

Amnesty International UK



Guidance on Termination of Pregnancy in Northern Ireland

Submission to the Northern Ireland

Department of Health, Social Services and Public
Safety

June 2013

Amnesty International UK
397 Ormeau Road, Belfast, BT7 3GP

Contact: Grainne Teggart
Grainne.teggart@amnesty.org.uk
02890643000
www.amnesty.org.uk/ni

Amnesty International UK (AIUK) is a national section of a global movement of over three million supporters, members and activists. We represent more than 230,000 supporters in the United Kingdom. Collectively, Amnesty International's 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.

AIUK welcomes the opportunity to comment on the draft guidance on termination of pregnancy in Northern Ireland. This submission highlights our particular concerns related to the potential human rights impact of the draft guidance. It includes recommendations to improve the guidance with a view to ensuring the provision of timely, acceptable, and affordable health care of appropriate quality to all¹, taking into account sections 58 and 59 of the Offences Against the Person Act 1861; section 25 of the Criminal Justice Act (Northern Ireland) 1945, and subsequent court decisions on relevant individual cases. The guidance should be developed with a view to ensuring women the best possible standards of care provided by health and social care professionals.

This submission also includes AIUK's concerns related to the human rights impact of the current scope of the Northern Ireland Laws on abortion, and their consistency with international human rights obligations, including the obligation to ensure women's human rights to non-discrimination, health, life, and physical integrity.

1. The human rights impact of restrictive abortion laws:

At the outset, AIUK takes this opportunity to remind the Northern Ireland Department of Health that restrictive abortion laws and practices and barriers to access to safe abortion to the full extent of the law are gender-discriminatory, denying women and girls treatment only they need.² Only women and girls risk physical and mental suffering or losing their lives as a result of delays in denial of medical treatment if complications arise during pregnancy. Only women and girls are compelled to continue a medically dangerous or unwanted pregnancy or face imprisonment. Only women and girls suffer the mental anguish and physical pain of an unsafe abortion, risking their health and life in the process. The development of guidance for health and social care professionals should be approached with this in mind.

AIUK demands the full decriminalization of voluntary abortion in all cases, subject only to such limitations as would be reasonable for any other type of medical intervention, and further demands that states ensure access to safe and legal abortions in cases of risk to mental and physical health, or in circumstances where pregnancy is a result of sexual violence, rape or incest. This is in line with international human rights standards, and would be a critical step to ensure that women in Northern Ireland can access the most appropriate health care, and that health and social care professionals can provide care, without the threat of prosecution.

¹ UN Convention on Economic Social and Cultural Rights General Comment 14 on the highest attainable standard of health (use full citation, though).

² See UN Committee on the Elimination of All Forms of Discrimination against Women, General Recommendation No. 24: Article 12 Of the Convention (women and health), paras. 14 and 31 (c)

The United Nations' independent expert body charged with overseeing the implementation of the Convention on the Elimination of all Forms of Discrimination Against Women, the Committee on the Elimination of Discrimination Against Women (CEDAW Committee), issues guidelines on the implementation of the convention provisions. In its General Recommendation 24 (Women and Health), the CEDAW Committee makes recommendations for government action to uphold Article 12 of the Convention. It identifies barriers to women's access to appropriate health care, and states that "laws that criminalise medical procedures only needed by women punish women who undergo those procedures"³ and therefore are counter to the Convention. It includes a recommendation instructing States that "When possible, legislation criminalising abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion."⁴

Several studies on access to abortion in countries with partial decriminalisation – such as in Northern Ireland - have concluded that as long as abortion is generally criminalised, medical service providers will be deterred from even providing care that is legal.⁵ In its ruling in the case of *A, B, and C v Ireland*, the European Court of Human Rights said it considered it evident that the criminal provisions on abortion "would constitute a significant chilling factor for both women and doctors in the medical consultation process" and that women would be deterred from seeking legal and necessary care, and doctors from providing it, because of this chilling effect.⁶ AIUK considers that the language used in the guidance could also contribute to a chilling factor giving rise to reluctance amongst medical professionals to provide abortion services within existing Northern Ireland law.

Furthermore, affirming "the right of all human beings, in particular women, to respect for their physical integrity and to freedom to control their own bodies", the Parliamentary Assembly of the Council of Europe has stated that "the ultimate decision on whether or not to have an abortion should be a matter for the woman concerned, who should have the means of exercising this right in an effective way."⁷ It has invited member states of the Council of Europe to "allow women freedom of choice and offer the conditions for a free and enlightened choice without specifically promoting abortion."⁸

In relation to Northern Ireland specifically, the UN Committee on the Elimination of Discrimination against Women has also recommended in its 2008 Concluding Observations on the UK that the government initiate:

"...a process of public consultation in Northern Ireland on the abortion law. In line with its general recommendation No.24 on women and health and the Beijing Declaration and Platform for Action, the Committee urges the State party to give consideration to

³ CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health) para.14

⁴ CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health) para.31 (c)

⁵ Human Rights Watch, *A State of Isolation: Access to Abortion for Women in Ireland*, January 2010; Human Rights Watch, *The Second Assault: Obstruction Access to Abortion after Rape in Mexico*, March 2006.

