The Abortion Rights Campaign (ARC) is an all-island grassroots movement for choice and change. Since 2012 we have been raising awareness and advocating for change to Ireland's abortion laws. ARC was a founding member of the 'Together For Yes' campaign which secured a resounding Yes vote in the recent referendum to repeal the 8th Amendment. We aim to protect the health and dignity of reproductive rights-holders across the island of Ireland in line with international best practice and human rights standards.

FAO: Julian Smith, Secretary of State for Northern Ireland; Northern Ireland Office

16 December 2019

As a grassroots organisation dedicated to reproductive rights, the Abortion Rights Campaign calls on the UK Government to make abortion free, safe, legal and locally available across Northern Ireland. As we explain in detail below, our top recommendations include:

- Abortion on request without gestational cut-offs
- No certification requirements
- No refusal of care
- Establishment of safe access zones

Free, safe, legal, local

ARC believes that abortion should be available as early as possible and as late as necessary, for anyone who wants or needs it. This belief is rooted in international best practice and in the core principle of bodily autonomy. All individuals have the right to make their own decisions about medical treatment, including abortion, without interference from the state. Free, safe, legal and local abortion on request is also the best way to respect patients' privacy, ensure services are accessible in practice, and demonstrate dedication to evidence-based regulation.

We are pleased to see the Government's commitment to upholding the 2018 recommendations of the United Nations Committee on the Elimination of Discrimination Against Women (CEDAW). We note that there are specific issues relating to the CEDAW obligations which the Government is seeking guidance on; we have addressed these areas below.

No gestational limits

We are pleased to note that the Goverment recognises the importance of unrestricted access to abortion for survivors of sexual crimes. We believe this same consideration must be extended to all people seeking abortion care. It is important to recognise that 12 weeks of pregnancy is only around 10 weeks since conception, which is a relatively short time period.

Imposing a gestational limit on early abortions would place an unnecessary burden on people seeking abortions, including survivors of sexual assault, people in coercive or abusive relationships, or people living in rural areas. Time limits would also negatively affect those with irregular menstrual cycles or those who were not expecting to become pregnant. For example, irregular periods are common among young people, which can lead to delays in the detection of pregnancy.[1] A study of people denied abortions because of gestational limits in the United States showed that they were younger and more likely to be unemployed than other abortion patients. Late detection of pregnancy was a main cause of patients missing the gestational cut-off;[2] other reasons included a lack of available appointments, fear of protesters, caring responsibilities, and difficulties arranging time off work.[3] Being denied an abortion because of gestational limits also has a lasting negative effect. For a period of five years after being denied an abortion, people who were turned away were more likely to be un- or under- employed, live in poverty, and require public assistance.[4] As gestational limits would unnecessarily restrict peoples' reproductive health care choices, ARC urges the Government to remove all time restrictions on abortion.

Time restrictions on abortion would also perpetuate the problem of people having to travel outside of Northern Ireland to obtain an abortion. The Government need look no further than the Republic of Ireland to find a cautionary tale. In the Republic, abortion is available on request up until 12 weeks, after which it is only available when pregnancy poses a 'risk to the life, or of serious harm to the health' of the pregnant person, or when a 'condition [is] likely to lead to death of foetus' before or within 28 days of birth.[5] People who need an abortion after 12 weeks and do not qualify under one of the exceptions are forced to travel outside of Ireland. This forced travel poses a financial and logistical hardship for many people, who may struggle to afford the costs associated with making last-minute travel arrangements, paying out of pocket for medical care, or arranging child care or time off work. People who are not Irish citizens are especially burdened because they often have to apply for special travel documents to be able to leave the country. The Government has a responsibility to ensure that all residents of Northern Ireland are able to access abortion care locally; gestational limits undermine the Government's obligation to meaningful access.

