A new legal framework for abortion services in Northern Ireland: Marie Stopes UK consultation response

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

    a. *Up to 12 weeks gestation (11 weeks + 6 days)*

    No

    b. *Up to 14 weeks gestation (13 weeks + 6 days)*

    No

Further Comments:

Legal gestation limits for early termination of pregnancy are not necessary for inclusion in abortion legislation and could potentially harm those most in need of timely access to services. We would recommend that abortion services should be available "without conditionality", as referenced in Section 2.1, Part 1 of this consultation, for women regardless of gestation. Medical practitioners working within clinical guidelines already assess whether a procedure is medically safe and appropriate to perform, and abortion should be no exception. We believe that this is the principal of decriminalisation so that abortion care can be managed and regulated like any other form of health care.

It is unnecessary to legally differentiate between abortions before and after 14 weeks gestation. This could make abortion care providers less likely to offer later services and so ultimately reduces care options for women.

The 2018 UN Committee on the Elimination of Discrimination against Women (CEDAW) report recommends that all those who become pregnant as a result of a sexual crime should have the option to access abortion care.[1] It is right that there should not be a specific regulation for rape/incest. As noted in Section 2.1, Part 1 of the consultation, there are particular difficulties in including rape and incest as specific criteria in law, and government should actively avoid any legal framework that excludes some victims of sexual crime who are not able to evidence that the crime resulted in the pregnancy. Considering these points, we believe that a 14 week limit for access "without conditionality is not long enough. Victims of sexual crime often face barriers to accessing early abortion care, and so to place gestation limits on women accessing care could mean that the UK would still be in breach of its international human rights obligations.

[1] Committee on the Elimination of Discrimination Against Women, Report of the inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, U.N Doc. CEDAW C/OP.8/GBR/1 (23 February 2018)
https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/GBR/INT_CEDAW_ITB_GBR_8637_E.pdf

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

No

Further Comments:

Certification for early terminations of pregnancy is medically unnecessary, as is certification at any gestation. Abortion care should be treated the same as any other form of medical care.

Clinical decisions and principles of informed consent and personal autonomy are already adequately covered by regulatory inspections by the Regulation and Quality Improvement Authority (RQIA), professional registration and licensing, and codes of standards from independent regulators such as British Medical Association (BMA), General Medical Council (GMC) and Nursing and Midwifery Council (NMC).

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:*

a. *21 weeks + 6 days gestation*

No

b. *23 weeks + 6 days gestation*

No

Further Comments:

Gestational limits are not necessary. By removing a gestation limit from legislation, abortion care will be regulated and managed as any other form of medical care.

Medical practitioners working within clinical guidelines already assess whether a procedure is medically safe and appropriate to perform and abortion should be no exception. We know that outside of accessing abortion services to save the woman's life or following diagnoses of fetal abnormality or fatal fetal abnormality, those who wish to access abortion care around 22 – 24 weeks gestation are among the most vulnerable, many of whom have experienced sexual violence, delays in accessing services, or mental health issues. In 2018, 126 clients visiting Marie Stopes UK clinics scanned over the legal gestation limit of 23+6 weeks, and around 20% required onward referral to social services due to having other children in care, substance abuse, or homelessness.

There is no evidence to suggest that increased, or absence of, gestational limits result in more women seeking terminations at a later gestation. For instance, the Australian Capital Territory has no gestational limit and this has not increased the number of terminations at later gestations, in fact they are rare.

Removing any gestation limit will not automatically make abortion post-24 weeks a service that is available everywhere for everyone. As with every other form of healthcare, we believe professional clinical guidelines

to assess whether a procedure is medically safe and appropriate to perform should inform abortion procedures, not legislation.

The consideration of a 22 week gestation limit, in contrast to the 24 week gestation limit in Great Britain, is not based on evidence of fetal viability. A reduction to a 22 week gestation limit will impact women with pregnancies where a fetal abnormality is detected at a 20 – 21 week scan. It would not be appropriate to have a gestation limit that would detrimentally impact those who wish to consider abortion care in these circumstances, as families should not feel under pressure when considering all information and options while experiencing a difficult and emotional time.

