# LEGAL BUT NOT LOCAL

# Barriers to accessing abortion services in Northern Ireland

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**Legal but not local: Barriers to accessing abortion services in Northern Ireland**

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## Barriers to accessing abortion services in Northern Ireland

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# Executive summary

> They didn't know how to deal with abortion issues. It is nowhere in their world of understanding, and they don't want to have to deal with it. They don't want to have to provide these services or information about these services, but they have to. They do. It's healthcare. You have to. You have to provide the services that we all have a right to, you know.
>
> If I can stop any other woman having to sit in a place where, because you need this medical procedure, that your life now means so little that they will take a risk to put you on a flight and put you through the mental torture of walking about a city all day after a termination for medical reasons, and think that is acceptable, then it is worth telling. Free, safe, and local is what we were promised here. But we haven't got that.
> **Marie* (not her real name), interviewed in December 2022**

> I was really frightened… A day, whenever you're pregnant, and you don't want to be, feels like a huge amount of time… Something's happening to you that you don't want to happen to you, and you know that, legally, it's okay for you to access this [abortion] service. But, in reality, nobody can help.
> **Katie Boyd, interviewed in December 2022**

Women, girls and other people who can get pregnant are legally entitled to access abortion care on broad grounds in Northern Ireland. However, their government has failed to comply with its human rights obligations to provide quality abortion services to the full extent of the law. Since 2020, when Northern Ireland's current legal framework on abortion came into effect, hundreds of women, girls and other pregnant people in Northern Ireland have been forced to travel to England or elsewhere for abortion care or opt for online abortion services. Others have had to carry unwanted pregnancies to term.

The Northern Ireland government's decades-long practice of exporting abortion care to England is ongoing, with significant repercussions for women's lives and health. Forcing women and other pregnant people in Northern Ireland to travel to England for essential healthcare or to carry an unwanted pregnancy to term, violates their human rights. This includes their right to make autonomous decisions about their sexual and reproductive health.

Between September 2022 and August 2023, Amnesty International conducted more than 60 interviews with women, healthcare providers, civil society representatives, academics and government representatives concerning access to abortion services in Northern Ireland. Interviews revealed systematic failures by the Northern Ireland Department of Health to fulfil its human rights obligations to provide quality abortion services and information. The interviews also detailed pervasive violations of women's human rights, including their rights to health, information and equality and non-discrimination. This report reflects interviews, other evidence gathering and tracks barriers to access to abortion services until the end of August 2023.

The lack of access to lawful abortion services and related information in Northern Ireland is a significant failure which has created multiple barriers to human rights compliant care. For more than three years after abortion was legalised in Northern Ireland, the former Minister of Health, Robin Swann, and his department failed to ensure service provision, with the minister citing the need for Executive approval in accordance with sections 20 and 28A of the Northern Ireland Act 1998 and the Ministerial Code (see Annex 1). Until the collapse of the devolved administration in October 2022, the minister and his department failed to commission services and provide Health and Social Care Trusts and healthcare professionals with the requisite funding, training, guidance, and institutional support to establish new abortion services. They failed to clarify the parameters of, and exercise oversight over, the practice of conscience-based refusals to provide abortion services. They also failed to provide information about the law and existing services to the public. Further, there was a failure to address the intimidating and threatening behaviour of anti-abortion activists seeking to deter people from accessing abortion services.

As a result, even after the Secretary of State for Northern Ireland finally instructed the Department of Health to commission abortion services in December 2022, abortion service provision remains limited and existing abortion services are precarious. Conscience-based refusals to provide abortion care are a significant barrier to quality service provision. Abortion stigma and judgemental attitudes from hospital staff remain pervasive. Public awareness about the abortion law and services remains shockingly low and women face freely operating anti-abortion 'clinics', eager to mislead and misinform. Anti-abortion activists outside of clinics and hospitals have only become more emboldened in their intimidation and scare tactics, traumatising women, their family members and support people, other patients, healthcare providers, and hospital and clinic employees.

States have an affirmative duty, under international human rights law, not only to ensure that their laws are human rights compliant but to ensure, as the European Court of Human Rights has affirmed, that the rights they guarantee are not 'theoretical or illusory but rights that are practical and effective'. The past three years and more have revealed significant human rights concerns around the then-Minister of Health's and Department of Health's failure to implement the new abortion law, and women's and other pregnant people's ability to exercise their right to abortion in Northern Ireland.

The Department of Health was provided with an opportunity to respond to the issues raised in this report. They dispute the findings as per their response in Annex 2. The former Minister of Health was provided with an opportunity to respond to the issues raised in this report and a summary of his response is set out in Annex 3.

## Legal barriers to accessing abortion services

Northern Ireland's 2020 Abortion Regulations were a substantial leap forward, providing abortion on request up to 12 weeks, on mental and physical health grounds until 24 weeks, and on life-saving and fatal or severe foetal impairment grounds at all gestations. They also permit medical practitioners, midwives, and nurses to provide abortions, incorporating a multi-disciplinary approach in line with abortion guidance from the World Health Organisation (WHO). However, some aspects of the regulations are not grounded in the latest human rights and public health evidence-base, including WHO abortion guidance, creating barriers to accessing abortion services. For example, the regulations incorporate third-party authorisation requirements, restrict the use of at-home medication abortion, and do not clarify the parameters of conscience-based refusals.

A significant limitation in the current regulatory framework is the lack of self-care interventions, including telemedicine for abortion. This has posed a substantial barrier to women, girls, and other pregnant people's access to abortion services. Arbitrary and inequitable limitations on self-care, including telemedicine and at-home medication abortion, are felt most by people facing barriers and discrimination in access to healthcare. This includes people who live in rural areas, have limited or no access to transport, are in violent or coercive relationships, have certain health conditions, have childcare or other caring responsibilities, have inflexible workplaces and precarious employment, are concerned about confidentiality, or fear anti-abortion protesters' intimidation and privacy breaches outside clinics and hospitals.

Although the Northern Ireland Department of Health has the power to introduce telemedicine, as England, Scotland and Wales have done, the former Minister of Health failed to do so. Some politicians in the now-collapsed Executive explicitly declared that they did not want abortion to be accessible. The former minister has stated that the Executive did not agree to his proposals in 2020 to commission such services, reiterating his view that such permission was required. To date, with the ongoing absence of a devolved Executive, the Department of Health continues to decline to exercise its legal authority to make its abortion law more human rights compliant by introducing telemedicine, despite acknowledging its benefits. When pressed as to why, they told Amnesty International that they do not have the authority to make this change.

## Failure to implement the law: limited access to legal abortion services

Access to existing abortion services in Northern Ireland is largely limited to those whose pregnancies have not advanced past nine weeks and six days. Each trust currently offers early medical abortion services until that point in pregnancy. After that, women's ability to access care depends on their address or postcode. Currently, only those who live in the Northern Trust area can obtain services between 10 and 12 weeks' gestation; women in the other four trust areas must travel to England or elsewhere for abortion services. Without formal pathways to care, accessing abortion services after 10 weeks' gestation may also be the luck of the draw for some women, dependent upon the provider you meet, the people you know, or the goodwill of whoever happens to be on duty in the gynaecology ward.

Access to abortion services after 12 weeks' gestation is extremely limited in Northern Ireland; most women in need of these services will be forced to travel for abortion care. Amnesty International's interviews indicate that abortion service provision on health grounds, permitted by law until 24 weeks' gestation, is virtually non-existent. Interviews and Freedom of Information Act requests reveal that there is limited access to abortion services on foetal impairment grounds in each of the trusts in Northern Ireland, although this is not publicly acknowledged by the government. However, access depends on the availability of a provider with the appropriate training and on the gestation of the pregnancy. There do not appear to be clear pathways to care in all trusts and some trusts have better access to care than others, leaving healthcare again subject to a postcode lottery.

In addition, unlike the rest of the UK, which follows the UK National Screening Committee's recommendations, Northern Ireland, because of its previously highly restrictive abortion law, does not offer routine first trimester screening for foetal anomalies during pregnancy. The lack of antenatal screening contravenes health standards and has significant repercussions for pregnant people's rights to personal autonomy and health. Women are learning about potential concerns with their pregnancy much later than necessary. They are then under greater time pressure and stress to process this information and decide whether to continue with the pregnancy. For those who do choose an abortion, they are faced with greater health risks and the prospect of services being unavailable in Northern Ireland and of needing to travel and obtain services, which further delays their care.

Access to surgical abortion services is especially limited, forcing women who need or want those services to travel to England or elsewhere. Although the Department of Health has commissioned surgical abortion services at all gestations, there are currently no surgical options available after 12 weeks' gestation, as no one in Northern Ireland has been trained to offer these services. Only the Northern Trust currently offers surgical abortion services below 12 weeks' gestation. These services were established very recently, in May 2023, and are run by a single healthcare provider. Women in the Southern, South Eastern, Belfast and Western Trusts have no access to surgical services as of August 2023.

Providing pregnant people with a choice of method (surgical or medical) ensures patient-centred abortion care that respects their autonomy, personal history, mental or physical health needs and individual preferences. Some people may want a surgical abortion in order to have their pregnancy terminated faster – perhaps because of their family situation, being in a coercive relationship, having to care for children, a prior difficult experience with medication abortion, or any host of reasons impossible to predict.

The limited nature of abortion services after 10 weeks' gestation impacts people who need access to services on health grounds – including, but not limited to, those who are pregnant as a result of sexual violence – or for foetal impairment reasons. Many of these people have instead been forced to travel for services. Travelling for abortion care can be particularly challenging for adolescents, people in violent or coercive relationships, and those with precarious work situations, child or eldercare responsibilities, complicated health status, or uncertain immigration status. These same groups are also particularly impacted by the lack of telemedicine in Northern Ireland.

## Provider-initiated early medical abortion services under significant pressure: understaffed and under-resourced

The establishment of early medical abortion services in the trusts was entirely initiated and organised by one or two healthcare providers from within each trust. The Department of Health provided no institutional support, whether in the form of funding, guidance, logistics or staffing. Most trusts, although not all, did not obstruct provider efforts to establish abortion services, but also did not offer significant support. Individually motivated abortion providers in each trust were permitted to 'provide the service, but we're just not allowed to talk about it'.

These ad hoc services have remained largely in place, albeit with lapses in service provision in some of the trusts. Despite the long-awaited commissioning of abortion services in December 2022, these services remain fragile, stretched thin and hard-pressed to keep up with demand – which has increased in all five trusts in the past year. All remain dependent on a small cohort of dedicated healthcare professionals, many of whom are the same providers that began the service in 2020. The providers that Amnesty International spoke to were personally committed to providing the service; some felt that it was a professional duty, part of their Hippocratic Oath, to do no harm.

Yet, almost four years on, many of these providers are overworked and burned out. Even with long-awaited commissioning, trusts have not during this time employed sufficient additional staff to relieve the extreme pressure on those who provide early medical abortion services. Severely understaffed, providers have experienced burnout and stress. Most of the abortion services could not be sustained if the provider in charge was on leave for any extended period of time: maternity leave, sick leave or annual leave, result in a lapse, or reduction, in what is an extremely time-sensitive service – even though health workers often forgo sick leave or annual leave. If services are unavailable for a week or two, women and pregnant people will miss the window in which they can access abortion services in Northern Ireland.

The Department of Health's service specification for commissioned abortion services includes the provision of early medical abortion services up to 11 weeks and 6 days' gestation in each of the five trusts. However, as of August 2023 only the Northern Trust has been able to offer these services until 11 weeks and 6 days' gestation; the Western, Southern, South Eastern, and Belfast Trusts do not have the staffing capacity or premises necessary to expand their current early medical abortion service provision. Women, girls, and other pregnant people outside of the Northern Trust continue to have to travel for early medical abortion services or to obtain pills online.

## A failure to monitor and regulate conscience-based refusals

Misinformation about the permissible scope of the practice of conscience-based refusal has been a significant barrier to abortion service provision. Many stakeholders interviewed by Amnesty International expressed concerns about the extent of the practice of refusing services based on conscience. They noted its impact on abortion service delivery and on trusts' ability to organise and effectively run their abortion service. It has been raised as a barrier to establishing and accessing abortion services in almost every interview Amnesty held with healthcare providers and those working to support people to access services, and as a barrier to accessing respectful, quality services in interviews with people who had sought an abortion.

The lack of Department of Health guidelines and knowledge about conscience-based refusal results in the lawful scope of the objection being misunderstood. Amnesty's interviews with healthcare providers and others in the field consistently revealed that most healthcare workers don't understand the parameters of objection – that it only extends to direct participation in the actual treatment. A wide range of individuals, including administrative staff and interpreters, who are not permitted to object are refusing to provide services to patients in need of abortion and there is no institutional monitoring or oversight from the trusts or the Department of Health.

When asked about the lack of guidance, the Department of Health noted that healthcare professionals are 'aware that they can conscientiously object and trusts are putting that into place. And the feedback that we've received to date is that it's been managed well, within trusts, there's been no impact to service delivery, as it currently stands.' In follow up, the Department of Health has stated that it does not plan to

issue any guidance or regulations, maintaining that this falls within the purview of the medical associations and the trusts. Yet, the lack of regulation, monitoring and oversight of conscience-based refusals has been raised as an issue by nearly every healthcare professional interviewed for this report.

Many interviewees noted that the abuse of conscience-based refusals can be addressed through values clarification workshops with healthcare providers. These have been conducted informally within certain trusts, at the initiative of individual providers and their unfaltering commitment to providing abortion care. Understanding how abortion care and treatment works, and its importance to women and pregnant people, can have a significant effect on the quality of care and the number of staff willing to provide and support the provision of abortion services.

## Failure to provide information on abortion law and services, misinformation and stigma allowed to flourish

Until the collapse of devolved government, the Department of Health continuously failed to provide information about the new regulations and available services on any government website or to conduct an awareness-raising campaign. This silence has hindered access to services, creating confusion and perpetuating stigma around abortion services in Northern Ireland and preventing people from accessing healthcare to which they are legally entitled. The DOH had a human rights obligation to disseminate information about these new, lawful healthcare services, particularly in the midst of a pandemic where options for healthcare and for travel were limited and this information could have been life-saving. Contributing to the confusion and poor access to information is the absence of a local contact number for booking appointments. An Amnesty International-commissioned survey, conducted in Northern Ireland in October 2022, found that only 47 per cent of adults and 46 per cent of women were aware that abortion is currently legal in Northern Ireland. And only a small fraction of those surveyed – 13 per cent of adults and 10 per cent of women – knew how to access abortion services.

This lack of official and comprehensive information about abortion services in Northern Ireland allows misinformation to flourish. For example, people seeking information online come across crisis pregnancy centres run by anti-choice agencies, determined to delay or deny them their right to access abortion. Some healthcare providers lack access to information about the current abortion law and how and where to access abortion services, with detrimental impacts on those seeking abortion services. Inaction and silence from the Royal College of General Practitioners, stemming from the absence of leadership from the Department of Health and a reluctance to tackle abortion stigma and contend with vocal anti-abortion general practitioners (GPs), has been a particular barrier to GPs' ability to facilitate access to abortion services.

In December 2022, after the Secretary of State's instruction to the Department of Health to commission abortion services, information on the abortion law and how to access abortion services was finally made publicly available on NIDirect, the official government website for people living in Northern Ireland. However, the information on the website about Northern Ireland's abortion law is unclear and incomplete. To date, the Department of Health has not undertaken an awareness-raising campaign to inform the public in Northern Ireland about the law and how to access available services.



Additionally, the Department of Health has failed to disclose comprehensive annual data on abortion to the public. Publicly accessible disaggregated data is critical to informing policy and improving service provision and dismantling the stigma and silence that have long surrounded abortion in Northern Ireland. The failure to effectively analyse data in a timely manner cannot be used by the Department of Health as a pretext to escape accountability for the ineffective implementation of laws and neglecting to meet the health needs of its population.

Interviewees consistently expressed to Amnesty that the lack of comprehensive and evidence-based sexuality education in schools is a huge factor driving the stigma around abortion and unwanted pregnancy in Northern Ireland. Although relationship and sexuality education (RSE) is a mandatory part of the curriculum in grant-aided primary and post-primary schools in Northern Ireland, to date there is no standardised RSE content for all schools. Each school has the discretion to develop their own policy and curricular content on RSE that reflects their school's ethos and values, which has created challenges in providing evidence-based education free from religious influence. Few schools are willing to discuss abortion.

In June 2023, however, nearly four years after the UK government assumed full responsibility under the law to implement all of the CEDAW report's recommendations, the Secretary of State issued regulations on relationship and sexuality education for Northern Ireland. The regulations make teaching on early pregnancy and abortion a compulsory component of the sex education curriculum for pupils aged 11-16 – although, contrary to human rights standards, parents may still opt out of having their children participate. The Northern Ireland Department of Education must issue guidance to schools by 1 January 2024 on the required curriculum.

## Intimidation and threatening behaviour by anti-abortion activists deters people from seeking abortion services and takes a toll on healthcare professionals

Nearly every single person Amnesty International spoke to for this report mentioned anti-abortion activists as a significant issue and barrier to accessing abortion services. Various forms of intimidation and threatening behaviour are displayed towards people seeking abortion, those providing abortion, and those supporting abortion rights in Northern Ireland. Methods of intimidation and threatening behaviour include verbal intimidation and physically threatening behaviour, trolling, and threats by text messages. Intimidation by anti-abortion activists outside clinics and hospitals has long been part of anti-abortion activities in Northern Ireland.

This harmful behaviour takes a significant toll on people seeking abortion services and on healthcare providers, as well as other patients and staff entering those buildings. In 2022, the Northern Ireland Assembly passed The Abortion Services (Safe Access Zones) Act to create safe access zones around premises where abortions are provided. The Act aimed to implement the UK's legal obligation, stemming from the CEDAW inquiry report, to prevent harassment outside abortion clinics. It is the first piece of legislation passed of its kind in the UK. The bill became law on 6 February 2023 and the zones became enforceable on 7 May 2023. As of August 2023, the zones have not been implemented and people entering healthcare facilities continue to be harassed, although the Department of Health has stated zones will be in place by the end of September 2023.

Many interviewees Amnesty International spoke with expressed hope that the Safe Access Zones Act would allow women and pregnant people in Northern Ireland to access abortion services free from intimidation and distressing and threatening behaviour. However, some also questioned whether the safe zones would be effectively enforced by police and whether fines would be enough to deter the anti-abortion activists from continuing to engage in this behaviour outside clinics and hospitals.

## Key recommendations

(Full recommendations on pages 130-138)

### To the Department of Health and the Secretary of State for Northern Ireland:

- Ensure the full provision of abortion services, including that abortion is available locally, in Northern Ireland, across all health trusts and at all gestations, and that patients have a choice of abortion method.
- Ensure that all abortion service provision respects patients' rights to physical and mental health and autonomy in decision-making, including informed choice.

### To the Department of Health:

- Provide and publish written approval for medication abortion to be delivered by telemedicine, as the department is authorised to do under Section 8 of The Abortion Regulations 2020, and as allowed in other parts of the UK and Ireland and recommended by the World Health Organisation (WHO).
- Issue evidence-based guidance for registered medical professionals that includes a comprehensive explanation of the circumstances under which abortion is lawful and the lawful scope of conscience-based refusals and provider obligations.
- Exercise oversight over conscience-based refusals to provide abortion treatment.
- Ensure that a range of healthcare providers, including nurses and midwives, receive clinical training on abortion service provision, as per WHO recommendations on task sharing on abortion.
- Initiate a public information campaign to inform people living in Northern Ireland of the abortion law, existing abortion services, and how to access those services, so that abortion becomes normalised as a healthcare service. Ensure this awareness campaign tackles abortion stigma.

### To the Department of Education:

- Ensure the implementation of the Relationships and Sexuality Education (Northern Ireland) (Amendment) Regulations 2023 and provide good quality, comprehensive and accurate education on sexual and reproductive health and rights, covering early pregnancy prevention and access to abortion, is a compulsory curriculum component for all learners.
- In accordance with UNESCO recommendations, invest in quality curriculum reform and teacher training and strengthen monitoring of the implementation of comprehensive sexuality education.



# Acronyms

| | |
|---|---|
| BPAS | British Pregnancy Advisory Service |
| CEDAW | United Nations Convention on the Elimination of All Forms of Discrimination against Women |
| CSE | comprehensive sexuality education |
| D&E | dilatation and evacuation |
| DOH | Department of Health (Northern Ireland) |
| EMA | early medical abortion |
| FSRH | The Faculty of Sexual and Reproductive Healthcare |
| HSC | Health and Social Care |
| ICCPR | International Covenant on Civil and Political Rights |
| ICESCR | International Covenant on Economic, Social and Cultural Rights |
| ICNI | Informing Choices Northern Ireland |
| MVA | manual vacuum aspiration |
| NGO | non-governmental organisation |
| NIACT | Northern Ireland Abortion and Contraception Taskgroup |
| NICE | National Institute for Health and Care Excellence |
| NIO | Northern Ireland Office |
| RCGP | Royal College of General Practitioners |
| RCM | Royal College of Midwives |
| RCN | Royal College of Nursing |
| RQIA | Regulation and Quality Improvement Authority |
| RSE | relationships and sexuality education |
| SRH | sexual and reproductive health |
| TMFR | termination for medical reasons |
| WHO | World Health Organisation |

# Glossary[1]

**Concluding observations**: Following submission of a state report and a dialogue with the state party to the particular convention, treaty bodies, which monitor state compliance with a treaty, issue concluding observations to the reporting state, which include recommendations to the state party on how to comply with the obligations of the convention. These are compiled in an annual report and sent to the United Nations General Assembly.

**Conscience-based refusal**: The practice of healthcare professionals refusing to provide abortion care on the basis of personal views or religious beliefs, sometimes referred to as conscientious objection.

**Decriminalisation**: Removing abortion from all penal/criminal laws, not applying other criminal offences (eg murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors.

**Dilatation and evacuation (D&E)**: D&E is used after 12-14 weeks of pregnancy. It is the safest and most effective surgical technique for later abortion, where skilled, experienced practitioners are available.

**General comments/recommendations**: A treaty body's interpretation of the content and operation of human rights conventions. General comments/recommendations seek to explain the duties of states parties with respect to certain provisions and suggest approaches to implementing treaty provisions.

**Gestational period (duration of pregnancy) or gestation**: The number of days or weeks since the first day of the woman's last normal menstrual period (LMP) in women with regular cycles.

**Medical abortion**: Use of pharmacological agents (combination of mifepristone and misoprostol) to terminate a pregnancy.

**Early medical abortion (EMA)**: Term used in Northern Ireland to refer to medical abortions under 12 weeks (up to 11 weeks, six days).

**Legalisation:** The introduction of laws and policies specific to abortion to formally regulate it, as opposed to decriminalisation, which refers to the removal of laws criminalising abortion.

**Miscarriage (spontaneous abortion)**: Spontaneous loss of a pregnancy prior to 24 weeks' gestation, that is, before the foetus is usually viable outside the uterus. If the pregnancy has been expelled, the miscarriage is termed 'complete' or 'incomplete' depending on whether or not tissues are retained in the uterus.

1 This glossary is primarily based on the World Health Organisation's Abortion Care Guideline (2022), pages xiii-xvi.



**Post-abortion care**: Provision of services after an abortion, such as contraceptive services and linkage to other needed services in the community or beyond. It can also include management of complications after an abortion.

**Self-management of abortion**: Self-management of the entire process of medical abortion or one or more of its component steps, such as self-assessment of eligibility for medical abortion, self-administration of medicines without the direct supervision of a health worker, and self-assessment of the success of the abortion process.

**Surgical methods of abortion (surgical abortion)**: Use of transcervical procedures for terminating pregnancy, including vacuum aspiration (MVA or EVA) and dilatation and evacuation (D&E) (see definitions in this list).

**Telemedicine (or Telehealth)**: A mode of health service delivery where providers and clients, or providers and consultants, are separated by distance. That interaction may take place in real time (synchronously), eg by telephone or video link. But it may also take place asynchronously (store-and-forward), when a query is submitted and an answer provided later, eg by email or text/voice/audio message.

**Treaty body**: Each of the international human rights treaties (see above) is monitored by a designated treaty monitoring body. The treaty monitoring bodies are committees composed of independent experts. Their main function is to monitor the states' compliance with the treaty in question, including through the examination of state reports.

**Vacuum aspiration (electrical or manual; EVA or MVA)**: Vacuum aspiration involves evacuation of the contents of the uterus through a plastic or metal cannula, attached to a vacuum source. Electric vacuum aspiration (EVA) employs an electric vacuum pump. With manual vacuum aspiration (MVA), the vacuum is created using a hand-held, hand-activated, plastic aspirator (also called a syringe).

# Methodology

## Research rationale

After years of persistent advocacy, and of human rights bodies repeatedly finding Northern Ireland's highly restrictive abortion law in violation of women's and girls' human rights, the UK Parliament passed a law decriminalising abortion in Northern Ireland in 2019. This marked a significant milestone in the fight for women's rights and gender equality in Northern Ireland and was a welcome and ground-breaking development.

However, despite a new abortion framework taking effect from 31 March 2020, the Minister of Health (prior to the collapse of devolved institutions), Department of Health and the Northern Ireland Office (NIO) have failed to ensure the effective implementation of that law. Amnesty's post-law reform advocacy on abortion – in Northern Ireland and elsewhere – has made clear that decriminalisation and legalisation, while critical and welcome steps, are not themselves sufficient to ensure that the right to access abortion services is meaningful, in practice.

States have an affirmative duty, under international human rights law, not only to ensure that their laws are human rights compliant but to ensure that the rights they guarantee are not 'theoretical or illusory but rights that are practical and effective'.[2] The past three years have revealed worrying human rights concerns around the government's failure to implement the new abortion law and people's ability to exercise their right to abortion in Northern Ireland.

In December 2022, after nearly three years of failure overseen by the Northern Ireland Minister of Health, the Northern Ireland Office ordered the commissioning of abortion services and Northern Ireland began the long-awaited process of formally rolling out abortion services as required under the abortion law. The in-depth research that informs this report provides insights into the ongoing barriers faced by women, girls and pregnant people in Northern Ireland to accessing the full range of abortion services to which they are lawfully entitled. The resulting recommendations seek to ensure that the government fulfils its human rights obligations to create an enabling environment for abortion care and to provide the full range of human rights-compliant abortion care.

## Methodology

This report is based on desk research, Freedom of Information Act requests, and semi-structured in-depth interviews carried out by Amnesty International between September 2022 and August 2023, and reflects barriers to abortion access in Northern Ireland as of 25 August 2023. All interviews were conducted in English and were carried out in person or remotely, via video calls.

2 *Tysiac v Poland*, European Court of Human Rights, (App No. 5410/03) (2007), para 113.



To determine the current state of abortion service provision in Northern Ireland, and barriers to providing these services, Amnesty International's researchers spoke with 23 members of the healthcare profession in all five Health and Social Care (HSC) Trust areas in Northern Ireland, including doctors, nurses and midwives, and Northern Ireland representatives of healthcare professional bodies. Researchers interviewed some healthcare providers multiple times over the course of a year to understand the long-term and ongoing challenges and barriers to service provision, both before and after services were commissioned.

In addition to abortion care providers and other healthcare professionals, Amnesty International interviewed 22 representatives from civil society organisations and academia, based in Belfast or Derry/Londonderry, Northern Ireland. Amnesty International also carried out interviews with representatives of the Northern Ireland Department of Health and the Northern Ireland Office. A representative of the Department of Health's Abortion Oversight Board provided additional information in writing. The Department of Health and the Northern Ireland Office were provided an opportunity to respond to the recommendations in this report prior to publication.

Amnesty International's researchers interviewed nine women living in Northern Ireland who have sought or undergone an abortion since the decriminalisation of abortion in 2019, and two who obtained an abortion prior to decriminalisation about their first-hand experience of accessing abortion services.

