

A new legal framework for abortion services in Northern Ireland

British Pregnancy Advisory Service (BPAS) response to UK Government consultation
November 2019

The British Pregnancy Advisory Service (BPAS) is a British reproductive healthcare charity that offers pregnancy counselling, abortion care, miscarriage management, contraception and STI testing to 85,000 women each year. We have long provided care to women travelling to England from Northern Ireland to access abortion care, and run the Central Booking Service which now provides appointments, travel, and accommodation to Northern Irish women travelling for care.

We also advocate for women’s reproductive choice – providing them with accurate and balanced information, and ensuring the right to make their own choices about their bodies and treatments including during pregnancy and birth.

Question 1 – Should the gestational limit for early terminations of pregnancy be:	Yes	No
Up to 12 weeks gestation (11 weeks + 6 days)		X
Up to 14 weeks gestation (13 weeks + 6 days)		X
<p>If neither, what alternative approach would you suggest?</p> <p>BPAS supports the aims of the proposals but believes that there is no justification for limiting decriminalised provision upon request of the woman to any time less than the end of the twenty-fourth week of pregnancy. There is no legal, medical, or ethical purpose to treating women who are seeking to end their pregnancy within the law in different ways – or for creating through the delineation of ‘early’ and other terminations a differentiated system where some women, acting within the law, are required to provide additional reasons for their decision to end their pregnancy. Doing so can cause additional delay, particularly if it is accompanied by additional certification requirements, increases stigma for women, and may make providers more likely to limit their care to women at earlier gestations. Rather, drawing any arbitrary time limit before that of viability risks seriously compromising the overall goal of the proposals.</p> <p>Under s9(1) of the Northern Ireland (Executive Formation etc) Act 2019 (“the Act”), the Secretary of State must ensure that the recommendations in paragraphs 85 and 86 of the CEDAW report are implemented. Restricting decriminalised provision upon request to either 12 or 14 weeks would fail to fulfil the requirements of the CEDAW report and therefore contravene the duty in s 9(1) of the Act in the following ways:</p> <ul style="list-style-type: none"> • Paragraph 85(a) requires that ‘no criminal charges can be brought against women or girls who undergo abortion or against qualified health care professionals and all others who provide and assist in abortion’. Artificially restricting abortion on request to a certain number of weeks would presumably require penalties to be in place for those providing abortions outside the restrictions of these regulations beyond that gestation – in direct contravention of the CEDAW report recommendation. If there are no additional penalties then restrictions up to 24 weeks have no legal weight. • Paragraph 85(d) requires that the government ‘adopt evidence-based protocols for healthcare professionals’. There is no evidence to justify treating women who are 12 or 14 weeks pregnant differently to those who are at later gestations but prior to the point 		

of viability. Instead, this delineation would place additional barriers in the way of women seeking abortion beyond the chosen 'early termination' gestational limit.

- Paragraph 86(a) requires that the State Party 'provide non-biased, scientifically sound and rights-based counselling and information sexual and reproductive health services'. A gestational limit for 'early terminations of pregnancy' would require health professionals to inform women that there is a difference between accessing pre- and post- 12 or 14 week procedures. As detailed above, this is not evidence-based and is not scientifically sound. Further, it is not rights-based as it would restrict the ability of women at later gestations to access abortion care.
- Paragraph 86(c) requires that the State Party 'provide women with access to high quality abortion and post-abortion care in all public health facilities'. Any early termination limit will likely lead to public health facilities opting only to provide services up to that limit – partly because of the implied 'difference' in providing services pre- and post- this point, and partly owing to the additional legal and administrative burden. This will mean some women will be unable to access care at certain (legal) gestations within local public health facilities. The reduced access will disproportionately impact disadvantaged groups, including disabled women, who are less able to travel to secure access to services. It will create further unnecessary barriers for women experiencing domestic abuse, women in crisis situations, and younger women, who can struggle to seek care and may be more likely to present at a later gestation.

This consultation states that the provision of abortion without restrictions is being considered in order to "cover the circumstances where the pregnancy is the result of sexual crime." Victims of a sexual crime may be less likely to present for abortion care due to trauma, physical injury, delayed identification of pregnancy, or barriers to travel if they live near or with the perpetrator. Therefore, in order to meet the government's stated aim of unrestricted access to cover victims of sexual violence, the government must allow for unrestricted access up to 24 weeks.