Medical best practice and use of professional clinical guidelines shows no need to have a gestation limit prescribed in law. The government will need to consider how this would interact with the present Criminal Justice Act (Northern Ireland) 1945, section 25. [2] The CEDAW report notes that, 'On 29 June 2017, the NI Court of Appeal allowed an appeal against an order made by Justice Horner in which he declared sections 58 and 59 of the Offences against the Person Act and section 25 of the Criminal Justice Act incompatible with Article 8 of the ECHR in so far it is an offence to procure an abortion in cases of FFA, rape or incest. While the appeal was allowed, the Chief Justice's decision instructs the legislature to urgently address "the pressing need to ensure that there is a practical and effective method of implementation of rights of women" regarding access to abortion.'[3]

4. *Should abortion without time limit be available for fetal abnormality where there is a substantial risk that:*

    a. *The fetus would die in utero (in the womb) or shortly after birth*

        Yes

    b. *The fetus if born would suffer a sever impairment, including a mental or physical disability which is likely to significantly limit either the length or quality of the child's life*

        Yes

Further Comments:

We support a proposal for abortion care to be available without gestation limit for both the above categories for when a pregnancy is diagnosed with fetal abnormality. Such diagnoses are often made at the 20-week scan, or at later scans, and represent difficult and complex cases. It would not be appropriate to have a gestation limit for those that wish to consider abortion care in these circumstances, as families should not feel under pressure when considering all information and options while experiencing a difficult and emotional time.

The UN Committee on the Elimination of Discrimination against Women (CEDAW) has made it clear that the UK is violating the rights of women in Northern Ireland if provision does not exist for those who have had a diagnosis of severe fetal abnormality or fatal fetal abnormality.[4] The Committee's report, published

[2] Criminal Justice Act (Northern Ireland) 1945. http://www.legislation.gov.uk/apni/1945/15/section/25

[3] Committee on the Elimination of Discrimination Against Women, Report of the inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, U.N Doc. CEDAW C/OP.8/GBR/1 (23 February 2018)
https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/GBR/INT_CEDAW_ITB_GBR_8637_E.pdf

[4] Ibid

in February 2018, found that should care not be provided for in these circumstances, the UK is responsible for,

'grave violations of rights under the Convention [on the Elimination of All Forms of Discrimination against Women] considering that the State party's criminal law compels women in cases of severe fetal impairment, including FFA [fatal fetal abnormality], and 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 inclusion of severe and fatal abnormalities in the CEDAW requirements is incredibly important for when patients and their healthcare providers have very difficult conversations about prognosis and the odds of survival when an abnormality is detected. It is often very difficult to determine if a diagnosed fetal abnormality is "fatal". As we have seen in the Republic of Ireland, where the law only provides for fatal fetal abnormality, women seeking abortion care after such a devastating diagnosis often have no choice but to travel to England as the obstetricians cannot risk breaking the law if their predictions on survival or likelihood of intrauterine death are unclear.

It is therefore essential that provision in the circumstances outlined in this question are supported.

5. Do you agree that provision should be made for abortion without gestational time limit where:

a. There is a risk to the life of the woman or girl greater than if the pregnancy were terminated?

Yes

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

Yes

Further Comments:

We support abortion without any gestation limit for both of these risks.

Under current legal precedent (the Bourne judgement) abortions can be performed in Northern Ireland if continuing the pregnancy at any stage would leave a woman "a mental or physical wreck".[5] With this judgement the court established that doctors do not have to wait until there is a risk for life of the woman or girl, and allows abortion care to be performed if the probable consequence of the continuance of the pregnancy would have permanent or long-term negative impact on her physical or mental health. By not allowing abortion care for each of the risks listed above would be regressive for Northern Irish women's reproductive healthcare.

As indicated in the question above, CEDAW's report outlines that should a victim of rape or incest be forced to carry a pregnancy to term against their will, subjecting them to severe physical and mental anguish, this would constitute gender-based violence against women. It is therefore essential that provision in these circumstances outlined in this question are supported.

