

Engender response to the UK Government consultation on a new legal framework for abortion services in Northern Ireland

INTRODUCTION

Engender unequivocally supports women in Northern Ireland’s autonomy over their bodies and lives, and considers abortion access fundamental to women’s rights and gender equality across the whole of the UK.

Until very recently the law discriminated against and criminalised some UK women based upon their residence in Northern Ireland alone. The United Nations CEDAW committee inquiry into restriction of abortion in NI found that the UK Government is responsible for both “grave and systematic violations” of women’s human rights under international law. We therefore welcome the opportunity to respond to this consultation on the means of correcting this denial of rights. These proposals offer scope to go beyond restrictions in place under the Abortion Act 1967, and to bring abortion law in Northern Ireland in line with the rest of the UK in certain areas.

However, this is by no means guaranteed by the options set out in this consultation document. As a bare minimum, the new legal framework for NI must afford women and girls the same rights and healthcare standards as those in England, Scotland and Wales. The creation of a new system also provides an opportunity to learn from issues with delivery of existing abortion services in other parts of the UK, and to set new standards with an improved clinical framework and model of service delivery that works for women and girls in different parts of Northern Ireland.

Engender works alongside Northern Ireland Women’s European Platform (NIWEP) in the UK Joint Committee on Women, and on human rights scrutiny through the shadow CEDAW process.¹ In this consultation response, we support NIWEP’s position on abortion in NI, as well as that of Alliance for Choice. Our response also draws on our research into women’s experiences of abortion care in Scotland.

¹ The United Nations CEDAW committee examines the UK on its obligations on women’s rights every five years

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?

Neither. We believe that the Northern Irish framework should allow access to abortion without restriction up to 24 weeks gestation, in addition to unrestricted access in extreme circumstances. Whilst the vast majority of abortions in England, Scotland and Wales are sought in the first trimester of pregnancy, there are a multitude of well-established reasons why women may delay in accessing abortion.

The experiences and realities of diverse groups of women shape their capacity and resource to access reproductive healthcare in specific ways. These include victim-survivors of sexual violence, women experiencing domestic abuse, teenage women and girls, women from deprived areas, LGBTI people, disabled women, BME and migrant women, homeless women, women with mental health or substance use issues, and women with insecure immigration status.

Terminations of pregnancy beyond 14 weeks gestation can be reduced with an intersectional approach to address issues with sex and relationships education, access to advice and information, barriers to healthcare for different groups of women, violence against women and girls, and the cultural stigma that surrounds abortion. It remains vital, however, that marginalised groups are able to access fundamental healthcare and support whenever they need it. Placing legal restrictions on abortion healthcare does not reduce the incidence of abortion, but does push them later into pregnancy and increases risks for women.²

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

No. Abortion should be regulated in line with other healthcare provision. There is no other health procedure that requires certification in this way. The need for discretionary approval for abortion, either from a stranger or a known practitioner, would be a significant barrier to access for many women. This is partly due to the enormous stigma and shame that surrounds abortion, particularly in Northern Ireland.

Layers of procedure add complications for women with coercive and controlling partners, and victim-survivors of sexual violence and domestic abuse. Groups of women who face multiple inequalities when accessing healthcare also stand to be especially disadvantaged by a certification process. For instance, disabled women, LGBT people and care-experienced women in Scotland report discrimination in

² TxPEP, University of Texas (2019) Change in second-trimester abortion after implementation of a restrictive state law

accessing reproductive health services.³ Women with insecure immigration status, adolescent girls (whose mental health is poorer than that of boys),⁴ refugee, asylum-seeking,⁵ migrant, learning disabled, and older Indian, Pakistani and Bangladeshi women⁶ also face particular economic, linguistic, social and practical barriers to healthcare and to good health.

Question 3: Should the gestational time limit in circumstances where the continuance of 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?

Neither. The legal framework in Northern Ireland must at minimum allow abortion on the same grounds as the rest of the UK. A situation whereby women and girls in NI are not afforded the same fundamental rights as those of us in other parts of the country is not acceptable.

The number of women in need of third trimester abortions, as recognised in the consultation document, is extremely low. However, those who do need to access this right in the UK, do so for exceptional and complex reasons.

At a minimum, therefore, abortion on the grounds of risk to the health of pregnant women, as well as trans men or non-binary people, or to those of their families, must be allowed up until 24 weeks of gestation. Given the history and culture of stigma around abortion in Northern Ireland, standards for clinical assessment of this must be clearly set out, and training for relevant healthcare professionals provided.

Anything less than this will force women to continue travelling to England, Scotland and Wales to obtain the abortions that they need. This has negative impacts on women's health and wellbeing, and many women lack the immediate resources needed to travel. Young women, particularly those under the age of eighteen, as well as the marginalised groups listed above are particularly affected by the trauma of travelling to Britain to access abortions.