In line with these same principles, ARC recommends that the Government avoid setting an upper gestational limit in any circumstance. We support the Government's proposal that abortion without time limit be available for cases of severe foetal abnormalities, risk of permanent grave phsyical or mental injury, or risk to the pregnant person's life. We also urge the Government to allow abortion without time limit for cases in which continuing a pregnancy risks injury to the pregnant person's mental or physical health. People seeking later abortions often do so because of tragic circumstances, including the detection of a catastrophic foetal abnormality or a health condition that endangers the pregnant person's

[1] The American College of Obstetricians and Gynecologists, 'Menstruation in Girls and Adolescents: Using the Menstrual Cycle as a Vital Sign' (ACOG Committee on Adolescent Health Care, December 2015), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Menstruation-in-Girls-and-Adolescents-Using-the-Menstrual-Cycle-as-a-Vital-Sign.
[2] Ushma Upadhyay et al., 'Denial of Abortion Because of Provider Gestational Age Limits in the United States,' *American Journal of Public Health* 104, no. 9 (2014).
[3] Ibid 2
[4] Diana Greene Foster et al., 'Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States,' *American Journal of Public Health* 108, no. 3 (2018).
[5] 'Health (Regulation of Termination of Pregnancy) Act 2018' (2018).

life. The best way that the Government can support pregnant people is to ensure that people are not confronted with unnecessary barriers while trying to access health care. Data from England and Wales demonstrate that abortions after 12 weeks are relatively rare. In 2018, 90% of abortions were performed before 12 weeks gestation, with only 0.1% of procedures being performed at or after 24 weeks gestation.[6] However, the fact that abortions later in pregnancy are quite rare does not justify the imposition of a gestational limit. Gestational limits - whether they be for 12, 22, or 24 weeks - create unnecessary barriers to accessing crucial reproductive health care.

No certification

ARC is opposed to certification requirements at any stage of pregnancy. In Great Britain, certification is required to ensure that patients meet the terms of the 1967 Abortion Act. As abortion has been fully decriminalized in Northern Ireland, certification is unnecessary. There is no evidence that certification benefits patients in any way; rather, requiring certification could cause delays in a patient receiving care. This risk of delay would especially affect people in rural areas, who may struggle to find a second doctor due to potential issues with refusal of care. By treating abortion differently than other forms of routine health care, certification contributes to abortion stigma. Although many patients may consult with their doctor about their health care decisions, physicians' permission should not be legally required.

Broadening the range of abortion providers

ARC supports widening the scope of medical professionals who can provide abortion care to include not only doctors, but also midwives, nurses, or other registered health care providers. Expanding the types of professionals who can provide abortion makes the procedure more accessible for those who need it. The World Health Organisation (WHO) and NICE guidelines both reccommend allowing nurses and midwives to provide abortion care.[7] As data from England and Wales suggests that over 80% of all abortions will be induced by medication, it is practical to allow nurses and midwives - who already prescribe this same medication for incomplete miscarriages - to deliver this care.[8]

Clinical evidence should determine where abortions are provided

Regarding the administration of medical abortion, ARC recommends that the Government allow pregnant people to take the first and second abortion pills at home. People in England, Scotland and Wales are currently only permitted to take the second pill at home due to restrictions in the 1967 Abortion Act, which does not apply to people in Northern Ireland.[9] Self-administering the medication at home is safe and prevents redundant, time-consuming trips back and forth to the clinic. Enabling people to take the medication at home removes barriers for people who may struggle to make two trips - such as people with disabilities, those with young children, or people living with domestic violence. Taking the medication at

[6] Department of Health and Social Care, 'Abortion Statistics, England and Wales: 2018,' June 13, 2019.
[7] World Health Organization, 'Safe Abortion: Technical and Policy Guidance for Health Systems' (Geneva, 2012), https://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf;jsessionid=8356A66C5D74F45CFA6C5FDA83F9C5D9?sequence=1; National Institute for Health and Care Excellence, 'Abortion Care: NICE Guideline [NG140],' September 2019, https://www.nice.org.uk/guidance/ng140/chapter/Recommendations#workforce-and-training.
[8] Department of Health and Social Care, 'Abortion Statistics, England and Wales: 2018.'
[9] 'Abortion Pill at Home to Be Legal in England,' *BBC News*, August 25, 2018, sec. Health, https://www.bbc.com/news/health-45295398.

home also ensures that the patient remains comfortable throughout the duration of the procedure; prior to the law taking effect in England, several women reported that they started experiencing uncomfortable symptoms of miscarriage while commuting home from the clinic.[10] We support the development of a flexible model of service provision in Northern Ireland, focused on providing the most effective and accessible care for women and pregnant people. Decisions regarding where abortion can be accessed should be clinical, not legal.