[5] *R v Bourne* [1939] 1 KB 687

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

Further Comments:

We agree that abortion care provision should maximise the role of nurses, midwives and Allied Health Professionals in providing care.

In 1967 when the Abortion Act was implemented in England, Scotland and Wales, abortion care was doctor-led, and provision did not include medical abortion. Now, due to innovation in accessible care, independent clinics that provide abortion treatment in Britain, such as Marie Stopes UK, are increasingly led by Registered Nurses and Midwives. Yet, nursing teams do not have the legal authority to simply allocate the medical abortion treatment, despite their sound knowledge and best practice. In Britain, nurses and midwives are authorised to manage miscarriage by performing the same procedures and providing the same medication that is involved in abortion care, and yet are not permitted to perform that same care for abortion services users. There is no clinical reason why this should be the case.

The decriminalisation of abortion in Northern Ireland should be the starting point to both reduce stigma and enable enhanced roles for nurses, midwives and Allied Health Professionals to be more widely developed and introduced. Marie Stopes UK strongly support task-sharing in abortion care provision for nurses and midwives to be authorised to perform procedures they are appropriately trained to provide in line with their professional body's requirements and guidelines. Recently published NICE guidelines also recommend that abortion provision should maximise the roles of nurses and midwives in providing care.

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

Further Comments:

We agree that the model of service delivery in Northern Ireland should provide for flexibility on where abortion procedures can take place as Northern Irish services develop. This is in line with the NICE guidelines that recommend that abortion services should be provided in a range of settings (including in the community and in hospitals) and this has been our experience within the Marie Stopes UK service model.

Specific requirements on abortion services written in law treats abortion care differently to all other healthcare procedures, we consider this over-regulation, which perpetuates stigma for providers and service users. Restriction on where abortion can be provided is included in the Abortion Act 1967, but this does not reflect current clinical efficacy and safety of abortion care.

Having flexibility on the locations of abortion care provision will allow Northern Irish abortion care to develop in a way that is best for service users, particularly those who would struggle to travel out of their local community to access care.

On this point, we would also support telemedicine being permitted, which would allow clinicians to send early medical abortion medications to those in rural communities, with initial consultations and medical history checks carried out using digital health tools. Barriers to accessing legal abortion services for women living outside of main towns and cities, as well as vulnerable women who are unable to travel to access care, was highlighted in CEDAW's report (s69)[6]. This would require an investment in e-health and telehealth. Telemedicine is used by abortion care providers in Australia in Australian Capital Territory, Queensland, Tasmania, New South Wales, Western Australia, Victoria and Northern Territory. One of our sister country programmes, Marie Stopes Australia, provides this service in these eligible areas. Their service delivers medical abortion via telephone for clients up to 8 weeks gestation via a combination of nurse consultations and a doctor consultation. Medication (the medical abortion drugs, anti-nausea and pain medication) are sent via courier along with a pathology request to ensure the process is successful. The team then follow up with a nurse consultation 14 days later. The telemedicine service has been especially useful for regional communities where there is a lack of access. For example, Wagga Wagga in NSW is one of the biggest users of the service as they have little to no abortion provision and very limited contraception provision.

Telemedicine is a safe and private way to terminate an early pregnancy with medication without having to visit a clinic or find a local prescriber. Studies from telemedicine abortion services in Iowa (US) have shown no significant difference in the prevalence of known complications of medical abortion reported among telemedicine patients compared with face-to-face patients.[7] Early next year Marie Stopes Australia will release results from a 3 year co-operative study with Monash University and Ibis Reproductive Health that measures the safety and efficacy of the service in Australia since its inception.

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

Further Comments:

We do not support a restriction on the location where abortion care after 22 weeks to 24 weeks gestation should be undertaken. There are no such restrictions for obstetric care locations. Decisions about where treatment is provided should be made through evidence-based guidance, founded on clinical need, safety and best practice.