³ Evidence submitted to Engender's shadow CEDAW report 2018

⁴ SAMH (2017) Going to be all right? A report on the mental health of young people in Scotland

⁵ Strathclyde University (2016) What do you mean, I have a right to health? Participatory action research on health and human rights

⁶ EHRC (2016) Is Scotland Fairer: The state of equality and human rights 2015

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?

Yes. It is vital that the law in Northern Ireland is on at least an equal footing with that of the rest of the UK. Please see our response to question 3 in this respect.

Furthermore, it is essential that all women faced with a personal and difficult decision after a fetal anomaly has been identified are enabled to do so in an informed, respectful and supported manner. Too often discussion of disability within medical settings, as well as more broadly, devalues disabled people and fails to reflect the social model of disability.⁷ Accurate information and support about different impairments, and appropriate input from healthcare professionals must be equally available to all. Those facing such a diagnosis must be afforded adequate time and support to reach a decision that is right for them.

Northern Ireland's clinical framework must also ensure that disabled women have equal access to reproductive and sexual health services, which are critical to preventing unwanted pregnancies, to supporting those that are wanted, and to enabling abortion where needed. Our research in Scotland shows that many disabled and learning-disabled women and girls experience infantilising treatment when accessing reproductive healthcare, note a widespread lack of accessible services and information, and lack consent and autonomy concerning reproduction and fertility. This lack of autonomy significantly restricts access to abortion and contraception, and can result in forced sterilisation.⁸ These human rights breaches must not be allowed to continue.

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?

Yes. Access to abortion without restrictions in these circumstances is essential. The United Nations CEDAW committee has condemned the UK for gravely and systematically breaching women's human rights, due to lack of protection against

⁷ This promotes independent living and focuses on social structures that are disabling to people with certain impairments, rather than on individuals and their perceived failings.

⁸ Engender (2018) Our Bodies, Our Rights: Identifying and removing barriers to disabled women's reproductive rights in Scotland

unwanted pregnancies that leave women and girls at risk of death or serious harm in Northern Irish law.

Please also see our response to question 3, in terms of equivalence of the law across the whole of the UK.

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

Yes. Improved access to services in the rest of the UK is curtailed by the Abortion Act, which prohibits full development of nurse or midwife-led services. These are widespread elsewhere and at the forefront of woman-centred maternity care. With advances in medical sciences, doctors are now taking a step back in labour wards and maternity units. These are increasingly led by midwives and nurses, with doctors on-call if required. However, nurses and midwives who can provide highly skilled, complex care in other fields are not permitted to provide straightforward abortion care. In 1967, abortion procedures may have been seen as uncommon, dangerous and complicated but medical advances have ensured that this is no longer the case.

In addition to the administration of abortifacient medication, studies from across the world have shown that nurses and midwives should be allowed to perform manual vacuum aspiration, which would expand early access to abortion care, reduce waiting times for women undergoing the procedure, and increase flexibility in rural areas.⁹ Since 2003, the World Health Organisation has been recommending that abortion care be provided at the 'lowest' appropriate level of the healthcare system and that vacuum aspiration can be provided by mid-level care providers, including nurses and midwives, in primary care facilities throughout the first trimester of pregnancy.

Northern Ireland could develop such a model, as part of a package of abortion care services that set new standards in best practice for the UK.

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

Yes. A set of principles for the model of service delivery, such as flexibility, equality of access, dignity and respect, should be established in consultation with women's organisations and other equalities groups in Northern Ireland.

Stemming from this, the administration of misoprostol for use at home should be included with NI's new framework, as is now the case across the rest of the UK. This has eradicated a significant barrier for many groups of women accessing abortion,

⁹ Jejeebhoy et al (2011) Can nurses perform MVA as safely and effectively as physicians: evidence from India; Weitz et al (2013) Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives and physician assistants under a California legal waiver

including those with controlling and abusive partners, those in rural areas, and those with limited flexibility in insecure employment. As with other forms of reproductive healthcare, abortion service provision should not be restricted to NHS providers, but extended to the independent sector. As in other parts of the UK, this would be regulated by a set of clear legal standards.

More broadly, the Northern Irish model of service delivery should also take into account the considerable resistance and lack of support that many women in need of abortion will face in NI, and aim to raise awareness of reproductive rights and to reduce stigma.

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?

No. The provision of later term abortions in certain hospitals should not be restricted in legislation. Whilst it is likely that capacity to deliver this service would initially be limited to certain NHS hospitals, the opportunity for NI to increase flexibility and improve equality of access across the country should be retained.

It is vital that NI develops the capacity to provide abortions at all stages that the law provides for. This includes surgical abortions, up to the legal threshold. In Scotland, women in need of abortion from 16-20 weeks of gestation must travel to England to realise their right to later abortion. The new legal framework for NI must ensure that this type of inequality of access is ironed out for women and girls in NI, in practice as well as on paper.