Question 2: Should a limited form of certification by a healthcare professional be required for early terminations of pregnancy?	Yes	No
	<p>If no, what alternative approach would you suggest?</p> <p>There should be no certification process for abortion at any period of gestation.</p> <p>Under the new framework, abortion is a lawful medical procedure available within Northern Ireland's healthcare system. Accordingly, the goal of maintaining quality abortion care will be best met through the established system of professional, regulatory and information-gathering mechanisms that ensure a high standard of care in all other areas of that healthcare system.</p> <p>There is no evidence base for certification. Any such requirement would therefore be inconsistent with the government's duty to implement the CEDAW Committee's paragraph 85(d) recommendation to adopt evidence-based protocols for healthcare professionals on providing legal abortions.</p> <p>Certification could also restrict access to abortion care, in breach of the duty to provide women with access to high-quality abortion care in all healthcare facilities under paragraph 86(c) of the CEDAW report. The proposed requirement to, as part of certification, to "confirm" a pregnancy has not exceeded a particular gestation is vague and open to interpretation. The CEDAW Committee found that ambiguous guidance has served to restrict abortion in Northern Ireland and that a lack of clarity in the law and in guidance has meant that women who should have been able to qualify for an abortion have been refused. While one clinician may feel confident in confirming the gestation of a pregnancy using a woman's report of Last</p>	

Menstrual Period, others may feel unable to authorise a termination without the woman first undergoing an ultrasound. This would cause delays and inequalities in access, which would present particular difficulties for women who for social or economic reasons are less able to travel to a separate clinic to confirm gestation, including disabled, migrant, refugee and asylum-seeking women, women in situations of poverty and women living in rural areas.

Question 3 – Should the gestational time limit in circumstances where the continuance of the pregnancy would cause risk of injury to the physical or mental health of the pregnant woman or girl, or any existing children or her family, greater than the risk of terminating the pregnancy, be:	Yes	No
21 weeks + 6 days gestation		X
23 weeks + 6 days gestation	X	
<p>If neither, what alternative approach would you suggest?</p> <p>BPAS does not believe there is any justification, evidence, or informed basis for making any change to the long-established legal time limit for abortions that exists across England, Scotland, or Wales. This position is supported by the medical community, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, and the British Association of Perinatal Medicine.</p> <p>Introducing a gestational time limit of 21 weeks and 6 days would fail to satisfy the recommendations in the CEDAW report in a number of respects:</p> <p><u>No evidence base for reduction</u></p> <p>Introducing a reduced time limit of 22 weeks would indicate that there is a scientific reason for changing this limit from that agreed by Parliament in 1990. The scientific basis for this simply does not exist. Accordingly, the limit would be inconsistent with the paragraphs 85(d) and 86(a) recommendations that the government ‘adopt evidence-based protocols for healthcare professionals on providing legal abortions particularly on the grounds of physical and mental health’ and ‘provide non-biased, scientifically sound and rights-based counselling and information on sexual and reproductive health services, including on all methods of contraception and abortion’.</p> <p>The most recent paper on this issue, published by the British Association of Perinatal Medicine, using data from MBRRACE, found that if a woman goes into spontaneous labour at 22 weeks, there is only a 3% chance that the baby will survive to its first birthday. For spontaneous labour during Week 23, less than 20% of babies survive to their first birthday. These figures do not indicate viability – quite far from it, they indicate that despite the best efforts of doctors and the admittance to high-quality neonatal intensive care units, babies born at these gestations are simply too premature to survive.</p> <p><u>Impact on terminations of pregnancy for foetal anomaly</u></p> <p>A time limit of 21+6 would also fail to satisfy the paragraph 85(b)(iii) recommendation that the government adopt legislation to provide for abortion in cases of severe foetal impairment, including fatal foetal anomaly.</p> <p>As noted by the CEDAW Committee, “due to the unavailability of publicly funded foetal anomaly tests in NI both prior to and during the second trimester of pregnancy, in contrast to what is offered under the NHS in the rest of the UK”, most women learn of a diagnosis of foetal anomaly late in their pregnancy.</p> <p>The 20-week scan in Northern Ireland happens between 20+0 and 20+6 weeks. In practice, this means that there could be as little as 5 working days between receiving a foetal anomaly</p>		

diagnosis and having a hard deadline for accessible abortion – which would not allow time for additional tests to confirm the type or severity of anomaly.

The consultation does indicate that the government intends to permit abortions for foetal anomaly under separate grounds post either 21+6 or 23+6 weeks. However, having a legal exemption that is strictly for cases of FA does not ensure women could access termination in these circumstances due to the chill factor of the potential for criminal sanction.

In England, Wales, and Scotland, abortion for foetal anomaly is legally permitted post-24 weeks. However, as the charity Antenatal Results and Choices have stated, “although post-24 week abortions are permitted under certain conditions by Clause E of the Abortion Act, there has always been professional caution around sanctioning terminations of pregnancy for foetal anomaly after 24 weeks.” As a result, “when an anomaly is diagnosed after the mid-pregnancy scan, some parents are asked to make a final decision about ending their pregnancy before the end of the 24th week” in Great Britain because clinicians will not authorise abortions post-24 weeks for fear of criminal sanction. As we will discuss in our response to Q4, providing exemptions on the basis of fatal foetal anomaly and/or severe impairment will not guarantee access to terminations for women with diagnosis of foetal anomaly.

