Submission on a Legal Framework for Abortion in Northern Ireland

2019

Summary

The National Women's Council of Ireland (NWCI) is making a submission as stakeholders to this consultation process. NWCI is an all-island organisation, representing members in Northern Ireland. We are also conscious that given the all-island nature of health services, women living in the Republic of Ireland, particularly those living in the border areas, are likely to use abortion services provided in Northern Ireland.

The roll-out of public abortion care in the Republic of Ireland in January 2019, following the introduction of the Health (Regulation of Termination of Pregnancy) Act 2018 (hereafter TOP Act 2018), provides very recent experience for the development of abortion services which can be beneficial as Northern Ireland establishes services. The TOP Act 2018, which provides the legal framework for abortion services in the Republic covers: abortion on request in early pregnancy; in cases of a fatal foetal diagnosis; due to a risk to the life or health of the woman; and review procedures for decisions made. While recognising that this legislation does not do everything women have advocated for, importantly it does not decriminalise abortion, it did enable roll-out for the first time in the state, of a free public abortion care service, provided through GPs and maternity hospitals. Supports for women include My Options, a health service-run online and telephone hub for women experiencing an unplanned pregnancy, providing information on services, nursing support and counselling services.

In responding to the consultation questions we focus on key issues which have emerged from abortion care provision in the Republic of Ireland over the first 12 months:

- Access difficulties emerging from the 12-week restriction and mandatory 3-day waiting period;
- The absence of safe access zones around care facilities and the consequent impact on women and care providers;
- Impact of conscientious objection on the roll-out of services.

In this submission, as in all our health work, NWCI focuses on women's experiences of care. We also draw on the experience of abortion care providers and of media reporting of service implementation. NWCI chairs the Abortion Working Group, a collective of 23 civil society organisations and healthcare providers formed in 2019, which is working together to monitor the continued roll out and strengthening of abortion care services and advocating for resources, changes

and improvements and further service development. Official data on abortion care in the Republic, and health service-commissioned research on care provision, will not be available until 2020.

While Northern Ireland is developing a legal framework to provide legal certainty, both to women and their healthcare providers, the certainty of the law must not hinder the requirements of clinical flexibility. The healthcare system is already regulated by mechanisms that serve to protect the interest of patients and guide healthcare professionals (for example: consent to medical treatment; confidentiality and data protection; malpractice). Abortion – as one of the safest medical procedures – should not be seen as a medical procedure so unique that it requires whole new regulatory thinking, or burdensome restrictions. Rather, abortion should be integrated within existing reproductive health services and by and large subsumed in existing healthcare and medical legislation.

Submission structure

The submission is framed around the consultation questionnaire and comprises the following sections:

1. Abortion in early pregnancy
2. Gestational time limits in later pregnancy
3. Foetal anomaly
4. Who should provide abortions
5. Where should abortions take place
6. Abortion after 22/24 weeks in acute hospital setting
7. Certification
8. Notification
9. Conscientious objection
10. Safe access zones
11. Other comments
12. NWCI's reproductive health work

Introduction

NWCI is Ireland's leading women's membership organisation, representing over 190 member groups and a growing number of individual members. We work to ensure women's equal access, participation, and recognition in Irish society. One way in which women's equality is realised is through women's control of their reproductive health. Our comments on a legal framework for abortion in Northern Ireland are grounded in NWCI's *Every Woman*[1] model for reproductive healthcare for women and girls. We engage with the issue of abortion from a broad perspective, reflecting the diversity of experiences women face and the different decisions women make about reproduction and family formation. NWCI's position on abortion has evolved over the past 30 years through discussions with our members rooted in analysis of gender equality and human rights. Throughout the decades, NWCI's role has been two-fold – to give voice to the experiences of women in Ireland who, until very recently, remained largely unrepresented in discussions about abortion

[1] NWCI (2017) '*Every Woman – affordable, accessible healthcare options for women and girls in Ireland*' https://www.nwci.ie/images/uploads/EveryWoman_Repro_Health_Model_-_Nov_2017.pdf

and to support women's access to reproductive health services. In 2018, NWCI was one of the three organisations which formed the Together for Yes civil society campaign to remove the 8th Amendment, the Republic of Ireland's Constitutional ban on abortion. See Section 12 below for further details of NWCI's reproductive health work.