⁶ European Court of Human Rights, *Case of A, B, and C v. Ireland*, Judgement of 16 December 2010, para 254.

⁷ Parliamentary Assembly of the Council of Europe Resolution 1607 (2008) Access to safe and legal abortion in Europe, para.6

⁸ Parliamentary Assembly of the Council of Europe Resolution 1607 (2008) Access to safe and legal abortion in Europe. Para. 7.3

amending the abortion law so as to remove punitive provisions imposed on women who undergo abortion.”⁹

As yet, the CEDAW Committee recommendation on Northern Ireland has not been implemented.

In consideration of the international human rights framework with regard to national level laws and policies on abortion, **we urge that the UK as state party, which has devolved decision-making responsibility in this area to Northern Ireland Executive, act without delay to: implement the CEDAW Committee recommendation; decriminalise abortion in Northern Ireland, and to enact the legal framework necessary to ensure the full range of women’s and girls’ human rights, including rights related to accessing safe and legal abortion.**

2. General Comments on the draft guidelines:

a. Risk of creating/ reinforcing a climate of fear resulting in denial of access to lawful abortion services:

AIUK is concerned that the framing of the guidance and the wording used will not foster an enabling environment to guide health and social care professionals in their obligations to provide appropriate and timely care to women. The draft guidelines as they stand risk creating or reinforcing a chilling environment within which health and social care professionals will need to make clinical decisions, with an over-emphasis on how their actions could be in breach of the law, rather than an overarching concern for the health of their patients.

Amnesty International research on access to abortion has shown that a climate of fear can hinder the provision of care with serious health consequences for women.¹⁰ In circumstances where abortion is subject to criminal law, health care providers are often compelled to make decisions regarding available health care interventions, with a view to avoiding potential prosecution, rather than a view to providing quality care.¹¹ Women have been denied abortions, even where their lives or health depended on an early intervention, with disastrous results.¹² The impact can be devastating for women, as well as for their families.

AIUK is concerned that the draft guidelines, as they stand, will not lead to improvements in clinical decision-making or in the administration of care for women, and may actually impact negatively on the ability of health and social care professionals to ensure appropriate, timely quality care.

Therefore, AIUK urges a careful re-drafting of the guidelines to ensure that language is in line with international human rights standards and best practices for the provision of

⁹UN CEDAW Concluding Observations United Kingdom of Great Britain and Northern Ireland. 2008. A/63/38 Para 289

¹⁰ Amnesty International, The total abortion ban in Nicaragua: Women’s lives and health endangered, medical professionals criminalized, AI Index AMR 43/001/2009

¹¹ Amnesty International, Briefing to the UN Committee on Economic, Social and Cultural Rights: Poland, 43rd session, November 2009, AI Index EUR 37/002/2009

¹² Amnesty International, El Salvador: Government must act immediately to save young woman’s life, 31 May 2013

reproductive and sexual health care, in order to safeguard against health and social care workers acting out of anxiety or fear of wrong doing.

AIUK further recommends the guidance is re-drafted in order to contribute to and enable clinical decision-making providing women with the quality care they choose, in particular with regard to access to legal abortion and other relevant pregnancy and abortion related care.

b. Importance of obligations to ensure women’s agency in health decisions:

The draft guidelines currently indicate that medical professionals are the ultimate decision-makers on the termination of a pregnancy. Accordingly, the role of the concerned woman is one restricted to giving informed consent once a clinical decision has been made as to whether or not she meets the criteria for a legal abortion.

International human rights standards are clear that individuals must have the main and final say in decisions about their health care.¹³ The CEDAW Committee has put this in the strongest terms possible in the context of reproduction: “Decisions to have children or not, while preferably made in consultation with spouse or partner, must not nevertheless be limited by spouse, parent, partner or Government.”¹⁴

The UN Committee on Economic, Social and Cultural Rights, which oversees the implementation of the International Covenant on Economic, Social, and Cultural Rights, has also noted that autonomy is key to the realisation of the right to health: “The right to health... includes the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference.”¹⁵ States have the obligation to ensure that women are fully informed at every stage with reference to their health care. This includes the provision of and access to information about their sexual and reproductive health.

AIUK is concerned about the lack of reference in the guidelines to the right of women and girls to receive full, accurate, and complete information about their health and care options to enable them to make informed decisions and give meaningful consent to care. Information and consultation is necessary throughout the care cycle. Pregnant women and girls (or their guardians where appropriate) must be the ultimate judge of whether or not a termination of the pregnancy is the best course of action for them. AIUK considers this lack of a reference to women’s decision-making prerogative to be a critical omission in the guidelines that could result in health and social care professionals

¹³ There may be narrow limitations to this principle where an individual is temporarily or permanently unable to make decisions for herself or himself.