In order to ensure that women with diagnosis of foetal anomaly are able to access abortion in NI, as required by the CEDAW Committee, the government must permit abortion up to 23+6.

Sexual crime

A time limit of 21+6 weeks would also fail to satisfy the recommendation in paragraph 85(b)(ii) which requires the State to legislate to provide for abortion in cases of sexual crime.

Women who are victims of a sexual crime may present at a later gestation. They may be struggling with trauma and physical injury, and they may find it difficult to access services without alerting the perpetrator. As noted by the CEDAW Committee, women and men in Northern Ireland experience very high rates of sexual abuse. Statistics show that the majority of victims are children, and that the recorded number of sexual offences involving children under 16 has dramatically increased over the past decade. Of the women who have terminations in the UK, young women are disproportionately likely to present later due to factors including irregular periods. Statistics from the DHSC demonstrate that women under 20 who opt for a termination are more likely than those in other age brackets to have their treatment at 20 weeks' gestation or later. A time limit of 21+6 would therefore result in the State continuing to be responsible for “grave violations of rights under the Convention considering that the State party's criminal law compels... victims of rape or incest to carry pregnancies to full term, thereby subjecting them to severe physical and mental anguish, constituting gender-based violence against women.”

The limit would also be highly likely result in women from Northern Ireland still being forced to travel to Great Britain to access the care we deem to be necessary for our own citizens, but not for citizens of Northern Ireland. This undermines both the letter and the spirit of the CEDAW requirements.

The placing of viability at 24 weeks does not preclude babies from being born prior to this point that survive – it is the point at which the best information suggests around half of babies survive and half do not. Indeed, across the UK the stillbirth registration limit remains 24 weeks – which indicates that the UK-wide consensus (which has recently been included in debate as part of the Government-sponsored Civil Partnership, Marriages and Deaths (Registration Etc) Act 2019) about this time limit has not changed.

Further, with the reduction of the abortion time limit there would be a two week period during which a woman would not be allowed to terminate her pregnancy, but if she were to go into labour, would not be able to register her child as having been stillborn. Given the recent change in policy from the Department of Health to reduce the time limit for abortion to 23+6 so as not

to contravene the stillbirth limits, this two week period makes a mockery of the treatment of women who have sadly lost their wanted pregnancies at such a stage.

Question 4 – Should abortion without time limit be available for foetal abnormality where there is a substantial risk that:	Yes	No
The foetus would die in utero (in the womb) or shortly after birth	X	
The foetus, if born, would suffer a severe impairment, including a mental or physical disability which is likely to significantly limit either the length or quality of the child’s life	X	
<p>If you answered ‘no’, what alternative approach would you suggest?</p> <p>BPAS believes that there has been a long-standing consensus in the UK that where parents receive a devastating diagnosis at their 20-week scan, the option should be available to them to terminate the pregnancy.</p> <p>We do not believe, given the role of Sarah Ewart and women like her in the change in law in Northern Ireland, that there is any justification at all to refuse to include a provision for fatal foetal abnormality in law regardless of gestation.</p> <p>We also believe that provision should be made for women who receive an equally devastating diagnosis where doctors are unsure about the prognosis of a pregnancy diagnosed with a severe foetal abnormality. Medical evidence shows that decisions about what classes as a ‘fatal’ abnormality and what does not are complicated and can leave doctors in an extremely difficult situation, particularly where the threat of criminal law still applies. Allowing only ‘fatal’ diagnoses to access termination services risks leaving women whose pregnancies are not at all functionally different to be forced to carry an extremely sick child to term. This difference in approach is all the more likely in a region which has only recently decriminalised abortion and where sizeable numbers of healthcare professionals hold conscientious objections and may prefer a woman proceeds with the pregnancy rather than being given the option to end it.</p> <p>In the past year, UK abortion providers have treated women from Ireland who have not been judged to meet the bar for a ‘fatal foetal abnormality’ abortion, including a woman whose case was made public in the Dáil where the foetus’s organs were outside the body, but where the hospital concerned decided that did not meet the requirements of the fatal anomaly law. This woman was left with no choice but to travel outside her country and healthcare system to access care – and this is exactly the position a law focused only on fatal anomalies would be imposing on women in Northern Ireland.</p> <p>As noted by the CEDAW Committee, prior to 2008, clinicians in NI did feel able to provide abortion in cases of fatal foetal anomaly under the previous law in Northern Ireland, yet due to “increased fear of criminal liability”, fewer abortions were performed from 2009. In order to enable clinicians to provide for termination for foetal anomaly, as required by the recommendations in the CEDAW report, it is crucial that the regulations do not perpetuate this chilling effect through a gestational restriction.</p> <p>We would also have additional concerns about the framing of any potential standalone fatal foetal anomaly provision, with the query of whether words such as ‘shortly after birth’ would be insufficiently accurate and so dissuade doctors from performing abortions for fatal conditions in the event there was no serious anomaly provision. It would be asking doctors to make a legal assessment which for them would carry serious legal ramifications – without clarity over what conditions, probabilities, or timescales would fall within or outside the law.</p> <p>On its own, all that a fatal foetal anomaly provision would serve to do is place obstetricians in untenable positions and force women with devastating diagnoses to continue a pregnancy to</p>		