Data collection

It is important that only data which is medically necessary be collected. In other jurisdictions, abortion-related data have been used as a tool by anti-choice campaigners to regulate pregnant people's choices. For example, healthcare providers in some areas have been mandated to record the reasons a person decided to terminate their pregnancy. These kinds of questions are both medically unnecessary and a violation of the pregnant person's privacy. It is also important that reporting forms avoid using politically charged, medically inaccurate language, such as referring to the foetus as an 'unborn child.'[11]

Similarly, it is important that abortion-related data collected by the Government be used only for legitimate public health purposes. Recently, the US state of Missouri was embroiled in scandal when it was discovered that the State's Department of Health and Senior Services had used data reported by the state's last remaining abortion clinic to look for evidence of 'failed abortions' in an effort to shut the clinic down.[12] Safeguards should be put in place to ensure that state-collected data is used to assess ways to improve the quality and accessibility of healthcare pathways, not to chip away at people's reproductive rights.

No refusal of care

The UK Government is responsible for ensuring that an appropriate number of providers are available in all parts of Northern Ireland, particularly in rural areas. Provisions that allow doctors to refuse to provide abortion care form one of the biggest barriers to access in other jurisdictions and often result in geographic disparities. Accordingly, the WHO has recognised that *all* forms of so-called 'conscientious objection' constitute barriers to safe abortion.[13] In the United States, 89% of counties have no abortion provider, forcing people to travel and experience significant delays in their treatment.[14] The Republic of Ireland is experiencing a similar problem. There is still one county without any abortion providers, and only 10 of 19 maternity hospitals provide abortions.[15] In many regions of Italy, up to 80 or even 90 percent of doctors refuse to provide abortion care,[16] leading to a number of devastating situations. For example, a woman in northeastern Italy was forced to visit 23 different hospitals before she could find a doctor willing to provide an abortion. In this case, the doctor only agreed to

[10] "My Abortion Pill Took Effect on the Tube Home," *Victoria Derbyshire* (BBC, July 31, 2018), https://www.bbc.com/news/av/uk-45018527/my-abortion-pill-took-effect-on-the-tube-home.
[11] Joerg Dreweke, 'Abortion Reporting: Promoting Public Health, Not Politics,' *Guttmacher Policy Review* 18, no. 2 (2015).
[12] Sabrina Tavernise, 'Dispute Over Data on Women's Periods Shadows Hearing for Last Missouri Abortion Clinic,' *The New York Times*, October 31, 2019, https://www.nytimes.com/2019/10/31/us/abortion-missouri-planned-parenthood.html.
[13] World Health Organization, 'Preventing Unsafe Abortion,' June 26, 2019, https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion.
[14] Rachel K. Jones and Jenna Jerman, 'Abortion Incidence and Service Availability In the United States, 2011,' *Perspectives on Sexual and Reproductive Health* 46, no. 1 (2014): 3–14, https://doi.org/10.1363/46e0414.
[15] Paul Cullen, 'No Abortion Service Being Provided in Four Counties,' *The Irish Times*, January 5, 2019, https://www.irishtimes.com/news/health/no-abortion-service-being-provided-in-four-counties-
[16] Paola Rivetti, 'Let's Talk About: What We Can Learn from Italy about 'Conscientious Objection,'' *Abortion Rights Campaign* (blog), October 23, 2018, https://www.abortionrightscampaign.ie/2018/10/23/lets-talk-about-what-we-can-learn-from-italy-about-conscientious-objection/.

provide an abortion after intervention from one of Italy's leading trade unions.[17] Currently, seven Sicilian doctors are on trial for manslaughter in the 2016 death of Valentina Milluzzo, who died of sepsis after 'conscientious objectors' refused to provide a life saving abortion.[18] It is imperative that the people of Northern Ireland are not subjected to similar treatment.

The UN CEDAW Committee has clarified that 'if health service providers refuse to perform [reproductive health] services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.'[19] However, the Center for Reproductive Rights has found that in many countries - including Italy, Hungary, Poland, and Croatia - there is no oversight mechanism in place to ensure that objectors provide referrals.[20] As a result, there is rampant abuse of the objection system and many people are left with no guidance as to how to proceed.