In NWCI we undertake our women's reproductive health work within a feminist and human rights framework. We always consider the impact of women's life experiences on their health; we recognise women as experts in their own health; and we draw out women's reproductive health needs through the different intersections of identity, social positions, policies and social structures. For NWCI, and the women we represent, access to legal abortion is indistinguishably linked to human rights values, full equality for women and women's right to accessible, quality health care.

In our work to ensure full access to reproductive healthcare services for women, we have witnessed the psychological and physical harm to women which was caused as a result of the restrictive abortion regimes in the two jurisdictions on the island of Ireland. Legal restrictions imposed on abortion have disproportionately impacted on women who were already marginalised and disadvantaged: those with little or no income, women with care responsibilities, minors in state care, women with disabilities, women with a pre-existing illness, women experiencing domestic or sexual violence, asylum seekers and women who are undocumented. As Northern Ireland develops a legal framework for abortion services it is important that we learn from the past to ensure that women's decision-making is central to abortion care and that healthcare providers have the space to exercise clinical judgement.

1. Abortion in Early Pregnancy (Consultation Qs1, 2)

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?

- Gestational time limits in early pregnancy undermine women's access to appropriate healthcare and weaken doctors' decision-making capacity. Women need space to make decisions that are best for them and their health and healthcare providers need space to exercise clinical judgement in the best interests of their patient.
- Abortion is best treated as a decriminalised procedure under medical supervision and considered a private matter with patient-doctor confidentiality protected. Creating an arbitrary time limit of 12 or 14 weeks has the potential to harm those most in need of services.
- The UK Government is obliged to implement the recommendation of the UN CEDAW to legalise abortion in the case of rape and incest.[2] The only way of effectively and compassionately providing for abortion in such cases is to provide for an unrestricted period of access in early pregnancy. Imposing a time limit – whether 12 or 14 weeks – would have

[2] UN Convention on the Elimination of All Forms of Discrimination Against Women, 6 March 2018, CEDAW/C/OP.8/GBR/1, paragraph 85(b)(ii).

the effect of causing additional distress and trauma to the pregnant person who may be dealing with the complexities of sexual crime or abuse.

- The legal framework must protect women's health and wellbeing and ensure that where a woman needs to end her pregnancy that she can receive care. Services should be based around an understanding that women and girls need to end pregnancies for many reasons and that those reasons should be respected and remain private.
- While a 14-week time limit is preferable to 12 weeks, it cannot overcome the problematic and arbitrary nature of a time limit in early pregnancy:
    - Time limits place unnecessary pressure on a pregnant person to make the significant decision of whether to continue with or end a pregnancy. This time pressure is exacerbated for those who do not realise that they are pregnant until later in gestation;
    - Many women who present for abortion later in pregnancy do so because of delayed detection – including as a result of the use of contraception which alters bleeding patterns or having an irregular menstrual cycle;
    - Where gestation is measured by Last Menstrual Period (LMP) as it is in the Republic of Ireland, 12 weeks of pregnancy is in fact approximately 10 weeks since conception. On average, a woman will not realise she is pregnant until 4 weeks after conception (6 weeks of pregnancy measured by LMP). This gives her just 6/8 weeks to make the decision to seek an abortion, attend an appointment with a provider (which can be made more difficult and time-consuming with conscientious objection), possibly attend for an ultrasound scan to verify gestation, attend for a second appointment with her provider and take the first pill;
    - Delayed recognition/presentation is more common amongst marginalised women, including women experiencing domestic abuse, therefore a time limit is likely to harm those who need the services most;
    - A time limit precludes individuals who experience a failed medical abortion[3] which may not be discovered until after the 12 or 14-week time limit.
- As we have seen in the Republic of Ireland, a time limit of 12 weeks is problematic, particularly for those who do not realise very quickly that they are pregnant. This is particularly so given the dating of pregnancy from LMP in the Republic, as well as the legal requirements for certification and a mandatory 3-day waiting period. For those who are past nine weeks, or for whom the date of their LMP needs to be verified, they are being referred for ultrasound. This can add further delay, especially in more rural areas. To compound the issue, many home pregnancy tests base gestation on date of conception rather than LMP which may cause women to believe that they have more time to access care than is the case.

[3] Early Medical Abortion carries a failure rate of approximately 1 – 2%. See RCOG, 'Best practice in comprehensive abortion care', June 2015. https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-2.pdf

2. Gestational time limits in later pregnancy (Consultation Qs 3, 5)

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?

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?