Healthcare providers in Northern Ireland shared stories about their direct experience with patients who have needed or accessed abortion services since decriminalisation, which are also reflected in this report. In addition, Amnesty International spoke with two representatives from the British Pregnancy Advisory Service (BPAS) and three representatives from MSI Reproductive Choices (MSI), abortion service providers in England, about their experiences with patients from Northern Ireland since the decriminalisation of abortion in Northern Ireland. BPAS and MSI representatives were based in London and Bristol, England.

Throughout this report, Amnesty International refers primarily to women and girls and other people who can get pregnant in discussing the impact of Northern Ireland's failure to ensure the full provision of lawful abortion services. This framing recognises that, while the majority of personal experiences with abortion relate to cisgender women and girls (that is, women and girls whose sense of personal identity and gender corresponds with the sex they are assigned at birth), intersex people, transgender men and boys, and people with other gender identities may have the reproductive capacity to become pregnant and may need and have abortions.[3]

Due to the pervasive stigma around abortion in Northern Ireland, and the fear of potential harassment and retaliation, it was difficult to identify healthcare providers and people who had sought or obtained an abortion that were willing to speak on the record about their experiences. Of those who spoke to Amnesty International, many opted to have their real names withheld or changed. In compliance with informed consent given by interviewees, and as is the norm in Amnesty International's investigations, we provide the date of when the interview took place but have protected

3 Amnesty International's Policy on Abortion: Explanatory Note (2020), p8, amnesty.org/en/wp-content/uploads/2021/05/POL3028472020ENGLISH.pdf. See also World Health Organisation (WHO), Abortion Care Guideline (2022), p4.

the identity of some of the people with whom we have spoken by using a pseudonym or other means to anonymise the individual, in accordance with their wishes. Where a person's name has been changed at their request, there is an asterisk after their name and the name change is indicated in a footnote.


## Acknowledgements

Amnesty International is grateful to all those who agreed to be interviewed or provided information for this report. Amnesty International especially appreciates the time and effort that people seeking abortion services took to share their personal experiences.

We are also grateful to the healthcare providers, academics and representatives of NGOs who generously shared their insights and expertise. Amnesty International would particularly like to acknowledge the dedication and conscientious commitment of the healthcare professionals who have worked tirelessly to ensure that women, girls, and other people who can get pregnant can access early medical abortion services in Northern Ireland.




# 1. Background

## 1.1 Abortion in Northern Ireland: historical context

To understand the current context of abortion access in Northern Ireland requires an appreciation of both the impact of the longstanding criminalisation of abortion and the enduring political and religious interests within Northern Ireland that seek to undermine law reform.

### 1.1.1 Over 150 years of the criminalisation of abortion

Northern Ireland has a long history of restricting access to abortion services. For over 150 years, abortion was criminalised.[4] In theory, abortion was available where there was risk to the pregnant person's life or of serious long-term or permanent injury to their physical or mental health,[5] but it was effectively unavailable in practice. Northern Ireland's criminal penalties for abortion were also among the harshest in Europe, with women and girls and those assisting them facing life imprisonment.[6]

Despite legislative changes in the rest of the UK in 1967, legalising abortion on certain grounds, Northern Ireland maintained its restrictive criminal laws until 2019, leading to people from Northern Ireland travelling to England for abortion care. One scholar noted, in 2020, that 'reported figures suggest that well over 60,000 women [from Northern Ireland] have made this journey since 1968'.[7] Figures of those who were forced to obtain abortion care outside of Northern Ireland's healthcare system are likely to be much higher when one considers those who gave a false address, for example of a relative in England, travelled to other countries, or accessed pills online. Those who could not travel – due to a range of circumstances such as health challenges, stigma or financial barriers – were left to purchase pills online, forced to resort to unsafe abortions or forced to continue their pregnancy.

Within Northern Ireland, particularly in the decades prior to the 2019 law reform, access to lawful abortion services was extremely limited. Healthcare professionals were unsure of the circumstances under which abortion was lawful and operated in a grey area, with the prospect of criminal prosecution should they get it wrong. In this climate, the lawful exceptions to criminalisation were interpreted in an increasingly restrictive manner by clinicians, rendering abortion essentially unavailable in practice

4 The 1861 Offences Against the Person Act's provisions on abortion prohibited 'unlawful procurement of miscarriage', without any explicit exceptions or defences. Offences Against the Person Act 1861, secs 58-59. In 1945, Northern Ireland's Criminal Justice Act introduced the additional criminal offence of intentional destruction of a child capable of being born alive, with viability presumed at 28 weeks' gestation. This, too, was punishable with life imprisonment. Criminal Justice Act, 1945.

5 The English case of *Rex v Bourne* (1938) affirmed a lawful exception for life-saving and therapeutic abortions, performed on physical or mental health grounds. Although not legally binding on Northern Ireland, it was affirmed to apply to Northern Ireland in later cases before the Northern Ireland courts. However, this health exception was narrowly interpreted by the courts in Northern Ireland, permitting abortion only where there was risk to the pregnant person's life or of serious long-term or permanent injury to their physical or mental health. See, eg, *In the Matter of an Application by The Family Planning Association of Northern Ireland for Judicial Review*, NIQB 48 (2003).

6 Offences Against the Person Act 1861, sections 58-59.

7 Sally Sheldon et al, '"Too Much, too Indigestible, too Fast"? The Decades of Struggle for Abortion Law Reform in Northern Ireland', *Modern Law Review* (2020) 83(4) p765.

in the years immediately prior to law reform. According to government statistics, only eight abortions were performed in Northern Ireland in 2018/2019.[8]

Moreover, criminal investigations and prosecutions did occur, with several cases receiving media attention in 2016 and 2017. One high profile case, in which Amnesty International intervened, involved the 2019 prosecution of a mother for procuring online abortion medication for her then fifteen-year-old daughter.[9]

### 1.1.2 Abortion law reform in 2019

The shift in the abortion law was brought about by decades of relentless campaigning, advocacy and strategic litigation by advocates and non-governmental organisations. The momentum behind law reform grew in 2018 and 2019, after a series of key legal and political developments and public campaigning. Notably, these occurred during a period where the Northern Ireland Assembly was suspended (January 2017-January 2020). Calls for law reform were therefore targeted at the UK Parliament (Westminster), in the absence of a devolved Assembly in Northern Ireland. (For more on the events leading to abortion law reform, see Annex 1.)

In 2018, the UN CEDAW Committee, the body charged with monitoring implementation of the Convention on the Elimination of all forms of Discrimination against Women, to which the UK is a state party, published a report on its inquiry on access to abortion in Northern Ireland. The Committee found that the UK government was responsible for grave and systematic violations of the rights of women in Northern Ireland under the Convention.

> The Committee assesses the gravity of the violations in NI [Northern Ireland] in light of the suffering experienced by women and girls who carry pregnancies to full term against their will due to the current restrictive legal regime on abortion. It notes the great harm and suffering resulting from the physical and mental anguish of carrying an unwanted pregnancy to full term… The systematic nature of the violations stems from the deliberate retention of criminal laws and state policy disproportionately restricting access to sexual and reproductive rights, in general, and highly restrictive abortion provision, in particular. Westminster and NI authorities acknowledge the magnitude of the phenomenon and choose to export it to England where NI women travel to access abortions. The UK's observations and interviews with NI authorities clarify the deliberate intention neither to decriminalise abortion nor to expand the grounds for legal abortion. Availability of abortion in other parts of the state party does not absolve it of its responsibility under the Convention to ensure accessibility in NI.[10]

8 Department of Health, Northern Ireland Termination of Pregnancy Statistics 2018/19, available at health-ni.gov.uk/sites/default/files/publications/health/hs-termination-of-pregnancy-stats-18-19.pdf.

9 Amnesty International UK, press release: Northern Ireland: Concern as mother who bought abortion pills for daughter to face criminal trial, 26 June 2019 amnesty.org.uk/press-releases/northern-ireland-concern-mother-who-bought-abortion-pills-daughter-face-criminal; House of Commons Women and Equalities Committee, Abortion Law in Northern Ireland: Eighth Report of Session 2017-2019 (2019), p15.

10 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*, UN Doc CEDAW/C/OP.8/GBR/1 (2018), paras 81-82 (CEDAW Inquiry Report).



The CEDAW Committee's report called upon the UK government to, among other things, decriminalise abortion and adopt legislation allowing for abortion in a wide range of circumstances.[11]

To comply with its obligations under CEDAW, in July 2019 the UK Parliament (Westminster) passed legislation decriminalising abortion in Northern Ireland.[12] In 2020, Westminster introduced regulations legalising abortion on a wide range of grounds.[13] With those votes, Northern Ireland went from a highly restrictive abortion regime, with a near total abortion ban and in which abortion was effectively inaccessible, to a legal framework that provides for access to abortion. The current abortion law is closer to being fully human rights compliant and even more progressive than the laws in force in England, Scotland, Wales and Ireland.

Abortion law reform was – and continues to be – vehemently and persistently opposed by some of Northern Ireland's political parties, religious leaders, and vocal anti-abortion activists.[14] This has had significant and ongoing implications for ensuring access to abortion in practice. Once Northern Ireland's devolved Executive was restored in 2020, repeated failure by the health minister and the Northern Ireland Executive continued to be a persistent and formidable obstacle to abortion service provision until the collapse of devolved institutions in October 2022.[15] This failure to act undermined access to lawful abortion services in Northern Ireland.

#### Human rights obligations to ensure equality and non-discrimination

The rights to equality and non-discrimination are central to human rights law. The principle of substantive equality, as set out in CEDAW, requires not only equality in law, but equality in results or impact. States must ensure equal outcomes for women, including different groups of women, which may require them to introduce policies and other measures to overcome historical discrimination and ensure that institutions guarantee the rights of all people.[16]

The Committee on Economic, Social and Cultural Rights (CESCR Committee), the body charged with monitoring implementation of the International Covenant on Economic, Social and Cultural Rights, has affirmed that:

11 CEDAW Inquiry Report, paras 85-86.

12 Northern Ireland (Executive Formation etc) Act 2019.

13 The Abortion (Northern Ireland) (No. 2) Regulations 2020.

14 For a brief political history until 2015, see Amnesty International, *Northern Ireland: Barriers to Accessing Abortion Services* (2015) EUR 45/1057/2015, amnesty.org/en/documents/eur45/1057/2015/en/. See the Annex for additional detailed history and context leading up to law reform.

15 For more on this, see the Annex.

16 Amnesty International, Abortion Policy: Explanatory Note (2020), p48; CEDAW Committee, General Recommendation 25, paras 8-10; CEDAW Committee, General Recommendation 28, para 20. See also Committee on Economic, Social and Cultural Rights [hereinafter CESCR Committee], General Comment 22, paras 35-36; Committee on Economic, Social and Cultural Rights, General Comment 3, para 10; Human Rights Committee, General Comment 28, para 3.

> The realisation of the rights of women and gender equality, both in law and in practice, requires repealing or reforming discriminatory laws, policies and practices in the area of sexual and reproductive health. Removal of all barriers interfering with access by women to comprehensive sexual and reproductive health services, goods, education and information is required… Preventing unintended pregnancies and unsafe abortions requires states to adopt legal and policy measures… to guarantee women and girls access to safe abortion services and quality post-abortion care, including by training healthcare providers; and to respect the right of women to make autonomous decisions about their sexual and reproductive health.[17]

Human rights bodies have also recognised that women may face intersecting discrimination based on multiple grounds.[18] The CEDAW Committee has noted that: 'The discrimination of women based on sex and gender is inextricably linked with other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, caste and sexual orientation and gender identity.'[19] The CESCR Committee has clarified that: 'Measures to guarantee non-discrimination and substantive equality should be cognisant of and seek to overcome the often exacerbated impact that intersectional discrimination has on the realisation of the right to sexual and reproductive health.'[20]

In addition, the UN Human Rights Committee, which monitors state compliance with the International Covenant on Civil and Political Rights, has long acknowledged the critical role that culture, and other social structures such as gender, has had on women's full enjoyment of their rights under the covenant. In its General Comment No. 28, the Human Rights Committee elaborated: 'Inequality in the enjoyment of rights by women throughout the world is deeply embedded in tradition, history and culture, including religious attitudes… States parties should ensure that traditional, historical, religious or cultural attitudes are not used to justify violations of women's… equal enjoyment of all Covenant rights.'[21]

## 1.2 The legal and policy framework governing abortion

Until 2019, Northern Ireland had one of the most restrictive abortion laws in the world. Governed by the 1861 Offences against the Person Act, there was a near total abortion ban. The Abortion Act 1967 and relevant provisions in the Human Fertilisation and Embryology Act 1990, legislation governing abortion in England, Scotland and Wales, did not extend to Northern Ireland.[22]

The 2019 Northern Ireland (Executive Formation etc) Act's provisions on abortion radically changed the legal landscape. The Act decriminalised abortion by repealing sections 58 and 59 of the Offences against the Person Act 1861 in Northern Ireland.[23] It also required the Secretary of State to ensure that the CEDAW Committee's report recommendations on abortion in Northern Ireland are fully implemented,[24] including by enacting regulations 'to provide for expanded grounds to legalise abortion'.[25]

On the same day that the Act came into force, in October 2019, the UK government implemented a revised abortion policy in which people living in Northern Ireland could continue to access abortion in England for free, with all travel and any necessary accommodation now fully funded by the UK government, regardless of income.[26] Scotland, England and Wales had previously announced, in 2017, that people who reside in Northern Ireland could access abortion services in their jurisdictions for free, funded by the UK government or NHS Scotland; however, until this point, funding for travel had only been available on a means-tested basis. The revised UK government policy is expected to remain in place until 'service provision in Northern Ireland is available to meet women's needs'.[27]

### 1.2.1 The Abortion (Northern Ireland) Regulations 2020

The Abortion (Northern Ireland) Regulations 2020[28] authorise medical professionals – specifically, medical practitioners, midwives and nurses – to provide abortions in a broad range of circumstances.[29] The 2020 regulations were ground-breaking, dramatically liberalising Northern Ireland's abortion law after over a century of exceptionally restricted access. At present, Northern Ireland's abortion law is more liberal than legislation governing abortion in England, Scotland and Wales and is consistent with abortion laws in Europe, the overwhelming majority of which allow for abortion on request and for broad social grounds, including mental and physical health grounds, thereafter.[30]

17 CESCR Committee, General Comment 22, para 28.
18 CESCR Committee, General Comment 22, para 30; CEDAW Committee, General Recommendation 28, para 18.
19 CEDAW Committee, General Recommendation 28, para 18.
20 CESCR Committee, General Comment 22, para 30.
21 Human Rights Committee, General Comment 28, para 5.
22 Abortion Act 1967, Section 7(3); Human Fertilisation and Embryology Act 1990, Section 48.
23 Northern Ireland (Executive Formation etc) Act 2019, Section 9(2).
24 Northern Ireland (Executive Formation etc) Act 2019, Section 9(1).
25 CEDAW Inquiry Report, para 85(b); see also Northern Ireland (Executive Formation etc) Act 2019, Sections 9(1), 9(4) and 9(5); Explanatory Memorandum to The Abortion (Northern Ireland) (No. 2) Regulations 2020, 2020 No. 503, para 7.4.
26 NIO, Guidance for Healthcare Professionals in Northern Ireland on Abortion Law and Terminations of Pregnancy in the Period 22 October 2019 to 31 March 2020 in Relation to the Northern Ireland (Executive Formation Etc) Act 2019, October 2019.
27 NIO, Guidance for Healthcare Professionals in Northern Ireland on Abortion Law and Terminations of Pregnancy in the Period 22 October 2019 to 31 March 2020 in Relation to the Northern Ireland (Executive Formation Etc) Act 2019, October 2019, pp4-5.
28 The Abortion (Northern Ireland) (No. 2) Regulations 2020. The regulations were subsequently amended and reissued in May 2020; however, the substantive content of the regulations remained the same except that cross-references were corrected. Explanatory Note to the Abortion (Northern Ireland) (No. 2) Regulations 2020, 2020 No. 503, Section 3.5, legislation.gov.uk/uksi/2020/503/pdfs/uksiem_20200503_en.pdf.
29 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 2.2.
30 Center for Reproductive Rights, *European Abortion Laws: A Comparative Overview*, 21 October 2022, reproductiverights.org/center-reproductive-rights-european-abortion-laws/.

### The law on abortion in Northern Ireland

Abortion is lawful in Northern Ireland:

- Until the 12th week of pregnancy, without restriction or conditions.[31]
- Until the 24th week of pregnancy where there is a risk to the pregnant person's physical or mental health.[32]
- At any point in a pregnancy where:
  - it is 'immediately necessary' to save the pregnant person's life or prevent grave permanent injury to the pregnant person's physical or mental health;[33]
  - there is risk to life or of grave permanent injury to the pregnant person's physical or mental health;[34] or
  - there is substantial risk of a fatal foetal impairment or severe mental or physical foetal impairment.[35]

The accompanying Explanatory Memorandum to the Regulations clarify that the inclusion of the risk to physical or mental health ground was intended to make abortion provision in Northern Ireland 'consistent with the position in England and Wales under the Abortion Act 1967'.[36] As such, 'risk to mental health is not required to be diagnosed, nor assessment needed prior to permitting the abortion'. In addition, the physical and mental effects need not be 'long term or permanent'.[37] The risk to health ground includes victims of sexual crime.[38]

The regulations also reflect evidence-based 'modern practice in respect of the provision of abortion services',[39] incorporating a multi-disciplinary approach that permits medical practitioners, nurses and midwives to provide abortions,[40] in line with abortion guidance from the World Health Organisation (WHO).[41]

Nurse and midwife-led abortion provision is critical to ensuring access to abortion services, particularly where health systems and health workforces are already under significant pressure, as in Northern Ireland today. However, more than three years after the regulations came into force, the Health and Social Care Trusts – the publicly-funded bodies responsible for healthcare service provision in Northern Ireland – have not taken meaningful steps to prioritise the training and hiring of independent nurse prescribers for early medical abortion services. (See Chapter 3.)

The regulations, while providing for certain premises where abortion provision may occur, also invest the Department of Health with the authority to approve additional places or, for the use of specified medicines, 'a class of places' where abortion treatment may be carried out.[42] The Explanatory Memorandum clarifies that this allows flexibility in the provision of services, for example, by approving treatment by independent providers, including treatment by prescribing medication abortion for home use.[43]

Although the regulations only permit the second stage of an early medication abortion to be carried out 'in the home of the pregnant woman',[44] Section 8 of the regulations additionally empowers the Department of Health to broaden access to treatment so that a person can complete the entire medical abortion at home. (See inset on Telemedicine, below, discussing the human rights implications of the lack of telemedicine.)

The Department of Health (DOH) has the legal authority to make this regulatory change, to allow for telemedicine for early medical abortion, by publishing written approval permitting the first stage of treatment, with mifepristone, to be carried out in the home of the person undergoing treatment for abortion.[45]

However, in speaking to Amnesty in 2023, representatives from the DOH made clear that telemedicine is not part of the current commissioning framework and expressed their position that they did not have the authority to make this change. Instead, according to DOH representatives, the introduction of telemedicine for abortion 'is subject to a ministerial decision because of the way the law is currently written and applied in Northern Ireland'[46] and requires a public consultation.[47]

### 1.2.2 Shortcomings of the 2020 Abortion Regulations

Although the 2020 regulations were a substantial leap forward, they are also unnecessarily restrictive and create barriers to accessing abortion services. Specifically, the regulations incorporate third-party authorisation requirements,[48] reintroduce criminal penalties in the form of a fine for abortion provision outside of the regulatory framework,[49] include gestational and grounds-based limits on access to abortion,[50] restrict the use of at-home medication abortion[51] and do not clarify the parameters of conscience-based refusals.[52]

31 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 3.
32 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 4.
33 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 5.
34 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 6.
35 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 7.
36 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, No. 503, para 7.12.
37 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, No. 503, para 7.13.
38 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, No. 503, para 7.13.
39 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, No. 503, para 7.18.
40 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, No. 503, para 7.18.
41 World Health Organisation, Abortion Care Guideline (2022).
42 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Sections 8(3), 8(4).
43 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, No. 503, para 7.22.
44 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Sections 8(1)(d).
45 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Sections 8(3), 8(4), 8(5).
46 Interview with the director of secondary care and the head of abortion policy, Department of Health, 2 March 2023. See also correspondence with the head of abortion policy, Department of Health, 24 August 2023 (on file with Amnesty International UK).
47 Correspondence with the head of abortion policy, Department of Health, 24 August 2023 (on file with Amnesty International UK).
48 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Sections 3-7.
49 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 11.
50 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Sections 3-7.
51 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 8.
52 See *Greater Glasgow Health Board v Doogan and another* [2014] UKSC 68.

The World Health Organisation's (WHO) Abortion Care Guideline recommends:

- the full decriminalisation of abortion, which includes 'removing abortion from all penal/criminal laws… and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors'.[53]
- 'against laws and other regulations that restrict abortion by grounds.'[54]
- 'against laws and other regulations that prohibit abortion based on gestational age limits.'[55]
- 'abortion be available on the request of the woman, girl or other pregnant person without the authorisation of any other individual, body or institution' including health workers.[56]
- 'against regulation on who can provide and manage abortion that is inconsistent with WHO guidance.'[57]
- 'that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection.'[58]

### Third-party authorisation and notification requirements

For each permitted ground for abortion, the 2020 regulations condition abortion access on either one or two medical professionals' opinions and contain specific certification requirements that providers must comply with or face criminal penalties.[59]

Human rights bodies and the World Health Organisation have made clear that third party authorisations contravene human rights standards and negatively impact the quality of abortion care.[60] The CEDAW Committee has expressed concern, for example, about 'convoluted abortion laws which require women to get certificates from two certified consultants before an abortion can be performed, thus making women dependent on the benevolent interpretation of a rule which nullifies their autonomy'.[61] The WHO's Abortion Care Guideline clarifies that abortion should instead 'be available on the request of the woman, girl or other pregnant person without the authorisation of any other individual, body or institution'.[62]

Notification paperwork, which providers must similarly comply with or face criminal penalties,[63] is also an unnecessary bureaucratic hurdle. Rather than normalising abortion as healthcare, these atypical certification and notification requirements exceptionalise abortion and perpetuate abortion stigma in the healthcare system. As one Northern Ireland activist and scholar interviewed by Amnesty International noted:

> The doctors have to notify the Department of Health of every single abortion, every single EMA [early medical abortion]. It is the only healthcare procedure where they have to notify, you know, and it's just ridiculous. I mean, what does it mean to decriminalise, if you're still saying that it's not normal healthcare, it's something else?[64]

An abortion provider concurs:

> What I find completely stigmatising is the notification form. For every abortion that's done in Northern Ireland, there has to be a notifiable form completed within 14 days and sent to the Chief Medical Officer. And I keep saying: 'Why?' I said, fair enough, if you want statistics pulled out of it great, but you can get those statistics through the online documentation, you can pull that off the computer system. You don't fill out the same type of form for cardiac surgery, so why do you have to do it for abortion? And it's like five, six pages long. It's such an onerous form.[65]

### Fines for medical professionals and others

Although the Northern Ireland (Executive Formation etc) Act 2019 was a major step forward in repealing the Penal Code provisions criminalising abortion, the 2020 regulations still include penalties for a person who 'intentionally terminates or procures the termination of pregnancy of a woman otherwise than in accordance' with the regulations.[66] Medical professionals and others may therefore still be held liable and face a fine (up to £5000) for any abortions performed or procured outside of those authorised by the regulations, unless the pregnancy was terminated in the context of good faith efforts to save the pregnant person's life or prevent grave permanent injury to their physical or mental health. A person who intentionally contravenes certification and notification requirements for abortion is also guilty of an offence and liable to a fine (up to £2,500).[67] The Explanatory Memo notes, as well, that 'it is an offense to supply unlawful pills to others.'[68] There is no criminal liability for the pregnant person who has the abortion.[69]

53 WHO, Abortion Care Guideline (2022) p24, Recommendation 1. The CEDAW Inquiry Report also called for decriminalisation. CEDAW Inquiry Report, Para. 85(a). See also International Commission of Jurists, *The 8 March Principles for a Human Rights-Based Approach to Criminal Law Proscribing Conduct Associated with Sex, Reproduction, Drug Use, HIV, Homelessness and Poverty*, March 2023 icj2.wpenginepowered.com/wp-content/uploads/2023/03/8-March-Principles-Report_final_print-version.pdf.

54 WHO, Abortion Care Guideline (2022) p26, Recommendation 2.

55 WHO, Abortion Care Guideline (2022) p28, Recommendation 3.

56 WHO, Abortion Care Guideline (2022) pp42-43, Recommendation 7.

57 WHO, Abortion Care Guideline (2022) p59, Recommendation 21.

58 WHO, Abortion Care Guideline (2022) pp60-61, Recommendation 22. The WHO Abortion Care Guideline also states that 'If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfills abortion seekers' rights, conscientious objection in abortion provision may become indefensible.' WHO, Abortion Care Guideline (2022) p60.

59 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Sections 3, 4, 5, 6, 7 and 9.

60 WHO, Abortion Care Guideline (2022) p43; CEDAW Committee, General Recommendation 24.

61 CEDAW Committee, *Concluding Observations: New Zealand*, UN Doc CEDAW/C/NZL/CO/7, para 34 (2012).

62 WHO, Abortion Care Guideline (2022) pp42-43.

63 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 10.

64 Interview with Goretti Horgan, Alliance for Choice Derry and senior lecturer in social policy, School of Applied Social and Policy Sciences, Ulster University, 29 September 2022.

65 Interview with a healthcare provider, 30 January 2023.

66 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 11.

67 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Sections 9(6) and 10(4).

68 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, No. 503, para 7.34 ('Under medicine legislation, abortion pills are prescription only medicines, the sale and supply of which is unlawful without a prescription. The medicines legislation is not affected by 2019 Act or 2020 Regs.'). See also Explanatory Memorandum, para 7.38.

69 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 11(2)(a). Note: The offence of child destruction remains in the Criminal Justice Act (Northern Ireland) 1945. Although it no longer applies to 'the pregnant woman herself', it could be applied to medical professionals and others for performing abortions not authorised by the 2020 Regulations in cases, for example, where the foetus is capable of being born alive. However, the Explanatory Memorandum of the 2020 regulations notes that where abortions 'are carried out in good faith in accordance with the Regulations, there must be no risk of a criminal prosecution being brought'. Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, No. 503, para 7.41. The penalty upon conviction is life imprisonment. Criminal Justice Act (Northern Ireland) 1945, Sec 25.

Critically, in recognition that 'the fear of prosecution under the previous abortion law in Northern Ireland had a chilling effect on doctors in providing abortion services,'[70] the regulations mandate that 'proceedings… may be brought only by, or with the consent of, the Director of Public Prosecutions for Northern Ireland'[71] to 'provide medical professionals with confidence' that they will be protected from unwarranted prosecutions.[72]

### Health and human rights standards on the criminalisation of abortion

Criminal penalties for healthcare providers can have a chilling effect on abortion service provision.[73] The fear of criminal liability can result in delays or denials of lawful abortion care and deter trained health professionals from providing abortion services entirely. Human rights bodies and the World Health Organisation[74] call for the full decriminalisation of abortion, in all circumstances. The WHO defines decriminalisation as: 'Removing abortion from all penal/criminal laws, not applying other criminal offences (eg murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors.'[75]

### Inadequate regulation of conscience-based refusals harms abortion provision

The regulations permit 'conscientious objection' to participation in abortion treatment, except where such treatment is necessary to save a pregnant person's life or prevent grave permanent injury to their mental or physical health.[76] 'Conscientious objection' is expressly limited to 'participation in treatment,'[77] however, the regulations offer no guidance on the scope of this statutory protection, which leaves the practice open to misinterpretation and abuse. The Department of Health has also failed to offer any guidance on conscience-based refusals since law reform and does not plan to do so. (See Chapter 4.)