In England, Marie Stopes UK perform over 62,000 abortions per year outside of acute hospital settings, from clients who either self-refer or are referred from primary/community care. It is estimated that approximately 15% of these clients have factors that require additional care and attention in their treatment pathway. To address this need and to ensure all clients are managed promptly and effectively in the correct healthcare setting, we introduced our 'Marie Stopes UK Right Care' programme, which aims to ensure all clients are treated in the right place, at the right time.

Abortion care providers should develop pathways for women with complex needs or significant comorbidities to be able to refer where needed, minimise delays in accessing care, and avoiding the need to repeat key steps in their treatment journey.

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[6] Committee on the Elimination of Discrimination Against Women, Report of the inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, U.N Doc. CEDAW C/OP.8/GBR/1 (23 February 2018) https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/GBR/INT_CEDAW_ITB_GBR_8637_E.pdf

[7] Grossman D, Grindlay K, Buchacker T, et al. Effectiveness and acceptability of medical abortion provided through telemedicine. Obstetrics and Gynecology 2011; 118: 296-303. doi: 10.1097/AOG.0b013e318224d110. https://www.ncbi.nlm.nih.gov/pubmed/21775845

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?*

No

a. *Alternatively, do you think that a process of certification by only one healthcare professionals is suitable in Northern Ireland for abortions after 12/14 weeks gestation?*

No

Further Comments:

Certification by two healthcare professionals, or indeed any certification, is medically unnecessary at any gestation.

Clinical decisions and principles of informed consent and personal autonomy are already adequately covered by regulatory inspections by the Regulation and Quality Improvement Authority (RQIA), professional registration and licensing, and codes of standards from independent regulators such as GMC and NMC.

No other healthcare procedure requires sign-off by two healthcare professionals and this requirement stigmatises abortion care and the professionals that would provide that care, and this form of over-regulation of services can cause access to care to be delayed. Furthermore, any certification that "the grounds for abortion have been properly considered" is patronising to both healthcare professionals and women seeking abortion care.

The legal requirement to certify abortion care is not suitable for a decriminalised framework of care as it reintroduces an unnecessary criminal element to abortion service delivery.

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?*

No

Further Comments:

It is not necessary to over-regulate services by including notification processes in legislation. Data collection can be implemented by the Department of Health if it wishes, but this should not be entrenched in law to distinguish abortion care from any other healthcare provision. Treating abortion care differently to other forms of healthcare is deeply stigmatising. We need to destigmatise abortion care for medical professionals as much as we need to destigmatise it for women and pregnant people wishing to access services. Services are already scrutinised through regulatory inspections by the Regulation and Quality Improvement Authority (RQIA) to ensure that all healthcare providers in Northern Ireland are meeting high standards in care delivery and it is right that access to services should be assessed, including waiting times.

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 with ancillary, administrative or managerial tasks?*

No

Further Comments:

We support the right of healthcare professionals to have a conscientious objection to participating in the provision of abortion care, except when treatment is necessary to save the life of a pregnant person or to prevent grave permanent injury to a pregnant person. However, we do not feel that is it necessary to include conscientious objection in abortion law.

The practice of conscientious objection for healthcare professionals around abortion care was introduced, and protected, by s4 of the 1967 Abortion Act in England, Scotland and Wales.[8](8) Some healthcare professionals choose to conscientiously object based on their personal views on when life begins, or due to religious practice. However, it is worth noting that in 2018 the All Party Parliamentary Group (APPG) on Population, Development, and Reproductive Health, reported that 'The imposition of a doctor's religious beliefs on a vulnerable patient is a way to harm women and CO [conscientious objection] nearly always involved services needed by women (contraception and abortion).'[9] (9)

As stated by the World Health Organisation, individual health-care providers have a right to conscientious objection to providing abortion (as rights to freedom of thought, conscience and religion are enshrined in Article 9 of the European Convention on Human Rights), but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk.[10](10) The WHO policy and technical guidance continues to outline that,

"…health-care providers must refer the woman to a willing and trained provider in the same, or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, the health-care professional who objects, must provide safe abortion to save the woman's life and to prevent serious injury to her health. Women who present with complications from an unsafe or illegal abortion must be treated urgently and respectfully, as any other emergency patient, without punitive, prejudiced or biased behaviours."