- Abortion in later pregnancy is rare. The vast majority of abortions in countries that provide for unrestricted access in early pregnancy take place at or before 10 weeks' gestation. For example, in the UK, 80% of all abortions in 2018 were performed at or under 10 weeks' gestation.[4]
- Provision must be made for access to abortion in cases of a risk to the life or health of the woman. However, time limits are no more appropriate or necessary in later pregnancy than they are in early pregnancy. Those who seek abortions in later pregnancy generally do so because of a sudden change in circumstances or because their unique situation made it difficult or impossible to attend for an appointment earlier. Even where no term limit exists, only a very small proportion of abortions will ever be carried out after 21 weeks and then only if there is a grave risk to the health or life of the woman, or the foetus has been diagnosed with a serious or fatal impairment.[5] In such cases, the best way to support and protect both healthcare professionals and women is to ensure that they do not have to overcome unnecessary barriers and restrictions such as gestational time limits.
- Abortion in the case of risk to life or grave risk to health is already provided in the rest of the UK without time limit – including in Northern Ireland under *Bourne* – and in the vast majority of other jurisdictions. In the absence of such provision in Northern Ireland, women would need to travel.
- Additionally, the legislation should not qualify risks to health with vague, non-clinical language such as 'serious'. That the risk to health is serious is already implicit in a request for a termination at a later stage in pregnancy.[6] We know from application of legislation in the Republic of Ireland that healthcare providers may be hesitant to provide abortion care on health grounds due to a lack of clarity around the classification of a health risk as 'serious' in the Act. Indeed, the UN CEDAW recommendations did not make a distinction between different types of health risks.[7]
- Importantly, the legislative framework should require medical providers to demonstrate that they have taken account of the woman's own assessment of the risks to her health and life and her capacity to continue with the pregnancy. Medical practitioners may certify

[4] Department of Health and Social Care, 'Abortion Statistics, England and Wales: 2018', June 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/808556/Abortion_Statistics__England_and_Wales_2018__1_.pdf
[5] See Nicky Priaulx, Oral evidence 'Inquiry on Abortion on the Grounds of Foetal Abnormality in England and Wales' (17 August 2013), p 39, https://orca.cf.ac.uk/50207/1/Oral%20Evidence_Parliamentary%20Inquiry%20February%202013_DisCopy.pdf.
[6] Ruth Fletcher, evidence to the Joint Committee on the Eighth Amendment to the Constitution, 8 November 2017, https://www.oireachtas.ie/en/debates/debate/joint_committee_on_the_eighth_amendment_of_the_constitution/2017-11-08/4/.
[7] UN Convention on the Elimination of All Forms of Discrimination Against Women, 6 March 2018, CEDAW/C/OP.8/GBR/1, paragraph 85(b)(i).

'qualification' for abortion care, but the pregnant person must have real agency in determining whether to continue with pregnancy.[8]

3. Foetal Anomaly (Consultation Q 4)

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?

- Abortion should be available without time limit both in cases of fatal and severe foetal anomaly. As recognised in the Royal College of Obstetricians and Gynaecologists (RCOG) guidance on best practice in abortion care[9], it is very important in cases of a diagnosis of foetal anomaly that the pregnant person is given sufficient time to understand and come to terms with the diagnosis and its implications. Limiting the time available to make an informed decision on whether to continue or end such a pregnancy through imposing a gestational time limit is therefore inappropriate. A time limit also heightens the difficulty and stress of these decisions. Time limits are particularly inappropriate in these cases given that an ultrasound scan, which is capable of identifying many severe or fatal foetal anomalies, will only be carried out between 18 and 21 weeks' gestation at the earliest.
- It has been held that legally enforcing the continuation of a non-viable pregnancy may violate the right to freedom from inhuman and degrading treatment,[10] as well as the right to private and family life.[11] The UK Government is also obligated to provide for abortion in these circumstances without time limits by the UN CEDAW Report which recommends the legalisation of unqualified access to abortion in cases of 'severe' as well as 'fatal' foetal impairment.[12]
- In legislating for abortion in cases of fatal and severe foetal anomaly, it is vital that clinical flexibility is maintained. Where there is a diagnosis of foetal anomaly, it is often very difficult, if not impossible, for medical practitioners to make precise and certain assessments regarding the likely fate of the foetus. Legislation should not be overly prescriptive in laying out the grounds for abortion in such circumstances and should be accompanied by the appropriate clinical guidance to aid clinical interpretation. We know from the application of the TOP Act 2018 in the Republic of Ireland, which permits abortion only where there is present a condition likely to lead to the death of the foetus "either before, or within 28 days of, birth", that clinicians may find it difficult to make such a precise prediction. This has resulted in some women with diagnoses of foetal abnormality continuing to travel to access abortion care.

