- Train medical providers and support staff on the rights of people with disabilities and on how to provide them with human-rights based medical care and support.
- Develop and promote enabling legislation and policy frameworks to address root causes of inequalities of people with disabilities.
- Raise public awareness about the rights of people with disabilities to eliminate stigma associated with disability and to promote an inclusive society.

States must also ensure that pregnant women are offered voluntary access to unbiased, evidence-based information, including from medical providers who have been trained to discuss pregnancy-related diagnoses in a disability-sensitive manner that also respects women's autonomous decision-making and in a format that is accessible to them. This includes voluntary access to:

- Unbiased information and non-directive counselling about their pregnancies, including prenatal diagnostic tests to ensure access to all information about their pregnancy;

- Unbiased information and non-directive counselling about what the diagnosis means for their pregnancy and health, including, e.g., risks of miscarriage or stillbirth;
- Referrals upon request to professional organizations who could provide unbiased information and non-directive counselling about what the diagnosis could mean if the pregnancy were carried to term, including information about available support services in the local community for children who are born with disabilities and their families and access to networks and other resources;
- Information about access to abortion, including its legal status and where to access safe and legal abortions; and
- Referrals upon request for counselling and other supports to process the information received, including referrals to support groups for women who have received similar prenatal diagnoses.

Question 5: 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?

Termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman or girl?

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

Answer: Yes, Yes

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

We disagree that risk to life or health of the pregnant woman or girl has to be qualified as 'grave permanent injury'. This is a worryingly high threshold of harm required and should be reduced. The right to the enjoyment of the highest attainable standard of physical and mental health in international human rights law is not qualified in any way by reference to the potential harm to the health of the rights-holder. The right to health applies to health in the most holistic sense, and not simply the absence of serious harm to health. To this end, the qualifier must be removed as it is not an internationally accepted threshold. In understanding international best practice around what a risk to health ground should holistically encompass, the WHO defines this in the following way: "*The fulfilment of human rights requires that women can access safe abortion when it is indicated to protect their health. Physical health is widely understood to include conditions that aggravate pregnancy and those aggravated by pregnancy. The scope of mental health includes psychological distress or mental suffering caused by, for example, coerced or forced sexual acts and diagnosis of severe foetal impairment. A woman's social circumstances are also taken into account to assess health risk.*"[13] We therefore recommend that this provision be amended to refer to "a risk to the health and wellbeing" of the pregnant woman, without attempting to qualify this in terms of the level of harm/injury, as this aligns with international human rights standards and best international medical practice.

Qualifying the level of risk to a woman's health, runs counter to international human rights standards and best medical practice. Decisions around the level of risk the woman is willing to

[13] WHO, Safe Abortion: Technical and Policy Guidance for Health Systems, 2012, second edition, 92.

accept in continuing a pregnancy should be left to her, based on medical advice and her own personal circumstance.

The experts providing advice to the Joint Oireachtas Committee in Ireland around best practice when legislating for a health ground also agreed that doctors are hindered from intervening to protect a woman's health or life when legislation governing the procedure requires them to wait until the risk is "serious", "grave" or "permanent". The following is a summary of expert advice provided to the Committee in warning against qualifying a risk to health ground[14]:

- In most European countries, abortion legislation includes an explicit health ground that is unqualified;
- Risk can escalate very quickly, therefore it is dangerous to categorise risk as not 'serious'/ 'grave';
- Doctors require flexibility in order to take into account all implications on health during pregnancy;
- Doctors feel it is unethical to allow a woman or girl's health to decline to any extent when this is entirely avoidable;
- The term used in international human rights law is simply "risk". The term used by the World Health Organisation is simply "risk" or "health risk";
- It is only after the event of a detrimental health outcome that risk can be categorised as 'serious'/'grave' or 'permanent';
- Risk to health cannot be defined as it depends on individual cases;
- Assessing a woman or girl's mental health in in terms of gradations is not possible for clinicians;
- Qualifying terms such as 'serious'/ 'grave' or 'permanent' negate the right of the woman or girl to decide the degree of risk she is willing to accept; it removes her from the decision-making process around her own health;
- In a clinical context, defining a risk to be 'serious'/ 'grave' or 'permanent' or not is arbitrary;
- Risk cannot be gauged rigidly; it cannot be fixed.