### Restrictions on access to abortion: gestational limits and grounds for termination

The 2020 regulations restrict access to abortion services based on gestation and specified grounds. These restrictions are not supported by public health evidence. Public health evidence-based guidance from the WHO recommends against restricting access to legal abortion based on specific, permitted grounds.[78] Abortion should instead be available on the request of the pregnant person. This is consistent with approaches taken by all international and regional treaty-based human rights bodies across the globe, which have never found abortion on request inconsistent with human rights obligations, have never set forth gestational limits, and have criticised countries with highly restrictive laws, calling on them to set forth minimum grounds for abortion.[79]

### Unnecessary restrictions on at-home medication abortion

The regulations also unnecessarily restrict self-care interventions,[80] including at-home medication abortion treatment, requiring women to come into a health facility to obtain a prescription and take mifepristone for the first stage of treatment. Moreover, the regulations only permit a person to take the medication (misoprostol) at home for the second stage of treatment if the pregnancy has not exceeded its 10th week.[81]

### WHO Abortion Care Guideline: self-managed abortion

The World Health Organisation's evidence-based guidance recommends the option of full self-management of abortion outside of a healthcare facility, including self-administration of both mifepristone and misoprostol 'without the direct supervision of a trained health worker' until 12 weeks' gestation.[82]

The 2022 WHO Abortion Care Guideline states:

> Women may self-manage parts or all the abortion process for a variety of reasons related to individual circumstances and preferences. For some women, this may be the only feasible option within their context and for others it may represent an active choice. However, from the perspective of the health system, self-management should not be considered a 'last resort' option or a substitute for a non-functioning health system. Self-management must be recognised as a potentially empowering and active extension of the health system and task-sharing approaches.[83]
>
> As part of the enabling environment, health workers and managers should recognise self-management as a legitimate pathway to abortion care, and should work to adapt health systems to facilitate and support women in their self-management of abortion – for example, by adapting clinical protocols used at their facility.[84]

70 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, No. 503, para. 7.39.
71 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Sections 9(7), 10(5), 11(4), 13(3).
72 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, No. 503, para. 7.39.
73 See, for example, *Tysiac v Poland*, European Court of Human Rights, (App No. 5410/03) (2007), para 116; *ABC v Ireland*, European Court of Human Rights, (255579/05) (2010), para 254.
74 See, for example, CESCR, General Comment 22, paras 34, 40, 49(a), 57; Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report to the United Nations General Assembly (2016) (A/HRC/32/32); Human Rights Committee, General Comment 36, para 8; Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Interim report to the General Assembly (2011) (A/66/254); CEDAW Committee, General Recommendation No. 24 (1999), para 31(c).; Committee on the Rights of the Child, *Camila v. Peru*, para 8.4, UN Doc CRC/C/93/D/136/2021 (2023); CERD Committee, *Concluding Observations: United States of America*, para 36, UN Doc CERD/C/USA/CO/10-12 (2022); CAT Committee, *Concluding Observations: El Salvador*, para 31, UN Doc CAT/C/SLV/CO/3 (2022); WHO, Abortion Care Guideline (2022), Recommendation 1, p24.
75 WHO, Abortion Care Guideline (2022), pxiii.
76 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 12.
77 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 12.
78 WHO, Abortion Care Guideline (2022), pp26-29.
79 See, for example, CEDAW Inquiry Report, para 85 (b)(iii); Human Rights Committee, General Comment 36, para 8.
80 WHO, WHO guideline on self-care interventions for health and well-being, 2022 revision (27 June 2022), who.int/publications/i/item/9789240052192.
81 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 8.
82 WHO, Abortion Care Guideline (2022), p98. See also WHO, Abortion Care Guideline (2022), p70 (no requirement for location).
83 WHO, Abortion Care Guideline (2022), p98.
84 WHO, Abortion Care Guideline (2022), p100.

## Arbitrary and inequitable limitations on self-care: negative impacts felt most by marginalised populations

> At the minute, we're not allowed at-home mifepristone like the rest of the UK, Scotland, Wales and Ireland.[85]
> **Doctor, Northern Ireland**

*Surveillance rather than safety*

Telemedicine is an alternative to in-person healthcare service delivery in which the care is provided remotely, without the need to attend a clinic or hospital. A woman can receive both pre- and post-abortion care via a teleconsultation with a healthcare worker, either by phone or video link or through an exchange over email, text or voice message.[86] The abortion medications, mifepristone and/or misoprostol, are then typically mailed by post, or picked up at a clinic or pharmacy, and self-administered at home.

At the start of the Covid-19 pandemic, in March and April 2020, Ministers in England, Wales, Scotland and Ireland made emergency provision for telemedicine for early medical abortion under 10 weeks of pregnancy (defined as up to nine weeks six days of pregnancy), with Scotland permitting it under 12 weeks of pregnancy (defined as up to 11 weeks six days of pregnancy). This move was seen as critical to ensuring the continued safe delivery of abortion care during the pandemic, providing for contactless service provision to reduce the risk of Covid-19 transmission.

Although Northern Ireland's Department of Health and health minister had the power to similarly introduce telemedicine to ensure access to services during the Covid-19 lockdown, they failed to do so, with some politicians within the Northern Ireland Executive explicitly declaring that they did not want abortion to be accessible.[87] The health minister stated in response to a written question in December 2020 that, with regards to early medical abortion, the Executive had not agreed to his proposals for commissioning such services, reiterating his view that such permission was required:

> Initial consideration of a commissioning specification was paused due to the COVID-19 pandemic. In April of this year, I sought Executive agreement, as required by the Ministerial Code when an issue is cross cutting and controversial, to introduce an emergency early medical abortion service for the duration of the pandemic. The Executive has yet to agree my proposal. I am therefore unable to give a timescale for the introduction of services.[88]

Throughout the pandemic to the present, women, girls and other pregnant people in Northern Ireland have had to physically come into a clinic or hospital site to obtain the abortion medication and take the first of two pills. The second pill can be taken at home, as long as their pregnancy is under 10 weeks (up to nine weeks, six days).

85 Interview with a healthcare provider, 13 September 2022.
86 WHO, Abortion Care Guideline (2022), p95.'
87 See, eg, BBC News, Abortion: New laws need full discussion says Arlene Foster, 6 April 2020, bbc.com/news/uk-northern-ireland-politics-52190465.
88 Written Answer, NI Assembly, AQW 10646/17-22, answered on 17/12/2020.



Olivia O'Neill, 26 years old, caught Covid-19 right when she needed an abortion, in December 2021:

> I couldn't go to get the medicines. Then I was asking people and going online [to websites that provide medical abortion pill services] to see if I could get any pills that could be dropped to the house. I could just do it while I was isolating, you know, and then it would be all done. But I couldn't get any because, theoretically, abortion is accessible in Northern Ireland [so these websites direct to locally available services]. I had to wait until my boyfriend at the time and I were both negative from Covid to go to the clinic and get my first pill because, obviously, I couldn't leave the house. The delay was another stressor. I just wanted this sorted.[89]

Paradoxically, prior to the Covid-19 pandemic, during the short period between decriminalisation in late 2019 and the introduction of the Abortion Regulations in March 2020, people in Northern Ireland did briefly (from February to March 2020) have access to telemedicine through the British Pregnancy Advisory Service (BPAS) in England. Donagh Stenson, innovation and marketing director at BPAS, recalls:

> It was awful, though, that once the regulations came in, we had to start telling women in Northern Ireland: you cannot have our pills by post now, because your politicians, your Department of Health, have not permitted it.[90]

Dr Fiona Bloomer, a Senior Lecturer in Social Policy at Ulster University, whose research focuses on abortion, remembers one woman who needed to access an abortion during the Covid-19 lockdown in 2020:

> They didn't have a car, there's no public transport, there were no taxis. Their partner wasn't allowed in with them to the clinic at all. So they essentially had to walk for miles to the clinic, feeling really isolated, and then go into the clinical setting. Where at that stage, obviously, everyone was in their full PPE gear and all of that. And then walk home again. You know, you think – why? Why was that happening when we should have had telemedicine?[91]

A general practitioner (GP) in the Belfast Trust interviewed for this report notes that 'the actual crazy thing is, people who are miscarrying are given some misoprostol and told to get on with it at home. The vast majority of cases after 10 weeks, if you wanted misoprostol, you could have miso at home for your medical miscarriage management. That is on the table and is offered.'[92] The decision not to allow telemedicine for abortion, according to this GP, is instead about control and surveillance: 'It wasn't about safety or about patient's well-being. It was about knowing who was doing what and where and when.'[93]

*Telemedicine is safe and effective and important for people who have historically had difficulty accessing healthcare due to discriminatory policies and practices*

Telemedicine for medication abortion has been found to be safe and effective,

89 Interview with Olivia O'Neill, 20 February 2023.
90 Interview with Donagh Stenson, innovation and marketing director, BPAS, 14 September 2022.
91 Interview with Dr Fiona Bloomer, senior lecturer in social policy, Ulster University, 12 December 2022.
92 Interview with a general practitioner, 13 December 2022.
93 Interview with a general practitioner, 13 December 2022.

with similar outcomes to in-person service delivery.[94] A recent study in the UK found that telemedicine was safe and improved access to care by reducing waiting times for abortion treatment and allowing people to access abortion services much earlier in their pregnancy.[95] The World Health Organisation recommends the option of telemedicine to deliver medical abortion services,[96] as does the International Federation of Gynecology and Obstetrics (FIGO),[97] Royal College of Obstetricians and Gynaecologists (RCOG)[98] and National Institute for Health and Care Excellence (NICE).[99]

Telemedicine is particularly critical for women, girls and other people who can get pregnant, who face barriers to accessing healthcare services. In Northern Ireland, this includes those who live in rural areas, have limited or no access to transportation, are in violent or coercive relationships, have certain health conditions, have childcare or elder care responsibilities, have inflexible workplaces or precarious employment, are concerned about confidentiality, or fear anti-abortion intimidation and privacy breaches outside of clinics and hospitals.

A doctor who provides early medical abortions in Northern Ireland explained to Amnesty International: '… even an eight pound bus ticket is a lot if you don't have any money. If you had telemedicine and they had everything posted to them, they wouldn't have any of those costs. Because we've had that a couple of times, where they've delayed treatment for a week or two because they needed the money for their benefit before they could have afforded the train.'[100]

Public transportation in some parts of Northern Ireland is also extremely limited, if not non-existent. For example, when the comparatively rural Western Trust stopped offering early medical abortion services for over a year, services were briefly offered by providers in neighbouring trusts. Goretti Horgan, a long-time pro-choice activist and a senior lecturer in social policy at Ulster University explains:

> It might not seem like much when you look at the map, to travel say, from Enniskillen, which is the western part of the Western Trust, to maybe Dungannon, or to Coleraine or one of these places in one of the other trusts. But, actually, if you don't have transport, if you don't have a car, it's impossible to do it by public transport, and it doesn't matter how early in the morning you got up and no matter how many different buses you took, it is impossible. So that puts poor women at a real disadvantage or people who just can't afford a car.[101]

94 WHO, Abortion Care Guideline (2022), p95, Recommendation 48.
95 *BJOG: An International Journal of Obstetrics and Gynaecology*, 'Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study', 18 February 2021, obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.16668.
96 WHO, Abortion Care Guideline (2022), p95, Recommendation 48.
97 FIGO, FIGO endorses the permanent adoption of telemedicine abortion services (2021), figo.org/FIGO-endorses-telemedicine-abortion-services#_edn3.
98 RCOG, *Best practice in abortion care* (March 2022), p7, rcog.org.uk/media/geify5bx/abortion-care-best-practice-paper-april-2022.pdf.
99 NICE, Abortion Care: NICE Guideline (NG140), pp40, 72, Recommendation 1.1.9 (25 September 2019), nice.org.uk/guidance/ng140/resources/abortion-care-pdf-66141773098693.
100 Interview with a healthcare provider, 27 September 2022.
101 Interview with Goretti Horgan, Alliance for Choice Derry and senior lecturer in social policy, School of Applied Social and Policy Sciences, Ulster University, 29 September 2022.



For women in violent or coercive relationships, telemedicine may be their only viable option. As Naomi Connor, co-convenor of Alliance for Choice, which provides support to people seeking abortion, relays: 'One of the things that lots of women who are in those relationships can't do is access abortion healthcare freely. They have to do it really, really discreetly to make sure that their coercive partner doesn't find out. And that does not involve walking into a clinic. It just doesn't.'[102]

The lack of telemedicine is a particular barrier for LGBT+ individuals, explains Danielle Roberts, Senior Policy and Development Officer at HereNI:

> LGBT people, trans people, in particular, are less likely to be employed. So, the cost of having to travel to appointments is more of a burden. And then I think there is a worry of experiencing homophobia or transphobia from healthcare professionals, which is often a perception rather than an actuality, but that perception can be enough to put people off. If telemedicine was available, that would enable more people, particularly people who are worried about homophobia or transphobia, because, you know, it's a phone call in their own home, rather than having to go to a clinic and you don't know how receptive they're going to be to you. And that is why people are continuing to use online sources that are safe. Telemedicine would cut out a lot of barriers.[103]

Telemedicine also offers the option of a more patient-centred approach. As one doctor who provides abortions underscored, 'Whenever our clinic is open, that's not always the right time. It doesn't always suit them, with childcare or work.'[104]

A woman who had an early medical abortion in December 2021, obtaining the pills through informal channels instead of through the healthcare system after being unable to get a clinic appointment in time, agreed: 'There's a set day that you have to go in. And there's a set day that you have to take a pill in front of them. And that actually might not suit me because of work and family commitments. I have two young children.'[105]

The lack of telemedicine explains, in part, the continued demand for online services in Northern Ireland. Dr Kate Guthrie of Women on Web, an online abortion provider, recalls the impact of telemedicine being introduced in England, Scotland and Wales during the Covid-19 lockdown, noting how it dramatically eliminated the need for online services:

> We literally got no requests [for abortion pills] from Britain for about six months. The only requests we got we solved by saying 'you probably aren't aware that the law has changed' [to allow for telemedicine]. So we didn't supply anybody [with abortion pills by post] in the mainland of Britain because of telemedicine.[106]

102 Interview with Naomi Connor, co-convenor, Alliance for Choice, 28 September 2022.
103 Interview with Danielle Roberts, senior policy and development officer, HereNI.
104 Interview with a healthcare provider, 13 September 2022.
105 Interview with Katie Boyd, 13 December 2022.
106 Interview with Dr Kate Guthrie, Women on Web, 5 October 2022.

Telemedicine for early medical abortion was made permanent in England, Wales and Scotland in 2022.[107] Telemedicine for medication abortion remains unavailable in Northern Ireland and the Department of Health has told Amnesty that they have no plans to introduce this option.[108] The DOH, although acknowledging that the 'benefits of telemedicine are well-documented'[109] has stated that telemedicine would require ministerial approval, which is not possible without a devolved administration in place.[110] Most recently, the DOH has explained to Amnesty International that:

> The implementation of telemedicine is a policy decision for a Minister and any change of service also requires a public consultation. … the current aim is that an external review of services will be undertaken in 2025. At that stage, any proposed changes to the service model will be brought forward to a Minister and for public consultation.[111]

However, the 2020 Abortion Regulations invest the power to approve the provision of abortion services in other locations, including at home, in the Northern Ireland Department of Health.[112] This does not require any amendments to the regulations; but rather, under the regulations, an approval must only be 'given in writing' and published by the Department of Health.[113]

Despite abortion law reform, women and girls and other people who can get pregnant in Northern Ireland continue to face barriers to healthcare that those in the rest of the UK do not. Dr Ralph Roberts, chair of The Northern Ireland Abortion and Contraception Taskgroup (NIACT), notes that telemedicine is 'something that we have been campaigning for, for a long, long time. And the answer so far [from the DOH] has been no.'[114]

### 1.2.3 The 2020 regulations fail to fully implement the requirements laid out in the CEDAW Committee report

The 2019 Northern Ireland (Executive Formation etc) Act places a legal obligation on the Secretary of State for Northern Ireland to ensure that the CEDAW report recommendations are implemented in Northern Ireland.[115] The 2020 regulations fail to address key CEDAW Committee recommendations.

107 Welsh Government, Written Statement: Arrangements for Early Medical Abortion at Home, 24 February 2022, gov.wales/written-statement-arrangements-early-medical-abortion-home; Gov.UK, At home early medical abortions made permanent in England and Wales, 23 August 2022, gov.uk/government/news/at-home-early-medical-abortions-made-permanent-in-england-and-wales; Scottish Government, Early medical abortion at home, 12 May 2022, gov.scot/news/early-medical-abortion-at-home-1/.

108 Interview with the head of abortion policy, Department of Health, 2 March 2023; Interview with the NIO, 31 January 2023.

109 Interview with the head of abortion policy, Department of Health, 2 March 2023.

110 Interview with the director of secondary care and the head of abortion policy, Department of Health, 2 March 2023.

111 Correspondence with the head of abortion policy, Department of Health, 24 August 2023 (on file with Amnesty International UK).

112 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Sections 8(1)(e), 8(3)-(5). See also Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, No. 503, para 7.22.

113 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 8(5).

114 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.

115 Northern Ireland (Executive Formation etc) Act 2019, Section 9(1).



#### Working 'in the dark': no protocols or guidance for healthcare professionals

The CEDAW report includes two recommendations on guidance, calling for the adoption of 'evidence-based protocols for healthcare professionals on providing legal abortions particularly on the grounds of physical and mental health' and guidance on doctor-patient confidentiality in the context of abortion care.[116]

Temporary interim guidance for health professionals was issued by the Northern Ireland Office,[117] in the absence of devolved institutions, to cover the period between decriminalisation and the coming into force of new regulations on abortion (22 October 2019 to 31 March 2020). The guidance, in effect for under six months, recognised 'that women must be made aware of the options and choices available to them under the law in Northern Ireland'.[118]

Although further guidance was promised by the Northern Ireland Office upon the 2020 regulations coming into effect,[119] none has been issued as of August 2023. The Explanatory Memo accompanying the 2020 regulations notes that the Department of Health will update the guidance on termination of pregnancy when abortion services are commissioned.[120] Abortion services were commissioned in December 2022.

Moreover, the Secretary of State's 2021 and 2022 Abortion Services Directions instructed the Department of Health (DOH) to issue guidance to replace the DOH's outdated 2016 abortion guidance and to endorse the National Institute for Health and Care Excellence (NICE) termination of pregnancy guidelines.[121] DOH representatives informed Amnesty International during a March 2023 meeting that they are now in the process of endorsing the NICE guidance.[122] However, to date, more than three years after healthcare professionals began offering abortion services under the new regulations, and nine months after abortion services were formally commissioned, neither the Northern Ireland Office nor the Department of Health has issued any updated abortion-related guidance for healthcare professionals.

There has similarly been no effort by the DOH to provide the Health and Social Care Trusts with guidance on the parameters of conscience-based refusals and their

116 CEDAW Inquiry Report, paras 85(d), 86(c).

117 NIO, UK Government Guidance for Healthcare Professionals in Northern Ireland on Abortion Law and Terminations of Pregnancy in the Period 22 October 2019 to 31 March 2020 in Relation to the Northern Ireland (Executive Formation Etc) Act 2019 (October 2019) web.archive.org/web/20191022195906/https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/837166/Guidance_for_the_medical_profession_in_Northern_Ireland.pdf.

118 NIO, UK Government Guidance for Healthcare Professionals in Northern Ireland on Abortion Law and Terminations of Pregnancy in the Period 22 October 2019 to 31 March 2020 in Relation to the Northern Ireland (Executive Formation Etc) Act 2019 (October 2019).

119 NIO, UK Government Guidance for Healthcare Professionals in Northern Ireland on Abortion Law and Terminations of Pregnancy in the Period 22 October 2019 to 31 March 2020 in Relation to the Northern Ireland (Executive Formation Etc) Act 2019 (October 2019).

120 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, No. 503, para 11.1.

121 Abortion Services Directions 2021, Section 4, assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005075/The_Abortion_Services_Directions_2021.pdf; Abortion Services Directions 2022, Section 4, assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1079095/Abortion_Services_Directions_2022.pdf. NIO, Secretary of State issues updated direction to Northern Ireland's Department of Health to make Abortion Services available, 21 July 2021. gov.uk/government/news/secretary-of-state-directs-northern-irelands-department-of-health-to-make-abortion-services-available (the 2022 Directions revoked the 2021 Abortion Services Directions).

122 Interview with the director of secondary care and the head of abortion policy, Department of Health, 2 March 2023. See also correspondence with the head of abortion policy, Department of Health, 24 August 2023 (on file with Amnesty International UK).

obligations regarding monitoring of the practice.[123] As explained later in this report, this failure has been a significant barrier to the provision of quality abortion services. (See Chapter 4.)

### Intimidation of providers and women by anti-abortion activists and the Safe Access Zones Bill

The 2020 Abortion Regulations did not address the CEDAW Committee's recommendation that the government take steps to protect women from 'harassment from anti-abortion protesters'.[124] In fact, the UK Supreme Court, in a July 2022 decision, noted that 'no action has yet been taken' by either the UK government or the devolved executive, prior to the collapse of devolved institutions, to implement the CEDAW report recommendation to take measures to protect women from such intimidation.[125]

However, the Northern Ireland Assembly's Safe Access Zones Act, which aims to protect people from harassment outside abortion clinics, came into effect in May 2023 and will require government enforcement and oversight. As of August 2023, the zones have not been implemented; the Department of Health advises that these will be in place by end September 2023. Intimidation by anti-abortion activists has been – and continues to be – a significant barrier to abortion access for people in need of abortion services in Northern Ireland. (See Chapter 6.)

### Failure to include provisions on sex education and contraception

The 2020 regulations do not address the CEDAW Committee's recommendation to make 'comprehensive and scientifically accurate education on sexual and reproductive health and rights a compulsory curriculum component for adolescents, covering early pregnancy prevention and access to abortion.'[126] Nor do the 2020 regulations address the many CEDAW report recommendations relating to contraceptive access and information.

In June 2023, however, nearly four years after the UK government assumed full responsibility under the law to implement all of the CEDAW report's recommendations, the Secretary of State issued separate regulations on relationship and sexuality education (RSE) for Northern Ireland.[127] The regulations make teaching on early pregnancy and abortion a compulsory component of the sex education curriculum for pupils aged 11-16, although, contrary to human rights standards, parents may still opt out of having their children participate.[128] The RSE regulations came into effect on 1 July 2023 and the Northern Ireland Department of Education must issue guidance to schools by 1 January 2024 on the required curriculum.[129] (See Chapter 5.) Outside of emergency contraception,[130] neither the UK government nor the government in Northern Ireland has substantially improved access to the full range of contraceptives.

123 Interview with the director of secondary care and the head of abortion policy, Department of Health, 2 March 2023; Correspondence with the assistant director, commissioning lead (Northern Area), Department of Health, 16 March 2023 (on file with Amnesty International UK). (Noting, 'It is for the trusts to manage and monitor conscientious objection among staff and to ensure that this does not act as a barrier to service provision.'); correspondence with the head of abortion policy, Department of Health, 24 August 2023 (on file with Amnesty International UK).

124 CEDAW Inquiry Report, para 86(g).

125 Judgment, Reference by the Attorney General for Northern Ireland-Abortion Services (Safe Access Zones) (Northern Ireland) Bill (2022) UKSC 32, Judgment given on 7 December 2022, para 79.

126 CEDAW Inquiry Report, para 86(d).

127 Gov.UK, *Press Release: New requirements for Relationship and Sexuality Education curriculum in Northern Ireland*, 6 June 2023, gov.uk/government/news/new-requirements-for-relationship-and-sexuality-education-curriculum-in-northern-ireland; The Relationships and Sexuality Education (Northern Ireland) (Amendment) Regulations 2023, egislation.gov.uk/uksi/2023/602/contents/made.

128 The Relationships and Sexuality Education (Northern Ireland) (Amendment) Regulations 2023, Section 2(3). See also Explanatory Memorandum to The Relationships and Sexuality Education (Northern Ireland) (Amendment) Regulations 2023, 2023 No. 602, para. 7.10, legislation.gov.uk/uksi/2023/602/pdfs/uksiem_20230602_en_001.pdf.



#### An enabling environment: WHO Abortion Care Guideline

Recognising that '[a] person's environment plays a crucial role in shaping their access to care and influencing their health outcomes,' the WHO's Abortion Care Guideline outlines three 'core components of an enabling environment for abortion care'. These are:

1. respect for human rights including a supportive framework of law and policy
2. the availability and accessibility of information, and
3. a supportive, universally accessible, affordable, and well-functioning health system.[131]

## 1.3 The politics of implementation: failure by the former health minister and Department of Health

The Northern Ireland Assembly was restored in early 2020, just months prior to the 2020 Abortion Regulations coming into effect on 31 March 2020. At this stage, the government's responsibility was to develop and implement new abortion services to comply with the regulations. This occurs through 'commissioning' by the Department of Health, 'defined as the process of securing the provision of services to meet the needs of a population. This encompasses assessing a population's health… needs, planning services to meet these needs, working with providers of services to agree the services to be delivered, monitoring delivery of services against agreed standards, and evaluating the impact of the services that have been commissioned.'[132]

The Secretary of State for Northern Ireland's efforts to compel the Department of Health to commission abortion services and to ensure the necessary funding, staffing and institutional planning were in place were, until late 2022, somewhat modest, largely deferential to devolved institutions in Northern Ireland. More than two and a half years elapsed without the government commissioning abortion services in Northern Ireland. During this time, healthcare services to which people in Northern Ireland were legally entitled, remained largely unavailable. The limited abortion services that were in place were entirely without any specific government funding or support.

Ultimately, in June 2022, in Parliamentary Committee debate, the Secretary of State for Northern Ireland expressed his intention to use his powers to commission abortion services:

129 The Relationships and Sexuality Education (Northern Ireland) (Amendment) Regulations 2023, Sections 1(2) and 2(3).

130 See Department of Health, Pharmacy First: Emergency Hormonal Contraception, hscbusiness.hscni.net/services/3289.htm (providing free emergency hormonal contraception in pharmacies across Northern Ireland, beginning in July 2022); SH:24, sh24.org.uk/ (working in partnership with the NHS, post emergency contraception, combined pills and progestogen-only pills throughout Northern Ireland).

131 WHO, Abortion Care Guideline (2022), pp5-6.

132 Department of Health, Social Services and Public Safety, *Review of HSC Commissioning Arrangements Final Report – October 2015*, p1, health-ni.gov.uk/sites/default/files/publications/dhssps/review-hsc-commissioning2015.pdf. See also, NHS England, What is commissioning?, england.nhs.uk/commissioning/what-is-commissioning/ (Commissioning 'is the continual process of planning, agreeing and monitoring services. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.').

> I do not expect the Minister of Health and the Department of Health to take this forward. I encourage him to do so, and I will still give him a little bit more space to do so. However, my experience of the last two years is that I think that he fundamentally will not and I expect, sadly, to use these powers relatively soon.[133]

At the same time, the Secretary noted:

> I am still clear that the Department of Health should drive forward the commissioning of abortion services without delay, and that as a devolved matter it remains the responsibility of the Northern Ireland Executive to fund those services. I will continue to engage with the Minister of Health and his Department, and I have asked my officials to continue their engagement. We are keen to work with the Minister to support him in the Department of Health's delivery of services.[134]

The Minister of Health continued to insist that he could not direct the commissioning of abortion services without the agreement of the Executive, having previously cited what he viewed to be the 'significance and sensitivity of the issue' and his view on the requirements of the Ministerial Code in the Northern Ireland Act 1998.[135]

On 24 October 2022, three years after the decriminalisation of abortion, the UK government announced it would commission abortion services.[136] Three days later, on 27 October 2022, Northern Ireland's devolved administration was dissolved and the Minister of Health left office.[137] Northern Ireland currently remains without a devolved administration and a Minister of Health.