term. This once again would undermine both the letter and the spirit of the CEDAW Committee's requirements.

Question 5 – Do you agree that provision should be made for abortion without gestational time limit where:	Yes	No
There is a risk to the life of the woman or girl greater than if the pregnancy were terminated?	X	
Termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman or girl?	X	
<p>If you answered 'no', what alternative provision do you suggest?</p> <p>BPAS believes that any attempt to produce rules that do not allow for terminations under both of these grounds would be a retrograde step which undermines the basic rights of women in Northern Ireland. This would be a clear breach of the government's duty to implement the CEDAW Committee's paragraph 85(b)(i) recommendation to adopt legislation for expanded grounds for abortion where there is a threat to the pregnant woman's physical health.</p> <p>The 1938 <i>Bourne</i> judgment enables doctors to perform an abortion, regardless of gestation, on a woman who, in the event of being forced to continue the pregnancy, would be left 'a physical or mental wreck'. This goes far beyond the simple provision that her life would be at risk, and recognises that despite the draconian auspices of an 1861 law, an independent, living woman's wellbeing has a standing in law beyond that of her pregnancy.</p> <p>To use this change in law and the requirement for regulations not to further women's independent rights but to assail them would be unacceptable and liable to challenge once again under our international treaty obligations.</p> <p>BPAS further believes that the provision for 'grave permanent injury' is too high a bar to preserve the health and wellbeing of pregnant women. More recent laws than the Abortion Act have included 'serious harm to the health of the pregnant woman' (Ireland) or 'grave long-term injury' (Isle of Man) so as to enable doctors to act in their patient's best medical interests. BPAS would therefore propose that this provision is amended to include 'risk of injury to the mental or physical health of the woman or girl'.</p>		

Question 6 – Do you agree that a medical practitioner or any other registered healthcare professional should be able to provide terminations provided they are appropriately trained and competent to provide the treatment in accordance with their professional body's requirements and guidelines?	Yes	No
		X
<p>If you answered 'no', what alternative provision do you suggest?</p> <p>Abortion provision and healthcare has developed since the Abortion Act 1967 placed restrictions as to which qualified professionals could lead on abortion provision. Where the Abortion Act sought to do away with the scourge of unqualified backstreet abortionists by requiring the involvement of registered medical practitioners, this law seeks to positively enable women's ability to access her rights by allowing her to access abortion care. At the time the Abortion Act was passed, abortion was an operation that required an average of 1 week in hospital – now it is a safe procedure which can be performed with medication in a community health setting.</p> <p>Across the world, healthcare professionals provide abortions without the direct oversight or direction of doctors. The involvement of qualified medical (rather than healthcare) professionals,</p>		

therefore, is not necessary for safety or clinical purposes, but instead a hangover from a law that was drafted in the mid-1960s.

BPAS believes that the most appropriate people to determine whether a healthcare professional is qualified to provide abortion care are those who provide training and qualifications at the professional body.

Question 7 – Do you agree that the model of service delivery for Northern Ireland should provide for flexibility on where abortion procedures can take place and be able to be developed within Northern Ireland?	Yes	No
	X	

If you answered ‘no’, what alternative provision do you suggest?

As per question 6, the restriction on place is a provision of the 1967 Abortion Act which is related not to safety or clinical efficacy but to addressing the mischief posed by illicit abortion procedures in the 1960s. Abortion is a safe, common medical procedure which can be provided entirely using medication in a community health setting. It is only appropriate that any new regulation and legislation recognises the developments in the way this healthcare is provided and enable healthcare professionals to provide care in the best way possible.

BPAS believes that there should be no specific restriction on where abortion procedures can be provided in law – and that this is a matter for regulation and commissioning rather than for legislation. A flexible model will best meet the needs of women who are less able to travel, including women who live in rural areas, disabled women, and women living in situations of poverty, and will help ensure that the government fulfils its duty to ensure all women have access to high-quality abortion care.