States that do not recognise a right to refuse care can provide a positive model for Northern Ireland. In Sweden and Finland, abortion cannot be refused on grounds of conscience, and we encourage the Government to implement a similar approach in Northern Ireland. Research has shown that a commonly cited reason for refusal of care is fear of stigma and ostracism from peers, rather than genuine personal moral objection.[21] We have already seen this dynamic in the Republic of Ireland, where many rural GPs are hesitant to provide abortion services because they fear negative social consequences.[22]

We urge the Government to reject so-called 'conscientious objection' in favour of a model of care that is patient-centred. Patient-centred care puts the rights and needs of the person seeking treatment first. Emphasising patients' needs, combined with active efforts to destigmatise abortion and thorough education and training for medical professionals, is an alternative way to engage physicians who may have qualms about providing abortion. Training in abortion procedures will provide doctors with an opportuity to voice their concerns, learn international medical best practice, and address their own values and perceptions. Providing practitioners who may otherwise refuse to provide abortion care with a constructive and open dialogue could help them become more comfortable with providing a full range of reproductive health services. ARC's own work in the Republic of Ireland has shown that people tend to adopt a pro-choice position when provided with accurate information and given an opportunity to ask questions. This same approach should be extended to medical professionals.

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[17] 'Abortion, CGIL complaint: 'Woman rejected by 23 hospitals, solution only after our intervention,'' *la Repubblica*, March 1, 2017, https://www.repubblica.it/cronaca/2017/03/01/news/padova_aborto_respinta_23_ospedali-159526952.

[18] Marianna Giusti and Hannah Roberts, 'Italian Doctors on Trial for Manslaughter after Refusing Abortion,' *Financial Times*, October 29, 2019, https://www.ft.com/content/5bd5e150-f994-11e9-a354-36acbbb0d9b6.

[19] UN CEDAW Committee, 'General Recommendations Adopted by the Committee on the Elimination of Discrimination Against Women,' § Article 12(1), paragraph 11 (1999), https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/INT_CEDAW_GEC_4738_E.pdf.

[20] Center for Reproductive Rights, 'Abortion Opponents Undercut Council of Europe Resolution on Conscientious Objection,' October 7, 2010, https://reproductiverights.org/press-room/abortion-opponents-undercut-council-of-europe-resolution-on-conscientious-objection.

[21] Lori Freedman et al., 'Obstacles to the Integration of Abortion Into Obstetrics and Gynecology Practice,' *Perspectives on Sexual and Reproductive Health* 42, no. 3 (2010): 146–51.

[22] Gráinne Ní Aodha, ''If You're the Only GP Providing Abortion Services in an Area, You Are Open to Protests,'' *TheJournal.Ie*, March 17, 2019, https://www.thejournal.ie/rural-abortion-services-gps-michael-harty-4543780-Mar2019.

Any ‘conscientious objection’ provisions should emphasise that all medical professionals and related staff have a duty to refer patients immediately to an abortion provider or national referral service. The right to refuse applies only to the direct provision of medical care, not to related activities, such as scheduling appointments. All medics and related staff should be offered values clarification training by a reputable source such as the WHO.

Pregnant people have a right to freedom from religious dogma and judgement when they are seeking healthcare. All medical professionals should receive training on the specific limits of ‘conscientious objection’ so that any who intend to object know how to appropriately communicate this information to patients. Health care providers should not attempt to dissuade patients from making the decision to have an abortion.