[8] De Londras and Enright (2018) 'Accessing abortion care: principles for legislative design' in 'Repealing the 8th: Reforming Irish abortion law,' Bristol University Press, Policy Press https://www.jstor.org/stable/j.ctv47w44r.8.
[9] RCOG, 'Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales' (25 June 2010), https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport18may2010.pdf. See also Priaulx, Nicky, Oral evidence 'Inquiry on Abortion on the Grounds of Foetal Abnormality in England and Wales' (17 August 2013), p 18 – 19, https://orca.cf.ac.uk/50207/1/Oral%20Evidence_Parliamentary%20Inquiry%20February%202013_DisCopy.pdf.
[10] See, for example, KL v Peru UNHRC, Communication No. 1153/2003 (2005). [7]; LC v Peru, UNCEDAW, Communication No. 22/2009, CEDAW/ C/50/D/22/2009 (2011).
[11] Northern Ireland Human Rights Commission, Re Judicial Review [2015] NIQB 96 and [2015] NIQB 102.
[12] UN Convention on the Elimination of All Forms of Discrimination Against Women, 6 March 2018, CEDAW/C/OP.8/GBR/1, paragraph 85(b)(iii).

4. Who should provide abortions (Consultation Q 6)

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

- Any registered healthcare provider who is appropriately trained and competent should be permitted to provide abortions in accordance with their professional body's requirements and guidelines.
- Engagement of nurses and midwives within the provision of termination services would support early access to care and reduce waiting times for women. Since 2003, the WHO has recommended that abortion care is provided at the lowest appropriate level of the healthcare.[13] According to RCOG guidance on abortion care[14], a range of providers, including nurses and midwives are competent to deliver termination services safely in a number of settings. The relevant NICE guidelines[15] also recommend use of nursing and midwifery staff for abortion care. Nurses and midwives provide highly skilled, complex care in other areas of healthcare, including in maternity units which are increasingly led by midwives and nurses, with doctors on-call. Additionally, midwives in Northern Ireland already administer the medication used for early medical abortion for the treatment of incomplete miscarriages.

5. Where should abortions take place (Consultation Q 7)

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

- The model of service delivery for abortions in Northern Ireland should provide for flexibility on where abortions can take place. Restrictions on where abortions can take place can have serious implications for the accessibility of services, particularly in rural areas and for women who experience compounded difficulties in accessing services for reasons of, for example, disability, poverty or migration status.
- As mentioned in the consultation document, completion of the second stage of medical abortion at home is becoming increasingly common across the United Kingdom. This approach has also been adopted and widely used in the Republic of Ireland and demonstrates an innovative means to make care more accessible. Home-administration of medical abortion pills in early pregnancy is recommended by the Royal College of Obstetricians and Gynaecologists,[16] the National Institute for Health and Care Excellence[17] and the Institute of Obstetricians and Gynaecologists in Ireland.[18] The effectiveness and safety of administering medical abortion outside of a clinic setting has been demonstrated

[13] WHO (2003), 'Safe abortion: technical and policy guidance for health systems' First Edition.
[14] RCOG, 'Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales' (25 June 2010), https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport18may2010.pdf.
[15] National Institute for Health and Care Excellence, NICE Guideline [NG104], September 2019. https://www.nice.org.uk/guidance/ng140
[16] Royal College of Obstetricians and Gynaecologists, 'Better for Women: Improving the health and wellbeing of girls and women', December 2019. https://www.rcog.org.uk/globalassets/documents/news/campaigns-and-opinions/better-for-women/better-for-women-full-report.pdf
[17] National Institute for Health and Care Excellence, NICE Guideline [NG104], September 2019. https://www.nice.org.uk/guidance/ng140
[18] Institution of Obstetricians and Gynaecologists 'INTERIM CLINICAL GUIDANCE: Termination of pregnancy under 12 weeks', December 2018. https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2018/12/FINAL-INTERIM-CLINICAL-GUIDANCE-TOP-12WEEKS.pdf

by several studies. For example, a systematic review of nine studies[19] comprising 4,522 participants observed that there is no difference in effectiveness or acceptability between home-based and clinic-based medical abortion.