Conscientious objection should never amount to obstruction of any part of abortion care.

Guidance for Health and Social Care Professionals on Termination of Pregnancy in Northern Ireland was issued in March 2016 by the Department of Health, Social Services and Public Safety, which outlines the duty that healthcare professionals in Northern Ireland have to women requesting abortion care or in need of aftercare support.[11](11) Section 4.9 of the guidance outlines how Northern Irish healthcare providers should continue to support their patients in non-emergency situations, even if they conscientiously object to abortion care. This section references The General Medical Council's (GMC's) Good Medical Practice (Nov 2013), which states that:

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[8] Abortion Act 1967, Section 4. http://www.legislation.gov.uk/ukpga/1967/87/section/4

[9] All Party Parliamentary Group (APPG) on Population, Development and Reproductive Health (2018), *Who Decides? We trust women: Abortion in the developing world and the UK*. http://www.appg-popdevrh.org.uk/APPG%202018%20AW.PDF

[10] World Health Organisation (2012), *Safe abortion: Technical and policy guidance for health systems (second edition).* http://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf;jsessionid=CB34210746659B058A640F283CB2F470?sequence=1

[11] Department of Health, Social Services and Public Safety (2016) *Guidance for Health and Social Care Professionals on Termination of Pregnancy in Northern Ireland.* https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/guidance-termination-pregnancy.pdf

‘You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient’s lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role’

However, we know this Department of Health guidance is not being followed in practice, and barriers to onward referral are occurring. A Client Service Advisor from our One Call contact centre reported: “I was told by a Northern Irish client who visited her local GP, her doctor was male and was very aggressive towards the client when she wanted to talk about her options - This doctor was very forceful with his own beliefs.”

Other barriers to abortion care also result from conscientious objection being used, with a One Call team member describing their difficulties in trying to arrange blood tests for Northern Irish clients at their local GP practice, and in obtaining letters confirming details of their medical history.

With regards to aftercare and onward referrals in Northern Ireland, it is a similar picture of current guidance not being followed. In section 1.7 of the guidance, it is stated that, ‘Regardless of where a termination of pregnancy has been carried out, where necessary, support must be provided for individuals through aftercare services including counselling and other psychological support services. It is the responsibility of Health and Social Care Trusts to provide access to aftercare support for all women where it has been assessed to be required.’

Section 5.16 also states,

‘Aftercare services should be available to any woman who presents with symptoms or complications following a termination of pregnancy, regardless of where it was carried out, so that she has access to appropriate treatment and counselling where required.’

Again, we know this is not happening in practice among some doctors in Northern Ireland. A Client Services Advisor at One Call reported a particularly disturbing incident, recalling “I have encountered a client who said her GP would not prescribe her antibiotics for an infection she developed after an abortion.” As healthcare providers who care about the wellbeing of our clients and the quality of our care, we know that if an infection is not treated it can lead to further serious problems, including pelvic inflammatory disease (PID), which requires urgent medical attention. That any doctor would ignore their patient’s aftercare needs is a dereliction of their duty and tantamount to intentional harm. The general care of patients undergoing abortion care should be supported and conscientious objection should not release medical professionals from this duty.

As ruled by courts in England and Wales, any refusal to treat a patient based on conscientious objection should be limited to the scope of participating in a “hands-on” capacity in the course of medical treatment bringing about an abortion, and does not include ancillary, administrative and managerial tasks that might be associated with abortion care. Health service managers must ensure that personal religious and/or moral views do not interfere with service delivery.

12. *Do you think any further protections or clarification regarding conscientious objection is require in the regulations?*

Yes

Further Comments:

If conscientious objection was to be included in regulation, we would support the introduction of regulation that ensures the right to conscientiously object is balanced with the right for women to not experience delays to their care. Conscientious objection should not be used as “conscientious obstruction”, and women should be protected from such obstruction occurring.

As described in our response to Question 11, women in Northern Ireland have long experienced barriers to accessing abortion care referrals, medical history details, and ongoing aftercare due to the personal beliefs of some doctors.