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?

No. Women, young women and girls, trans men and non-binary people that do wish to consult healthcare staff should have access to intersectional advice and support that is sensitive to their needs. However, access to abortion should not be subject to the discretion of medical staff. This leaves women vulnerable to the views of others, who essentially know nothing of their circumstances, experiences and needs.

In Britain, the need for two doctors to sign off an abortion is one of the most paternalistic aspects of the Abortion Act. It undermines women's autonomy and reproductive decision-making and, in many cases, is an entirely unnecessary, time-consuming hoop through which women must jump in order to make choices over their own body. It is also entirely out of step with the increasing emphasis of patient

autonomy in other areas of medical treatment. It is a unique requirement amongst routine medical procedures, which gives power and privilege to doctors' opinions over the wishes of women regarding an unwanted pregnancy.

Research shows that women's access to abortion is still shaped by the particular healthcare professionals they happen to encounter and that "significant effort is required for individuals to assert their candidacy for pregnancy or abortion services".¹⁰ Clearly, not all women are equally equipped to make these assertions, due to a host of factors and experiences that include patriarchal culture, community background, faith or belief, mental or physical health, language, confidence and self-esteem.

Certification processes therefore restrict access by preventing women from coming forward due to practical, social, cultural, psychological and emotional barriers. Experience of sexual violence, domestic abuse, wider gender inequalities and stigmatisation can make it difficult for women to speak about abortion, in particular with men.

Meanwhile, international evidence shows that removing the approval of healthcare professionals does not lead to an increased incidence of abortion.¹¹ Women must have autonomy over their own bodies and their own lives.

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

Yes. We note the concern of women's organisations in NI that only the bare minimum of information should be collected from women accessing abortion, such as gestation at time of termination, method of termination, age range and local area.

Where possible, we further recommend that equalities data should be collected, in order to improve understanding of the experiences and barriers faced by diverse groups of women. Given the significant barriers to healthcare experienced by disabled women, LGBTI people, refugee and asylum seeking women, and women from certain minority ethnic communities in the UK, it is likely that access to safe abortion is also limited in particular ways for these groups. To develop our understanding of this and better enable all women, trans men and non-binary people to realise their reproductive rights, it will be vital to know where, when and how different groups of women are accessing abortion in Northern Ireland. Under the Abortion Act 1967, a woman's marital status is also recorded. In 2019, inclusion of this data would clearly be inappropriate.

¹⁰ Purcell et al (2014) Access to and experience of later abortion: accounts from women in Scotland

¹¹ Centre for Reproductive Rights: <https://reproductiverights.org/worldabortionlaws>

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

Yes. We agree that an equivalent of the ‘conscience clause’ should not be applied to auxiliary staff. The British Medical Association is clear that conscientious objection must not undermine the patient’s “right to receive objective and non-judgemental medical advice and treatment”, and that any health practitioner invoking the clause should inform patients and make arrangements for referral as quickly as possible.¹²

Historically, invoking the ‘conscience clause’ of the 1967 Abortion Act, abortion, has been widespread in Scotland, and contributed to the emergence of geographical variations in provision. This has clear and damaging repercussions on women’s ability to make decisions about their fertility and reproductive health. Given the historical and current culture around abortion in Northern Ireland, it seems likely that this scenario may also arise in NI. The Northern Irish model of abortion care should seek to avoid this, with a strategy to tackle the stigma attached to seeking abortion and to protect women’s right to service provision against the ‘conscientious objection’ of auxiliary staff to supporting abortion care.

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

If you answered ‘yes’, please suggest additional measures that would improve the regulations:

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?

Don’t know. We are minded to respect NIWEP’s position that provision for exclusion zones would not be appropriate in the Northern Irish framework, and that the very existence of exclusion zones condones protests that harm women. We would further call for a robust strategy to respond to protests as harassment and abuse towards women.

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

Please see our response to question 13.

¹² British Medical Association (2014) The law and ethics on abortion: BMA views

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

The new legal framework should provide the bones of a wider system of abortion care that centres women's rights and equality in Northern Ireland. Such a system should be expressly intersectional and ensure that service delivery is inclusive of trans men, non-binary people, disabled women, BME and migrant women, women with insecure immigration status, young women and girls, and women in rural areas. Healthcare professionals providing abortion care should receive training on the impacts of domestic abuse, sexual violence and other gender-based violence or trauma.

Women's organisations in Northern Ireland should be involved in developing this model of abortion care, and a particular focus should be given to current issues with services in England, Scotland and Wales. This will help to ensure this opportunity for women's reproductive rights to be realised is maximised in practice.

FOR FURTHER INFORMATION

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ABOUT US

Engender is a membership organisation working on feminist agendas in Scotland and Europe, to increase women's power and influence and to make visible the impact of sexism on women, men and society. We provide support to individuals, organisations and institutions who seek to achieve gender equality and justice.