Implement safe access zones

The Government has an obligation to ensure access to safe abortion, which includes creating safe access zones to protect the mental and physical health of patients, medical staff, and the community at large. In jurisdictions without safe access (or ‘buffer’) zones, such as most parts of Great Britain and many parts of the US, patients and staff members are routinely harassed by anti-choice campaigners. This harassment has been shown to have a profoundly negative effect on both patients and providers, as well as the broader community. A large study of abortion patients and clinic staff in Great Britain found that people felt that anti-abortion protesters were invading their privacy and stigmatising their personal health decisions. Many reported that the presence of anti-choice protesters was the most stressful part of their abortion experience, while others reported feeling intimidated or threatened and fearing physical injury.[23] In Canada, both patients and staff reported feeling harassed and distressed at the hands of anti-choice protestors.[24]

In 2018, Ealing became the first municipal authority in the UK to introduce a Public Spaces Protection Order outside of an abortion clinic; those who violate this order are liable to criminal prosecution.[25] The Government now has the opportunity to implement this model, which prioritises the well-being and safety of patients, in Northern Ireland. This solution already has cross-community political support within Northern Ireland. In 2017, the Belfast City Council passed a resolution condemning anti-abortion harassment and intimidation outside of reproductive health care clinics in the city.[26] The implementation of safe access zones would recognise that people’s medical decisions should be treated confidentially and with respect.

Beyond the fact that the mere presence of protestors serves as a source of intimidation of intimidation and stigma for many, it is important to note that many of the demonstrations that take place outside of abortion providing facilities are not contained to ‘peaceful’ protests.

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[23] Graeme Hayes and Pam Lowe, "'A Hard Enough Decision to Make': Anti-Abortion Activism Outside Clinics in the Eyes of Clinic Users' (Birmingham, UK: Aston University, September 2015).

[24] Clare Clancy, 'NDP to Consider Legislating Buffer Zones around Abortion Clinics,' *Edmonton Journal*, March 10, 2018, https://edmontonjournal.com/news/politics/ndp-to-consider-legislating-buffer-zones-around-abortion-clinics.

[25] Ealing Council, 'Ealing Council’s Cabinet Members Have Taken the Decision to Implement a Public Spaces Protection Order (PSPO) around the Marie Stopes Clinic on Mattock Lane, Ealing,' April 10, 2018, https://www.ealing.gov.uk/news/article/1760/ealing_introduces_first_uk_safe_zone_outside_abortion_clinic.

[26] Suzanne Breen, 'SDLP Suffers New Blow as City Hall Trio Quits Party in Abortion Row,' *Belfast Telegraph*, June 19, 2017, https://www.belfasttelegraph.co.uk/news/northern-ireland/sdlp-suffers-new-blow-as-city-hall-trio-quits-party-in-abortion-row-35839603.html.

One study of abortion clinics in the United States found that only 6% of facilities had experienced 'peaceful' picketing alone. The overwhelming majority of facilities were subjected to a wide array of severely disruptive or even violent demonstrations such as abortion opponents falsely booking large numbers of 'no-show' appointments, clinics being invaded or blockaded by demonstrators, vandalism, death threats to staff members, and picketing physicians' homes.[27] Anti-abortion protestors in Great Britain have recently adopted many of the more aggressive tactics deployed by their American counterparts, including toting signs with grisly imagery, blocking clinic entrances or driveways, and engaging in 'pavement counseling,' a tactic in which protestors attempt to physically intercept arriving patients and 'persuade' them not to have an abortion.[28] People's right to express an opinion does not include a right to damage property, harass and threaten people, or physically obstruct the path of people attempting to access healthcare. Safe access zones are therefore required to ensure patients and staff members are able to freely and safely enter a healthcare facility.

Conclusion

We have set out a comprehensive vision for abortion services in Northern Ireland, based on principles of bodily autonomy and patient-centred care. We recommend that the Northern Ireland Office operate under these principles in order to remain in full compliance with CEDAW recommendations.

Specifically, we advocate the following:

- Abortion on request without gestational cut-offs
- No certification requirements
- No refusal of care
- Establishment of safe access zones.

For further information, please contact:

Abortion Rights Campaign
Email: policy@abortionrights.ie

[27] Catherine Cozzarelli and Brenda Major, 'The Effects of Anti-Abortion Demonstrators and Pro-Choice Escorts on Women's Psychological Responses to Abortion,' *Journal of Social and Clinical Psychology* 13, no. 4 (1994): 404–27.
[28] Pam Lowe and Graeme Hayes, 'Anti-Abortion Clinic Activism, Civil Inattention and the Problem of Gendered Harassment,' *Sociology* 53, no. 2 (April 2019): 330–46, https://doi.org/10.1177/0038038518762075.