¹⁴ CEDAW Committee, General Recommendation 21 on Equality in Marriage and Family Relations (1994), para. 22.

¹⁵ Committee on Economic, Social and Cultural Rights, General Comment 14, The Right to the Highest Attainable Standard of Health, U.N. Doc> E/C.12/2000/4 (2000) para. 8

misunderstanding the importance of their obligations to ensure women's full and informed consent to care or to continue a pregnancy.

AIUK recommends that the guidelines include an additional section on the importance of the responsibility to ensure women are fully informed, and that their consent is required at every stage of the care-cycle. AIUK also recommends that a segment be added to clarify the right to second medical opinions, and for the exercise of this right to be facilitated and supported in a timely manner.

c. Use of language and terminology:

AIUK considers that some of the terms used in the draft guidelines are inconsistent with international human rights standards, and with clinical terminology. Specifically, the draft guidelines refer to pregnant women as "mothers", and to the foetus as "the unborn child". Ensuring proper and consistent use of language on sexual and reproductive health and rights and maintaining neutral terminology is critical to effort to ensure provision of health care in a manner that does not presuppose any particular view or opinion.

AIUK recommends that terms used are consistent with medical and human rights terminology, specifically that pregnant women and girls are referred to as "women and girls", and that references to "the unborn child" are replaced with proper medical terminology depending on the stage of the pregnancy referred to, for example fertilised ovum, implantation, embryo, foetus etc.¹⁶

d. No reference to a complaints and review mechanism for girls and women denied access to abortion information and care

The draft guidelines fail to set out or refer to an administrative mechanism available to girls and women to challenge medical professionals' decisions to deny them access to abortion information and services.

The lack of an effective remedy for women and girls to challenge decisions made by doctors that negatively impact their right to the highest attainable standard of health is inconsistent with the state's obligations under Article 2(2) and 12 of the International Covenant on Civil and Political Rights. As the Human Rights Committee has clarified in its General Comment No. 20 (on non-discrimination) "national legislation, strategies, policies and plans should provide for mechanisms and institutions that effectively address the individual and structural nature of the harm caused by discrimination in the field of economic, social and cultural rights... These institutions should adjudicate or investigate complaints promptly, impartially, and independently and address alleged violations relating to article 2, paragraph 2, including actions or omissions by private

¹⁶ Royal College of Obstetricians and Gynaecologists, Medical terms explained. At: <http://www.rcog.org.uk/womens-health/patient-information/medical-terms-explained>. See also Centre for Reproductive Rights, Whose right to life? Women's rights and prenatal protections under human rights and comparative law. At: http://reproductiverights.org/sites/crr.civicactions.net/files/documents/RTL_3%2014%2012.pdf

actors”.¹⁷

In its judgment in the case of *Tysi c v. Poland*, the European Court of Human Rights concluded that the absence of timely and effective domestic measures to review doctors’ decisions for denying access to abortion services, including consideration of the concerned woman’s views and submission of written grounds for the review decision, could be “said to amount to the failure of the State to comply with its positive obligations” under Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (right to respect for private life). The Court stated that post-factum reviews of decisions to deny access to abortion services (including tort actions for damages or criminal complaints against doctors) would be inadequate.¹⁸

The Court considered that the Polish authorities had failed to ensure effective institutional and procedural mechanisms to ensure adjudication and resolution of disputes between pregnant women and doctors on “whether the conditions for obtaining a lawful abortion had been met” in specific cases.¹⁹ It noted that concepts of lawfulness and the rule of law required that the review mechanism should be timely; independent; allow the woman to be heard in person and for her views to be considered during the review procedure; that written grounds for decisions made should be issued.²⁰

e. Absence of review process and monitoring:

The guidelines contain no mention of an oversight body, or review mechanism for care given, and references to data collection are inadequate. AIUK is concerned that without a review mechanism or an oversight body, there will be no way of ensuring that health and social care professionals are aware of the guidance or that they use the guidance appropriately in their work. There will also not be a mechanism to evaluate whether the guidelines are providing sufficient clarity to health care providers to ensure appropriate quality care.

AIUK is also concerned that the guidance document is not placed within a broader framework on monitoring the application of abortion care services (including lawful terminations) in Northern Ireland. Comprehensive data is critical to good policy decisions, and data collection should therefore be integral to the development of any new guidelines. Nevertheless, there is only one reference in the guidance documents to the development of a data collection system, and then only in order to collect information on the grounds for termination of pregnancies taking place.