We also believe it has been clear from the establishment of a GP-led service in Ireland that there are new and innovative ways to provide local, accessible abortion care within the existing health infrastructure which would be unduly curtailed by placing an artificial restriction on where services could be provided. This would not be desirable within a framework that seeks to recognise women’s reproductive rights.

Disabled women and medically complex women have an increased likelihood of requiring specialist placements for abortion care. Many women with co-morbidities, such as uncontrolled epilepsy, diabetes, heart conditions or cancer, cannot be treated in a stand-alone community clinic and must instead be managed in a hospital setting with swift access to backup care and specific clinical expertise in the event of an emergency. In England and Wales, hospital provision becomes increasingly limited the further a pregnancy advances. To ensure these groups of women have equal access to high quality care in all public health facilities, as required by paragraph 86(c) of the CEDAW Committee’s report, It is essential to ensure that abortion services are commissioned in hospitals in all instances allowed by these regulations.

Question 8 – Do you agree that terminations after 22/24 weeks should only be undertaken by health and social care providers within acute sector hospitals?	Yes	No
		X

If you answered ‘no’, what alternative provision do you suggest?

There is no justification for placing a restriction on location beyond 24 weeks within the legislative framework for abortion provision. This was long the case with abortion in England, Scotland, and Wales where abortion-specific legislation did not place gestational restrictions on

provision – instead this was the responsibility of the Department of Health as part of the regulatory process in the form of licensing.

Over the course of abortion developing as a medical procedure, abortion care has become safer throughout pregnancy and become more possible to provide at community level. Future changes in safety and risk profiles may well mean that it becomes increasingly safe to provide later procedures at sites outside acute sector hospitals, and that the evidence base for this provision changes – but legislation would not leave this decision up to medical decision-making or the clinical evidence base. Instead, it would become an outdated facet of legislation, which has the potential to limit the ability of women to access care. This would contravene paragraph 85(d) of the CEDAW recommendations into the future with the ongoing requirement to adopt evidence-based protocols.

A requirement that post-22/24 week abortions should only be undertaken within an acute sector hospital will restrict access to services. This could leave the State in continued violation of the Convention, as it was found to be due to the “concentration of services” which previously required women to travel to either Belfast or Great Britain to access care. As noted by the CEDAW Committee, this would seriously impact disadvantaged groups who are unable to travel significant distances, exacerbating multiple forms of discrimination already suffered women living in rural areas, migrant, refugee and asylum-seeking women, disabled women, and women in situations of poverty.

BPAS believes decisions about clinically appropriate settings for care would be most appropriate to be made as part of the commissioning provisions on the basis of up to date medical evidence, and not form part of legislative restrictions.

Question 9 – Do you think that a process of certification by two healthcare professionals should be put in place for abortions after 12/14 weeks gestation in Northern Ireland?	Yes	No
Alternatively, do you think that a process of certification by only one healthcare professional is suitable in Northern Ireland for abortions after 12/13 weeks gestation?		X
If you answered ‘no’ to either or both of the above, what alternative approach would you suggest?		
<p>There should be no certification process for abortion at any period of gestation.</p> <p>Under the new framework, abortion is a lawful medical procedure available within Northern Ireland’s healthcare system. Accordingly, the goal of maintaining quality abortion care will be best met through the established system of professional, regulatory and information-gathering mechanisms that ensure a high standard of care in all other areas of that healthcare system. Imposing a certification process with no clinical basis would be inconsistent with the recommendation in paragraph 85(d) of the CEDAW report, which requires the State to “adopt evidence-based protocols for healthcare professionals on providing legal abortions.”</p> <p>In providing abortion services, healthcare professionals will need to make clinical decisions about the safety and acceptability of any requested procedure. If the new legal framework requires healthcare professionals to make a good-faith decision about whether continuing a pregnancy after 12 or 14 weeks gestation would cause risk of injury to the physical or mental health of the pregnant person or their family, that decision will be matter of clinical opinion for the professional based on a full consideration of information specific to the patient before them. The provider will be required to document the care provided in accordance with the Department of Health’s ‘Good management, good records’ clinical record-keeping policy.</p>		

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

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

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

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

First, certification is unnecessary. Certification serves no medical or safety purpose and only operates to place the procedure on a criminal footing. In England and Wales, the certification process is in place to protect health professionals from criminal prosecution under the specific provisions of the Offences Against the Person Act 1861 and Abortion Act 1967, a criminal regime that the Government has chosen to move beyond in Northern Ireland.