While those who do have a conscientious objection to abortion care should not be marginalised or discriminated against, it should also be recognised that healthcare providers who conscientiously commit to providing abortion care or onward referrals to care, should not face discrimination or stigmatisation either.

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

Further Comments:

We support the inclusion of Safe Access Zones in abortion legislation, and believe that a designated Safe Access Zone is the best way to protect abortion care service users by prohibiting the specific activities which are known to cause service users and healthcare providers to feel intimidated, distressed, harassed, afraid and alarmed.

Anti-abortion gatherings occur outside abortion clinics across the UK, including both NHS and independent sector premises that provide abortion care services. This causes service users to feel harassed and intimidated when trying to attend their appointments.

From when the Marie Stopes Belfast clinic opened in 2012 until its closure in late 2017, the level of harassment and intimidation felt by team members and clients alike was relentless. The hostile environment meant that the clinic had to take extra measures to keep clients safe, such as employing security guards to be stationed at the entrance, and training teams of volunteer client escorts to walk with clients, often past large and intimidating gatherings.

The activity outside of our Belfast Clinic represented the most intimidating behaviour that could be witnessed outside of any location in the UK. One internal incident report from 05/01/2017 stated, “When a staff volunteer was entering the building one of the protesters said 'She's here'. As she opened the door, two other protesters walked towards the entrance and glared at her. One of them mouthed 'I’m going to get you' through the glass.”

Every woman of reproductive age was targeted by the anti-abortion groups, even if they were entering the building to visit one of the many other offices. Clients often confided in our teams at the One Call contact centre about their experiences of harassment outside of the Belfast Clinic. One Client Service Advisor at One Call, recalled, “I have spoken with clients who were physically assaulted outside our clinic in Northern Ireland. One of these wasn't coming for an abortion, but a private smear test.”

For those few, vulnerable women who were eligible to access legal abortion care at our Belfast clinic, the ordeal they faced at the hands of the anti-abortion groups was abhorrent. As seen from two internally logged incidents from our Belfast Clinic on 09/03/2017 and 13/04/2017 respectively, our clients and their companions were directly targeted. Protestors attempted to make clients miss their appointment or “out” them as potential clients which shattered their confidentiality and right to privacy:

“On return for 2nd stage MA [medical abortion], the client and her mother made us aware that they were harassed by protesters outside the building when leaving the day before. They said no to the protesters leaflets and were shown a plastic 'foetus'. The protester tried to draw attention to them by shouting loudly and she grabbed the mother’s arm and tried to pull her back.”

“Our client arrived for 2nd stage MA [medical abortion] extremely upset and crying in reception. A protester at the front door had blocked her entrance to the building and put a plastic 'foetus' up to her face. She told her that 'a baby at 20 days old has a heartbeat.' Building security tried to accompany client in the lift but she thought he was a protester and did not listen when he explained he worked for Marie Stopes.”

In all cases, the police were informed. In 2015, our former Programme Director of Northern Ireland, Dawn Purvis, pursued charges of harassment against Bernadette Smyth (Director of the anti-abortion group Precious Life). Smyth was convicted of having caused harassment which barred her from the area around the Belfast Clinic and from engaging with Dawn. However, the conviction was overturned not long after, in June 2015. This shows that existing harassment law is not suitable to protect service users and providers from activities that have a clear detrimental effect on their wellbeing.

CEDAW mentioned how the presence of these anti-abortion groups impedes access to abortion services in Northern Ireland in section 19 and 70 of the “Report of the inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women” (2018). CEDAW concluded that the harassing activities of anti-abortion protestors was in violation of a woman’s right to seek sexual and reproductive health services and information, and that women are subjected to this harassment by anti-abortion protestors who are emboldened by lack of prosecution.

We believe in the rights of protest, assembly, and freedom of expression, but we also believe that women and pregnant people have the right to access healthcare services without being harassed or intimidated. These gatherings cause emotional distress to service users and leaves them open to having their privacy invaded. A designated Safe Access Zone to prevent groups from gathering at the premises of all those who provide confidential sexual and reproductive healthcare services and advice would prevent the harassment and intimidation of women and pregnant people.