Furthermore, the Joint Oireachtas Committee report, which forms the basis of the Health (Regulation of Termination of Pregnancy) Bill in Ireland, specifically states: "*The Committee notes that, in some European countries where a health exception permits a termination beyond the time limits for termination on request, the law does not define risk. Having regard to the expert evidence made available, the Committee accepts that risk depends to a large extent on individual circumstances. The Committee is therefore of the opinion that it is difficult to define in legislation the circumstances in which a risk to the health of the mother might arise*[15] *The advice to the Committee is that the assessment of that risk is best considered in a clinical setting rather than being fixed in legislation. The Committee accepts this advice. The Committee also accepts that, in the case of women presenting with mental health issues, the grading of risk is particularly difficult.*"[16]

[14] See Amnesty International Ireland, "Submission on the Health (Regulation of Termination of Pregnancy) Bill 2018", p. 5-6, available at: https://www.amnesty.ie/wp-content/uploads/2018/11/Amnesty-submission-on-Health-Regulation-of-Termination-of-Pregnancy-Bi....pdf

[15] Report of the Joint Oireachtas Committee on the Eighth Amendment, 2017, page 8, para 2.13. 27

[16] Report of the Joint Oireachtas Committee on the Eighth Amendment, 2017, page 8, para 2.13.

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?

Answer: Yes.

Abortion is a healthcare procedure and as such is conducted by a healthcare professional who is subject to governance and guidelines.

Under current statutory healthcare regulation in the UK, there are 32 regulated occupations ranging from doctors to nurses to pharmacists. To work in any of these 32 professions, professionals must be registered with the appropriate regulator. The General Medical Council is the body responsible for the regulation of doctors across the UK, the Nursing and Midwifery Council regulates nurses and midwives etc.

Regulations are also inspected by a statutory body in Northern Ireland, the Regulations and Quality Improvement Authority. Regulations exist to ensure medicines are provided appropriately, clinical services are delivered to high standards, safeguarding procedures are in place and informed consent is obtained.

Cases of malpractice, including flawed or inadequate consent, would continue to be dealt with through the general criminal law or medical disciplinary procedures.

The WHO Safe Abortion Guidelines advise that "abortion care can be safely provided by any properly trained health-care provider, including midlevel (i.e. non-physician) providers."[17] The guidelines clarify that "midlevel providers" include "midwives, nurse practitioners, clinical officers, physician assistants, family welfare visitors and others who are trained to provide basic clinical procedures related to reproductive health."[18]

We recommend that the criteria of who can provide abortion services is aligned with international best practice; we also recommend that this not be included in the legislation but instead within the medical guidelines, as lawmakers need not designate who can provide abortion in the law.[19]

[17] See World Health Organisation, 2012. Safe abortion: technical and policy guidance for health systems, second edition, Geneva: WHO, p. 65.
[18] Ibid.
[19] IPAS, Who can provide abortion care? Considerations for law and policy makers. 2015, 1.

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?

Answer: Yes.

There should be no specific restriction on where abortion procedures can be provided in law – this is a matter for regulation and commissioning. Flexibility in abortion care is critical to enable the service to evolve and ensure accessibility, especially to those most marginalised in our society. Attempts to place restrictions on where services can be provided would not be conducive to a framework which is intended to have rights and choice firmly at the centre.

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?

Answer: No

There is no justification for placing a restriction on location beyond 24 weeks within the legislative framework for abortion provision.

Future changes in safety and risk profiles may well mean that it becomes increasingly safe to provide later procedures at sites outside acute sector hospitals, flexibility is needed to ensure this decision would be most appropriately made as part of the commissioning provisions on the basis of up to date medical evidence, and not form part of legislative restrictions.

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?

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 provision do you suggest?

Answer: No

There should be no certification process for abortion at any period of gestation.

Under the new framework, abortion is decriminalised and has been made a lawful medical procedure to be made available within Northern Ireland's healthcare system. Accordingly, the goal of maintaining quality abortion care will be best met through the established system of professional, regulatory and information-gathering mechanisms that ensure a high standard of care in all other areas of that healthcare system.

In providing abortion services, healthcare professionals will need to make clinical decisions about the safety and acceptability of any requested procedure. If the new legal framework requires healthcare professionals to make a good-faith decision about whether continuing a pregnancy after 14 weeks gestation would cause risk to health and wellbeing of the pregnant person or their family, that decision will be matter of clinical opinion for the professional based on a full consideration of information specific to the patient they are caring for.

This clinical decision-making process for abortion care will be protected by the robust system of professional and regulatory checks on the healthcare system. In particular, healthcare professionals will be subject to:

- clinical practice standards, including general principles of informed consent and capacity decision-making and the Royal College of Obstetricians & Gynaecologists (RCOG) clinical guidelines on abortion;
- professional standards set by the General Medical Council and the Nursing and Midwifery Council; and
- civil and criminal law, including standards of medical negligence.