Finally, on 2 December 2022, the Secretary of State announced the formal commissioning and funding of abortion services in Northern Ireland and instructed the Department of Health (DOH) to commission services.[138] The NIO says that its commitment is to 'ensure that funding for abortion services is made available', although its position is that it remains the responsibility of the Northern Ireland Executive to fund abortion services in Northern Ireland. The UK government has ringfenced £4,334,896 for the 2023-2024 fiscal year, although it has not been decided if this would be additional funding, if required, or from within the existing Northern Ireland block grant, with the expectation that the DOH will fund abortion services thereafter.[139]

The Strategic Planning and Performance Group (SPPG) within the Department of Health, in collaboration with the Northern Ireland Office, has developed a commissioning framework and service specification. Implementation of this framework

133 UK Parliament, Hansard: Abortion (Northern Ireland) Regulations 2022, debated on 16 June 2022, hansard.parliament.uk/Commons/2022-06-16/debates/a37f3df5-3861-4f49-b97b-1cf7719df501/Abortion(NorthernIreland)Regulations2022.

134 UK Parliament, Hansard: Abortion (Northern Ireland) Regulations 2022, debated on 16 June 2022.

135 'No abortion services plan despite Westminster intervention', AgendaNI, September 2022 agendani.com/no-abortion-services-plan-despite-westminster-intervention/

136 NIO, press release: UK Government to Commission Abortion Services in Northern Ireland, 25 October 2022, gov.uk/government/news/uk-government-to-commission-abortion-services-in-northern-ireland.

137 Department of Health, Departing Minister thanks health and care staff, 27 October 2022, health-ni.gov.uk/news/departing-minister-thanks-health-and-care-staff.

138 NIO, press release: Secretary of State for Northern Ireland Instructs the Department of Health to Commission Abortion Services, 2 December 2022, gov.uk/government/news/secretary-of-state-for-northern-ireland-instructs-the-department-of-health-to-commission-abortion-services.

139 Correspondence from the NIO, 27 September 2023.



and these planned services is now underway. However, as of August 2023, abortion service provision remains limited.

There is a memorandum of understanding between the Northern Ireland Office and the Department of Health that commits them to working together to ensure that abortion services are effectively provided in Northern Ireland.[140] The NIO has explained to Amnesty International that the Department of Health is ultimately the body responsible for implementing and monitoring the services and it will work directly with the trusts to do so.[141] The NIO, for its part, will be kept informed of service planning and delivery, participate in governance meetings and monthly meetings with the DOH, and 'will need to continue to be assured that services delivered are compliant with CEDAW.'[142] However, given that the ultimate implementation responsibility and direct oversight of the trusts rests with the Department of Health, it is unclear how the Northern Ireland Office will effectively ensure abortion service provision if the DOH fails to institute timely roll-out of services.

## 1.4 Realities of implementation: a health system in crisis

In addition to the politicisation of commissioning abortion services, the realities of rolling out a new service in the context of an already overstretched healthcare system, newly emerging from the crisis of the Covid-19 pandemic, cannot be overstated. Goretti Horgan, a long-time pro-choice activist and a senior lecturer in social policy at Ulster University, explains that in Northern Ireland 'Everybody is totally overworked at the Health Service. Everybody. And it's worse in the Western [Trust] areas because they find it very difficult to recruit doctors.'[143]

Although sexual and reproductive health services are grappling with significant and longstanding workforce and funding deficits (see Chapter 7), this is not the only sector facing challenges. Northern Ireland's healthcare system is in crisis and the Health and Social Care Trusts are generally overwhelmed.[144] This has made implementing and funding a new and stigmatised abortion service all the more challenging.

140 Interview with the NIO, 31 January 2023.

141 Interview with the NIO, 31 January 2023.

142 Interview with the NIO, 31 January 2023.

143 Interview with Goretti Horgan, Alliance for Choice Derry and senior lecturer in social policy, School of Applied Social and Policy Sciences, Ulster University, 29 September 2022.

144 See, eg, the *Guardian*, 'Northern Irish healthcare in crisis amid political deadlock', 19 November 2022, theguardian.com/uk-news/2022/nov/19/northern-irish-healthcare-in-crisis-amid-political-deadlock; BBC News, NHS staff across Northern Ireland staged 24 hour walkouts in December 2022 and January and February 2023, 26 January 2023, bbc.com/news/uk-northern-ireland-64400715; bbc.co.uk/news/uk-northern-ireland-64730103.

# 2. Failure to implement the law: limited access to legal abortion services

> 'The situation in Northern Ireland is a perfect example of how decriminalisation or legalisation of abortion, whichever way you want to look at it, is necessary, but entirely insufficient to ensure service delivery.'[145]
> **Dr Patricia Lohr**

The Department of Health's failure to commission abortion services until legally instructed to do so by the Secretary of State in December 2022,[146] and the consequent lack of funding, clinical guidance and healthcare professional training on abortion service provision between 2020 and 2022, has significantly hindered the provision of abortion services in all five of Northern Ireland's Health and Social Care Trusts.[147]

For more than three years after legalisation, abortion service provision in Northern Ireland was essentially limited to early medical abortion services, up to nine weeks and six days' gestation. In the Western Trust, even this limited early medical abortion service was unavailable for 18 months and only resumed service provision in October 2022. The Northern Trust extended its medical abortion service to 11 weeks and six days' gestation in 2022. The other four trusts have yet to follow suit. Amnesty has learned that the Western and South Eastern Trusts plan to similarly expand their medical abortion service in 2023 and that, at present, the Belfast and Southern Trusts do not anticipate expanding their early medical abortion service beyond nine weeks and six days' gestation.

Surgical abortion services have been unavailable until very recently, and even then have only been offered in certain trusts. In April 2023, the Belfast Trust briefly introduced limited surgical abortion services between seven and 12 weeks' gestation; however, that service was paused in June 2023 due to staffing constraints. The Belfast Trust intends to re-establish this service later in 2023. The Northern Trust introduced surgical abortion services up to 11 weeks and 6 days' gestation in early May 2023. The remaining three trusts plan to follow suit and offer surgical abortion services under 12 weeks' gestation later in 2023 or some time in 2024.[148]

Across Northern Ireland, abortion services after nine weeks six days (and 11 weeks six days in Northern Trust) of pregnancy have been largely unavailable for the past three and a half years, except for a small number of later term abortions performed on foetal impairment grounds. This means that people seeking abortion on request from 10-12 weeks, undergoing abortion on the broad grounds permitted by the law after 12 weeks, or in need of later term abortions for reasons other than foetal impairment, have typically been forced to travel or, for earlier gestations, to order pills online. 'That's a hole in the service… a gap in service provision,'[149] says Dr Ralph Roberts, chair of NIACT.

## 2.1 Postcode lottery: where you live in Northern Ireland determines whether you can access services locally

Northern Ireland's abortion law guarantees access to abortion services on request up to 12 weeks' gestation. Although all five trusts – Northern, Southern, Western, South Eastern and Belfast Trusts – currently offer early medical abortion services until nine weeks six days gestation, routine access to medical and surgical abortion services until 12 weeks' gestation is only available in the Northern Trust.[150] The Belfast Trust began offering surgical abortion services for people between 7-12 weeks' gestation in April 2023; however, this service has been suspended since June 2023. As such, your address determines whether you can receive services locally and obtain your preferred method of abortion (surgical or medical), or whether you must travel outside of Northern Ireland after 10 weeks' gestation for abortion care.

This is because, at present, abortion services under 12 weeks' gestation in Northern Ireland cannot be obtained outside a person's designated trust catchment area, which is assigned based on their home postcode. However, the Northern Ireland Office and Department of Health have informed Amnesty International that this will eventually change, as part of the commissioning process, so that everyone will be allowed to obtain an abortion in any of the trusts.[151] The DOH has explained that they 'are keen to secure an open access model for early abortion services. However, that is not yet possible as not all trusts are currently providing EMA [medical abortion] and MVA [surgical abortion] up to 12 weeks. As the full-service model is implemented, we will move to an open access service' where people can access abortion services in any trust.[152]

As of late August 2023, after 10 weeks' gestation, people who live within the Southern, South Eastern, Belfast and Western Trust catchment areas must call the number for MSI Reproductive Choices in England and travel to England or elsewhere for services. Moreover, there is no official service or referral pathway within these trusts for people who present after 10 weeks' gestation. If gestation is determined to be too late for trust services, women are told to call the number for MSI in England to arrange for care.[153] Since an appointment can only be made through central booking services, most women and other pregnant people who are past the 10-week mark never even present in their trust.

145 Interview with Dr Patricia Lohr, medical director, BPAS, 8 December 2022.

146 NIO, press release: Secretary of State for Northern Ireland Instructs the Department of Health to Commission Abortion Services, 2 December 2022, gov.uk/government/news/secretary-of-state-for-northern-ireland-instructs-the-department-of-health-to-commission-abortion-services.

147 There are five Health and Social Care Trusts in Northern Ireland that provide health and social care services to the public within their designated catchment areas, as well as regionally. The five trusts are: Northern, Southern, Western, South Eastern and Belfast Trusts. NIDirect, Health and Social Care trusts nidirect.gov.uk/contacts/health-and-social-care-trusts.

148 Interview with a healthcare provider, 26 April 2023; interview with a healthcare provider, 3 May 2023; interview with a healthcare provider, 3 May 2023; interview with a healthcare provider, 5 May 2023; interview with a healthcare provider, 9 May 2023; interview with a healthcare provider, 14 August 2023; interview with a healthcare provider, 15 August 2023; interview with a healthcare provider, 15 August 2023; interview with a healthcare provider, 16 August 2023; interview with a healthcare provider, 25 August 2023.

149 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.

150 NIDirect, *Abortion Services* nidirect.gov.uk/articles/abortion-services.

151 Interview with the NIO, 31 January 2023; interview with the director of secondary care and the head of abortion policy, Department of Health, 2 March 2023.

152 Correspondence with the assistant director, commissioning lead (Northern Area), Department of Health, 16 March 2023 (on file with Amnesty International UK).

153 NIDirect, *Abortion Services* nidirect.gov.uk/articles/abortion-services.

MSI data from April 2021 through August 2022 show that 132 people from Northern Ireland obtained abortions in England between 10-12 weeks' gestation.[154] People may also obtain medical abortions through online services like Women Help Women (WHW) and Women on Web (WoW). For example, in 2021-2022, WHW dispatched 228 packages of abortion pills to Northern Ireland for people who were 10-12 weeks pregnant.[155]

One obstacle to medical abortion service provision between 10-12 weeks is the perceived need, in some trusts, for these services to be provided in a hospital setting. This is not a requirement specified in the regulations; rather, it comes from a narrow reading of the regulations' Explanatory Memorandum, which notes: 'In practice, for abortions beyond 10 weeks' gestation… women will complete all their treatment within an appropriate medical facility which can provide safe access to surgical or medical procedures.'[156]

Without further clinical or interpretive guidance from the DOH, some trusts have interpreted the Memorandum's note narrowly. However, the regulations do not legally prohibit the provision of early medical abortion (EMA) services up to 12 weeks within the trusts' existing EMA clinical settings. Moreover, according to the Explanatory Memorandum, the regulations are intended to reflect 'modern practice in respect of the provision of abortion services'.[157] As such, the most recent evidence-based guidance from the World Health Organisation should be taken into consideration. The WHO does not recommend requiring a facility location for medical abortion performed before 12 weeks' gestation, noting that they can be done safely entirely off-site up to 12 weeks' gestation.[158]

## 2.2 'Luck of the draw': ad hoc early medical abortion provision

Although, officially, after 10 weeks' gestation (12 weeks in the Northern Trust), people are advised to call the central contact number and arrange for travel to Britain for treatment,[159] a very limited number of medical abortions, Amnesty International learned, are performed after these gestations on an ad hoc basis. As Karen Murray of the Royal College of Midwives Northern Ireland notes, it 'becomes down to the luck of the draw for that woman, whether or not she meets the right practitioner or not in her journey, which isn't acceptable'.[160] There are no formalised referral pathways for patients who present later in their pregnancy.

According to one early medical abortion (EMA) provider, for cases where they have needed to provide services after 10 weeks, often where women are unable to travel for health or other reasons, the process is time-consuming to navigate and entirely dependent on the goodwill of whomever is on duty within the gynaecology department. The provider explains: 'The main obstacle is when we need gynae [gynaecology] support. That's the main difficulty. We don't have any proper pathways. [It can take] quite a bit of time to find a gynaecologist and speak to them and get them to agree to it. We need to be able to pick up the phone and have a pathway.'[161]

The EMA provider recalled patients who were a suicide risk or had mental health problems and were just past the 10-week mark: 'They were in no fit state to travel to England.' After healthcare providers raised this point with management, the trust sometimes agreed to provide the woman with a medical abortion.

> But there was usually a whole kerfuffle, you know. I would speak to the consultant, and often this was all going on all weekend. They would say, 'I have to find out who's on the ward, I have to find out whether there are any conscientious objectors on the ward, before I can find a bed for her.' And then she could be left sitting in the corridor for ages while they found someone that was able to take her into the hospital. And often she's texting me constantly and phoning me constantly and phoning the [EMA] nurse constantly. That gives you an example of the sort of trouble that we have.[162]

## 2.3 After 12 weeks: limited number of abortions, primarily on foetal impairment grounds

By law, abortions services should be available on health grounds from 12-24 weeks and on severe or fatal foetal impairment, health- (mental and physical) and life-saving grounds at any point in the pregnancy. Although, the government does not publicly state that services are available after 12 weeks' gestation in Northern Ireland,[163] data from both the Department of Health and the HSC trusts reveals that there are some abortions being provided at later gestations. However, these services are limited, primarily provided on foetal impairment grounds, and access to quality services is often dependent upon your postcode.

### 2.3.1 Department of Health data

Although publicly available government data on abortion provision is extremely limited and opaque, according to the Department of Health's most recent official government statistics there were 53 hospital-based terminations of pregnancy in Northern Ireland between April 2021 and March 2022.[164] Early medical abortions are performed in clinics in Northern Ireland, so these hospital-based terminations were likely performed after 10 weeks' gestation.

Notably, MSI data shows that three times that number of abortions post-10 weeks' gestation were carried out in England for people living in Northern Ireland during the same time period, suggesting that far more women and girls and other people who can get pregnant were having to travel for services than received them locally, in Northern Ireland.[165] The abortions that were performed in Northern Ireland were somewhat

154 MSI data, on file with Amnesty International UK. Of those living in Northern Ireland, 132 people were at 10-12 weeks gestation, 101 were at 13-19 weeks gestation and 20 were at 20-23 weeks gestation at the time of the booking call.
155 Data obtained from Women Help Women and on file with Amnesty International UK.
156 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, No. 503, para 7.19.
157 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, 2020 No. 503, para. 7.18.
158 WHO, Abortion Care Guideline (2022), p70.
159 NIDirect, *Abortion Services* nidirect.gov.uk/articles/abortion-services.
160 Interview with Karen Murray, Northern Ireland director, Royal College of Midwives (RCM), 27 September 2022.
161 Interview with a healthcare provider, 29 September 2022.
162 Interview with a healthcare provider, 29 September 2022.
163 See NIDirect, *Abortion Services* nidirect.gov.uk/articles/abortion-services (NIDirect, the government website for people living in Northern Ireland, provides information on abortion services in Northern Ireland and states that 'if your pregnancy is over 10 weeks (12 weeks and over for Northern HSC Trust residents)… care can be accessed in Great Britain'.)
164 Information and Analysis Directorate, Department of Health, *Northern Ireland Hospital Based Termination of Pregnancy Statistics 2021/22* (January 2023), datavis.nisra.gov.uk/health/ni-termination-of-pregnancy-stats-21-22.html (The DOH defines termination of pregnancy as 'any patient who has a live pregnancy terminated for indications that are legally acceptable and medically approved in Northern Ireland'.)
165 MSI data, on file with Amnesty International UK.

evenly distributed between four of the five trusts, with Western Trust being an outlier and providing significantly less later term abortions, if any at all,[166] suggesting barriers to access for those living within the Western Trust catchment area.

The Department of Health's publicly released annual statistics provide no information on the grounds for these terminations, or the gestation at which they occurred, making it difficult to discern the services being provided in each trust.[167] Amnesty International's interviews with healthcare professionals suggest that abortions on health grounds, between 12-24 weeks, are extremely rare in Northern Ireland.[168] One provider of abortion services notes, 'We don't even hear from them.'[169] If they call BPAS, or find abortion service information on the trust website, or contact The Rowan Sexual Assault Referral Centre if they are pregnant after a sexual assault, they are directed to call MSI directly and arrange for care in England after 12 weeks' gestation. MSI data and Amnesty International's interviews affirm that women and girls have had to travel to England for services since law reform. Between April 2021 and July 2022, MSI booked appointments in England for 121 people from Northern Ireland who were post-12 weeks' gestation.[170]

### 2.3.2 Data from Health and Social Care Trusts

Nonetheless, there are a limited number of terminations carried out on foetal impairment grounds in Northern Ireland, which may explain the government's abortion statistics. Amnesty International's Freedom of Information Act (FOIA) requests reveal that there have been 32 abortions on severe or fatal foetal impairment grounds in the Belfast Trust between March 2020 and December 2022.[171] There were 33 terminations on severe or fatal foetal impairment grounds in the South Eastern Trust during the same time period;[172] and 44 terminations below 20 weeks' gestation on grounds of suspected or confirmed foetal impairment in Northern Trust between March 2020 and January 2020, with 10 foetal impairment terminations above 20 weeks' gestation since May 2020.[173] In the Western Trust, there have been 32 terminations on grounds of severe or fatal foetal impairment between March 2020 and August 2022.[174] The Southern Trust said that information on the number of severe or fatal foetal impairment terminations 'is not collated by the Trust'.[175]

### 2.3.3 Postcode lottery

Amnesty's interviews reveal that access to abortion services on foetal impairment grounds in Northern Ireland is dependent on the availability of a provider with the appropriate training and on the gestation of the pregnancy. There do not appear to be clear pathways to care in all trusts and some trusts have better access to care than others, leaving healthcare subject to a postcode lottery. (See Marie's Experience, described below.)

Suzie Heaney, Northern Ireland Coordinator at Antenatal Results and Choices (ARC) and a midwife, notes, 'I know one trust, in particular, they've a fantastic person working there who has developed a kind of care pathway for parents who are going through an anomaly diagnosis, and whether they continue or choose a TFMR [termination for medical reasons, a reference to termination on grounds of severe or fatal foetal impairment]. And that's all from her own work. It hasn't come from a regional approach or that kind of wider effort.'[176] (See inset on Anti-Abortion Antenatal Screening Practices, below.)

## 2.4 Surgical options largely unavailable in Northern Ireland

As of March 2023, the services being provided within Northern Ireland were exclusively medical abortions. In April and May 2023, the Belfast Trust and the Northern Trust, respectively, began offering surgical (MVA) abortion services prior to 12 weeks' gestation.[177] Surgical services in both trusts are dependent upon a single doctor.[178] In June 2023, the Belfast Trust had to suspend its surgical abortion service due to staffing constraints.[179] As of August 2023, outside the Northern Trust, there are no surgical abortion services available in Northern Ireland. There are also no healthcare professionals in Northern Ireland currently providing surgical abortion services after 12 weeks' gestation.[180] If a person has a preference or a medical indication for a surgical abortion, and they live outside the Northern Trust area or require an abortion after 12 weeks' gestation, they must travel to England or elsewhere.[181]

According to information Amnesty International obtained from the Department of Health, commissioned services include manual vacuum aspiration (MVA), a specific type of surgical abortion, and each trust will provide MVA until 12 weeks' gestation.[182] The DOH has explained: 'The commissioning intention is to offer women and girls a choice of abortion procedure, where clinically appropriate. While the focus has been on securing an EMA service in each trust, service mobilisation will involve each trust providing an MVA service up to 12 weeks. That service is not yet available in all trusts but training of staff is underway and trusts are working towards being able to offer women a choice of procedure.'[183]

166 Information and Analysis Directorate, Department of Health, *Northern Ireland Hospital Based Termination of Pregnancy Statistics 2021/22* (January 2023).
167 Information and Analysis Directorate, Department of Health, *Northern Ireland Hospital Based Termination of Pregnancy Statistics 2021/22* (January 2023).
168 See also NIACT, *Report on Sexual and Reproductive Health in Northern Ireland* (March 2021), p57; NIACT, *Report on Sexual and Reproductive Health in Northern Ireland Annual Review 2022* (June 2022).
169 Interview with a healthcare provider, 30 January 2023.
170 MSI data, on file with Amnesty International UK. Of those living in Northern Ireland, 132 people were at 10-12 weeks' gestation, 101 were at 13-19 weeks' gestation and 20 were at 20-23 weeks' gestation at the time of the booking call.
171 Belfast Health and Social Care Trust, FOIA request, received 9 November 2022.
172 South Eastern Health and Social Care Trust, FOIA request, received 7 February 2023.
173 Northern Health and Social Care Trust, FOIA request, received 15 February 2023.
174 Western Health and Social Care Trust, FOIA request, received 23 February 2023.
175 Southern Health and Social Care Trust, FOIA request, received 21 November 2022.
176 Interview with Suzie Heaney, midwife and ARC coordinator NI, 14 December 2022.
177 Interview with a healthcare provider, 26 April 2023; interview with a healthcare provider, 5 May 2023.
178 Interview with a healthcare provider, 26 April 2023; interview with a healthcare provider, 5 May 2023.
179 Interview with a healthcare provider, 14 August 2023.
180 Interview with a healthcare provider, 3 May 2023; interview with a healthcare provider, 25 August 2023.
181 NIDirect, *Abortion services* nidirect.gov.uk/articles/abortion-services.
182 Interview with the director of secondary care and the head of abortion policy, Department of Health, 2 March 2023; correspondence with the assistant director, commissioning lead (Northern Area), Department of Health, 16 March 2023 (on file with Amnesty International UK).
183 Correspondence with the assistant director, commissioning lead (Northern Area), Department of Health, 16 March 2023 (on file with Amnesty International UK).

### Choice of abortion methods is critical to provision of acceptable services

The NICE 2019 Abortion Care Guideline, which Amnesty International is advised the Department of Health is in the process of endorsing,[184] underscores the importance of choice of methods.[185] The NICE guidelines recommend that healthcare providers '[o]ffer a choice between medical or surgical abortion up to and including 23+6 weeks' [23 weeks, six days] gestation'.[186] NICE has published two decision aid leaflets to help people decide what option is best for them.[187]

Specifically, NICE guidance instructs healthcare workers to: 'Provide information about the differences between medical and surgical abortion (including the benefits and risks), taking account of the woman's needs and preferences. Do this without being directive, so that women can make their own choice.'[188] The NICE guidelines also provide for a duty to 'ensure that women are promptly referred onwards if a service cannot provide an abortion after a specific gestational age or by the woman's preferred method'.[189]

The Royal College of Obstetricians and Gynaecologists (RCOG) provides similar guidance.[190] The WHO likewise notes in its Abortion Care Guideline, 'Individual health preferences may vary; no one model of abortion care will meet the needs of everyone seeking abortion care.'[191] The WHO stresses that service provision must be based 'upon women's values and preferences, the acceptability of each intervention, and the availability of resources to provide the chosen method safely'.[192]

Providing people with a choice of method ensures patient-centred care that respects their autonomy, personal history, mental or physical health needs and individual preferences. Some people may want a surgical abortion in order to have their pregnancy terminated faster – perhaps because of their family situation, being in a coercive relationship, having to care for children, a prior difficult experience with medication abortion, or any host of reasons impossible to predict.

Nicola* had a surgical abortion in Liverpool in 2011 and a medical abortion in 2021 in Belfast. 'My first procedure in England was a surgical abortion, under local anaesthetic. And it was quick and easy. It was much easier to tolerate, I suppose, in terms of getting back to life and less traumatic overall. I find it much easier. [For the medical abortion,] it was traumatic. But that was just because of the amount of bleeding, it wasn't anything to do with trying to get the services. I don't think I can get a surgical abortion in Northern Ireland at the moment. So, it's very difficult. Because that would definitely be my choice. I would not want to travel to England or go through that, you know, with my life and my children and everything. I wouldn't really be able to.'[193]

184 Interview with the director of secondary care and the head of abortion policy, Department of Health, 2 March 2023; correspondence with the head of abortion policy, Department of Health, 24 August 2023 (on file with Amnesty International UK).

185 NICE, Abortion Care: NICE Guideline (NG140), (25 September 2019), p72, Section 1.6, nice.org.uk/guidance/ng140/resources/abortion-care-pdf-66141773098693.

186 NICE, Abortion Care: NICE Guideline (NG140), (25 September 2019), p72, Section 1.6.1. See also: NICE, Quality Standard (QS199), (26 January 2021), pp11-14, Quality Statement 2: Choice of Abortion Procedure, nice.org.uk/guidance/qs199/chapter/Quality-statement-2-Choice-of-abortion-procedure.

187 NICE, Patient decision aids and user guides, (25 September 2019), nice.org.uk/guidance/ng140/resources/patient-decision-aids-and-user-guides-6906582256.

188 NICE, Abortion Care: NICE Guideline (NG140) (25 September 2019), para 1.2.2.

189 NICE, Abortion Care: NICE Guideline (NG140), para 1.1.1.

190 RCOG, The Care of Women Requesting Induced Abortion: Evidence-Based Clinical Guideline Number 7 (Nov. 2011) p34, Recommendation 4.23, rcog.org.uk/media/nwcjrf0o/abortion-guideline_web_1.pdf.

191 WHO, Abortion Care Guideline (2022) p4.

192 WHO, Abortion Care Guideline (2022) p63.



Another doctor explains how the lack of surgical abortion provision impacts people who need an abortion on health grounds, between 12-24 weeks gestation:

> If you go over to England, Scotland, Wales, the majority – unless it's fatal foetal or a foetal reason – the majority of patients over 12 weeks will undertake a surgical termination. If you have someone who fulfils criteria B, which is the physical, mental, emotional health, absolutely, technically, you can carry that out here [in Northern Ireland]. But we can only offer them medical [abortion]. And for these women, that could be extremely distressing, as they would rather get it over with quickly.[194]

Donagh Stenson of BPAS underscores the stigma of having people from Northern Ireland continue to travel for surgical services, while others can receive medical abortion at home:

> Now, there's the fact that you are sending somebody away that stigmatises them further. It goes back to that thing about 'good' abortions versus 'bad' abortions. So, you're having a good abortion because you're only going up to 10 weeks. Anybody over 10 weeks is ostracised even further now. So, if it wasn't stigmatised as a whole group, you've now stigmatised that group even further by saying that surgical abortion is something different from everybody else. So that drives it further underground. And that's where you start having problems. You have people who take risks, that don't need to take risks, in a developed country.[195]

## 2.5 Groups particularly impacted by limited provision of abortion

The limited nature of abortion services after 10 weeks' gestation impacts people who need access to services on health grounds, including those who are pregnant as a result of sexual violence, or for foetal impairment reasons. Many of these people have instead been forced to travel for services. Travelling for abortion care can be particularly challenging for adolescents, people in violent or coercive relationships, and those with precarious work situations, child or eldercare responsibilities, complicated health status, or uncertain immigration status. These same groups are also particularly impacted by the lack of telemedicine in Northern Ireland (see Chapter 1.)

Niamh Rowan of the Migration Justice Project explains that one issue…

193 Interview with Nicola (name has been changed), 10 January 2023.

194 Interview with a healthcare provider, 30 January 2023.

195 Interview with Donagh Stenson, innovation and marketing director, BPAS, 14 September 2022.

> Would be whether or not an asylum seeker would have any difficulties to get on a plane to travel to another part of the UK. If they were in London, and they wanted to jump on a bus to go to Manchester, it's no problem. But because we're a separate island, and you're talking about planes and boats, where there may be immigration checks. And it's not that they've done anything wrong, because they should be allowed to move freely within the country as a whole. But asylum seekers wouldn't be 100 per cent confident that the ID that they are traveling on would be universally accepted. Because there is a hostile environment here for asylum seekers and refugees.
>
> And even if they did make it over to England or Scotland to have the procedure, they potentially would lose their NASS accommodation and any support network that they had in that accommodation if they were away for a few days. If you are deemed to abscond – disappear for a day or two – the accommodation providers may report that to the Home Office and then all of your support could be stopped. And there may be a case to be argued that there should be an exception for a medical procedure. But that would be a piece of work in itself, finding out if that was possible.[196]

Moreover, for travel and related expenses to be covered by the UK government, a person must have a Northern Ireland postcode and be registered with a Northern Ireland GP (with a Northern Ireland postcode).[197] For those who already face challenges in accessing healthcare – such as irregular migrants and asylum-seekers – this can be yet another hurdle to accessing abortion services in England.