- Additionally, telemedicine solutions, such as phone consultations, would further ensure the removal of barriers to accessing early medical abortion. RCOG recently endorsed telemedicine as a means of improving access to abortion.[20]
- Finally, while the vast majority of abortions in early pregnancy are performed medically, early surgical abortion may be the preferred choice of women and their healthcare providers for a number of reasons. In many cases, early surgical abortions could be carried out in primary care settings, given properly equipped providers.

6. Abortion after 22/24 weeks in acute hospital (Consultation Q 8)

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

- The model of service delivery should provide for flexibility on where abortions can take place. It is unnecessary for legislation to go into this level of clinical specificity; rather decisions regarding clinical safety, efficacy and best practice should be made at regulatory/clinical guidance level. As the clinical evidence base evolves, practitioners should be enabled through changes in clinical guidance to tailor practices to provide the safest and most effective medical care.
- Furthermore, stipulating the type of setting abortions can take place in legislation treats abortion differently to other medical procedures and therefore is potentially stigmatising.

7. Certification (Consultation Qs 2, 9)

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?

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?

- Requiring a pregnant woman to disclose her circumstances to multiple clinicians has been deemed to breach human rights, particularly the right to individual privacy.[21]
- A certification process should not be necessary for abortion. There is no clinical evidence available to suggest it either assists with the delivery of abortion services or provides any

[19] Ngo *et al* 2011 'Comparative effectiveness, safety and acceptability of medical abortion at home and in a clinic: a systematic review' (4 May 2011) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3089386/
[20] Royal College of Obstetricians and Gynaecologists, 'Better for Women: Improving the health and wellbeing of girls and women', December 2019. https://www.rcog.org.uk/globalassets/documents/news/campaigns-and-opinions/better-for-women/better-for-women-full-report.pdf
[21] Tysiąc v Poland [2007] ECHR 219; A, B and C v Ireland [2011] 53 EHRR 13; KL v Peru UNHRC, Communication No. 1153/2003 (2005) [7]; LC v Peru, UNCEDAW, Communication No. 22/2009, CEDAW/ C/50/D/22/2009 (2011).

additional safeguards for patients. In fact, the only likely effect is to create an added administrative burden for providers, which could result in delays for patients.

- Additionally, a legal requirement for certification treats abortion differently from other medical procedures and is potentially stigmatising. As a lawful medical procedure, abortion should be treated in the same manner as other medical care, within the established system of regulation.

8. Notification (Consultation Q 10)

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

- A mandatory notification process for abortions in Northern Ireland is unnecessary and would treat abortion differently to other medical procedures. However, routine data collection and monitoring is essential to ensure good quality care. It is also important that this data can be disaggregated by race/ethnicity and migration status to ensure the access needs of marginalised women are captured. Quality assurance can and should be achieved through the existing system for collecting healthcare data in Northern Ireland – in line with all other medical procedures – and designed to monitor quality and healthcare outcomes. In particular, monitoring the national distribution of abortion provision and conscientious objection would facilitate the meaningful evaluation of the service access and inform service development in the interests of women.

9. Conscientious objection (Consultation Qs 11, 12)

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?

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

- Permitting healthcare providers to refuse to provide care on the basis of a conscientious objection has the potential to create a significant barrier to accessing services. Provision for conscientious objection therefore must be framed in such a way as to respect women's right to access abortion care services and include a number of essential safeguards, particularly:
  - The legislative framework should reflect s.4(2) of the 1967 Act to ensure that conscientious objection cannot be exercised in emergency situations where abortion is necessary to save the life or prevent grave permanent injury to the health of a patient;
  - The provision should cover those performing or authorising the procedure only and not the associated ancillary, administrative or managerial tasks;
  - A robust referral system must be put in place to ensure that a woman who would be refused care for reasons of conscientious objection is promptly referred to a healthcare professional who can provide treatment. The obligation to refer, including the specific referral pathways, must be formally enshrined in clinical guidance and compulsory for all healthcare providers;

- It must be clear that protection for conscientious objection does not apply to institutions. It is generally accepted under international human rights law that, unlike individuals, institutions do not have consciences that can be protected by the right to freedom of conscience.[22] As we have seen in the Republic of Ireland, with just over half of maternity units providing a full abortion care service 12 months after commencement, it may be necessary to make provision for obliging institutions or healthcare authorities to ensure adequate availability of services;
- It must be possible for women to access the necessary information on how and where to access abortion care services. For example, in the Republic of Ireland, a centralised, telephone-based 'My Options' system directs women to available services in their area, as well as providing free and confidential counselling and information.