Healthcare providers will be subject to the Quality Standards for Health and Social Care. The independent Regulation and Quality Improvement Authority (RQIA) will be responsible for monitoring the services provided, including to ensure that services are accessible, well-managed and meet the governing standards.

We recommend that the Government should support this established safeguarding system, rather than imposing a distinct certification process, for three key reasons.

First, certification is unnecessary. Certification serves no medical or safety purpose and only operates in an environment where the procedure is criminalised. In England and Wales, the certification process is in place to protect health professionals from criminal prosecution under the specific provisions of the Offences Against the Person Act 1861 and Abortion Act 1967.

Second, a certification process would undermine the Government's overall commitment to provide a safe, accessible abortion service that respects the rights of women in Northern Ireland. We know that some healthcare professionals in Great Britain are discouraged from providing abortion care due to the need to make a legal declaration under the opaque certification requirement. Any formal certification process beyond standard clinical record-keeping requirements would impose an administrative burden (unrelated to any medical or

safety need) and cause delay for women seeking to access services. Most importantly, a certification process would take abortion outside of the standard healthcare model, where decisions reached in a healthcare professional/patient relationship are subject to the supervision of colleagues and general regulatory or professional bodies. Certification requirements would continue to exceptionalise abortion and thus reinforce the "stigmatising impact on women" that CEDAW identified as depriving women of privacy, self-determination, autonomy of decision, offending their equal status and constituting discrimination. Recently published NICE guideline on Abortion Care recommends a system of self-referral. A system of self-referral not only reduces the likelihood of delays but could improve women's experiences by allowing them to avoid stigma and negative attitudes when requesting an abortion.[20]

Third, a certification requirement does not acknowledge the role the woman or girl's own decision-making plays in determining the degree of risk she is willing to accept in respect of her own health or life. International human rights law and medical ethics are predicated on the principles of dignity and autonomy, meaning that individuals have a right to informed consent, to avail of and refuse medical treatment, and to participate in making healthcare decisions. Any certification procedure must ensure the participation of the woman or girl or pregnant person in abortion decision making where there is any degree of risk in relation to their health or life, in order to realise their right to informed consent. Additionally, the requirement that more than one medical practitioner must certify a risk to health runs counter to international human rights law and standards, as well as best medical practice. In its concluding observations to New Zealand, the UN Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW Committee) called on New Zealand to simplify its abortion laws and ensure women's autonomy.[21] In New Zealand, women are required to get certification from two doctors before an abortion can be performed, which the committee described as "nullifying their autonomy."[22] Furthermore, in its concluding observations to Timor Leste, the CEDAW Committee expressed concern about the requirement for multiple medical authorisations before an abortion can be carried out, such as permission from a panel of doctors.[23] This is particularly important in cases where access is sought by a survivor of rape after the 12- or 14-week window has passed. It is well established that, due to rape trauma syndrome, there may be significant delays before a survivor is able to seek access to health services and other supports. In cases where a patient reports becoming pregnant as a result of rape, this should not require examination or certification by multiple doctors. It is important that this process does not re-traumatise the rape survivor, place them in a position of having to 'prove' that a rape occurred, or compound the experience of being denied autonomy over one's own body.

[20] NICE (2019) Abortion Care. Retrieved 27 November 2019, from https://www.nice.org.uk/guidance/ng140/chapter/Rationale-and-impact

[21] CEDAW Committee, Concluding Observations: New Zealand, UN Doc. CEDAW-C-NZL-CO-7 (2012), paras. 33-34.

[22] Ibid.

[23] CEDAW Committee, Concluding Observations: Timor Leste, UN Doc. CEDAW/-C-TLS-CO-2-3 (2015) para 31(a).

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?

Answer: No

Scrutiny of abortion services should be achieved through the existing system for collecting and distributing anonymised, aggregated healthcare data in Northern Ireland.

In particular, we suggest the Government should encourage the Department of Health to strengthen its current process for preparing the Northern Ireland Termination of Pregnancy Statistics. The Department of Health publishes a yearly report on the number of medical abortions and terminations of pregnancies at health and social care (HSC) trusts in Northern Ireland, detailed by HSC Trust of treatment, country of residence and age band. The Department's statisticians prepare the report by accessing de-identified data managed by the HSC Business Services Organisation, which does not include any names or addresses of patients. We suggest this process should be continued and extended to include records of gestation, method of termination, and any other information necessary to scrutinise equitable access to abortion services. Publication of this anonymised and aggregated data would facilitate scrutiny of abortion services by policy-makers, members of parliament or Assembly and other interested bodies while maintaining the strong data security protections that are critical to protecting women's exercise of reproductive rights.