Clare Mullaly, from End Deportations Belfast, an organisation that raises awareness of the harms of detention and garners support for community-based alternatives, has called for Larne House, a short-term holding facility in County Antrim for the detention of migrants or undocumented people detained at the decision of an immigration official, to be closed because of inhumane conditions. She noted in terms of healthcare that there is a privately hired nurse, but the nurse operates outside the wider NHS and 'there aren't any routine midwife visits, nor any clear pathways for maternal health or other reproductive healthcare services, including abortion.'[198] Members of the Legislative Assembly of Northern Ireland have called for an end to the detention of pregnant women there.[199]

The absence of surgical (MVA) services for early abortion may also be challenging for those experiencing homelessness or who don't have a safe place where they can complete a medical abortion. In addition, there are certain groups of people who may want surgical abortion services because their mental or physical health would make a medical abortion extremely difficult or painful. These include adolescents; people who have not previously given birth; survivors of sexual violence; people with certain mental health conditions; and some transgender men.

196 Interview with Niamh Rowan, community engagement officer, Migration Justice Project, Law Centre NI, 7 December 2022.

197 MSI UK Reproductive Choices, Travelling from Northern Ireland msichoices.org.uk/abortion-services/travelling-from-northern-ireland/

198 Interview with Clare Mullaly, End Deportations Belfast, 6 March 2023.

199 *Belfast Telegraph*, 'Larne immigration centre: MLAs call for end to detention of pregnant women', 13 January 2023, belfasttelegraph.co.uk/news/politics/larne-immigration-centre-mlas-call-for-end-to-detention-of-pregnant-women/42282530.html



Danielle Roberts, who works with HereNI, an organisation that advocates for lesbian and bisexual women and their families, explains:

> If somebody has been taking hormones, then there can be [vaginal] atrophy. And so, actually, using the pills then can be a lot more difficult, a lot more painful. As well as dysphoric for some people. For others, they prefer the privacy of EMA. So I think there are particular issues when it comes to abortion, that maybe it would be more appropriate for some trans people to have the option to choose surgical, and at the minute the option just isn't there. Some people are wanting surgical for reasons of it being like less painful, and also less traumatic for them mentally.[200]

### Queen's University Students' Union supports abortion access on campus

On 15 February 2023, the Students' Union of Queen's University, Belfast passed a historic motion calling for the provision of early medical abortion in its Sexual Health Clinic. The clinic is located in the Students' Union and is run by the Belfast Trust. Although emergency contraception and other contraceptives and sexual health services are provided through the nurse-led clinic, EMA is not offered. Through this motion, the Council mandated the Students' Union to lobby for the inclusion of EMA in the Students' Union clinic; advertise the current information support available in the Sexual Health Clinic for those seeking abortion; and to continue to hold a pro-choice stance and push for the full decriminalisation of abortion across the UK and in Ireland.

Jenny Steele, Student Councillor, and Jess Crisp, Women Students' Officer – respectively co-chair and member of Project Choice at Queen's University, the organisation pushing for this motion – explained the importance of it: 'Students are really disproportionately disadvantaged by the limited and unclear access to abortions, especially the growing number of international students, who aren't familiar with the health system in NI, who face stress around being in an unfamiliar place and do not understand the extreme stigma around abortion in our society.'[201]

The Students' Union will be meeting with the Belfast Trust to discuss the implementation of this motion and noted that 'although we expect some pushback, we are hopeful for a positive outcome, and will continue to advocate until we get one.' They explained:

> We believe that the students should be able to exercise their bodily autonomy in a supportive atmosphere that supports their mental well-being. The Students' Union Sexual Health Clinic is such a place.[202]

200 Interview with Danielle Roberts, senior policy and development officer, HereNI. See also Moseson H, et al, 'Abortion experiences and preferences of transgender, nonbinary, and gender-expansive people in the United States', *American Journal of Obstetrics & Gynecology* (April 2021) 224(4):376.e1-376.e11 pubmed.ncbi.nlm.nih.gov/32986990/

201 Jenny Steele, co-chair, and Jess Crisp, member, Project Choice, 2 March 2023. The other co-chair of Project Choice is Thea Mawhinney.

202 Jenny Steele, co-chair, and Jess Crisp, member, Project Choice, 2 March 2023. The other co-chair of Project Choice is Thea Mawhinney.

They noted that another one of the impetuses behind the motion are the rogue clinics, which provide misinformation to people seeking abortion. They know of students who have been to Stanton, one of these clinics, and feel strongly that 'students should not have to seek information about their human rights from places that are flooded with scientifically inaccurate anti-choice propaganda.'[203]

Vic Young, an abortion doula, emphasises that while restrictions on availability of abortion impacts everyone, and everyone's needs should be taken into account, it is important to listen to those most marginalised:

> The people who need the help the most, people who are already stigmatised by society or looked down upon by society – sex workers, migrant folk, trans people, queer folk, people who are in coercive control relationships, people who are in direct provision, people from lower income areas, or rural areas where the services might not be rolled out as easily, people from travelling communities… I will continue to help fight and push for a service that catches everybody, that is gender affirming for those who need it, that is inclusive of all walks of society and will help everybody. And it will take the BPAS line, 'as early as possible, as late as necessary'. We will help everybody who needs abortion healthcare, for as long as they need it and in as many ways as we can, whether that's making sure there's childcare, whether that's making sure that there's a counsellor there to talk to someone afterwards if they need it, and to provide ongoing support.
>
> There's not a one size fits all, it's not an umbrella catchment. I think for an awful lot of those groups, there is healthy, reasonable and understandable mistrust of the state, for various different reasons. Like for trans folks, it's an incredibly long list of reasons that you're not 'acceptable' to the state, and that you can't be trusted to make your own decisions about any of your healthcare. For people in direct provision, it's knowing that you're under constant surveillance and anything can be used to send you back, for people from travelling communities, there is centuries worth of mistrust, and rightly so. Every group has different reasons, and different needs to be met and different things that they require. And I am by no means able to, nor or would I, speak for anyone on their behalf. I would say as a trans person, as a non-binary person, I have friends who are trans men or masculine presenting and who have had abortions. You know, they're five years down the line on testosterone. They've got big beards, voices that are incredibly deep, and they've walked in, and are misgendered the entire time because that's the model that healthcare workers have to operate under. Outside of an already incredibly traumatic experience for various reasons. Like, you know, finding yourself as a man, and being, in a position where you're pregnant unexpectedly, having to then go in, and being misgendered throughout the whole experience, it is incredibly traumatising. So I know that gender-affirming care has to be something that's looked into.
>
> Listen to the people here on the ground. Listen to the people who've been doing this day in and day out for years. Listen to the people who have had to fight the hardest to get their voice heard, because they know what is needed. Listen to the people who've experienced it. Don't sit there listening to old men in suits who haven't had to deal with this on a first-hand level. And make a system that helps everybody, because when you help the most marginalised and the most excluded in our society, everybody benefits.
>
> Listen. That's my advice. That would be my recommendation.[204]

### Human rights standards on the right to sexual and reproductive health facilities, goods and services, including abortion services

- States must ensure that sexual and reproductive healthcare facilities, goods and services are available, accessible, acceptable and of good quality. This includes:
- Ensuring an adequate number of sexual and reproductive healthcare facilities, goods and services, including the 'availability of trained medical and professional personnel and skilled providers who are trained to perform the full range of sexual and reproductive healthcare services'.[205] 'States must ensure… that such providers are equitably distributed throughout the State.'[206]
- Ensuring that healthcare and services are financially accessible[207] and 'within safe physical and geographical reach for all, so that persons in need can receive timely services and information'.[208]
- Ensuring good quality sexual and reproductive health services, 'meaning that they are evidence-based and scientifically and medically appropriate and up-to-date. This requires trained and skilled healthcare personnel and scientifically approved and unexpired drugs and equipment.'[209]

Moreover, the Committee on Economic, Social and Cultural Rights has underscored state obligations to address intersectional discrimination, noting that 'individuals belonging to particular groups may be disproportionately affected by intersectional discrimination in the context of sexual and reproductive health. As identified by the Committee, groups such as, but not limited to, poor women, persons with disabilities, migrants, indigenous or other ethnic minorities, adolescents, lesbian, gay, bisexual, transgender and intersex persons, and people living with HIV/AIDS are more likely to experience multiple discrimination… Measures to guarantee non-discrimination and substantive equality should be cognisant of and seek to overcome the often exacerbated impact that intersectional discrimination has on the realisation of the right to sexual and reproductive health.'[210]

203 Jenny Steele, co-chair, and Jess Crisp, member, Project Choice, 2 March 2023. The other co-chair of Project Choice is Thea Mawhinney.

204 Interview with Vic Young, abortion doula with Lucht Cabhrach, 13 December 2022.
205 CESCR Committee, General Comment 22, para 13. See also CESCR Committee, General Comment 14, para 12(a).
206 CESCR Committee, General Comment 22, para 46.
207 CESCR Committee, General Comment 22, para 17.
208 CESCR Committee, General Comment 22, para 16.
209 CESCR Committee, General Comment 22, para 21.
210 CESCR Committee, General Comment 22, para 30.

## 2.6 Forced to travel or opt for online care

Women, girls and other people who can get pregnant in Northern Ireland are continuing to have to travel for abortion care or opt for online abortion services. In 2021-2022, hundreds of people living in Northern Ireland received abortion services outside the Northern Ireland healthcare system.[211]

Online providers offer access to early medical abortion until 12 weeks' gestation. However, where abortion services are available locally, Women Help Women (WHW), one online provider, will refer people to those local services, as they are often faster and WHW don't have the capacity to supply pills to all who would prefer to have an abortion at home.[212] (See Katie Boyd's Experience p74.)

Alternatively, people who cannot access services locally are forced to travel. Most people from Northern Ireland are traveling after 10 weeks' gestation, when 'they're over the limit when they can access treatment at home,' says Emma May, a nurse and clinical team lead at MSI.[213]

When they call the MSI booking number, they will be booked to receive services from one of three providers in England: BPAS, MSI or National Unplanned Pregnancy Advisory Service (NUPAS). 'From what I've heard [from those traveling after 10 weeks' gestation],' says May, 'it hasn't changed a huge amount because it may be legal, but it's still incredibly hard to access the service. So, you know, people are saying it's not changed my experience, because I still can't get a termination at home. I have to travel.'[214]

She recalls:

> One girl [from Northern Ireland] came in [in early December 2022], she was up at half past three in the morning to get on a flight to come over to have treatment that day, and she was flying back that evening. And just think, that is one hell of a day, for anyone, without having [that] kind of treatment in the middle. It's just, it's mind boggling. It's just completely unfair.[215]

The need to travel can also add unnecessary stress to what may already be a very stressful situation, says May:

> I think that because it's hard to get here, it almost adds extra pressure onto their decision because they get here and they're like, I've travelled for all this way, it's cost all this money. I feel like I kind of have to go through with this. Whereas if you're living an hour down the road, it's kind of not so big of an idea if you change your mind, and you're like, I'm actually not sure, I think I might want to come back next week and think about it. It's just huge pressure on you to, you know, make that decision and make it while you're here.[216]

Travel for later term abortions can be very time-consuming and financially stressful as well. As Emma May explains, travel may entail a full three days in England:

> If they're over 18 weeks and six days, the way that we do our treatment is we bring them in the day before to give them cervical preparation before their treatment the following day. So we quite often will have people come in on a Sunday and have their first part of the treatment on the Monday, their actual treatment on the Tuesday, and then they'll fly back on the Wednesday.[217]

Although travel and treatment are currently covered by the UK government, childcare and missed workdays may still present a financial burden. May recalls a woman who recently travelled from Northern Ireland and had to arrange for childcare for her three kids and then 'obviously, she was missing work, her partner's missing work, because they were here. So they miss like, three or four days of work. So it's also that financial kind of strain on them, because they couldn't work while they were here.'[218] The need to travel to England for an abortion also perpetuates the longstanding stigma surrounding abortion care in Northern Ireland.

Moreover, there may be some people with a strong preference for a medical abortion at a later gestation, particularly for terminations for foetal impairment. Without formal pathways to care and with inconsistent local service provision in Northern Ireland, these women and their partners may be forced to travel. However, later term access to medical abortion in England can be challenging to arrange for someone travelling from Northern Ireland. A private provider, such as MSI, would offer surgical abortion after 10 weeks' gestation. However, explains Emma May of MSI, 'if they would prefer to have a medical option, then we would refer them into the NHS. The problem is we can't guarantee when or where they'd be seen because the service isn't routinely provided [within the NHS].'[219]

## 2.7 Need to train healthcare professionals in surgical abortion provision

Ensuring abortion service provision to the full extent of the law, in a setting where abortion had been nearly fully criminalised for over 150 years, requires a significant clinical and cultural shift. Medical, nursing and midwifery schools in Northern Ireland have not historically offered any clinical training on abortion care; clinics and hospitals in Northern Ireland have very limited experience with abortion service provision. As one doctor notes, this is 'the biggest thing that's happened in medicine since Northern

211 Data on the number of people who access abortions outside of Northern Ireland is incomplete and existing figures are probably underestimates. This figure (hundreds of people living in Northern Ireland) is a minimal estimate based on available data. According to the UK government, 'In 2021 there were 161 abortions for women from Northern Ireland' in England and Wales. UK Government, Office for Health Improvement and Disparities, *National Statistics: Abortion statistics, England and Wales: 2021*, 30 January 2023, gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021. At the time of publication, UK government data on abortion was not yet available for 2022, although provisional data for January-June 2022 indicates that at least 96 women from Northern Ireland came to England or Wales for an abortion during the first half of 2022: UK Government, Office for Health Improvement and Disparities, *Official Statistics: Abortion statistics for England and Wales: January to June 2022*, 22 June 2023, gov.uk/government/statistics/abortion-statistics-for-england-and-wales-january-to-june-2022/abortion-statistics-for-england-and-wales-january-to-june-2022. Data on the total number of abortions through pills obtained online is not accessible; however, one web-based telemedicine provider, Women Help Women, reports that 228 people from Northern Ireland accessed abortion pills through their website in 2021-22. Data obtained from Women Help Women and on file with Amnesty International UK.

212 Interview with Women Help Women, 4 October 2022.

213 Interview with Emma May, registered nurse-clinical team lead, MSI Reproductive Choices, 9 December 2022.

214 Interview with Emma May, registered nurse-clinical team lead, MSI Reproductive Choices, 9 December 2022.

215 Interview with Emma May, registered nurse-clinical team lead, MSI Reproductive Choices, 9 December 2022.

216 Interview with Emma May, registered nurse-clinical team lead, MSI Reproductive Choices, 9 December 2022.

217 Interview with Emma May, registered nurse-clinical team lead, MSI Reproductive Choices, 9 December 2022.

218 Interview with Emma May, registered nurse-clinical team lead, MSI Reproductive Choices, 9 December 2022.

219 Interview with Emma May, registered nurse-clinical team lead, MSI Reproductive Choices, 9 December 2022.

Ireland came into being 100 years ago'.[220] One critical clinical need is for healthcare professionals to be trained to provide surgical abortion services. There is also a need for entirely new models of care. All of this requires robust commissioning and a sustained commitment to implementation.

### 2.7.1 Training on vacuum aspiration for abortion

In addition to medical management of abortion at all stages of pregnancy, the WHO and RCOG recommend two methods of surgical abortion. The first is the use of vacuum aspiration (electric or manual) until 14 weeks pregnancy.[221] The WHO notes that it 'can be performed in a primary care facility and on an outpatient basis'[222] and that medical practitioners, nurses and midwives can all safely and effectively provide this service.[223]

Although some nurses, midwives and medical practitioners are trained in manual vacuum aspiration (MVA) for medical management of miscarriage, and the skills are effectively the same as for abortion, MVA for abortion has not historically been part of the curriculum in Northern Ireland due to the previously restrictive abortion law. Dr Hans Nagar, Northern Ireland representative for RCOG, notes, 'That was a concern of mine, because most of the doctors that have been trained have not been involved in abortion care. Many of the consultants, because they've been trained in Northern Ireland, have never been exposed to abortion. So I think that's an important issue. But the transferable skills of MVA for miscarriage and MVA for abortion are very, very similar. Same techniques.'[224]

Trusts were initially hesitant to offer MVA services for abortion without the commissioning of abortion services.[225] Since commissioning, in December 2022, there has been some movement. A handful of providers from Northern Ireland have travelled to England to be trained on MVA for abortion.[226] However, only two (Belfast and Northern Trusts) of the five trusts have begun to offer MVA services, and both of these trusts are reliant on a single healthcare provider to maintain the service.[227] The Belfast Trust halted MVA service provision in June 2023, shortly after it began, due to staffing constraints; as of August 2023, the Belfast Trust's service remains suspended.[228]More trained providers are needed to ensure that the service is sustainable.

In one trust, they have faced challenges in finding a location to provide the MVA service that healthcare workers feel comfortable with, and there have been concerns about those who object to having to work alongside an MVA abortion service. At the same time, there is a desire to integrate the service, rather than keep it separate and perhaps have it operate only on certain days, thereby exceptionalising it and making it more of a target for anti-abortion activists.[229] (See Chapter 6.)

In another trust, providers have expressed willingness to offer MVA services, and some are already trained to carry out MVAs, but they have been slow in getting them off the ground since commissioning, including because of the challenges of finding locations and the amount of time it takes to hire new staff. One doctor notes: 'Of course, we could have had an MVA service up and running,' but providers need support to be able to set it up:

> [A few providers] can all carry out MVAs and are willing to carry out MVAs. Again, for different reasons, it comes down to support from our senior management. We've had no funding, we have no extra staff, we don't really have a decent location for it. For the job posts open now, they still haven't shortlisted and haven't interviewed and haven't appointed. So how can they expect us to run a service? When they haven't given us the staff nor the funding to provide this?[230]

### 2.7.2 Later term surgical abortion training: stigma as barrier

A common second trimester method of surgical abortion recommended by the WHO and RCOG is dilatation and evacuation.[231] To date, surgical abortion services after 12 weeks' gestation, although commissioned by the DOH, have not yet been instituted in Northern Ireland.[232]

With institutional support and funding through the trusts, healthcare providers could travel to England for a dedicated period to obtain the necessary surgical training for dilatation and evacuation. Dr Patricia Lohr, medical director at British Pregnancy Advisory Service (BPAS) in England, which has clinics in England and Wales, facilitates this training, and observes:

> If there are enough training sites, a willingness to commission and a willingness to provide and they can get first trimester and early second trimester services established, say to approximately 16-17 weeks, that would make a big difference. Few abortions are happening later in pregnancy, and it takes longer to acquire those skills, but they can be developed with enough dedicated time.[233]

But, explains Dr Lohr, 'You have to have more than just the doctors skilled to do the procedure; the whole surrounding team needs to be on board with delivering the service. And that's a challenge with second trimester abortion and, in particular, second trimester surgical abortion.'[234] Stigma was seen by a number of interviewees as a particular barrier to later term surgical abortion provision.

220 Interview with a healthcare provider, 28 September 2022.
221 WHO, Abortion Care Guideline (2022) p63; RCOG, The Care of Women Requesting Induced Abortion: Evidence-Based Clinical Guideline Number 7 (November 2011), pp59-60, rcog.org.uk/media/nwcjrf0o/abortion-guideline_web_1.pdf.
222 WHO, Abortion Care Guideline (2022) p64.
223 WHO, Abortion Care Guideline (2022) p64.
224 Interview with Hans Nagar, NI representative, RCOG, 2 February 2023.
225 Interview with a healthcare provider, 13 September 2022.
226 Interview with a healthcare provider, 30 January 2023; interview with a healthcare provider, 26 April 2023; interview with a healthcare provider, 5 May 2023; interview with a healthcare provider, 7 February 2023; interview with a healthcare provider, 9 May 2023.
227 Interview with a healthcare provider, 26 April 2023; interview with a healthcare provider, 5 May 2023.
228 Interview with a healthcare provider, 14 August 2023.
229 Interview with a healthcare provider, 7 February 2023.
230 Interview with a healthcare provider, 30 January 2023.
231 WHO, Abortion Care Guideline (2022) p66; RCOG, The Care of Women Requesting Induced Abortion: Evidence-Based Clinical Guideline Number 7 (November 2011), p63.
232 Interview with the director of secondary care and the head of abortion policy, Department of Health, 2 March 2023.
233 Interview with Dr Patricia Lohr, medical director, BPAS, 8 December 2022.
234 Interview with Dr Patricia Lohr, medical director, BPAS, 8 December 2022.

Dr Lohr observes that, with surgical abortion:

> The problem of stigma is present here [in England], but we have established services which are both within and outside of hospitals which helps ensure women can get the care they need even in later pregnancy. I would imagine stigma will be very powerful there [in Northern Ireland] in the early stages of development. We can't underestimate how difficult it is for people working in mainstream obstetrics and gynaecology in a hospital to provide abortions. They often become marginalised, or they worry, and rightly so, that they might be the only person in the department who does this, if there isn't institutional support.[235]

In addition to obstetrician-gynaecologists, theatre teams – anaesthesiologists, nurses, and other providers – will need appropriate clinical training. However, equally as important, trust management will also need to foster team-wide conversations, lead values clarification sessions[236] and ensure they understand their employees' position on participation in abortion service provision (See Chapter 4.) Trust management will need to address and unpack the stigma around later term surgical abortion.

It is unclear how many providers, at present, would be willing to offer these services. One study, undertaken in 2019-2020, just prior to the Abortion Regulations coming into force, surveyed over 300 healthcare professionals in Northern Ireland and found that:

> There is a willingness amongst obstetricians and gynaecologists, anaesthetists and theatre nurses to participate in surgical abortion in certain circumstances. This suggests favourable conditions for the development and implementation of a surgical abortion service within Northern Ireland… despite regional variation, the results indicate that there are sufficient numbers of clinicians to provide a service within each HSC Trust.[237]

Dr Roberts notes, 'It's a logistical issue. I don't think it's a barrier, because I think that our surveys have informed us that there are enough people who are willing, but it means that those logistics have to be thought out carefully.'[238] So far, however, Trust management do not seem to have approached human resource service planning for surgical provision in a systematic or transparent way.

Dr Roberts emphasised the need to make sure that there is a vision of how services will work and how people will fit into the services. When asked why these conversations are not happening, Dr Roberts ventures: 'I suspect that stigma is an element of it.'[239]

235 Interview with Dr Patricia Lohr, medical director, BPAS, 8 December 2022.

236 'Abortion values clarification and attitude transformation workshops are conducted with abortion providers, trainers, and policymakers and other stakeholders to mitigate the effects of abortion stigma and increase provision of and access to abortion care.' Turner, K.L., Pearson, E., George, A. et al, 'Values clarification workshops to improve abortion knowledge, attitudes and intentions: a pre-post assessment in 12 countries', *Reproductive Health* 15, 40 (2018).

237 Bloomer F, Kavanagh J, Morgan L, et al, 'Abortion provision in Northern Ireland: the views of health professionals working in obstetrics and gynaecology units', *BMJ Sexual & Reproductive Health* 2022;48:35-40, srh.bmj.com/content/48/1/35.long

238 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.

239 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.



## 2.8 Need to integrate abortion into pre-service training

Abortion stigma needs to be addressed pre-service as well, in undergraduate education, including in medical and nursing and midwifery schools. Dr Lohr explains:

> They need to start with health professionals and training at very early stages, teaching them about the importance of abortion in women's lives, that it is part of the spectrum of reproductive healthcare, the frequency with which it occurs, and the public health implications of not having abortion available. During the pandemic, when people could not travel, some were driven to suicide when they had pregnancies that they couldn't continue for whatever reason. These days, we might not have septic wards anymore, filled with people who have had unsafe abortions, but harm occurs in other ways when abortion is restricted. Early education is essential and then that needs to carry through to post-graduate training, not only for doctors, nurses and midwives who will directly provide abortions, but those other healthcare professionals who may encounter women who have had or will need an abortion.[240]

Amnesty International's interviews reveal that education on abortion for healthcare professionals has not changed substantially since law reform and is far from robust. At present, the medical school curriculum for obstetrics and gynaecology placement during fourth year at Queen's University includes a single lecture on ethics that discusses abortion, an interactive session on unplanned pregnancy discussing legal aspects and management, and some information on the management of pregnancy testing and unplanned pregnancy in sexual and reproductive health. However, there are plans to adopt RCOG's more comprehensive abortion curriculum beginning in September 2023.[241]

Likewise, Karen Murray, the Royal College of Midwives' Northern Ireland director, observes:

> I wouldn't say there has been change, you know, because I worked in Queen's [University], we always did teaching around abortion. I know when I was there, we looked at it from the point of view of an ethical moral issue at that stage, because obviously, when I was teaching, we didn't have the [2020 Abortion] Regulation… That teaching, my understanding is, still goes on. But there probably hasn't been much addition to that. Because you know, what are you adding in? Because you haven't got the guidance, you haven't got the pathways. So you're sort of stuck in what you can teach. You can teach the regulations.[242]

## 2.9 Lack of comprehensive abortion services impacts pregnancy care

The Department of Health's failure to ensure the full roll out of commissioned abortion services, and to ensure that healthcare providers are adequately trained in abortion provision, has repercussions beyond abortion care. When healthcare professionals have such a significant gap in their training, this negatively impacts the quality of care

240 Interview with Dr Patricia Lohr, medical director, BPAS, 8 December 2022.

241 Interview with Dr Janitha Costa, clinical senior lecturer/consultant obstetrician, Centre for Medical Education, Queens University Belfast, 20 January 2023.

242 Interview with Karen Murray, Northern Ireland director, RCM, 27 September 2022.

that is provided during pregnancy and can have serious consequences for the health of women and girls and other people who can get pregnant.

Dr Cairns, a GP, observes that the lack of training on essential procedures and care, 'Restricts people's choices not just about ending pregnancies but about pregnancies that have ended and how these are managed… If you're not trained to provide abortions, you're not trained fully to manage complicated miscarriages well, either.'[243]

Conversely, introducing the broader spectrum of sexual and reproductive healthcare, can improve care for all. For example, explains Dr Lohr of BPAS:

> If you need to have an evacuation of the uterus rapidly for some other reason [than abortion], like preterm premature rupture of membranes in the setting of infection, you don't want to be messing about with a lengthy medical induction, you want to get the uterus emptied, because otherwise people can become septic. When you start having those skills to do a uterine evacuation surgically, it means you can then apply those in other settings. So there is an opportunity to improve obstetric care by training providers in surgical abortion care.[244]

## 2.10 Need for improved pathways for late term medical abortions

Later term medical abortions on foetal impairment grounds are not a new service in Northern Ireland. These procedures were sporadically performed in Northern Ireland prior to law reform. However, they were done in a context of criminalisation and uncertainty, in a largely ad hoc manner, rather than as part of an intentional approach to service provision and clinical education.[245]

Suzie Heaney, a midwife and ARC Northern Ireland representative notes: 'I suppose we haven't approached this from a structural point of view before, you know, even from my midwifery training, it was very minimal what you were taught about foetal anomaly or foetal anomaly diagnosis, because there was nothing really that would have been done, you know, there was no right [to abortion], there's no pathway around it.'[246]

To ensure that all people in Northern Ireland can obtain these services locally, healthcare providers will need training on later term medical abortion and feticide. Currently, there are a limited number of doctors in Northern Ireland that are trained and can offer this service; very few doctors in Northern Ireland are currently trained in feticide, a procedure undertaken before delivery during a termination of pregnancy, which the Royal College of Obstetricians and Gynaecologists recommends for medical abortion after 21+6 weeks' [21 weeks, six days] gestation.[247] The DOH has advised Amnesty International that, 'Given the specialist skills required, a feticide service is only available in one trust. It is however a regional service and all women and girls, regardless of where they live or where they have booked for care, can access this regional service.'[248]

243 Interview with Dr Katie Cairns, general practitioner, 13 December 2022.
244 Interview with Dr Patricia Lohr, medical director, BPAS, 8 December 2022.
245 See Amnesty International, *Northern Ireland: Barriers to Accessing Abortion Services* (2015) EUR 45/1057/2015, pp29, 38-39, amnesty.org/en/documents/eur45/1057/2015/en/
246 Interview with Suzie Heaney, midwife and ARC coordinator NI, 14 December 2022.
247 RCOG, The Care of Women Requesting Induced Abortion: Evidence-Based Clinical Guideline Number 7 (November 2011) p12.
248 Correspondence with the assistant director, commissioning lead (Northern Area), Department of Health, 16 March 2023 (on file with Amnesty International UK).