AIUK considers this to be a critical omission, and recommends that a review mechanism and oversight body is identified, and that gaps in data collection on equitable access to

¹⁷ UN Committee on Economic, Social and Cultural Rights, *General Comment No. 20 (Non-Discrimination in Economic, Social and Cultural Rights; Art 2, para 2)*, UN Doc. E/C.12/GC/20, (CESCR General Comment No. 20), para 40.

¹⁸ *Tysi c v. Poland* (App. No. 5410/03), judgment of the European Court of Human Rights of 20/03/2007, para 118.

¹⁹ *Tysi c v. Poland*, judgment of the European Court of Human Rights of 20/03/2007, para 124

²⁰ *Tysi c v. Poland*, judgment of the European Court of Human Rights of 20/03/2007, paras 117-118.

quality sexual and reproductive health care services are identified and measures taken to address them urgently.

3. Detailed comments on the draft:

Section 1: Introduction

- a) **Lack of clarity on the purpose of the guidelines:** The introductory section of the draft document does not include a clear statement of purpose for the guidelines, identifying what they aim to do, and who should use them in their work.

Recommendation: The introduction section should include a clear statement of purpose, which AIUK understands to be to clarify the laws relating to termination of pregnancy in Northern Ireland, to ensure the highest attainable standard of sexual and reproductive care to women and girls within the confines of the law. AIUK also suggests that a central aim should be to ensure the fulfilment of women and girls' human rights to health, life, non-discrimination, and physical integrity.

- b) **Terminology:** The guidelines should use consistent, appropriate, and accepted clinical and legal terminology throughout. For example, the document uses the term 'the mother' in places where 'the pregnant woman' would be the most appropriate term.

The term 'the unborn child' is also inappropriate and not consistent with terminology used in a clinical or medical setting, or with international standards.

Recommendation: The text should be reviewed to ensure consistent use of terms throughout and to ensure use of language is consistent with internationally accepted clinical and legal terminology.

- c) **Obligations to uphold women's right to health:** There is no reference to the obligations to respect, protect and fulfil women's rights to life, health, and non-discrimination anywhere in the document. AIUK is concerned that the draft guidelines do not make it clear that a pregnancy which poses a threat to the life or health of the pregnant woman or girl should be treated as an emergency, and should give rise to a consideration of all clinical options, including a termination. For example, paragraph 1.6, underscores the need for all health and social care professionals to be familiar with the legal framework, but does not underscore the responsibility to ensure appropriate and timely medical intervention in order to save a woman's life. Case law on Northern Ireland does provide information for such circumstances, for example on carrying out termination of a pregnancy in order to preserve the life of a woman, as well as to preserve the mental health of a woman, they are included in an annex to the guidance, yet not referenced in this section.²¹

It is our view that the guidelines should facilitate a positive approach to ensure that health and social care professionals are able to intervene in a timely and responsive manner to ensure that all women and girls receive the appropriate quality care they need and want.

²¹ R v Bourne (1939), 1993, case of Re K, 1994, case of Re A,M,N,H. referenced in Annex A, Case Law on Abortion in Northern Ireland, Department of Health Guidance on Termination of Pregnancy in Northern Ireland.

Recommendation: This section should cross-reference with the information included in the annex to ensure that health and social care professionals understand relevant legal developments. Specific text should be included to ensure that professionals are reminded of their responsibilities towards upholding women's human rights.

- d) **Data collection system:** Further to general comments provided already, the development of a data collection system in section 1.8, does not make any reference to ensuring consistency with human rights principles, including around confidentiality. In fact, the reference implies that the purpose of a data collection system is also to "reassure the public" rather than to further good policy making and adequate resource allocation for the health system, for example. The purpose of such information should be to inform policy and decisions around health care practice, and to review and monitor health services.

Recommendation: The reference to reassuring the public should be removed, and development of relevant data collection systems must be consistent with human rights principles, including on the confidentiality of personal health information.

Section 2: Law on termination of pregnancy in Northern Ireland:

- a) **Confusing statements on the legal framework:** The law in Northern Ireland is referenced a number of times in the document using different language. In some areas applicable standards are referenced in a highly subjective and imprecise manner, potentially adding to the confusing among health care providers. For example, paragraph 1.2 "The circumstances where a termination of pregnancy is lawful in Northern Ireland are highly exceptional."

There is unnecessary repetition of aspects of the legal framework, for example both paragraphs 1.4 and 2.2, state that the 1967 Abortion Act does not extend to Northern Ireland.

In addition, the actual wording of the legal framework around abortion in Northern Ireland is referenced in paragraph 2.3, but not properly iterated until paragraphs 2.7 and 2.8. AIUK is concerned that this approach to outlining the legal framework could lead to confusion and misinterpretation.

Recommendation: The guidelines should set out the legal framework using the actual terminology of the law, in one section only, so it is clear and unambiguous, and cross-referenced where appropriate. Remove references that offer opinion on the likelihood of particular cases and circumstances occurring.