Second, a certification process would undermine the Government’s overall commitment to provide a safe, accessible abortion service that respects the rights of women in Northern Ireland. We know that some healthcare professionals in Great Britain are discouraged from providing abortion care due to the need to make a legal declaration under the opaque certification requirement. Any formal certification process beyond standard clinical record-keeping requirements would impose an administrative burden (unrelated to any medical or safety need) and cause delay for women seeking to access services. Most importantly, a certification process would take abortion outside of the standard healthcare model, where decisions reached in a healthcare professional/patient relationship are subject to the supervision of colleagues and general regulatory or professional bodies. Certification requirements would continue to exceptionalise abortion and thus reinforce the “stigmatising impact on women” that the CEDAW Committee identified as depriving women of privacy, self-determination, autonomy of decision, offending their equal status and constituting discrimination.

Question 10 – Do you consider a notification process should be put in place in Northern Ireland to provide scrutiny of the services provided, as well as ensuring data is available to provide transparency around access to services?	Yes	No
		X

If you answered ‘no’, what alternative approach do you suggest?

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

In particular, we suggest the Government should encourage the Department of Health to strengthen its current process for preparing the Northern Ireland Termination of Pregnancy Statistics. The Department of Health publishes a yearly report on the number of medical abortions and terminations of pregnancies at health and social care (HSC) trusts in Northern Ireland, detailed by HSC Trust of treatment, country of residence and age band. The

Department’s statisticians prepare the report by accessing de-identified data managed by the HSC Business Services Organisation, which does not include any names or addresses of patients. We suggest this process should be continued and extended to include records of gestation, method of termination, and any other information necessary to scrutinise equitable access to abortion services. Publication of this anonymised and aggregated data would facilitate scrutiny of abortion services by policy-makers, members of parliament and other interested bodies while maintaining the strong data security protections that are critical to protecting women’s exercise of reproductive rights.

Notification in England and Wales is not designed with anonymous high-level scrutiny in mind; it is focused on informing the Chief Medical Officer of a practitioner’s decision to provide an individual, identified patient of a service performed within a criminal law regime. To this end, each HS4 form for notification includes the patient’s name or NHS number, date of birth and postcode or full address. There is a strong argument that this anachronistic system of processing sensitive health-related records of clearly identifiable individuals is now out of step with the General Data Protection Regulation (GDPR) standards and the Data Protection Act 2018, in that HS4 notification goes beyond what could be necessary for the management or provision of health care. The process would certainly breach the GDPR standards in the Northern Ireland context, where any theoretical need to trace individuals for criminal prosecution has been removed.

The proposal acknowledges that it would need to attempt to establish confidentiality within any notification system developed from the England and Wales model. This suggestion overlooks the fact that the system is fundamentally out-of-step with modern data protection expectations. The individualised, disaggregated process would risk identification through reversal of pseudonyms or identifiers. Even in the absence of a data breach, the public perception of data insecurity would itself undermine the service. Patients may be reluctant to access care from their national provider if they are aware that their contact will trigger an automatic, individualised notification to a government organisation, particularly in the Northern Ireland context where a small, vocal minority continues to threaten women’s rights to use these essential services and where members of this small, vocal minority are in positions of political and administrative power.

Any notification requirement would be inconsistent with the vision of the CEDAW report. The CEDAW committee noted that within Northern Ireland, abortion has been characterised as a “moral issue rather than a health and human rights one” and that the “moral characterisations of abortion reinforce the stigma associated with the procedure.” A specific notification process to “scrutinise” services and provide “transparency” beyond what is considered appropriate for any other medical procedure would add to the stigma that ultimately “hinders access to sexual and reproductive health services and information”.

Overall, the notification process would pose unacceptable risks to data protection but offer no additional benefit to the transparent scrutiny of service provision beyond what is achieved within the Department of Health’s anonymised, aggregated service.

Question 11 – Do you agree that the proposed conscientious objection provision should reflect practice in the rest of the United Kingdom, covering participation in the whole course of treatment for the abortion, but not associated ancillary, administrative, or managerial tasks?	Yes	No
		X
<p>If you answered ‘no’, what alternative approach do you suggest?</p> <p>BPAS believes that conscientious objection should be provided for in Northern Ireland by directly copying s4 of the Abortion Act 1967 in new regulations.</p>		

BPAS fully supports the right of healthcare professionals not to provide abortion care if they conscientiously object to doing so, within the bounds of the law as currently set out in Great Britain by the Abortion Act 1967 and as interpreted in the 2014 Supreme Court case *Greater Glasgow Health Board vs Doogan and another*. The benefit of using such existing provisions is that there will be no confusion amongst professionals on the ground in Northern Ireland or delay in providing accessible care while new provisions are tested in the courts.

Having this provision in law is particularly important for nurses and midwives, whose professional rules only allow them to conscientiously object in line with legislation, and do not accommodate further refusal as is the case with the General Medical Council for doctors or the General Pharmaceutical Council for pharmacists.