There is also the need for a new pathway of care to provide quality services to people undergoing terminations for medical reasons (TFMR), as these are typically wanted pregnancies in which women and their partners have a distinct set of clinical care and support needs. Suzie Heaney of ARC, who carried out the Bluebell Study in 2020 exploring the healthcare experiences and needs of parents who have a TFMR in Ireland and Northern Ireland, recalls:

> Some healthcare staff that took part in my study had trained in England, and they came back here and they said it was so different in an established service, it was just kind of part of your job. And the parents that travelled to England, they said it felt so different in England. There was no shame. There was this openness from the staff of: this is the service we provide. They were very comfortable with it. And we definitely don't have that here.[249]

Quality services include: appropriate communication; non-judgmental counselling; ensuring patient privacy and a distinct care unit, separate from other maternity services; appropriate aftercare; and bereavement support and counselling, when requested. Suzie Heaney, from ARC, underscores that 'Specifically for TFMR, I definitely think midwives are well positioned to support this pathway of care.'[250]

Emma,* who had a termination for medical reasons in 2022, reflects on the impact the failure to enact these structural changes has on a person who is going through this experience. As she waited to undergo a prenatal test (amniocentesis):

> The problem is that that room is right next door and connected to the scanning room. So that day, for two hours, we listened to other women having their 20 weeks scans and their babies' heartbeats being played. And you know, 'it's a boy' or 'it's a girl' or you know, whatever their news was. It was a whole different level of horror. And I'm convinced the staff aren't aware of perhaps how loud it is when you're sitting in total silence.[251]

And then, right before the termination of pregnancy:

> … back to listening to the scans next door and having to sit there and wait because they have to bring a second doctor down to sign all the legal documentation and have my tablet that day. And all of this is being serviced while there's a maternity clinic going on.[252]

Staffing and resource constraints have prevented the strengthening of this service. In 2021, the Foetal Medicine Unit at the Royal Jubilee Maternity Hospital, severely understaffed with respect to both midwives and medical practitioners, was highlighted as an at-risk service to the Department of Health and in danger of collapsing. Struggling with the workload, providers referred patients to Dublin and London and the unit could not afford the time to give leave to providers to obtain needed training in England.[253]

249 Interview with Suzie Heaney, midwife and ARC coordinator NI, 14 December 2022.
250 Interview with Suzie Heaney, midwife and ARC coordinator NI, 14 December 2022.
251 Interview with Emma (name has been changed), 12 January 2023.
252 Interview with Emma (name has been changed), 12 January 2023.
253 Interview with Dr Carolyn Bailie, obstetrician and fetal medicine consultant, Belfast Trust, 14 December 2022.

One factor that has placed added pressure on the Royal's Foetal Medicine Unit and their ability to provide abortions is the lack of first trimester pregnancy screening in Northern Ireland. Introducing this screening, which is provided throughout the rest of the United Kingdom, 'would take a lot of the pressure off. Having first trimester screening in Northern Ireland would significantly reduce the number of later abortions and would give women much more time to make these difficult decisions,' says foetal medicine consultant Dr Carolyn Bailie.[254] (See inset on Anti-Abortion Antenatal Screening Practices, below.)

**Emma's* experience, September 2022**[255]
So I was 19 and a half weeks, I think, for my big scan. Up to this point, I'd had really limited contact with the hospital and had one appointment, one scan, everything was very quick. I had a student midwife that day, when I was 12 weeks. And so far, I would say we probably weren't really delighted about this level of service. But with the hangover from Covid, we just assumed that everything was still getting back on its feet. So we went for the 19 week scan. And she was really thorough, and we could tell she was being really, really thorough.

The sonographer who was conducting our ultrasound scan said, 'There is one thing that is concerning. It may be nothing, but…' And that was the first that we knew anything was wrong. She ushered us out to another midwife, and into the room next door, and I think we were in total shock. And at the time, everyone was wearing masks. So it was really hard to read facial expressions, like, is she concerned? How concerned are they? Is this normal? Is it a minor thing that they just have to run a few tests on? And they ushered us into the room next door with another midwife. And this other midwife, she looked really nervous. And she kept saying things like, 'I know, this must be a big shock, too.' And I was thinking, well, yes, it's a big shock. But you haven't told me what the problem is.

I don't think it was about them not having time. For me, it almost felt with hindsight as though they feel it's not their place. They feel it's the place of a consultant to tell you what the potential outcomes are. But she said to me in the meantime, 'Do not Google this.' I remember really clearly saying to her, 'I can tell you with absolute certainty that I'm going to be Googling this.' And she went 'Well, please try not to.' I said, 'Well, you know, you haven't given me anything here.' So no condition was mentioned to me. Absolutely none.

I'm in a lot of online forums, and you know, I speak to a lot of other women. And a lot of them are much earlier in their pregnancy when they find out because, in England, for example, they screen at your dating scan at 11 and 12 weeks. And when I found this out, I couldn't believe it. I didn't know that there wasn't screening when it's your first baby. And I know that seems totally ridiculous.

And so when I found this out, and I went to [the midwife] and I said, 'Was this not checked at my 12 week scan?' She said she was as frustrated as I was. She said 'No.' And I asked 'Why are we not doing this?' And she couldn't really give me an answer, but I was feeling she was intimating to me that it was because, prior to a couple of years ago, there were no options, so it didn't matter to them because they weren't going to offer you anything after that.

I feel like if I was told at 12 or 13 weeks, that the decision making would have been much less complicated and conflicted because, by the time I knew, my baby was already kicking. I had a bump, I was big, and my baby was moving a lot, kicking a lot. And I feel like that makes it so complicated.

We went on the following Thursday morning to see the doctor. [After this appointment, I opted to] do the amnio [additional prenatal testing]. Results were back by the Tuesday the following week. At this stage I was over 21 weeks. [The midwife explained,] if we wait until you're 22 weeks, then you will need to go to England, and have feticide. I assumed that meant I had to go to England and deliver the baby there. And I thought this was horrific. The idea of this for me was awful. On both levels, the feticide, and also the idea of being far from home, potentially, in a hotel, depending on where I had to go.

So that created a massive panic. And we've been at that stage. I think we had all but decided anyway. So I was caught just in time to be able to have the service in Northern Ireland. So I was 21 plus five when I went in. So that was the Wednesday, we had made the decision on Thursday.

I didn't realise – I got a lot of information that I didn't have back then – I didn't realise that had I been at the Royal I wouldn't have waited a week to see a consultant, potentially, because they run clinics every day, whereas the Ulster only run them on a Thursday. But I didn't know any of that then.

I knew I was going to have to at least tell somebody in Northern Ireland who is running the screening services, or decides the protocols, I knew I had to tell them at some stage or another the impact that not having screening the way that they do in England is having. I know that it's a new service in Northern Ireland. But that's not to say women haven't been going to England for years, because we know they have, right.

And so for me that that's the one thing, I did say, when I have the mental capacity for this – I don't have the capacity mentally to do that right now, I am going to need some time to deal with my own thing, before I can fight for everybody else – but I need to confront the lack of screening in Northern Ireland to bring us into line, at least, with England.

254 Interview with Dr Carolyn Bailie, obstetrician and fetal medicine consultant, Belfast Trust, 14 December 2022.
255 Interview with Emma (name has been changed), 12 January 2023.

## Anti-abortion antenatal screening practices

Unlike the rest of the UK,[256] which follows the UK National Screening Committee's recommendations,[257] Northern Ireland, because of its previously highly restrictive abortion law, does not offer routine first trimester screening for foetal anomalies during pregnancy.[258] Advocates in Northern Ireland have been raising this denial of parity of access to antenatal tests, as compared to Britain, for decades, including as an issue of the right to information.[259]

Pregnant people in England, Wales and Scotland are offered a combined test, which entails a blood test and ultrasound, typically between 10-14 weeks pregnancy, with the option of an additional blood test, or non-invasive prenatal screening test (NIPT), should the combined screening indicate a higher chance of a foetal anomaly. If appropriate, a person would then be offered diagnostic tests. These tests are offered by NHS, as part of routine antenatal care.

In contrast, women and girls and other people who can get pregnant in Northern Ireland are not offered any routine screening for foetal anomalies in the first trimester. However, NIPT is available in the private sector,[260] where it can cost anywhere from £350-500, which is prohibitively expensive for many. Dr Katie Cairns notes that it's largely 'upper middle-class women' that can afford the test.[261] Suzie Heaney of ARC explains: 'I think there is an increasing uptake of it but it's not kind of standard.' And, if you do choose to get NIPT privately, 'there's no link back into the NHS system. So you have these results. And then you have to go find, what do I do with these results?'[262]

Instead, says Heaney, 'for a lot of people, it's usually more likely the 20-week scan, or the anomaly or the anatomy scan, that they find out that there's something wrong. And I suppose that's kind of the inequity of they're finding out a lot later in the second trimester, whereas someone in England, Scotland and Wales might find out about a condition at 13 weeks compared to 21 weeks.'[263]

Moreover, specific types of screening in the second trimester appear to be ad hoc by trust. For example, Amnesty International was informed that trusts offer the quadruple test, but to varying degrees – for free, for a fee, or if a person meets certain criteria, such as age or history of foetal anomaly diagnosis. However, the NIDirect government website says that the quadruple test, as with NIPT, is one of the 'private tests which need to be self-funded'.[264] Rather than a Northern Ireland-wide screening pathway of care, access to screening – as with access to abortion services – is dependent on where you happen to live. Suzie Heaney of ARC remarks: 'For such a small region, we are a complete postcode lottery in terms of care options and the care provided.'[265]

The longstanding failure to implement the UK National Screening Committee recommendations in Northern Ireland is intentional. The goal is to prevent access to information that might allow a pregnant person time to evaluate their options, including abortion. Suzie Heaney of ARC observes that 'there has been a real inequity of information.'[266] One doctor explains:

> I mean, when the rest of the UK introduced nuchal translucency screening [an ultrasound that screens for Down's syndrome], there was a hard push to try and get that introduced in Northern Ireland. But you know what the political scene has been like here with regards to abortion. So people didn't want to introduce that. Because that would be, you know, creating more cases where women will discover early they might have a pregnancy that they don't want to continue. So it was likely to increase the numbers of women seeking abortion. Whereas, you know, if you're getting a diagnosis at 22 weeks, women are less likely at that stage to proceed with an abortion. So I am sure lack of screening was all about abortion.[267]

The lack of screening contravenes health standards and has significant repercussions for women's rights to personal autonomy and health. Women and girls and other people who can get pregnant are learning about potential concerns with their pregnancy much later than necessary. They are then under greater time pressure and stress to process this information and decide whether to continue with the pregnancy. Those who do choose an abortion face greater health risks and the prospect of services being unavailable in Northern Ireland and of needing to travel and obtain services, which further delays their care.

Heaney says of the people she works with who have received a foetal impairment diagnosis:

> I will say most would prefer earlier screening. And most parents would say it would have been a very different, possibly easier, possibly not, experience at 14 weeks than it was at 22 weeks. But then equally, some parents have said, you know, I am glad that I had bonded with the baby more… So, everyone's different. And it's all about choice, and autonomy and empowerment.[268]

Dr Bailie explains, 'It is intense. The fact that we don't have first trimester screening means that most women are 20 weeks before we see them. It's created a lot of pressure, doing investigations and getting results, which can take two weeks, getting as much information for the woman as possible. So there's not much time and some women are having to make their decisions quickly.'

256 NHS, Screening tests in pregnancy nhs.uk/pregnancy/your-pregnancy-care/screening-tests/
257 UK National Screening Committee, UK NSC Recommendations view-health-screening-recommendations.service.gov.uk/?name=&affects=antenatal&screen=yes
258 HSC Public Health Agency, Antenatal screening publichealth.hscni.net/directorate-public-health/service-development-and-screening/antenatal-screening
259 Fiona Bloomer and Emma Campbell, eds, *Decriminalizing Abortion in Northern Ireland* (2022) p120 (noting that one of the five main issues considered during the 1987 International Tribunal on Abortion, organised by the Northern Ireland Abortion Law Reform Association, was that 'certain antenatal tests, which are commonly available in Britain, are not routinely offered to women in NI').
260 NIDirect, Tests to find abnormalities or chromosomal conditions nidirect.gov.uk/articles/tests-find-abnormalities-or-chromosomal-conditions#toc-1
261 Interview with Dr Katie Cairns, general practitioner, 13 December 2022.
262 Interview with Suzie Heaney, midwife and ARC coordinator NI, 14 December 2022.
263 Interview with Suzie Heaney, midwife and ARC coordinator NI, 14 December 2022.
264 NIDirect, Tests to find abnormalities or chromosomal conditions nidirect.gov.uk/articles/tests-find-abnormalities-or-chromosomal-conditions#toc-1
265 Interview with Suzie Heaney, midwife and ARC coordinator NI, 14 December 2022.
266 Interview with Suzie Heaney, midwife and ARC coordinator NI, 14 December 2022.
267 Interview with a healthcare provider, 14 December 2022.
268 Interview with Suzie Heaney, midwife and ARC coordinator NI, 14 December 2022.

And with the Department of Foetal Medicine overstretched in the past few years, having pregnant people present at 20-21 weeks, 'who need investigations and we perhaps can't see them for another five days. It's resulting in more women in NI needing later abortions compared to the rest of the UK. First trimester screening would help so much,' explains Dr Bailie.[269]

Later term abortions are also medically more complex and may pose more risk to a person's health than having an abortion at an earlier gestation. Earlier access to abortion services is always preferable from a health perspective. Says Dr Bailie:

> We've been highlighting the need for first trimester screening. It's better and safer for a woman to be able to have an abortion at 14 weeks as compared to almost 24 weeks. It also makes it equitable with the rest of the UK, because at the moment it's not.[270]

When asked about plans to introduce these screening recommendations as part of the commissioning of abortion services, the DOH replied that it was not within the service specification for commissioning. Instead, they explained that this is a policy decision that needed to be taken by the Minister of Health. However, they did clarify that the Northern Ireland Screening Committee 'have endorsed and recommended that first trimester screening should be introduced for Northern Ireland. It's just that nobody is authorised to, at the minute, in the absence of a Minister, to progress that. So the status of it is: pending policy or ministerial decision.'[271]

### Human rights standards on implementation of abortion laws

The European Court of Human Rights has consistently found the state failure to implement existing abortion laws, and barriers to accessing abortion, to be violations of the European Convention on Human Rights.[272] In a 2007 case concerning a woman who had been denied effective access to lawful abortion services in Poland, the European Court of Human Rights stated: 'Once the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it.'[273]

In *R.R. v. Poland*, a case concerning the state's failure to guarantee a woman access to timely prenatal diagnostic examinations and information that were a 'necessary prerequisite'[274] for determining whether to exercise her right to abortion, the European Court found the state had violated her rights to freedom from inhuman and degrading treatment and respect for her private life. In assessing the case, the Court noted that 'it should be borne in mind that the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective'.[275] The Court concluded:

269 Interview with Dr Carolyn Bailie, obstetrician and fetal medicine consultant, Belfast Trust, 14 December 2022.
270 Interview with Dr Carolyn Bailie, obstetrician and fetal medicine consultant, Belfast Trust, 14 December 2022.
271 Interview with the director of secondary care, Department of Health, 2 March 2023.
272 *Tysiac v Poland*, European Court of Human Rights (App No. 5410/03) (2007); *R.R. v Poland*, European Court of Human Rights (App. No. 27617/04) (2011); *P. and S. v Poland*, European Court of Human Rights (App No. 5735/08) (2012); *A.B.C. v Ireland*, European Court of Human Rights (App No. 25579/05) (2010).
273 *Tysiac v Poland*, European Court of Human Rights (App No. 5410/03) (2007), para 116.
274 *R.R. v Poland*, (App No. 27617/04) (2011), para 199.
275 *R.R. v Poland*, (App No. 27617/04) (2011), para 191.



> The State is under a positive obligation to create a procedural framework enabling a pregnant woman to exercise her right of access to lawful abortion… In other words, if the domestic law allows for abortion in cases of foetal malformation, there must be an adequate legal and procedural framework to guarantee that relevant, full and reliable information on the foetus' health is available to pregnant women.[276]

Moreover, in a 2004 decision that was issued much before abortion law reform, the Court of Appeal in Northern Ireland held[277] that the Northern Ireland Department of Health has an affirmative duty to ensure the provision of adequate abortion services[278] and provide 'adequate guidance'[279] to clinicians on the abortion law in Northern Ireland, so that women and girls and other people who can get pregnant can access abortion services to which they are legally entitled.

In his opinion, which remains strikingly relevant nearly 20 years later, Judge Campbell concluded:

> The cumulative effect of the evidence is to demonstrate a failure to provide the breadth of service that is appropriate. It is not a case of providing no service. The statement made on behalf of the Department that it sees no need to investigate whether women in Northern Ireland are receiving 'satisfactory' services in respect of actual or potential terminations because all lawful terminations will be provided if required, shows a failure to appreciate that simply to provide lawful abortions without more is insufficient. The attitude that it has been adopted makes it difficult to conclude that the Department is doing its 'best'. On the contrary, the Department has created the impression that it has distanced itself from this service and is leaving it to others such as the medical profession and the appellant [the Family Planning Association of NI] (which it helps to fund) to see that a service is provided, even though the appellant as one of these providers has made it plain that the service is inadequate. The very considerable degree of latitude given to the Department does not mean that it can decline even to inform itself if there is a need for services that is not being met.[280]

276 *R.R. v Poland*, (App No. 27617/04) (2011), para 200.
277 *Family Planning Association of Northern Ireland v Minister for Health, Social Services and Public Safety* [2004] NICA 37 (8 October 2004); *Family Planning Association of Northern Ireland v Minister for Health, Social Services and Public Safety* [2004] NICA 38 (8 October 2004); *Family Planning Association of Northern Ireland v Minister for Health, Social Services and Public Safety* [2004] NICA 39 (8 October 2004).
278 *Family Planning Association of Northern Ireland v Minister for Health, Social Services and Public Safety* [2004] NICA 38 (8 October 2004) at para 48.
279 *Family Planning Association of Northern Ireland v Minister for Health, Social Services and Public Safety* [2004] NICA 39 (8 October 2004), para 92.
280 *Family Planning Association of Northern Ireland v Minister for Health, Social Services and Public Safety* [2004] NICA 38 (8 October 2004) at para 48. judiciaryni.uk/sites/judiciary/files/decisions/Family%20Planning%20Association%20of%20NI%20v%20Minister%20for%20Health%20Social%20Services%20and%20Public%20Safety%20NICA%2038.pdf

# 3. Provider-initiated early medical abortion services under significant pressure: understaffed and under-resourced

At the time of publication, each of the five trusts in Northern Ireland provides an early medical abortion (EMA) service. These services were established by a small group of motivated providers shortly after the 2020 regulations came into effect, although not all of them have operated continuously since that time. Depending on the trust, clinics may operate anywhere from one to four days a week, typically in a single location, often reliant upon one or two providers per trust, with some trusts also having support from additional medical professionals. As of August 2023, four of the trusts provide services until nine weeks six days gestation; one trust, the Northern Trust, offers EMA services until 11 weeks six days gestation. Services are overstretched and hard-pressed to keep up with demand, which has increased in the past year.[281] Despite the long-awaited commissioning of abortion services in December 2022, these services remain fragile.[282]

## 3.1 No government support after legalisation: services established by dedicated providers

Although the Northern Ireland Department of Health was tasked with ensuring abortion service provision after law reform, the then health minister had not done so by the date the Abortion Regulations came into force on 31 March 2020. The Minister of Health's plan was to allow 'things to continue as they were,' in the opinion of one healthcare professional who provides EMA services,[283] with the safety valve of women continuing to travel to England for abortion services. But then the Covid-19 pandemic lockdown began, effectively cutting off access to healthcare services outside of Northern Ireland.

This had immediate repercussions for people who needed abortions – a time-sensitive treatment.[284] That same EMA provider recalls:

> When lockdown happened, two ladies attended the accident and emergency department in Antrim hospital with self-harm [attempted suicide], because they had had arrangements made to travel for termination of pregnancy, and then flights were all cancelled, and ferries were all cancelled. These women were being told, 'Well, there's an arrangement in place, you can travel to England for your termination.' And they couldn't.

281 Interview with a healthcare provider, 3 May 2023; interview with a healthcare provider, 26 April 2023; interview with a healthcare provider, 5 May 2023; interview with a healthcare provider, 9 May 2023; interview with a healthcare provider, 14 August 2023; interview with a healthcare provider, 15 August 2023; interview with a healthcare provider, 15 August 2023; interview with a healthcare provider, 25 August 2023.

282 Interview with a healthcare provider, 26 April 2023; interview with a healthcare provider, 3 May 2023; interview with a healthcare provider, 3 May 2023; interview with a healthcare provider, 9 May 2023; interview with a healthcare provider, 14 August 2023; interview with a healthcare provider, 16 August 2023.

283 Interview with a healthcare provider, 30 September 2022.

284 Amnesty International UK, press release: Northern Ireland: Abortion regulations fail to protect women during Covid-19 crisis, 25 March 2020, amnesty.org.uk/press-releases/northern-ireland-abortion-regulations-fail-protect-women-during-covid-19-crisis.



> And also we felt at that time, with the pandemic, how is it morally right, even when ferries – the freight [cargo] ferries then started up again for goods – they said well these ladies can go, you know. And we said, how is it right to put ladies from Northern Ireland at risk of contracting Covid because they have to travel for something that's their legal right now to have? Never mind the sort of moral and ethical side of it. And we sort of thought about it and felt, well, that was kind of going against our Hippocratic Oath, you know, to do no harm. By not providing the EMA here [in Northern Ireland] we felt we were doing harm to these women.[285]

A handful of healthcare providers committed themselves to providing services locally. Under the auspices of The Northern Ireland Abortion and Contraception Taskgroup (NIACT), providers met and 'we decided we were going to try and set up an emergency temporary early medical abortion service in Northern Ireland… which we're still doing two and a half years later,'[286] explained one of the providers in September 2022.

With other service provision temporarily suspended due to Covid-19, these providers had the capacity to pivot and take on a new service. They worked together, pushing the trusts and the Department of Health to authorise service provision. The Department of Health, under significant pressure after news leaked of the attempted suicides, and after receiving legal advice, reluctantly granted permission to trusts to provide abortions in Northern Ireland in April 2020.[287]

### The Northern Ireland Abortion and Contraception Taskgroup (NIACT)

NIACT 'is a group of multidisciplinary professionals who have come together in response to the Abortion (Northern Ireland) Regulations 2020, to give guidance on minimising the need for abortion in Northern Ireland and achieving a compassionate and caring abortion service within the framework of the regulations.'[288] NIACT was formed in response to the complete absence of Northern Ireland Executive and, specifically, Department of Health, leadership on abortion and contraception access. NIACT chair, Dr Ralph Roberts, explains:

> Medical staff had to be proactive. EMA services were basically set up through NIACT members getting together and talking and saying, 'How do we do this'?[289]

In 2021, NIACT issued a report for implementing the CEDAW inquiry recommendations, offering an 'evidence base to inform the funding and commissioning of Relationships and Sexuality Education (RSE) provision, and integrated sexual and reproductive healthcare for the population of Northern Ireland,' including abortion services provision. This comprehensive report sets

285 Interview with a healthcare provider, 30 September 2022.

286 Interview with a healthcare provider, 13 September 2022.

287 Reuters, British provider to post abortion pills to ensure Northern Irish women have access, 9 April 2020, reuters.com/article/britain-nireland-abortion/british-provider-to-post-abortion-pills-to-ensure-northern-irish-women-have-access-idINKCN21R2XE; Kirk S, Morgan L, McDermott S, et al, 'Introduction of the National Health Service early medical abortion service in Northern Ireland – an emergency response to the Covid-19 pandemic', *BMJ Sexual & Reproductive Health* 2021;47:293-295, srh.bmj.com/content/47/4/293.

288 NIACT, *Report on Sexual and Reproductive Health in Northern Ireland* (March 2021) fsrh.org/news/northern-ireland-abortion-contraception-taskgroup-report-2021/

289 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.

out recommendations to government on how to ensure the provision of quality abortion services. In 2022, NIACT issued an Annual Review,[290] noting the lack of progress in achieving many of the 2021 report recommendations and highlighting continuing gaps in abortion service provision.

'NIACT, I think, has played a very important role in getting us to where we are at the minute. And NIACT, because of the scope of the people that it has within it, I think is potentially a really valuable resource,' says Dr Roberts. 'But because we were not formed at the behest of the Department of Health, we don't really carry any significant political weight. [And so] I do think that we've been ignored [by the Department of Health], which is a pity. Because I think that, those two documents in particular, there is such a wealth of information. And pointing to good practice.'[291]

The establishment of the early medical abortion (EMA) services in the trusts was entirely initiated and organised by one or two healthcare providers from within each trust. The Department of Health provided no institutional support, whether in the form of funding, guidance, logistics or staffing. Most trusts did not obstruct provider efforts but they offered no significant support. One EMA provider explains how a small group of dedicated providers 'designed all protocols, all the pathways, all the paperwork, engaged with all the different stakeholders like pharmacy, pathology, obs and gynae, sexual and reproductive health, senior management, nursing staff, etc.' to establish services within their trusts.[292] Even writing the content on trust websites was a provider initiative. Another provider recalls that despite all the challenges, 'within about eight weeks, we had a regional service established. But, really, just one or two members of staff in each trust.'[293]

In the intervening three years, these ad hoc services have remained largely in place. However, they all remain dependent on a small cohort of dedicated healthcare professionals – many of whom are the same providers that began the service in 2020. At times, the early medication abortion service in certain trusts has been suspended, due to a lack of staffing capacity to continue with provision.[294] This reality has been felt most acutely in the Western Trust, where a single provider offered services for a year.

An EMA provider remembers, 'There was a doctor, an SRH [sexual and reproductive health] doctor, providing EMA in the Western Trust when we were all starting out, from the very beginning. And she had no support at all. She had no admin support. She had no nursing support. She had no management support. She just, you know, one person can't do that. And that doctor now, sadly, she has just retired. And she was high level and a very experienced doctor, you know.'[295]

290 NIACT, *Report on Sexual and Reproductive Health in Northern Ireland Annual Review 2022* (June 2022), fsrh.org/documents/annual-review-sexual-reproductive-health-northern-ireland-2022/; NIACT, press release: New report from multidisciplinary group highlights fragile abortion service in Northern Ireland (June 2022) fsrh.org/news/press-release-niact-report-srh-northern-ireland-2022/

291 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.

292 Interview with a healthcare provider, 28 September 2022.

293 Interview with a healthcare provider, 13 September 2022.

294 See, eg, Amnesty International UK, press release: Northern Ireland: women blocked from abortion care, one year since law change, 21 October 2020, amnesty.org.uk/press-releases/northern-ireland-women-blocked-abortion-care-one-year-law-change; Amnesty International UK, press release: Northern Ireland: women blocked from care as Western Trust ceases early medical abortion service, 23 April 2021, amnesty.org.uk/press-releases/northern-ireland-women-blocked-care-western-trust-ceases-early-medical-abortion.