Patients may be reluctant to access care from their NHS provider if they are aware that their contact will trigger an automatic, individualised notification to a government organisation, particularly in the Northern Ireland context where a small, vocal minority (including MLAs and NI MPs) continues to threaten women's rights to use these essential services and where members of this small, vocal minority include those who would be members of the Northern Ireland Assembly and Executive should the devolved institutions be restored. Overall, the notification process offers no additional benefit to the transparent scrutiny of service provision beyond what is achieved within the Department of Health's anonymised, aggregated service.

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?

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

While international human rights law does not require states to allow conscience-based refusals to abortion, the UN human rights treaty bodies have noted that where states do allow for it, they must regulate it to ensure that it does not deny or hinder women's access to lawful services. They have explicitly confirmed that the relevant regulatory framework must ensure an obligation on healthcare providers to refer women to alternative health providers[24] and must not allow institutional refusals of care.[25] Human rights bodies have also clarified that health professionals not directly participating in a medical procedure cannot refuse to provide care. Provisions in the legislation concerning conscience-based refusals should make it clear that such refusal does not apply to institutions or those not directly participating in the abortion procedure (for example, reception staff).

If the decision is taken to institute conscience-based refusal then we refer you to the 2014 Supreme Court judgment in *Greater Glasgow Health Board vs Doogan and another,* which makes clear that conscience-based refusal refers to the procedure itself and not associated ancillary, administrative or managerial tasks. This ruling clarified section 4 of 1967 Abortion Act.

Medical providers must always provide care, regardless of their personal beliefs or objections, in emergency circumstances when abortion services are necessary to save a woman's life or prevent serious harm, in cases of life-saving post-abortion care, or where a referral or continuity of care is not possible.[26]

S4(2) from the Abortion Act 1967 requires individuals, no matter their ethical beliefs, to participate in treatment necessary to save the life or prevent grave permanent injury to the mental or physical health of a pregnant woman.

If conscientious provision was extended, as is proposed, then it must be explicitly clear that regulations do not permit further refusal.

While this would likely not be provided for in the legislation, it is important to note that the UN Committee on Economic, Social and Cultural Rights has specifically recommended that states should also ensure that an "adequate number of health-care providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach".[27]

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[24] See, e.g., CEDAW, General Recommendation No. 24: Article 12 of the Convention (Women and Health), para. 11, UN Doc. A/54/38/Rev.1, chap. I.

[25] See, e.g., CEDAW, Concluding Observations: Hungary, para. 31(d), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); CRC, Concluding Observations: Slovakia, paras. 41(f), U.N. Doc. CRC/C/SVK/CO/3-5 (2016).

[26] '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, available at: https://reproductiverights.org/sites/default/files/documents/GLP_Refusals_FS_Web.pdf

[27] UN CESCR, Gen. Comment No. 22, paras. 14, 43 ("Unavailability of goods and services due to ideologically based policies or practices, such as the refusal to provide services based on conscience, must not be a barrier to accessing services. An adequate number of health-care providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach. … Where health-care providers are allowed to invoke conscientious objection, States must appropriately regulate this practice to ensure that it does not inhibit anyone's

Though it is perhaps presently less recognisable than the term 'conscientious objection,' the regulations should replace the phrase 'conscientious objection' with the more accurate 'conscience-based refusal to provide care' as the effect of this action is in essence refusing to provide a healthcare service, protected by law, to a patient.

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

Answer: No

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?

Answer: Yes

States have an obligation to take effective measures to protect and guarantee women, girls and pregnant persons' right to health, physical integrity, non-discrimination and privacy as they seek healthcare information and services, free of harassment and intimidation amounting to obstruction of their access to that healthcare. In particular, as these are services needed only by women, girls and persons who can get pregnant and are often timebound and urgent.

One measure to ensure such protection could be putting in place an exclusion or safe access zone through which the right to healthcare and other rights can be exercised. This will be particularly important in Northern Ireland, where provision of abortion services is likely to be spread across a range of services. Women's and girls' right to privacy is also particularly important in this context given the stigma that surrounds reproductive health services, which (as noted by the CEDAW Committee) can be a barrier to access.

While the right of protesters to freedom of expression must be respected, this right is not absolute - it can be subject to limitations by the state, so long as such limitations are demonstrably necessary and proportionate to the interest of protecting the rights of those who seek or provide abortion services.