- Large-scale conscientious objection, by reducing the number of practitioners providing care, is likely to significantly increase the workload of those who are providing. This can make service provision more difficult and has the potential to lead to 'burnout' or discourage those who would otherwise provide care from doing so. Supports should be put in place to protect and resource healthcare providers who make the conscientious commitment to provide abortion care. For example: protection from discrimination from colleagues or employers; protection from harassment and obstruction from anti-abortion groups; and inclusion of providers in the process of continuous quality improvement and service development.

10. Safe access zones (Consultation Qs 13, 14)

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

Question 14: Do you consider there should also be a power to designate a separate zone where protest can take place under certain conditions?
If you answered 'no', what alternative approach do you suggest?

- Legislated safe access zones are necessary to ensure women can access abortion care services free from targeted anti-abortion interference, harassment or intimidation. The implementation of safe access zones is necessitated by the UN CEDAW recommendation to 'protect women from harassment from anti-abortion protestors'[23] and was recently deemed essential to realising women's right to adequate healthcare by RCOG.[24]
- Displays of intimidating, harassing and distressing behaviour outside healthcare facilities have been ongoing in both the Republic and North of Ireland, both before and since the commencement of any level of abortion service provision. Since the introduction of services in the Republic, we have continued to see such activity in a range of locations, including outside the National Maternity Hospital. Not only are these displays harmful and distressing for women who are trying to access abortion services, they can also cause vicarious trauma to patients attending healthcare facilities for other reasons, including families who have experienced other types of pregnancy loss. Additionally, we know that anti-abortion displays

[22] See CEDAW, Concluding Observations: Hungary, (note 69) [31(d)] U.N. Doc. CEDAW/C/HUN/CO/7-8; see also the Colombian Constitutional Court in Sentencia T-388/09
[23] UN Convention on the Elimination of All Forms of Discrimination Against Women, 6 March 2018, CEDAW/C/OP.8/GBR/1, paragraph 86(g).
[24] Royal College of Obstetricians and Gynaecologists, 'Better for Women: Improving the health and wellbeing of girls and women', December 2019. https://www.rcog.org.uk/globalassets/documents/news/campaigns-and-opinions/better-for-women/better-for-women-full-report.pdf.

outside clinics and hospitals are acting as an active deterrent to potential GP providers in the Republic, thereby reducing local availability of services, hindering women's access and placing further burden on GPs who do provide the service.

- Dedicated legislation creating safe access zones is the only effective means to prevent targeted and organised attempts to harass and intimidate people as they enter healthcare facilities. Neither the localised and *ad hoc* Public Services Protection Order (PSPO) system nor any other existing, specialised legal mechanisms can effectively tackle this type of behaviour. For example, in the Republic, the fact that demonstrations have been ongoing despite the existence of legal mechanisms such as public order law, harassment law and behaviour warnings suggests that such mechanisms are ineffective.

13. Other comments (Q 15)

When developing the legal framework for abortion, attention must be paid to the diversity of people who can become pregnant, including trans, non-binary, intersex, bisexual and queer individuals, to ensure that services are inclusive and accessible to all those who require them.

14. NWCI's reproductive health work

NWCI advocates for reproductive healthcare services which are based on best medical practice and which reflect the lived experiences of women. In NWCI, we recognise that a woman's reproductive healthcare needs span her lifetime, from relationship and sexual health education in school to menopause services as she ages. In the Republic of Ireland, we are actively advocating for improved access to contraception, better maternity entitlements, affordable and quality childcare and for the ongoing development of women-centred maternity care.

Our comments on a legal framework for abortion in Northern Ireland are grounded in NWCI's 2017 *Every Woman*[25] model for quality, universal reproductive healthcare for women and girls. The model recognises that women have a life-long need for reproductive healthcare services across six priority areas, which should be available through the health system:

1. Relationship and sexual health education
2. Affordable and accessible contraception
3. Sexual and reproductive health services
4. **Comprehensive pregnancy care, including abortion and abortion after-care**
5. Reproductive cancer care
6. Menopause services

Every Woman further describes key principles which should underpin the provision of all reproductive healthcare services: Services should be private, with confidentiality between the doctor and patient protected; services should be accessible through public funding; services should be comprehensive**;** services should be of high quality, complying with best medical practice and standards; and services should be adequately funded to ensure timely access.

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[25] NWCI (2017) '*Every Woman – affordable, accessible healthcare options for women and girls in Ireland*'.