295 Interview with a healthcare provider, 30 September 2022.



That Western Trust doctor, Dr Sandra McDermott, recalls having to do it all herself, because everyone else in sexual and reproductive healthcare within the trust refused to provide or support the service:

> Taking the referral, doing the consultation with the patient on the phone, providing the termination at the clinic, alongside all the administrative work involved, even photocopying all the paperwork needed, everything, no one else took any responsibility… I was continually asking management for help… It just wasn't on their radar. It seemed that they just didn't care.[296]

Except when other staff complained about the anti-abortion protesters outside the clinic, then 'suddenly management were jumping to the people who were complaining about it, as opposed to the requests from the person who was providing the service and needing help'.[297]

Another doctor explains how the trust then allowed the service to collapse, after Dr McDermott retired:

> And that was just it. Women from the Western Trust could order online or they could go to England. You know, there was no pressure on the trust to provide the service, really. And [because of the stigma around abortion] women are not going to advocate, they're not going to complain. They're not going to protest about it. So for a year and a half, there was nothing in the Western Trust at all. Those women had no service at all.[298]

Eventually, overworked EMA providers from other trusts volunteered to cover the Western Trust, but this proved unsustainable, putting too much of a strain on already stretched service provision in the other trusts. The Western Trust stopped providing early medical abortion services on April 23, 2021 and failed to re-establish any services until October 2022. Service provision in that trust remains fragile.[299]

A healthcare provider from another trust recounted her experience with trust management, prior to the commissioning of abortion services:

> It's kind of difficult, I mean, they haven't been obstructive. I don't know if supportive is the right word. I keep being told that they're wanting a gold standard service, but they just want the funding to be able to provide the service. And in some ways they've been good, and just let me run with it, and there hasn't been too much interference. So we've been able just to get on with it and design the service to where it is now. But with that, there hasn't been a huge amount of support, and I would have appreciated more support, in that respect. It was quite a stressful time. A lot of times, I feel as though it's the cart before the horse.[300]

296 Interview with Dr Sandra McDermott, retired physician, former EMA provider in the Western Health and Social Care Trust, 28 September 2022.

297 Interview with Dr Sandra McDermott, retired physician, former EMA provider in the Western Health and Social Care Trust, 28 September 2022.

298 Interview with a healthcare provider, 29 September 2022.

299 Interview with a healthcare provider, 26 April 2023; interview with a healthcare provider, 5 May 2023; interview with a healthcare provider, 9 May 2023; interview with a healthcare provider, 15 August 2023; interview with a healthcare provider 16 August 2023.

300 Interview with a healthcare provider, 28 September 2022.

Operating for years prior to commissioning without any dedicated funding for abortion services, trusts' neglect and mismanagement of the abortion service may partly be the product of a stark economic reality. Trusts are facing severe financial pressures, striking staff and an overall lack of service capacity. Dr Hans Nagar of the Royal College of Obstetricians and Gynaecologists (RCOG) explains:

> We're in a very challenging economic climate in the UK, Northern Ireland in particular. There are issues with doctors taking on additional duties at the moment and there's all sorts of reasons for that. People are reluctant post-Covid, I think, to do extra work, many people are reducing their hours; there are pension restrictions for doctors, which means they don't want to do extra work. So it is difficult to ask doctors to do extra sessions and also to recruit doctors into posts. There's a shortage of doctors in obstetrics and gynaecology and sexual and reproductive health.[301]

Although trust managements' motivations are hard to discern, it is clear that, for years, the abortion services within some trusts did not have robust institutional support and were subject to poor service planning. This was, in large part, due to the longstanding absence of commissioned services and Department of Health support. The pervasive abortion stigma in Northern Ireland, lack of guidance on conscience-based refusals and values clarification (see Chapter 4), along with a history of decades-long neglect of SRH services, more generally, further contributed to this posture.

Donagh Stenson of BPAS noted, prior to commissioning: 'You've got a really motivated bunch of doctors there, but that's not going to sustain this service forever.'[302]

## 3.2 The toll on doctors: 'You just can't do that forever without burning out, you know?'

More than three years in, many of these providers are overworked and burned out. Trusts have not during this time employed sufficient additional staff to relieve the pressure on those who provide EMA services.

One doctor recounted, in September 2022, prior to commissioning:

> Staff have been working for prolonged periods with only limited annual leave. That is our choice, the trust don't force people to not take annual leave. My feeling is, if I take annual leave, then women wait until I come back again. Cause there isn't the staff there. I was always of the belief that, okay, in three months it's going to get better, in three months it's going to get better… So now I have held that belief for a long time. So I mean, that is a major challenge but it's really a challenge that comes because the Department of Health and NIO haven't acted. It should have been commissioned a long time ago. There's no point in decriminalising [abortion] and regulating for it and then not actually funding it. You can't have the best abortion laws in the UK and then not actually be able to use them.[303]

301 Interview with Dr Hans Nagar, NI Representation, RCOG, 2 February 2023.
302 Interview with Donagh Stenson, innovation and marketing director, BPAS, 14 September 2022.
303 Interview with a healthcare provider, 27 September 2022.



Doctors work nights and weekends, on call for patients who may have questions or concerns. One provider explains, 'I do two EMA clinics a week. I do most of the face-to-face treatments. And I also carry a phone, which is like a help and advice line. And that can ring anytime, day or night. And I have to deal with that.'[304]

Severely understaffed, most of the abortion services could not be sustained if the provider in charge was on leave for any extended period of time: maternity leave, sick leave or annual leave results in a lapse, or reduction, in what is an extremely time-sensitive service. If services are unavailable or limited for a week or two, people will miss the window in which they can access abortion services in Northern Ireland.

Megan, who underwent an EMA at nine weeks in May 2021, was studying for her master's degree at the time and had to wait a week before getting an appointment. She explained, 'I was under extreme stress, concerned about being unable to complete my final assignments on time and anxious and worried about going over 10 weeks,' at which point abortion services would no longer be accessible in Northern Ireland.[305]

Providers have also had to resume other commitments that had been on hold during the lockdown phase of the Covid-19 pandemic. One provider explains:

> They had no extra funds or anything. So then the problem was when we had to go back to do our normal work day jobs. It became very difficult to continue because we were seeing large numbers of women for EMA and just couldn't do it anymore. Just couldn't sustain that… We're seeing maybe 50 to 60 people a month. You're talking for each patient approximately two hours work. Whenever you're doing that, just in your own extra time: night-time, weekends and we've all been staying late after work. But you know, at the same time, you don't choose to be here till 8 o'clock at night, Saturday mornings, and that kind of thing. It's not that any of us have chosen it, but it's just we feel obligated to. You just can't do that forever without burning out, you know?[306]

Overworked EMA providers struggle to stay on top of their own caseload, making it challenging to take on patients from outside their trust area: 'It's really a skeleton [thinly stretched] service. You know, we're doing this on top of our other work. So, there's no way we could take on women from other trusts because it's just too busy.'[307]

Every single healthcare organisation and healthcare provider Amnesty International spoke with, whether they were providing EMA or not, noted how abortion services cannot be dependent on one or a small number of people. It is not sustainable.

304 Interview with a healthcare provider, 29 September 2022.
305 Interview on 3 March 2023.
306 Interview with a healthcare provider, 30 September 2022.
307 Interview with a healthcare provider, 13 September 2022.

### Conscientious commitment

> 'Those doctors are heroes, as far as I'm concerned. Because we hear an awful lot about conscientious objection. But then, you know, the level of their conscientious commitment was amazing.'
> **Goretti Horgan, a long-time pro-choice activist and senior lecturer in social policy at Ulster University.**[308]

The providers whom Amnesty International spoke to were personally committed to providing the service; some felt that it was a professional duty, part of their Hippocratic Oath, to do no harm.[309]

In the words of providers:

> I mean, it wasn't my wish to take on the EMA service. I just felt it was inequitable. You know, I've always thought it inequitable that women should have to travel to England from Northern Ireland. And it wasn't right that the trust wasn't interested [in offering services]. I mean, it's just like, that's not good enough. The trust not interested.[310]

> I keep saying, I feel quite strongly about my clinic. Everyone's different, but my clinic, I feel very strongly about it because it's a clinic that is purely there for women to feel empowered to make the right choice for them. That's solely what that clinic is about.[311]

Some noted that the work had been the most rewarding of their career.

> To be honest I have found it challenging but very rewarding. But there does come a point where you're just too physically tired. At the same time, it's been a privilege to be involved in it… I think because you just feel you've done something really worthwhile, and it's just nice to be able to help women. Some women are coming in and it's just a choice to end their pregnancy and they're quite matter of fact about it. And it's not very difficult or emotional for them. But some women really are in a situation where, you know, they have very little control of whether they get pregnant or not, especially in difficult relationships, and it's just so nice to be able to empower, to help those women to just empower their lives a wee bit, you know, I find that very rewarding… And I really feel very committed to it, and I feel it's definitely the right thing to do. And I feel privileged to have worked with the people that I've been working with.[312]

308 Interview with Goretti Horgan, Alliance for Choice Derry and senior lecturer in social policy, School of Applied Social and Policy Sciences, Ulster University, 29 September 2022.
309 Interview with a healthcare provider, 30 September 2022.
310 Interview with a healthcare provider, 29 September 2022.
311 Interview with a healthcare provider, 28 September 2022.
312 Interview with a healthcare provider, 30 September 2022.



> I've just retired after 38 years of being a doctor, 33-34 of those in Sexual and Reproductive Healthcare, and it [abortion service provision] was the most rewarding year of my career. As a clinician in Sexual and Reproductive Healthcare, I have always felt incredibly privileged to be in a situation of being trusted by patients talking about the most intimate side of their lives… being able to provide women with EMA was a step further. The patients were so grateful, they were so so grateful. And for so many of them, their situation revealed so much support from family and friends whom they had previously thought would be opposed to abortion.[313]

## 3.3 Post-commissioning: continued failure to provide institutional support

Although abortion services were finally commissioned in December 2022, and funding was made available to trusts to provide the service, trusts (with the exception of the Northern Trust) have been slow to hire staff and find additional premises for the service.[314] One provider notes that this phase is really 'about securing a very fragile EMA service. Because you can't keep working on your own time forever.'[315]

The Western Trust, after eventually re-establishing EMA services in October 2022, has faced continued staffing pressures and has been run largely by a single healthcare provider. It has continued to be challenging to find doctors willing to provide the service in the Western Trust. Demand had also exceeded expectations. The lack of adequate staffing has prevented the clinic from expanding their early medical abortion service to 11 weeks six days' gestation and from establishing a first trimester surgical abortion service.[316]

In two trusts, due to staffing limitations and broader workforce and financial pressures on the NHS in Northern Ireland as a whole, providers were having to reduce the number of EMA clinics they do per week.[317] Staffing limitations and the failure to identify and invest in premises have also prevented trusts from expanding early medical abortion services from nine weeks, six days' to 11 weeks, six days' gestation[318] and from offering surgical abortion services in the first trimester.[319] The majority of trusts continue to have only a single clinic location within the trust, which can present a significant barrier to access for those without access to transportation. This barrier is felt most acutely in the large and rural Western Trust.

At the same time, there have been sporadic demands and pressure from some trusts' management, for political reasons, that EMA services continue running, or that

313 Interview with Dr Sandra McDermott, retired physician, former EMA provider in the Western Health and Social Care Trust, 28 September 2022.
314 Interview with a healthcare provider, 3 May 2023; interview with a healthcare provider, 3 May 2023; interview with a healthcare provider, 26 April 2023; interview with a healthcare provider, 14 August 2023; interview with a healthcare provider, 16 August 2023..
315 Interview with a healthcare provider, 30 September 2022.
316 Interview with a healthcare provider, 9 May 2023; interview with a healthcare provider, 16 August 2023.
317 Interview with a healthcare provider, 30 January 2023; interview with a healthcare provider, 3 May 2023; interview with a healthcare provider, 25 August 2023.
318 Interview with a healthcare provider, 26 April 2023; interview with a healthcare provider, 3 May 2023; interview with a healthcare provider, 3 May 2023; interview with a healthcare provider, 14 August 2023; interview with a healthcare provider, 16 August 2023.
319 Interview with a healthcare provider, 14 August 2023; interview with a healthcare provider, 15 August 2023; interview with a healthcare provider, 16 August 2023.

providers begin offering manual vacuum aspiration (MVA) services, but limited institutional support or meaningful planning or provision of premises, to ensure a durable and sustainable service.

Only one trust has provided their abortion service with the resources and support necessary to begin offering EMA services until 11 weeks, six days: Northern Trust. One healthcare professional observes:

> We're from the Northern Trust. I feel we're fortunate, we have reasonably good SRH [sexual and reproductive health] service, we've had good nurse management, our service manager is very forward, she's really good at her job, she's very supportive of clinicians, she'll come and say: what does the service need, what do we need to move forward? And she'll do her very best to get that for us. We're in a good position, relatively good position [compared to] some of the other trusts.[320]

### An untapped workforce: nurse- and midwife-led early medical abortion provision

The 2020 Abortion Regulations authorise nurses and midwives to independently provide abortion services, in line with contemporary public health evidence and in contrast to the more antiquated, doctor-led abortion service provision found in the rest of the UK. Nurses and midwives are particularly well-placed to offer early medical abortion services, which the WHO, in a comprehensive review of public health evidence, has found can be safely and efficiently offered by mid-level providers.[321] However, early medical abortion services in Northern Ireland are currently all doctor-led, with nurses and midwives playing a supporting role.

Trusts' management have a critical resource in nurses and midwives to support the accessibility and availability of abortion services. This is particularly significant at a time of unprecedented pressure on the HSC Trusts, burnout among doctors providing abortion services, and reports of 'unprecedented' demand for abortion services in the rest of the UK – driven by shared issues such as 'the economic downturn, the cost of living crisis and [lack of] access to good quality contraception'.[322]

Medical practitioners currently offering EMA services agree that nurses and midwives should be independently providing these services. One doctor noted: 'I would be doing a real disservice for me not to train myself almost out of EMA… A trained nurse should be more than capable of them and that's always going to be a cheaper way'[323] than paying for a doctor to run a service. Another EMA provider concurs: 'In an ideal scenario, the EMA service should be completely nurse led.'[324]

Michelle McGrath, a Nurse Specialist and member of the Royal College of Nursing Northern Ireland's Sexual Health Network, remarked, 'There should be a training pathway for EMA services in Sexual and Reproductive Health. Taken as a whole, not that everyone needs to provide EMA, but people should be trained in it.'[325] Recent advertisements of nursing and midwifery posts in abortion care have received great interest and several applications, according to one doctor who provides EMA services, suggesting there are willing providers among nurses and midwives.[326]

However, the trusts haven't yet meaningfully invested in service planning and increasing their workforce capacity. Establishing nurse- and midwife-led services requires hiring independent nurse prescribers, who can prescribe medication independently, or offering professional development support for nurse/midwife independent prescribing certification, and training in the provision of pregnancy ultrasounds.

As explained by one doctor, 'The limitation in it is the nurses cannot prescribe [the abortion medication without first taking a 9-months long prescribing course]. On that basis, you need a medical person there. As opposed to going and training six nurses in nurse prescribing, which takes a year. So that you might have a big outlay initially, but actually then, after that, the cost of the clinic drops significantly'[327] because you are no longer paying for a doctor to run the service.

A representative of the Royal College of Nursing (RCN) NI is clear that a nurse-led service is both lawful and preferable but says, 'What worries me a little bit, based on years of experience with this issue, is there are still far too many people in Northern Ireland who think that their own personal views and opinions are more important than, in this case, what's now the law. And I worry that there will be people in the service who will deliberately try and spin this one out, without being obviously antagonistic but kind of drag their heels' in developing a nurse- or midwife-led service.[328]

According to the DOH, the commissioning model wouldn't address this level of detail, concerning who provides the services; however, nurse- or midwife-led services would be 'probably open for consideration' once the abortion services were fully established. In the interim, they will 'keep things under review as to what the best delivery model would be'.[329]

## 3.4 Trust pharmacies as barriers to abortion service provision

Interviews indicate that some trust pharmacy departments took an overly cautious approach to handling mifepristone (one of two abortion medications) after legalisation, treating mifepristone as a controlled substance, despite it not being classified as one, or in other exceptional ways. Controlled drugs are considered 'dangerous or otherwise harmful' drugs that are being, or appear likely to be, misused.[330] The Department of Health has confirmed to Amnesty International that 'mifepristone is not a controlled drug'.[331] Although at least one trust pharmacy was forced to stop the practice of

320 Interview with a healthcare provider, 30 September 2022.
321 WHO, Abortion Care Guideline (2002), p69-70, Recommendation 28.
322 The *Guardian*, 'UK facing crisis point in abortion provision, experts say', 26 January 2023, theguardian.com/society/2023/jan/26/uk-facing-crisis-point-in-abortion-provision-experts-say
323 Interview with a healthcare provider, 27 September 2022.
324 Interview with a healthcare provider, 30 January 2023.
325 Interview with Michele McGrath, Nurse, Sexual Health Network, RCN NI, 8 February 2023.
326 Correspondence with a healthcare provider, 8 March 2023.
327 Interview with a healthcare provider, 30 January 2023.
328 Interview with RCN NI, 8 February 2023.
329 Interview with the director of secondary care and the head of abortion policy, Department of Health, 2 March 2023.
330 Misuse of Drugs Act 1971, legislation.gov.uk/ukpga/1971/38/1995-01-09?view=plain
331 Correspondence with the assistant director, commissioning lead (Northern Area), Department of Health, 16 March 2023 (on file with Amnesty International UK).

treating mifepristone as a controlled drug early on, after pushback from healthcare providers within the trust,[332] this practice continued in at least two other trusts for years after the legalisation of abortion.[333]

This unwarranted treatment further stigmatises abortion because it exceptionalises abortion care, requiring overworked providers to jump through unnecessary and time-consuming administrative hoops to provide abortion services. Controlled drugs must be picked up at the pharmacy instead of delivered to the clinic and then securely stored; controlled drugs also require separate, special record-keeping, including additional steps for ordering the drug from pharmacy, and may require an additional healthcare provider to sign off.[334] One provider explained, 'This is one of my real bugbears: mifepristone is not a controlled drug, but we have to treat it as such. It's all the extra work involved with it.'[335]

A former EMA provider in the Western Trust, Dr Sandra McDermott, remembers: 'At the start, pharmacy seemed to be putting up a bit of a brick wall. They were putting up a few barriers, saying that the drugs involved were controlled drugs. So, the likes of you know, diamorphine and stuff like that. They were claiming that these were controlled drugs. But they're not. So that was a big issue, with practical consequences for my clinic. They were putting up barriers that shouldn't have existed.'[336]

Another provider, in a different trust, notes: 'It adds an extra layer of bureaucracy, really, just that you have to keep the medication in a secured and a controlled drug cupboard, which is more secure. A register has to be kept for each patient who's prescribed mifepristone, we have to keep a register of that. A controlled drug log.'[337]

Dr Fiona Bloomer from the Ulster University observed, 'I think it's another layer of abortion stigma coming into play, in terms of some of the trusts are still very wary of the situation. Those kind of hurdles that have to be jumped over. There's no need for them.'[338]

## Katie Boyd's experience

I accessed an abortion in September 2019, which was right before the service was decriminalised. I then accessed a second abortion in December 2021. Effectively, one when the service wasn't decriminalised, and one when it was.

Whenever I had the first abortion, it was in an underground capacity. So, somebody speaks to somebody, who speaks to somebody else. That's how you access the pills.

And it was really seamless. I had autonomy over my body. Over when and where it happened.

Then this time last year, myself and my partner found out we were pregnant again. I figured, given decriminalisation, it would be an even more seamless process. If nothing else, it would definitely be more straightforward to access.

So you have to contact BPAS… you get through to almost like a call centre. And they take your details and they say, 'Okay, we're going to pass this on to the clinic in Belfast, and we'll get back to you, max, five working days.'

But it was a month before anybody got back to me. Even one day, whenever you're pregnant, and don't want to be feels really like a very long time. It's very distressing.

In terms of where I was at with my gestational limit, a month was the difference between being able to access an abortion in Northern Ireland, via pills, or having to go to England for a procedure.

I phoned BPAS back quite a few times, to follow up as no one had called me back. The only thing they could do for me was to continue to email the clinic in Belfast on my behalf. I asked if they could give me the number to the clinic in Belfast so I could speak with them directly. They said, 'No, we can't, it doesn't work like that, there's a system whereby we email them and they then get in contact with you.' It became pretty clear to me that I wasn't going to access an abortion in the timescale that I needed to, via this channel.

So I found myself back at the beginning again. I contacted the place where I had got gotten abortion pills from in 2019 and they said, 'We actually can't help you, because we can only help women from countries where it's illegal. It's not illegal in your country.'

I was really frightened. Something's happening to you that you don't want to happen to you, and you know that, legally, it's okay for you to access this service. But, in reality, nobody can help.

*Katie was ultimately able to access abortion pills from an online source but then experienced sustained bleeding and needed post-abortion care. Having gone outside the healthcare system for care, she found accessing post-abortion care challenging.*

There was nowhere for me to go back to because I hadn't accessed the pills from the channel that I should have. So everybody was kind of a bit like, you didn't get it from us.

So, for me, having a direct comparison of accessing an abortion in Northern Ireland that wasn't legal, and one that was, it was clear that one was respectful of my autonomy. It was a gentle, caring experience. And the other was just brutal.[339]

332 Interview with a healthcare provider, 3 May 2023.
333 Interview with Dr Sandra McDermott, retired physician, former EMA provider in the Western Health and Social Care Trust, 28 September 2022; interview with a healthcare provider, 30 September 2022; interview with a healthcare provider, 8 February 2023.
334 Department of Health, *Controlled drugs* health-ni.gov.uk/articles/controlled-drugs.
335 Interview with a healthcare provider, 8 February 2023.
336 Interview with Dr Sandra McDermott, retired physician, former EMA provider in the Western Health and Social Care Trust, 28 September 2022.
337 Interview with a healthcare provider, 30 September 2022.
338 Interview with Dr Fiona Bloomer, senior lecturer in social policy, Ulster University, 12 December 2022.
339 Interview with Katie Boyd, 13 December 2022.

## Marie's* Experience[340]

*Marie and her partner happily found out she was pregnant in early 2022. However, she suffered from hyperemesis gravidarum during her pregnancy. This condition is characterised by a permanent feeling of nausea and severe vomiting and dehydration:*

So I'm really sick and by St. Paddy's Day, I had to go a Northern Trust Hospital because I could feel my brain shutting down. I was seven weeks pregnant at the time and I was told by an older doctor to go home and eat some ginger biscuits, that there was nothing else he could give me. No tests were taken. I was so dehydrated when my local GP tested the next day that I was admitted for fluids within the hour. I was in hospital for three days.

I bled three times between March and June as well, and they just kept telling me that it was normal. That it was normal! I also had really bad mental health the year before and I was to have support from the perinatal mental health midwife and a consultant that was specialising in mental health for pregnant people, and none of that materialised. Staffing issues is all I kept being told.

Then I got Covid at the end of June and my partner was ringing my local Northern Trust maternity to ask how to support me since I was pregnant. But they did not provide any advice. I had a risk assessment carried out with a Covid nurse on the phone and was deemed no risk. I tested negative after 11 days and on day 12 I had an appointment with my consultant who scanned me and said everything was ok and that I had a lot of fluid. I asked about mental health support again because at this stage, I still hadn't had any. And I was starting to get anxious about my chances of intense postnatal depression. I was told that they had put a note in my file and they would follow up.

The very next day my waters broke. We went to the hospital. They admitted me with preterm premature rupture of the membranes and put me in a bed and the midwife came around and noted that I was 22 weeks and 2 days pregnant. When I asked if it has anything to do with the Covid I just had she said, 'Don't be ridiculous' that 'These things just happen'. She later told me to get up out of bed and keep moving. So, me and my partner were walking around and I'm still losing water at this point. On the third day, a retired midwife came in and asked me why I was walking and told me to stay in bed and don't move. I told her that we were advised to keep moving. She said that was incorrect information that I was losing my waters and needed to stay still. Staff at the Northern Trust hospital just kept telling me there is nothing they could do for us, that I would have to wait and they would send me to the Belfast Trust at 23 weeks, but that the hospital up there would not admit me before then, as they would not intervene to save a life before 23 weeks. Northern Trust just kept saying to 'think positive.' So, I lay in in that hospital losing my water from 22 weeks and 2 days until 23 weeks.

I was in the labour ward as well, with all other women going and coming back with their babies. We were whispering with the consultant behind a curtain, and everyone on the ward could hear our conversation, but because it was a labour ward no one wanted to speak too loudly. We felt shame. A neonatal consultant came to us to explain what would happen if I went into labour in Northern Trust. All they could offer at this stage was comfort care, as there was no neonatal facilities in Northern Trust and, even if there was, there was minimal chance of survival.

I asked if going to England would be an option at this stage and I was told it was too late and, even if I went over, there would be no guarantee that they would admit me. We were completely misinformed. Northern Trust didn't want to deal with the abortion issue. They didn't know how to deal with abortion issues. It is nowhere in their world of understanding, and they don't want to have to deal with it. I believe that the protests outside that specific hospital in the Northern Trust area and the culture inside are connected. They don't want to have to provide these services or information about these services, but they have to. They do. It's healthcare. You have to. You have to provide the services that we all have a right to, you know.

I suddenly had signs of infection and, because I was running the risk of sepsis, it was an emergency. Northern Trust then looked at my dates and suddenly quickly sent me to the Belfast Trust. Northern Trust fully discharged me and I had to make my own way to Belfast. Thankfully my partner and mum were with me, but we were confused how I went from being told to stay in bed to being discharged.

I get to the Belfast Trust and it's a whole different place. I was walked through everything compassionately by three consultants and explained that there was not a good outlook at this point because I had no waters left. At that point, I asked if I had any choice. And they are looking at me like they were wondering what I meant. They said that they were told that I wanted resuscitation and they were concerned, as they wanted me to be very aware of how difficult that could be with next to no chances of survival. I told them that the staff in the Northern Trust never asked us that question. It became clear that Northern Trust had failed to provide me with information on all my options or ask us how we wanted to proceed at all. They kept this decision from us.

I was alone at first because my partner wasn't allowed in with me because of Covid restrictions. The three consultants then walked me through my options very compassionately and later allowed my partner to come in and talked to us again and said they wanted us to take time to discuss our options. The same consultant came back to talk to us a few times, even telling me to stay in bed because with no waters at all there was a small chance that the umbilical cord could fall out. They found us a room away from the main labour ward. We got a private room and were able to have some alone time to talk. I was very weepy at this point, but the culture in the Belfast Trust was different, and I was able to openly discuss the decision I was making, and it was met with compassion, particularly from the younger midwives.

Everything changed the next day. We were sent down to see a second consultant for a scan. I asked for information about seeking a termination for medical reasons in Northern Ireland and they started to rush us and said I had to decide before they could move forward. I kept saying, how could I move forward and decide without all the information? Me and my partner reminded them that we were told they were going to advise us if we met the requirements for a termination for medical reasons. I started to cry and said that we had been told that this was what we were coming down to talk about, so we couldn't understand why they seem shocked.

340 This experience was relayed to Amnesty International by Marie (name has been changed) in an interview on 12 December 2022. It was also sent to Amnesty International afterwards, in writing, by Marie and her partner.

The midwife tried to help and be clearer but there was a sense of panic with her as well. We did meet the markers for a termination for medical reasons, but they were not being as clear as they could be with us, or it felt like they were throwing information at us but not giving us time to process and understand what it meant in terms of the legalities, the procedure and service provision for us in Northern Ireland. That was confusing us. They also commented a few times on how this was all new for them.

We were quickly told that there was a staffing issue and there was no staff in Northern Ireland who could do the procedure and so we had to go to England. I was told to book my own flight and accommodation in Liverpool. The services was supposed to be paid for by the trust and, when I said this, I was told 'Keep your receipts, you might get a refund'. When I told this point to another consultant she told my partner and me to stay where we were and not to book anything because we had been given the wrong information. Looking back this was the first point we realised we were unsafe and our care was compromised.