When opinions are expressed in a form that amounts to, or are clearly bound up with, intimidation or threatening behaviour towards a target group – in this case those who need or provide abortion services, it is necessary for the government to take effective action and proactive steps to protect the target group against that intimidatory or threatening conduct.

This proposal does not make clear how safe access zones will look but in principle in order to enable women, girls and pregnant person to exercise their rights, this may be appropriate as it does not remove protesters' right to freedom of expression but rather seeks to limit it in a way that which does not jeopardise pregnant person's right to access healthcare, as protesters still can exercise their right to freedom of expression elsewhere.

access to sexual and reproductive healthcare, including by requiring referrals to an accessible provider capable of and willing to provide the services being sought, and that it does not inhibit the performance of services in urgent or emergency situations").

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

Answer: No

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

- **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 access to services.** Governments are prohibited from engaging in discrimination of any kind in their health-related laws, policies and practices including grounds such as age, gender, gender identity and sexual orientation, socio-economic status, minority, migrant or refugee status. It is essential that Government put in place regulations that are inclusive and accessible for all people who can become pregnant. While the majority of personal experiences with abortion relate to cisgender women and girls, it also holds true that intersex people, transgender men and boys, and people with other gender identities or who are gender non-conforming may have the reproductive capacity to get pregnant.

  In addition, the legislation must ensure that any barriers certain groups will/may experience are identified and addressed. This includes women and girls with disabilities, including in respect of their legal capacity to consent to or refuse treatment In respect of adolescent girls' access to services and their evolving capacity to consent to medical treatment, since 2015, the UN Committee on the Rights of the Child has consistently recommended that states: "Decriminalize abortions in all circumstances and review legislation with a view to ensuring children's access to safe abortion and post-abortion care services. The views of the child should always be heard and respected in abortion decisions."[28] The legislation must support pregnant person's reproductive autonomy, including through supported decision-making for pregnant people with disabilities when necessarily.

  Non-nationals, including refugees, asylum-seekers, stateless persons, migrant workers and victims of international trafficking, should have equal access to abortion services, free from discrimination.[29] Furthermore, according to the 2017 CESCR Committee's statement on access to services for refugees and migrants, "Any distinction, exclusion, restriction or preference, or other differential treatment on grounds of nationality or legal status, should therefore be in accordance with the law, pursue a legitimate aim and remain proportionate to the aim pursued. A difference in treatment that does not satisfy such conditions should be seen as unlawful discrimination".[30]

[28] See CRC/C/GMB/CO/2-3; CRC/C/HND/CO/4-5; CRC/C/HTI/CO/2-3CRC; CRC/C/GBR/CO/5; CRC/C/ZWE/CO/2; CRC/C/SLE/CO/3-5; CRC/C/BTN/CO/3-5. This is also in CRC General Comment 20 on Adolescents. See CRC/C/GC/20, art. 60.
[29] CESCR Committee, General Comment 20: *Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights)*, 2 July 2009, E/C.12/GC/20, para.30.
[30] CESCR Committee, Statement on Duties of States towards refugees and migrants under the International Covenant on Economic, Social and Cultural Rights, UN Doc. E/C.12/2017/1, para. 5, 2017.

- **Ensuring access to accurate, evidence-based and unbiased information about abortion.** UN treaty bodies have consistently emphasized that access to information is a critical element of accessing abortion services.[31] Further, the CEDAW Committee has called on states to eliminate information barriers to abortion services, such as mandatory biased counselling requirements,[32] and ensure that information provided is science- and evidence-based and includes both the risks of having an abortion and of carrying a pregnancy to term in order to ensure women's autonomy and informed decision-making.[33] In addressing abortion in its updated General Comment No. 36, the HRC called on states to "ensure access for women and men, and, especially, girls and boys, to quality and evidence-based information and education about sexual and reproductive health and to a wide range of affordable contraceptive methods, and prevent the stigmatization of women and girls seeking abortion."[34]

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[31] CEDAW Committee, Concluding Observations: Zambia, paras. 33, 34, U.N. Doc. CEDAW/C/ZMB/ CO/5-6 (2011).
[32] CEDAW Committee, Concluding Observations: Hungary, para. 30, U.N. Doc. CEDAW/C/HUN/ CO/7-8 (2013).
[33] CEDAW Committee, Concluding Observations: Slovakia, para. 31, U.N. Doc. CEDAW/C/SVK/CO/5- 6.
[34] HRC, General Comment 36 (right to life), UN Doc. CCPR/C/GC/36, para. 8, 2018