- b) **Lack of clarity over the authority of the guidelines and over-emphasis on punitive measures:** AIUK is concerned that the tone of the draft document and the lack of clarity on the purpose of the guidelines could cause confusion for health and social care professionals. The impact of such confusion could lead to unacceptable delays in clinical decisions regarding available care to women and girls who need to terminate pregnancies to save their lives or outright denial of required care. In particular we are concerned that the draft document goes to great lengths to emphasise the punitive measures that health and social care professionals face in interpreting when it is lawful to advise women of the option of a termination. At a minimum, care providers (and the

state) should also clarify that they and it incurs responsibility where an appropriate clinical course of action is known and available but not taken due to fear, hesitation, or unclear guidance.

Recommendation: Clearly stating the law once in the document would be sufficient to ensure health and social care professionals are aware of the circumstances in which a termination could be lawfully performed.

- c) Inclusion of inappropriate references, emphasis and language:** In some places, the draft includes language that is inconsistent with guidance from human rights bodies. For example, the recommendation to have two doctors assess a woman's case is presented in the context of the threat of criminal prosecution, rather than as a best practice to ensure the most appropriate medical care for women. Where a woman's health or life may be compromised through delayed care, there cannot be an excuse to seek another doctor's opinion solely to avoid incurring criminal sanctions for providing otherwise available and appropriate quality health care.

Foetal abnormality (2.11) is singled out and clearly stated as not recognised as grounds for termination in Northern Ireland. However, there may be circumstances where the possibility of foetal abnormality could have significant and long term health consequences for women. Whether or not continuing with a pregnancy could cause 'real and serious' and 'permanent or long term' effects on the physical or mental health of a woman should be assessed by the appropriate health and social care professionals, yet this is not underscored in the draft as it stands.

It is important for any guidelines developed on access to legal abortion in Northern Ireland to be reflective of the fact that medicine is not an exact science and that any delay in the provision of abortion services may in fact contribute to deterioration in the health situation of the pregnant woman. In this sense, guidelines should incentivize swift decision-making and access to services, and must not punish medical service providers for prioritising the health and life of their patient over seeking to intervene only where all medical providers everywhere would agree the risk was real and substantial. There cannot be any justification for allowing a situation of imminent risk to a pregnant woman's life or health to continue or worsen, if an effective course of medical action is known and can be taken.

The section also includes 'perception' or 'opinion' on the number and frequency of cases that would meet the criteria for a legal termination that medical practitioners may face. However, the inclusion of a reference to the establishment of a data collection system indicates a lack of information to support the perception on the rarity of such cases. The inclusion of terms like "extremely rare" and "more likely than not" are unnecessary as health and social care professionals, understanding the legal framework, are best placed to determine on a case by case basis whether or not a termination is an appropriate option, and relay this information to the pregnant woman and girl (and her guardians, as appropriate) to make an informed decision about care. The reference to unsubstantiated perception of case incidence could contribute to a chilling effect, placing medical practitioners in a situation where they fear the consequences of their clinical recommendations.

Recommendation: Remove the paragraph singling out foetal abnormality. Ensure that the guidance references best medical practices to ensure that health care decisions are made by the pregnant woman or girl in consultation with her health care provider. Remove language that gives opinions on the likely quantity of specific cases and ensure that the guidance enables health and social care professionals to determine the most appropriate course of action on a case by case basis, based on medical evidence, so that they can relay this information to the pregnant woman or girl for her to decide on her care.

Section 3: Clinical assessment

- a) **Restricted scope of best practice guidance:** It appears from point 3.1 that best practice procedures outlined in the guidance refer only to ensuring that the Abortion Law is adhered to when doctors and other care providers determine whether a case meets the criteria for a legal abortion. The guidance does not include specific criteria to guide health and social care professionals in understanding their responsibilities to protect the right to life and health of pregnant women and girls. For example there is little reference to best practice in ensuring that women and girls (and their guardians) are fully informed at every stage of the care-cycle. Neither is there any reference to women's agency in decision-making around their healthcare, both of which are essential best practice approaches to safeguard women's human rights and health.

Recommendation: The guidelines should be broadened to ensure adherence with best practice in all relevant stages of decision-making on access to legal abortion and related care. The importance of ensuring the agency of pregnant women and girls throughout the care-cycle must be emphasised.

- b) **Guidance around timescales:** The guidance only makes a vague reference to the need to ensure that decisions are made in a timely manner. As such, the guidance risks being of little use in helping health and social care professionals discharge their responsibility to complete clinical assessments within a reasonable time-line to ensure access to timely and appropriate quality care.

There is also no reference to the responsibility to ensure that information and data is gathered on how far clinical assessments are meeting best practice in terms of timeliness.

Recommendation: The guidelines should include clear references to timely action and decision-making, in line with international standards of best practice,²² and data collected assessing the timings of assessments.