Some local councils in England have used their powers to implement localised solutions to harassment outside clinics, such as Public Spaces Protection Orders (PSPO). Our West London Centre in the London Borough of Ealing implemented PSPO for this purpose in 2018. However, relying on local councils alone creates a postcode lottery, and can only ever be a temporary measure, with a PSPO lasting only three years. A danger of only enacting Safe Access Zones around some providers could be that harassing activities will become focused on those areas without this protection. No one should be harassed for accessing care in the location of their choice.

The introduction of Safe Access Zones within abortion legislation to prohibit activities that cause harassment and intimidation would outline that the right of assembly and free speech of these groups can be exercised somewhere that does not discriminate against women and pregnant people or infringe on their right to privacy and family life.

The Isle of Man legislature understood that anti-abortion activity which aims to distress and coerce people away from making informed healthcare decisions, could become a fixture outside abortion clinics once reform was enacted. In response, it included an amendment in their Abortion Reform Bill 2018 to provide for 'Access Zones' outside of any premises that provides abortion or abortion counselling, as well as outside abortion providers' homes. They understood the importance of protecting those accessing and providing abortion care from harassment, intimidation and gross invasion of privacy.

For Safe Access Zones to be implemented, there needs to be a clear outline of all behaviours that are known to cause feelings of harassment and intimidation to service users and team members entering abortion clinics. The Isle of Man has stipulated that prohibited conduct within Access Zones as outlined in Part 3 of the Abortion Reform Act 2018.[12] (12)

Considerations would also need to be made as to the distance that a Safe Access Zone would cover. A standardised or set distance may not be as effective in some clinic locations. The Isle of Man Abortion Reform Act stipulates an access zone of 100 meters, however the geography of some clinic locations would mean that service users could still face targeted harassment at this distance.

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

No

Further Comments:

We do not believe it is necessary to include "designated zones" within Safe Access Zone protections in abortion legislation. The area outside the Safe Access Zone boundary would be a suitable place for any protestors to gather if they wish to, as this will be at a distance so as to protect service user's access to the services.

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

Further Comments:

Marie Stopes UK is an independent provider of abortion care services throughout England, providing quality abortion services to more than 62,000 women every year. We formerly operated a clinic in Belfast, Northern Ireland, where our team worked tirelessly to drive awareness of women's options and provide the services allowed within the highly restrictive legal framework. We are the only independent abortion care provider that was working in Northern Ireland whilst abortion care was severely restricted.

[12] Isle of Man, Abortion Reform Bill 2018. Available at: http://www.tynwald.org.im/business/bills/Bills/Abortion_Reform_Bill_2018_as_amended_by_KEYS.PDF

Marie Stopes UK is a country programme within the global charity, Marie Stopes International. Our 36 sister country programmes around the world provide life-saving reproductive health services in some of the world's most economically deprived and hard-to-reach communities. Some also operate in restricted environments and see first-hand the impact of unsafe abortion, when women are forced to take matters into their own hands because healthcare providers cannot offer them safe, legal services. An estimated 25 million unsafe abortions happen each year, and as a result an estimated 27,000 women die and 7 million more experience complications. As noted by the World Health Organisation, the legal status of abortion has no effect on a woman's need for an abortion, but it dramatically affects her access to safe services.

Decriminalisation of abortion in Northern Ireland should be seen as significant progress for women's sexual and reproductive health and rights. The Abortion Act 1967 does not extend to Northern Ireland and so government is in the position to create better provision of care than even the Abortion Act allows in Great Britain. The Abortion Act was ground-breaking when introduced in the late 60's, but as abortion care and medical practice has evolved, the Abortion Act should not be used as a template for the best abortion care framework. The recent Isle of Man Abortion Reform Act is a far better framework for inspiration on how to support women to access the best and most appropriate care.

We therefore ask the government to recognise women's agency and autonomy and provide full and unrestricted access to abortion services in Northern Ireland. States must make every effort to avoid over-regulation to ensure universal access. Providing women with greater access to abortion care by bringing it in line with other healthcare provision should be a priority for the country.