It is also incredibly important to include s4(2) from the Abortion Act 1967 which requires individuals, no matter their ethical beliefs, to participate in treatment necessary to save the life or prevent grave permanent injury to the mental or physical health of a pregnant woman. We believe it is appropriate that any healthcare professional who refuses to participate in such emergency care should face the full weight of their regulatory body's disciplinary system.

Question 12 – Do you think any further protections or clarification regarding conscientious objection is required in the regulations?	Yes	No
		X

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

BPAS strongly believes that the British law as currently drafted and interpreted effectively balances the rights of healthcare professionals to conscientiously object with the rights of patients to access safe, timely, free, and legal healthcare. We oppose any attempt to extend the provisions as laid out in the Abortion Act 1967 – whether through amendment to the law or ‘clarification’ that would seek to undermine the clarity bestowed by *Doogan*.

We want to be clear that there is a difference between conscientious objection to taking a hands-on role in providing abortion care and conscientious obstruction of anybody seeking to provide such care. The ‘further protections’ to cover other areas such as administrative and managerial tasks that have been suggested by some individuals who wish to conscientiously object will functionally make abortion unavailable within vast swathes of the NHS estate, where small numbers of widely-drawn objections would decimate local services. This could have a serious impact on disadvantaged women less able to travel who may rely on such local services to exercise their rights to access care.

Any additions to the law on conscientious objection which enables individuals to refuse to undertake any tasks related to the provision of an abortion service would pose a serious risk of contravening paragraph 86(c) of the CEDAW recommendations that women are provided with “access to high quality abortion and post-abortion care in all public health facilities”.

In the last Parliament, the House of Lords debated a bill brought forward by Nuala O’Loan which sought to extend the definition of conscientious objection in England and Wales along similar lines to those which opponents of abortion provision are requesting are introduced in Northern Ireland. Many amendments were laid at Committee Stage of this bill and a succession of Peers spoke against the bill on the grounds of the impact this proposed extension would have on the provision of care – particularly care provided directly by the NHS (as opposed to independent providers) and care for women with complex medical comorbidities. The bill did not proceed. [https://hansard.parliament.uk/Lords/2018-03-23/debates/BB7AB7EB-BE1F-4D9D-8E9B-CE227AB1D4C2/ConscientiousObjection\(MedicalActivities\)Bill\(HL\)](https://hansard.parliament.uk/Lords/2018-03-23/debates/BB7AB7EB-BE1F-4D9D-8E9B-CE227AB1D4C2/ConscientiousObjection(MedicalActivities)Bill(HL))

Finally, there is simply no justification under equality or human rights law for having a conscientious objection provision in place in Northern Ireland that goes further than that in the rest of the UK – the standard for religious and ethical protection in relation to basic legal rights should not vary based on national or regional location.

Question 13 – Do you agree that there should be provision for powers which allow for an exclusion or safe zone to be put in place?	Yes	No
		X
<p>If you answered ‘no’, what alternative approach do you suggest?</p> <p>Unless the government provides for exclusion / safe zones around clinics, it will remain in contravention of the spirit of CEDAW.</p> <p>The CEDAW Committee recommends that the State party “protect women from harassment by anti-abortion protestors by investigating complaints, prosecuting and punishing perpetrators”. However, despite repeated reports of harassment and violence outside the Belfast clinic, no perpetrators were effectively punished. Therefore, we believe the government must legislate for buffer zones to satisfy this recommendation and to protect access to services.</p> <p>Anti-abortion clinic protests are commonplace across the UK and pose serious issues to both women accessing care and staff providing this care. We have seen repeatedly over many years, including in Belfast outside Marie Stopes Northern Ireland and the Family Planning Association offices, that existing criminal law does not provide police or local authorities with the ability to prevent the intimidation and harassment that occurs.</p> <p>Further to the wider context, anti-abortion clinic protests in Northern Ireland have historically been more intimidating and physical than anywhere else in the UK, with a number of prosecutions related to activity outside such clinics, the need for a persistent police presence, and a large group of pro-choice ‘escorts’ who would help women to pass the protesters outside.</p> <p>The CEDAW Committee referred to the aggressive behaviour of anti-abortion protestors at a now-closed abortion care clinic in Belfast, where access to abortion was rendered “virtually impossible” in part due to the impunity of protestors for assaults perpetrated against women seeking care. BPAS run the Back Off campaign against anti-abortion protests at the clinic gate, and we have received 48 individual accounts related to Marie Stopes Northern Ireland in Belfast. We have emailed these reports in to the consultation team in full. These accounts have been reported by clients (women receiving treatment), those accompanying clients, passers-by, and healthcare staff. These accounts include:</p> <ul style="list-style-type: none"> • The clinic having to hire a dedicated bodyguard over and above the security that the building already had in place • At one point having two dedicated police officers outside the door • The physical harassment and obstruction of women, with clients being chased down the street, their arms being grabbed, and volunteers and healthcare workers being bruised and assaulted • Protesters shouting at women that they were murdering their baby • Filming clients, and telling them that the films were going to be broadcast on television • Displaying graphic images on placards • Forcing leaflets and foetus dolls onto individuals accessing the clinic 		

- Clients under the age of 18 being approached, undermining safeguarding standards and putting children at risk of harm.