- c) **Recording of decisions:** Paragraphs 3.3 and 3.10 make reference to the need to record the pregnant woman or girl's stated reasons for termination of pregnancy in a woman's health notes. These reasons are private and unrelated to the legality of the intervention. As such, they should be irrelevant to the clinical decision-making. The

²² The World Health Organisation refers to minimising delays in access to care, including those related to the time required between requesting and scheduling the procedure, the waiting time and the total time in hospital/clinic. See World Health Organisation, Safe Abortion: Technical and policy guidance for health systems, Second edition, 2012. At: http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/

rationale for a health care provider to deny care, however, is highly relevant to ensure accountability. The guidance does not require this information to be recorded.

There should also be provision to ensure that health and social care professionals recognise and accept the right of women and girls (or their guardians) to make informed decisions about their own health care (and to challenge decisions made for them), in the lead up to, during and after the need for health care. It is imperative that assessments of the legality of an intervention are properly recorded.

Recommendation: Include more robust guidance for health and social care professionals with regard to recording information and decisions for clinical reasons, in addition to ensuring consistency with international human rights standards and principles with regard to decisions on women's health care. Eliminate the requirement to record a pregnant woman or girl's private reasons to desire a termination of her pregnancy.

- a) **Defining exceptional circumstances:** The only exceptional circumstance where a single doctor can authorise an abortion referenced in the guidelines, is in circumstances of "imminent death emergency". This is far too narrow an interpretation to ensure consistency with the state's obligations to respect, protect and fulfil human rights, and does not take into account the developments in Northern Ireland case law, nor in international human rights law.

It is not possible, in medical science, to definitely distinguish between risk to health and risk to life: the health risk arising from a relatively minor infection, for example, can be threatening to a person's life, depending on the overall health of the patient, contextual issues such as access to medicine and trained care, and many other factors. Moreover, the denial of health care can put a person's life at risk without ultimately resulting in death. In the context of abortion, it is uncontested that denial of access to abortion on health grounds can put women's lives at risk. Conversely, limiting abortion access to cases of real and substantive risk to life can lead to prolonged physical and mental pain and suffering, as well as preventable risk of ill-health and death.

Where medical providers are pushed to draw a distinction between risk to health and risk to life in the context of abortion, doctors are prevented from properly advising their patients where abortion is an effective action to prevent risk to health that may deteriorate to threaten their life.

The death of Savita Halappanavar in the Republic of Ireland has demonstrated how a risk to health can move very quickly to a situation of 'imminent death', and where the delay in waiting to see if the health situation of a woman deteriorates significantly to allow a single doctor to decide, could actually result in it being too late for a termination to make any difference to the health outcome for the woman.

Such a narrow and restricted approach to guidance and best practice seriously undermines the clinical judgements that health and social care professionals need to make to ensure that they are providing the best possible health care to women to safeguard their health and life. It could result in doctors waiting unnecessarily to either find a second doctor to agree and sign off on the intervention, or risk prosecution because of the narrow guidance on "imminent death emergency". The guidance on this

is also inconsistent with international human rights standards where courts have instructed States to be proactive in protecting women's human rights.²³

Recommendation: Ensure that the guidance in this section is consistent with the clarifications in Northern Ireland case law, and in line with developments in international human rights law.

- b) **Assumptions on the occurrence of cases of threat to a woman's mental health:** Paragraph 3.6, pre-judges the likelihood of a pregnant woman or girl incurring mental health problems through continuing a pregnancy, noting that such cases are "very rare", without any reference to the statistical basis for such a judgement. AIUK considers it to be inappropriate to make such judgements in clinical guidelines, because clinical judgements as to whether or not a woman's health considerations meet the criteria for a legal abortion should be made on a case by case basis, and by health and social care professionals based on clinical and medical evidence.

Recommendation: Remove all references to opinion on the likelihood of particular cases, and ensure that the guidance enables health and social care professionals to make decisions on a case by case basis, based on clinical and medical evidence.

- c) **Guidance on clinical assessments of women with a learning disability:** AIUK considers the provision of guidance in this section to be inadequate, only referencing the need to ensure a Consultant Psychiatrist specialising in Learning Disability as appropriate for clinical assessment. There is no reference to guide health and social care professionals on ensuring they (in line with recommendations to act in a timely way especially in cases of medical urgency) draw on the experience of others who may already be providing long term support to a woman with a learning disability and may provide information that would enable a more thorough assessment.

There is also no guidance to ensure that women with learning disabilities, are given the support they need to make informed decisions about their health and lives, in line with the UN Convention on the Rights of People With Disabilities, especially in ensuring that those with learning disabilities should be supported in their agency, and that no one should substitute their decisions for them, unless they are incapable of individual decision-making.²⁴

No other reference is made to other women or girls who might need specialised assistance, for example women who do not have English as their first language, or women who are vulnerable to or experiencing domestic violence or other forms of violence and abuse.

Recommendation: Draw on the expertise of agencies supporting women and girls with additional needs and ensure the guidance is drafted to ensure the fulfilment of the human rights of all women in Northern Ireland.

Section 4: The right to conscientious objection

²³ UN Committee on the Elimination of Discrimination against Women, Views on Communication No. 22/2009, UN Doc. CEDAW/C/50/D/22/2009

²⁴ UN Convention on the Rights of People With Disabilities (put in proper footnote)

- a) **Defining conscientious objection:** Paragraph 4.1 confuses conscientious objection with perceptions on what is lawful, stating that “no-one is required to participate in a procedure that he or she may consider unlawful”, or whether they consider the direct primary purpose being “the death of the unborn child”.

While the right to express one’s freedom of thought, conscience, religion or belief potentially includes the right to object to personally providing certain care, this right is not absolute and must be weighed against the various human rights of a patient needing urgent care. AIUK considers that this section does not provide enough clarification on how far and to what extent conscientious objections can be applied in the provision of abortion related care.

In this connection, the UN Committee on the Elimination of Discrimination Against Women (CEDAW Committee) has stated, with regard to reproductive health services generally, “if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.”²⁵

Conscientious objection should only be permitted insofar as the person seeking care can still be guaranteed timely and appropriate quality care. The perception of any given health care provider regarding whether an otherwise clinically advisable intervention is lawful is irrelevant in this context.

Furthermore, in his 2011 report to the United Nations General Assembly, the Special Rapporteur on the right to health cites inadequate regulation of conscientious objection as a legal restriction that contributes to making legal abortions inaccessible. “Conscientious objection laws create barriers to access by permitting health-care providers and ancillary personnel, such as receptionists and pharmacists, to refuse to provide abortion services, information about procedures and referrals to alternative facilities and providers.”²⁶ He recommends that States “ensure that conscientious objection exemptions are well-defined in scope and well-regulated in use and that referrals and alternative services are available in case where the objection is raised by a service provider.”²⁷

Recommendation: Include a clear legal definition of conscientious objection consistent with human rights, and with internationally recognised standards. Clarify that an individual’s access to appropriate and timely quality care must not be compromised through the recognition of conscientious objection. This requires, at a minimum, a timely referral system, an obligation on objecting health service providers to provide comprehensive information and an obligation to provide needed care where no other provider is available and accessible to the pregnant woman or girl.

Recommendation: Ensure the guidelines include a clear declaration of the scope of conscientious objection and that the rights of women to access information and services must be upheld. The guidelines must therefore make clear that in emergency situations

²⁵ CEDAW Committee General Recommendation 24 on women and health (1999), para. 11

²⁶ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, U.N. Doc. A/66/254, para.24

²⁷ Ibid., para 65 (m)

where no referral or alternative service is available, accessible or adequate, there can be no room for conscientious objection.

Take forward recommendations from the UN Special Rapporteur on the Right to Health, on regulation of conscientious objection.

- b) **Assumptions on the occurrence of life-threatening situations:** Paragraph 4.4 assumes that life-threatening situations will occur “very infrequently” without any reference to a statistical basis for this assumption. Statements such as this could create a chilling effect for health and social care professionals. As stated elsewhere, it is inappropriate to include unfounded comments such as this in official guidelines, in fact the potential impact could be dangerous for women whose lives may be at risk.

Recommendation: Remove language that implies prejudgement on the number and frequency of cases that are likely to occur.

Section 5: Provision of counselling services

- a) **Specialist counselling for vulnerable women:** There is no guidance included on when specialist counselling services would be most appropriate, this is particularly important for women who may have specific needs, which includes women from ethnic minorities, women who do not have English as a first language, young women, women who are at risk of experiencing violence and abuse including trafficked women, women who have existing or previous mental health concerns, or women who are sex workers.

Recommendation: The provision of counselling services should be reflective of the particular needs of women, and the circumstances they are in. Therefore referencing the special needs of some groups of women, and ensuring counselling services reflect those needs, would be an important point to include in the guidelines.

- b) **The purpose of counselling:** This section is also unclear. The draft guidelines do not state that the provision of counselling services are a critical part of good quality health care, and therefore of protecting and upholding women’s right to health.

Recommendation: Include a clear statement on the purpose of counselling services within the context of sexual and reproductive health including abortion services, consistent with international human rights standards and principles. Specifically, counselling should be aimed at providing women and girls with accurate and full information to enable them make informed decisions about their health.

- c) **Lack of guidance on when counselling, including information, should be available:** AIUK is concerned that this section of the draft guidelines provides little information on when counselling should be available. For example, there is no guidance on the timing and length of the availability of counselling services. At the moment, counselling services are only mentioned in the context of determining the legality of a pregnancy termination. The guidelines do not mention support or guidance for women and girls during the pregnancy, or after a pregnancy is terminated.