More recently we have reports from Ireland that protests outside GP surgeries and hospitals have become commonplace and that additional legislation is needed to tackle this problem. In Northern Ireland, existing law fell short in addressing harassment, with one individual receiving six Police Information Notices which were all subsequently deleted. Even where protesters were successfully prosecuted, as in the case of an employee of the FPA - "This offender did not realise that this member of staff worked for FPA and she pursued her down the street, trying to force leaflets into her handbag, and in the end hit her with a clipboard she was carrying. She was left shaken and upset by the assault," (Mark Breslin, former Director of FPA NI), the perpetrator was then allowed to go straight back to protesting outside the clinic without any restriction on her activity or movement.

However, Public Spaces Protection Orders and any legislation that sought to introduce something similar to PSPOs in Northern Ireland, are not sufficient to address the issues raised by clinic protests. Specific legislation is needed to introduce exclusion zones outside all premises that provide services without the need for prolonged delay and gathering of evidence about the undeniable harm done to women:

- In the two councils in England that have taken action using PSPOs to curtail anti-abortion protest activity outside clinics, the protests had been going on for years and the work of collecting evidence and attempting (unsuccessfully) to negotiate alternative arrangements took around a year. During this period of time, women were continually exposed to harm.
- The bar for evidence in PSPO guidance excludes many clinics from protection – 37 clinics across England and Wales have experienced protests in the last year, including 7 completely new protests. Only about 5 of these would be able to get a buffer zone under PSPO framework – leaving out such instances as the weekly presence of two street preachers standing by the clinic gate and using a loudspeaker to call women and staff murderers, a street preacher telling a sexual health worker's in front of her 6-year old grandson that she 'murdered babies' on the street outside her place of work, and a group of people with body cameras stood outside the clinic gate with oversized pictures of dismembered fetuses.
- Failing to have national provision of exclusion zones creates a postcode lottery where women in one area are protected from activity that tries to stop them accessing legal care, while women in another area are not
- Local exclusion zones are expensive to introduce and uphold in court for individual local councils – where we have seen in England and across the world that they will be challenged repeatedly by well-funded anti-abortion protesters

Question 14 – Do you consider there should also be a power to designate a separate zone where protest can take place under certain conditions?	Yes	No
<p>If you answered 'no', what alternative approach do you suggest?</p> <p>This question misunderstands the purpose of an exclusion zone. It is an area where protest that is otherwise allowed cannot take place because, on evaluation of competing rights, it is judged that it is reasonable to restrict the rights of protesters to protect the ability of women to access medical care. This restriction applies only within the geographical constraints of the exclusion zone. The 'separate zone', therefore, is anywhere else that is outside the exclusion zone – from high streets, to outside Stormont, to the internet.</p>		X

'Designated zones' are not standard for Public Spaces Protection Orders in England. In the two PSPOs currently in place, one (Ealing) has a designated zone, and one (Richmond) does not. In Ealing where there is a designated zone, it still has a direct sightline to the entrance to the clinic, and thus poses an ongoing threat to the confidentiality of service users – in Northern Ireland where we know there is a history of anti-abortion protesters using cameras, this threat to privacy would be acute.

At a wider level, if the outer borders of a buffer zone are to be justifiable, it must be because to have protest activity closer to a clinic has a detrimental effect on access, privacy, and the local residents' quality of life – allowing a 'Designated zone' within this area undermines the case for limits beyond that point.

Anti-abortion attendees have made clear across the UK that they want 'direct access' to women as they enter and leave clinics. Any exclusion zone would prevent this, and a 'Designated zone' is unlikely to be seen as a reasonable alternative – and so will not reduce the risk of legal challenge. We have seen this in Ealing, where legal challenge continues despite the presence of such a zone.

Cordoning the designated zone, and containing both pro- and anti-choice protesters in such a small area, is likely to present a continued policing challenge. Given historic policing issues with anti-abortion protests in Northern Ireland, as well as comparatively large numbers having previously been present outside clinics, having additional rules in a small area will likely need constant enforcement and police presence – heightening tensions near to any clinic and taking up a disproportionate amount of police time and funding.