Section 5.12 on advice on services in other UK jurisdictions is also very unclear. It does not clarify whether the information provided to pregnant women and girls will vary with the jurisdiction in which they seek a termination. Furthermore, the guidance declares

information about travelling for care as a legal ‘grey area’ potentially creating a chilling effect on the information health care providers feel empowered to impart. AIUK reminds the government that women and girls are entitled to full and accurate information about their health and available health care options.

Recommendation: This section should be re-drafted to ensure clear guidance on the responsibility to ensure access to appropriate counselling services at any stage of a pregnancy, and in line with the needs of individual women. Remove text that compels counsellors to seek legal advice before giving pregnancy women and girls available and relevant information, thus generating needless delays. Avoid wording that could result in a chilling effect amongst counsellors, and restrict the information and advice they feel able to impart.

- d) **Problematic language and terminology:** Some of the text in this section is inappropriate and inconsistent with international human rights principles. In particular section 5.15 instructs counsellors to “exercise extreme caution” before they consider referring a woman or girl who qualifies a legal abortion for counselling. This could lead to substantial delays in access to counselling services for women who meet the criteria for a legal abortion (and will therefore be in need of substantial medical and health support).

Furthermore, this section guides counsellors to be overly cautious, bordering on suspicious, of a woman’s account of her health. Here, the guidance notes that “[a] counsellor should appreciate that the woman’s account of her practitioner’s assessment of those risks may, on occasions, be inaccurate or incomplete”. This undermines a woman’s agency and devalues her experience. Counselling services should be responsive to the psychological support needed by women. To guide counsellors to question or distrust a woman’s experience of her health situation would undermine the objective of the service—which is built on trust. It would be inconsistent with international human rights principles, which recognises the individual as the main agent with regard to his or her own health.

Recommendation: Remove any text that puts into question a woman’s opinion or assessment of her own health. Ensure that counsellors are empowered to provide appropriate support based on their clinical assessments of the counselling needs of each individual woman, and that confidentiality is maintained at all times.

Section 6: Ensuring Appropriate Consent:

- a) Use of the term ‘Appropriate’: the terminology should be consistent with the Department’s Guide to Consent for Examination, Treatment or Care (March 2003).

Recommendation: Remove the term ‘Appropriate’ from the heading. Consent should always be obtained before providing care (or not providing appropriate quality care), except in situations of absolute emergency, where a person is temporarily unable to consent, and where the delay of care would result in a severe deterioration of health.

- b) **Potential for confusion:** Paragraph 6.8 guides health and social care workers to “afford women the time to consider the decision to have a termination of pregnancy”, whilst at the same time acknowledging that these circumstances would indicate the urgency for the procedure. AIUK is concerned that this could be interpreted as a requirement for an undefined quasi-mandatory waiting period, at the discretion of the

counsellor, also where the pregnant woman or girl is already certain of her decision with regard to her health. This could lead to further negative health consequences for women in need of urgent interventions to save their lives and health. Moreover, the Department's Reference Guide to Consent for Examination, Treatment or Care (March 2003) already seeks to ensure that women are not placed under pressure or otherwise compelled to consent to care (or lack of care) they do not want (or want).

- c) **Recommendation:** Re-draft to ensure consistency with the Department's Reference Guide to Consent, and remove text advising a waiting period.

Section 7: Consideration of sexual offences

- a) **Potential unintended consequences for victims:** It is unclear why sexual offences are being addressed in the context of these guidelines. Sexual violence is a criminal offence in Northern Ireland. The current legal framework as it stands does not make any explicit provision for legal abortion where the pregnancy is a result of rape, sexual violence or incest, though it is clear that rape victims who are forced to carry through a pregnancy, result of the rape, in many cases suffer severe mental health consequences. Access to legal abortion for rape victims can and should be allowed to protect the rape victim's health.

However, this section focuses exclusively on the obligation of health and social care professionals to report a criminal offence, rather than identifying the particular needs of the rape victim. The focus in reporting may inadvertently lead to rape victims seeking abortion services outside of the health system, for fear of triggering a criminal investigation.

Recommendation: Remove this section and ensure that the particular needs of women who have suffered or are at risk of violence are referenced and included throughout the document especially in the sections on clinical assessment and on counselling. See further recommendations on the legal framework in Section 2 of this submission.

Section 8: Alternative options

- a) **Inappropriate reference to faith based services:** AIUK considers it inappropriate for official government guidelines to specifically reference faith-based services, and guide Trusts to "make women aware of the chaplaincy services available to them for spiritual and pastoral care". The inclusion of additional but selective community or faith based services should not form part of this guidance. International human rights bodies have clarified that the right to thought, conscience, and religion includes the right to have no religion, or to be an atheist, and that the state cannot impose a legal framework based exclusively on one faith on those who do not share it.

Recommendation: Remove paragraph 8.5