The midwife came back to us and said that she was taking care of it and that my flight and accommodation would be booked and paid for by the trust. I waited for a call from a booking agent. When I got the flight information I also asked about a hotel for the day of the procedure because the flight home wasn't booked until the evening. I was told that they couldn't book me a hotel room for the day and that the hospital wasn't far from Liverpool city centre. And I thought, aye, right, like that is acceptable that I would just walk about Liverpool all day after an abortion. It's unbelievable! How did I go from lying in a bed because the umbilical cord might fall out to being told you're fit and healthy to go on a flight and walk around a city all day?

Alliance for Choice Belfast helped me a lot. I called them at this point, or my mum did. I should have called them when I was in the Northern Trust hospital but I believed that consultant, that there was nothing I could do at that point. Emma from Alliance for Choice saved my life. She talked to my mum about my human rights and the risk of getting on a flight and that these services should have been provided in Belfast already and that I did not have to go to Liverpool to access medical care. Emma was raging at what they were asking me to do and the risk they were willing to place on my life. Calling Alliance for Choice and getting that perspective gave me what I needed to validate that this was out of line, and I shouldn't be being put through this. I'm so glad that I knew to call Alliance for Choice and I worry about anyone else going through this who doesn't have access to this support.

When we confirmed we wanted the termination the Belfast Trust discharged me. Emma explained to me how I should not be being discharged and I should not leave the hospital as my condition was a medical emergency. I understood what she was saying, but they wanted us out of there at that point and I knew it would be a fight. My heart rate was already racing, and I kept saying to my partner that I didn't want to have a heart attack. I no longer felt safe in the hospital and so we decided to go back to the apartment for the evening and monitor things from there. The midwife who was looking after me was lovely and she said she was glad I was only going to be ten minutes over the road and not all the way up home in the North Coast. But we were like, how can you be concerned about me being an hour away tonight and I'm still being sent on a flight tomorrow?



They sent me home with a list of signs of infection. The next morning I got up and I met all the markers – I think it was to return if you had three, and I did. I called Emma and told her that my body was telling me not to get on the flight and that I was scared. I explained that I was going back down to the Belfast Trust as I had a high temperature and heart rate. I went back to Belfast Trust and was eventually readmitted. They were not going to at first. Some of the staff had an attitude. One nurse asked why I thought I could not fly to Liverpool. There was a real awkwardness in the air that I had returned to the hospital, and I was repeatedly told that I was medically ok and not at any risk and didn't need to be in the hospital. I asked what I was supposed to do if I went back home and kept meeting the three markers of infection and had to keep coming back down?

One consultant admitted that she had concerns I was being put through a really hard time and that what they were asking me to do was disgusting. When the main doctor came in again he explained his reasons for sending me to Liverpool was due to staffing issues [and a lack of trained doctors] and that they would send staff with me to Liverpool, as I presented a training opportunity to allow for the extension of services in Northern Ireland. He said to me 'I don't suppose that helps you right now, but… ' and I said, 'No it doesn't'.

They had concerns about who I was taking advice from and kept repeating that 'legal advice is not medical advice, legal advice is not medical advice'. They meant I should not be listening to legal arguments if they said I was medically fit to fly. Which is hilarious in considering it was legal arguments in Northern Ireland that was used to block the opening of the medical services I needed. I fought, I dug my heels in thanks to help and support from Alliance for Choice and Phoenix Law who Emma organised for us. When me and my mum were inside the Belfast Trust fighting to be readmitted, my partner was outside consulting with our lawyer. There was a point that we didn't know if the trust was going to give in and agree to doing the procedure in Belfast. They eventually agreed and Phoenix Law confirmed that I would be getting the procedure done at home and would not have to travel.

During the procedure [to terminate the pregnancy], I felt that the consultants who were supportive of me were being monitored carefully by management. It was really tense. Everybody was really tense and it had an impact on the consultant. The procedure [to stop the foetal heartbeat] ended up having to be done three times as it requires accuracy or my life would be put at risk as well. By the third time I had the limit of localised anaesthetic, and they needed a bigger needle. I felt everything. But I also knew I was safe in a room full of conscientious providers, three female consultants, a bereavement midwife, the Sister who had been with me from the start and my supportive partner who didn't let go of me for a second.

After, there was also an issue on which ward to put me on. The labour ward was not appropriate, so they found another ward. I had actually been in that ward for two nights before I was discharged but a Sister on this ward came right to up to the door as we were entering, put her hand up and said, 'She's not coming in here.' I don't think they wanted the hassle. I ended up in a sort of private ward. It felt like it was in the dungeons. We decided to go home after a few hours and be in our own space and come back on Sunday.

[After being medically induced to end the pregnancy,] I went into labour, it was intense, a lot of pain, it was difficult. It turns out it was confirmed by post-mortem that Covid caused an infection in my placenta, as I suspected earlier but had been told I was ridiculous. The post-mortem also revealed that there was debris in our daughter's lungs and she had stopped growing and confirmed what we had always known.

I think the stigma and culture in Northern Ireland is to just push it down and don't talk about it and then use the image of talking about it to block actual progress. Nobody wants to deal with anything. The trusts didn't want to have to deal with my medical needs. What they put me through was disgusting. It was a decision that we didn't want to have to make because it was a very wanted pregnancy. But we just knew, there was just something telling us that this was the most compassionate thing we could do at this point, because our baby had no chance of survival. We wanted to make an informed compassionate choice. Northern Trust ran the clock down on us and the Belfast Trust didn't want pressure of the spotlight of the lack of services being placed on them and they focused on technicalities, not my medical needs, human rights or compassion for a couple losing their child. They all collectively made this harder than it needed to be.

I beat myself up sometimes for talking about it so much. But, if I can stop any other woman having to sit in a place where, because you need this medical procedure, that your life now means so little that they will take a risk to put you on a flight and put you through the mental torture of walking about a city all day after a termination for medical reasons, and think that is acceptable, then it is worth telling. Free, safe, and local is what we were promised here. But we haven't got that.

Because of the experience I've had, I started thinking negatively about the outcome of commissioning [of abortion services] and if we will ever get the services. What I tried to remember is that, even though it was people here that put me through this, it was also people from here who supported me and got me the help and gave me the support that I needed. My partner, parents, Alliance for Choice, Phoenix Law and all the conscientious providers who carried out the procedure, they're also from here, right? So I think it's them we have to focus on, and keep them at the front of our minds.



# 4. Denial of care and disrespect of patients: the need for regulation of conscience-based refusals and for values clarification

The practice of healthcare providers refusing to perform abortion services, which they object to on the grounds of their religious beliefs or personal views, is sometimes referred to as 'conscience-based refusals' or 'conscientious objection'.[341] The Northern Ireland Executive Formation Act 2019 does not address the situation of healthcare providers' refusals to provide services based on their conscience.

Regulation 12 of the 2020 Abortion Regulations, however, does include an exemption to the duty of care that providers are normally under. This clause states that 'a person is not under a duty to participate in any treatment authorised by these regulations to which the person has a conscientious objection,'[342] noting that this allowance does not include an exemption from 'any duty to participate in treatment which is necessary to save the life, or to prevent grave permanent injury to the physical or mental health of a pregnant woman or girl'.[343]

The scope of the conscience-based exemption is set forth in the UK Supreme Court decision of *Greater Glasgow Health Board v Doogan and Another* (2014), which clarified that the exemption is limited to direct participation in the treatment.[344] The court confirmed that 'treatment' does not extend to the ancillary, administrative and managerial tasks that might be associated with that care, such as booking appointments, organising the ordering or gathering of the required drugs, or providing aftercare.[345] In accordance with the notion that healthcare professionals normally have a duty of care to provide services, the regulation confirms that the burden of proof of conscience-based refusal rests on the person claiming to rely on it.[346] However, to date, the Department of Health has not issued any guidance to the trusts on how to implement the regulation or on monitoring or oversight of conscience-based refusals.

Although ethical guidance and professional standards issued by the General Medical Council and the Nursing and Midwifery Council, as well as guidance or statements from healthcare professional bodies in Northern Ireland, such as RCOG, RCM, RCGP, RCN and the Faculty of Sexual and Reproductive Healthcare (FSRH) exist, and some

341 Amnesty International avoids using the latter term as it conflates refusals to provide medical care with 'conscientious objection to military service – a different situation where individuals object to compulsory military service imposed by governments. Amnesty International Abortion Policy Explanatory Note, p8 amnesty.org/en/wp-content/uploads/2021/05/POL3028472020ENGLISH.pdf. In the context of abortion, WHO defines it as 'the practice of healthcare professionals refusing to provide abortion care on the basis of personal conscience or religious belief'. And as stated in law and policy Recommendation 22, 'In some countries conscientious objection is expressly regulated through employment law, employment contracts or the law on abortion.' WHO, Abortion Care Guideline (2022), Glossary, 3.3.9, pp60-61.

342 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 12(1). Note also that, in the case of GPs, their contract with the DOH includes a contractual right to opt out of providing SRH services, including contraceptive and abortion services.

343 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 12(3).

344 *Greater Glasgow Health Board v Doogan and another* [2014] UKSC 68.

345 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, 2020 No. 503, para. 7.40.

346 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Section 12(4).

provide guidance, they are not consistent with each other in terms of the breadth of obligations covered. Moreover, none are comprehensive, and all are outdated, published prior to the decriminalisation of abortion.[347] In addition, these standards do not place a legal obligation on trusts or the Department of Health to monitor and oversee the practice to ensure that an adequate number of providers are available and willing to provide services that people are legally entitled to receive. Despite this, the Department of Health maintains that it does not plan to issue any guidance or regulations on the scope, monitoring or oversight of conscience-based refusals, stating that this falls within the purview of the medical associations and the trusts.[348]

The lack of Northern Ireland-wide guidelines, applicable to all trusts, on the implementation, monitoring and oversight of conscience-based refusals is a huge gap and barrier to effective service provision. It has created significant confusion and led to the refusal being invoked outside the lawful scope of the exemption, by people not directly involved in treatment. The absence of any monitoring and oversight of conscience-based refusals has also created a real lack of knowledge by trust management of who among their employees is refusing to provide services and what specific services they are refusing to provide. This makes it challenging for management to ensure an adequate number of providers willing and able to provide quality abortion services that people are legally entitled to receive. This failure to properly regulate has had a negative impact on people seeking abortion services, resulting in delays and disrespectful care.

The failure to commission services in the three years following law reform allowed misinformation about the permissible scope of the practice of conscience-based refusals to fester. Yet, monitoring and oversight is not dependent upon commissioning and should have been addressed by government early on, given Northern Ireland's long history of criminalising abortion and the lack of knowledge among Northern Ireland's healthcare providers about the abortion procedure.

When asked about the lack of guidance, the Department of Health pointed to existing clinical professional guidance and noted that healthcare professionals are 'aware that they can conscientiously object and trusts are putting that into place. And the feedback that we've received to date is that it's been managed well, within trusts, there's been no impact to service delivery, as it currently stands.'[349] The Department of Health has further stated that they are 'working collaboratively with the trusts to stand up abortion services. It is for the trusts to manage and monitor conscientious objection among staff and to ensure that this does not act as a barrier to service provision. Trusts have advised us that conscientious objection is not preventing the delivery of services.'[350]

The lack of regulation, monitoring and oversight of conscience-based refusals has been raised as a barrier to establishing and accessing quality abortion services in almost every interview Amnesty conducted, including as recently as August 2023. Setting up services in the Western Trust in 2020 was a particular problem because providers and administrative staff did not want to participate in the clinic and there was no values

347 See generally, NIACT, *Report on Sexual and Reproductive Health in Northern Ireland* (March 2021), pp64-66.

348 Interview with the Department of Health, 17 August 2023; correspondence with the head of abortion policy, Department of Health, 24 August 2023 (on file with Amnesty International UK).

349 Interview with the head of abortion policy, Department of Health, 2 March 2023. See also correspondence with the head of abortion policy, Department of Health, 24 August 2023 (on file with Amnesty International UK).

350 Correspondence with the assistant director, commissioning lead (Northern Area), Department of Health, 16 March 2023 (on file with Amnesty International UK). See also correspondence with the head of abortion policy, Department of Health, 24 August 2023 (on file with Amnesty International UK).



clarification to try to get people on board. In another trust, a healthcare provider explained that there are so few providing abortion care because the majority of the existing sexual and reproductive health staff in the clinic are 'conscientious objectors'.[351]

Amnesty International also learned that, in the Northern Trust, there is only one pharmacist in mid-Ulster Hospital who is willing to dispense medication for abortion purposes, the others will only dispense for other gynaecological uses.[352]

Many healthcare professionals expressed concerns about the extent of the practice and its impact on access to services and trusts' ability to organise and effectively run the abortion service. Dr Ralph Roberts, chair of NIACT, articulated the views of the many other doctors interviewed by Amnesty:

> There should be formal guidance to units. A clinical director needs to know where all his medical staff stand. And, a nurse manager, or midwife manager, needs to know where all her staff stand, so that they can provide that service without patients or staff being compromised. Trusts have not been told that they need to educate their staff and there has been no guidance and no political will to do this… if you have people within a trust who support the provision of services, they can get on with it and do it. But it's not going to be consistent and not across hospitals. There needs to be some top-down guidance saying this is an area that we need to provide services and this is how it is run.[353]

NIACT's 2021 report and progress report of 2022 raise this as a continuing problem, which requires training 'for all HSC and primary care staff working in SRH [sexual and reproductive health] and maternity services, including professionally regulated clinical staff, managers, administrative and other support staff'.[354]

Dr Katie Cairns stated clearly: 'If we're saying, okay, we're commissioning services, and we're going from a blank sheet, then actually to work out what service you can provide, you have to know who is willing to provide it, and who is going to be a barrier to provision.' Speaking in her capacity as a GP she noted, 'The situation now with GPs is that there is *a "feeling"* that GPs probably wouldn't like to provide abortions. Well, that level of understanding is not really good enough when you're creating a legally mandated CEDAW-compliant service.'[355]

During interviews for this report, Amnesty International heard that trust employees are refusing to provide care based on what appears to be their conscience, but since there is no regulation and no formal guidance from the Department of Health on registering

351 Interview with a healthcare provider, 13 September 2022.

352 Interview with a healthcare provider, 8 February 2023.

353 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.

354 NIACT, *Report on Sexual and Reproductive Health in Northern Ireland Annual Review 2022* (June 2022), p14. (Recommendation 37: 'Training in conscientious objection should be provided for all HSC and primary care staff working in SRH and maternity services, including professionally regulated clinical staff, managers, administrative and other support staff. Non-structured training has been provided in some trusts. However, in general, training is lacking and, as a result, we have seen evidence of staff either being misinformed about the scope of conscientious objection or misinterpreting its legislative provision.'; Recommendation 38: 'We recommend that professional leads within the relevant departments should keep a secure record of the position of their staff with regard to conscientious objection to allow for service planning and delivery. In the absence of commissioning, service provision is limited to a small number of people in specified areas and no progress on this has been made within the wider staff community. Summary There has been limited progress in this area which reflects the perceived lack of need due to the failure to commission and the absence of a full service.')

355 Interview with Dr Katie Cairns, general practitioner, 13 December 2022.

objection, management of these refusals becomes dependent on the individual trust. Amnesty learned of only two trusts that have a form for employees to complete to record their refusal.[356] These forms explain that employees may only refuse to participate in clinical processes directly resulting in the termination of pregnancy, and that this does not apply in emergency situations. Both forms ask for the objector's job role.[357]

One of the trust's forms explains in more detail the limits of conscience-based refusals according to General Medical Council, Royal College of Midwives and Royal College of Nursing guidance, but only provides space to object to early medical abortion services.[358] The other trust's form only provides the option to object to early medical abortion and/or surgical abortion post 12 weeks.[359] No explanation of oversight and monitoring of the practice of conscience-based refusals is provided on the forms, except that one of the forms seems to include a positive declaration on willingness to participate in treatment, noting that this is 'for completeness and to ensure informed decisions can be made in relation to resourcing this process of treatment.'[360] This ad hoc approach to monitoring is another illustration of why regulation is needed. Dr Roberts also noted that 'there are enough people out there to provide a service. But I think that also there is clearly quite a lot of conscientious objection'.[361]

Dr Fiona Bloomer, a researcher at Ulster University, has conducted surveys with healthcare providers on this issue, with promising results for the development, implementation and delivery of local abortion care in Northern Ireland. Specifically, the majority of responding clinical staff working in Northern Ireland's obstetrics and gynaecology units support decriminalisation of abortion up to 24 weeks gestation. There is also willingness amongst clinical staff to participate in medical and surgical abortion in 'certain circumstances'.[362]

Healthcare professionals and other interviewees noted that there is a spectrum of refusals based on conscience, with some providers willing to participate in certain – but not all – abortion-related provision.[363] Preliminary research findings by Martha Nicholson of the Open University and International Planned Parenthood Federation indicate that nurses and midwives in Northern Ireland were less willing to participate in surgical abortion care than in early medical abortion and the provision of information and counselling, and that there is a gap in awareness and training on different abortion methods.[364] She noted, 'There is a lack of acceptance of abortion as part of the role of nurses and midwives, and limited awareness of the law and opportunities for training and education.'[365]

356 Western HSC Trust and Southern HSC Trust, forms for recording conscientious objection (on file with Amnesty International UK).
357 Western HSC Trust and Southern HSC Trust, forms for recording conscientious objection (on file with Amnesty International UK).
358 Southern HSC Trust form (on file with Amnesty International UK).
359 Western HSC Trust form (on file with Amnesty International UK).
360 Western HSC Trust form (on file with Amnesty International UK).
361 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.
362 Bloomer F, Kavanagh J, Morgan L, et al, Abortion provision in Northern Ireland: the views of health professionals working in obstetrics and gynaecology units, BMJ Sexual & Reproductive Health 2022;48:35-40, srh.bmj.com/content/48/1/35.long
363 For example, interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022; interview with a healthcare provider, 28 September 2022; interview with a healthcare provider, 27 September 2022; interview with a healthcare provider, 30 September 2022; interview with a healthcare provider, 13 September 2022.
364 Interview with Martha Nicholson, PhD, 4 April 2023.
365 Interview with Martha Nicholson, PhD, 4 April 2023.



Dr Ralph Roberts has also emphasised the real importance of the need to understand the nuance of it, as it is something he had to reconcile with himself: 'I'm pro-choice, I believe that women should have the opportunity to make their own decisions. And I'm very happy to facilitate that. I'm happy to counsel and do all of those things, and I'm happy to prescribe medication that they take. But I wouldn't want to go and do a surgical termination. I would find it very difficult to actually do it.'[366] He and others expressed the legitimacy of this position, noting that there are probably a lot of healthcare professionals in this camp, but that such nuances are not known.

Suzie Heaney, of ARC, expressed the sentiment of many interviewed for this report: 'We don't know the extent and what people believe. We have been in the dark, we need open conversations.'[367] Dr Roberts explains, 'As far as I'm aware, there isn't anyone in my department who knows what my feelings are, because no one's ever asked me. There is a need to have open conversations about conscientious objection and be really up front about it. You've got to know, and to talk to your people and say, ok, we need to know how you feel. And then where you will fit in within this service. It's just having a grown-up conversation.'[368]

## 4.1 Data on conscience-based refusals from Freedom of Information Act requests

All trusts have responded to Amnesty International's Freedom of Information Act requests, albeit with delays, which included several questions on conscience-based refusals and values clarification, including the number and job titles of trust employees registering their objection to participating in abortion service provision.

Belfast Trust, response dated 9 November 2022, noted that 'there have been seven employees who have registered their objection – three doctors and four nurses'.[369]

Northern Trust, response received on 15 February 2023, noted that '221 nurses, 14 midwives, one obstetrician and seven anaesthetists have notified their managers of a conscientious objection relating to abortion services'.[370]

South Eastern Trust responded on 7 February 2023, but did not provide any data, noting that 'the information requested is not held on a central information system. To obtain this information would require a manual review of records. This would exceed the "Appropriate Limit" as defined by the Freedom of Information Act 2000. The trust therefore exempts the release of this information.'[371]

Southern Trust, response dated 21 November 2022, noted that eight obstetricians, 64 midwives and fewer than five nurses registered their objection.[372] Southern Trust included a form that staff are asked to complete to record any objection to abortion.

366 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.
367 Interview with Suzie Heaney, midwife and ARC coordinator NI, 14 December 2022.
368 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.
369 Belfast Health and Social Care Trust, FOIA request, received 9 November 2022.
370 Northern Health and Social Care Trust, FOIA request, received 15 February 2023.
371 South Eastern Health and Social Care Trust, FOIA request, received 7 February 2023.
372 Southern Health and Social Care Trust, FOIA request, received 21 November 2022.

The Western Trust noted that it 'does not have a policy or protocol relating to conscientious objection' and 'does not hold a central record of staff who register their objection'. However, Amnesty International obtained, from an anonymous source, a form from the Western Health and Social Care Trust for recording staff objections.

The Western Trust noted that it does not have a policy on values clarification but 'a number of staff have attended regional values clarification training and there are plans for further training in the near future'.[373] Northern, Southern and South Eastern Trusts also expressly referred to holding values clarification sessions on the topic with relevant staff. Belfast had yet to hold any by the date of the FOIA response.

No trust provided any information on how refusals are monitored and what steps are taken to ensure that only those directly providing services may refuse to participate.

## 4.2 Abuse of conscience-based refusals: disrespectful care and denial of care

Because of the lack of guidelines and knowledge, the lawful scope of the refusal is misunderstood. Healthcare providers Amnesty International interviewed, and others in the field, have consistently explained that most healthcare workers don't understand the parameters of conscience-based refusals – that it only extends to direct participation in the actual treatment. A wide range of individuals who are not legally permitted to refuse to provide services to women based on conscience are claiming the exemption, and there is no institutional monitoring or oversight.

For example, Amnesty International has been told about interpreters refusing to interpret during an abortion consultation. The doctor explained:

> We do have women who need an interpreter, some asylum seekers, probably about two a week would need an interpreter. There's been problems getting interpreters for some languages and sometimes we need a telephone interpreting service, which isn't ideal. And, sometimes, when you get them on the other end of the phone, once they discover what the consultation is about, they refuse to take part and we're having to ring up again and try and get another interpreter. We explain usually in the booking for interpretation that it's for an abortion consultation, so that they don't turn up and then say 'I'm not doing this,' and that potentially delays everything… they don't know that conscientious objection is for treatment, not for interpreting.[374]

Another doctor recalled refusals to provide opinions on women's haematology disorders because the patients were terminating their pregnancies, explaining, 'There have been a number of occasions where our EMA providers have sought, for instance, an haematology opinion because they had someone with a haematology disorder and a person in the haematology department says, "I'm not going to give you advice, because the patient is having a termination of pregnancy." Now that's totally inappropriate. That's not within their realm, that's not within the bounds of legitimate conscientious objection.'[375]

373 Western Health and Social Care Trust, FOIA request, received 21 February 2023.
374 Interview with a healthcare provider, 13 September 2022.
375 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.



Amnesty International has also been told of an A&E (emergency department) provider declining to treat a woman who sensed she was bleeding heavily after an EMA: 'She had gone up to A&E over the weekend, and unfortunately, she happened to see a GP [general practitioner] in A&E who was very vocally anti-abortion, very vocally… And the girl was straight up, told her that she had a termination and she was bleeding heavily. The GP told her to contact her EMA provider on Monday, that it has nothing to do with her, and turned her away. As it turned out, the girl ended up being ok, thankfully.'[376]

Due to the lack of regulation of refusals based on conscience, pervasive stigma around abortion, and the lack of values clarification, the line between refusing to provide care based on conscience and the duty of care becomes blurred.

Dr Roberts explains the importance of informing staff on the practice:

> You could make sure that the staff who had a conscientious objection understood what the legitimate boundaries of that conscientious objection are, so there is a kind of a mutual respect, so that their wishes are respected, and they feel some security in that, but also that they're not saying, 'Well, look, I'm not going to provide any care at all because I disagree with that.'[377]

Every single person Amnesty International interviewed noted that general attitudes against abortion and stigma in the health sector are a problem, resulting in judgmental and directive services that compromise respectful, quality care, with very real consequences, including denials of care.

Suzie Heaney of ARC remembers, 'There's one parent that I worked with who said, "Judgment can be very subtle, but it's so obvious. And so loud when you see it." I think that healthcare staff don't understand what conscientious objection is, and the limits to it.'[378]

Amnesty International's interviews revealed incidences of:

- persons going to hospitals or clinics for abortion care and being treated poorly by staff or left unattended.[379]
- a midwife giving midwifery students a tour of a hospital and pointing to the clinical area where abortions are performed, saying, 'That is where they kill babies.'[380]
- an EMA provider referring a woman to the early pregnancy clinic for a scan and being told by the midwives there: 'I don't know if we do that here' and 'You'll have to talk to someone else.'[381]
- a woman being referred to the early pregnancy unit for a scan to determine gestational age before having an early medical abortion and being told by providers there that she should not have an abortion and being shown the ultrasound monitor without her consent.[382]

376 Interview with Dr Sandra McDermott, retired physician, former EMA provider in the Western Health and Social Care Trust, 28 September 2022.
377 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.
378 Interview with Suzie Heaney, midwife and ARC coordinator NI, 14 December 2022.
379 See for example, interview with Marie (name has been changed), 30 January 2023; interview with Susan (name has been changed), 13 January 2023; interview with a healthcare provider, 28 Sept 2022; and other women and providers as shown throughout the report.
380 Interview with a healthcare provider, 28 September 2022.
381 Interview with a healthcare provider, 29 September 2022.
382 Interview with Dr Sandra McDermott, retired physician, former EMA provider in the Western Health and Social Care Trust, 28 September 2022.

- a doctor not allowing a TFMR patient to be treated in their hospital wing.[383]
- a person recommended to Stanton, a fake abortion clinic in Belfast that deliberately misinforms and misleads abortion seekers,[384] by a GP receptionist when calling in to ask for information about abortion.[385]

Women Help Women and Dr Kate Guthrie of Women on Web, two online medical abortion pill services, explained that negative and judgmental attitudes are one reason why people from Northern Ireland seek online services. Women Help Women notes:

> People have mentioned that they aren't going through trusts because trusts have been rude to them on the phone. They felt judged, or feared they would be judged, so they didn't make the call.[386]

Megan, 23 years old, who had an abortion in May 2021 in Belfast, moved to Northern Ireland from England to study. She explained that she experienced a lot of pain during the passing of the pregnancy but was concerned about who to ring during the clinic's off hours. She noted that:

> In England, I would be pretty certain I was supported, I wouldn't be as afraid, I would expect medical professionals not to be biased. I would ring a GP in England if I felt I was having a problem during the abortion, or wander into a pharmacy. Whereas here [in Northern Ireland], I wouldn't ring a doctor and I wouldn't wander into a pharmacy. Because you don't know what they think. You can't expect impartiality from medical professionals in Northern Ireland. That's a big thing.[387]

## 4.3 Lack of data on extent of conscience-based refusals among general practitioners

There is no data available on the extent of refusals of care based on conscience by general practitioners (GPs). Providers and others interviewed underscored challenges with GPs. They also noted how the Royal College of General Practitioners Northern Ireland has been reluctant to share abortion-related information with members, and to gather information from their members on their views and positions on abortion and on objection, for fear of alienating them.[388] (See Chapter 5.)

Dr Maeve O'Brien of Alliance for Choice Derry, noted:

383 This experience was relayed to Amnesty International by Marie* (name has been changed) in an interview on 12 December 2022. See inset on Marie's experience, above.

384 See for example, The *Times*, 'Anti-abortion centre Stanton healthcare peddling false cancer claims to women', 2 June 2018, thetimes.co.uk/article/belfast-anti-abortion-centre-stanton-healthcare-peddling-false-cancer-claims-to-women-669bnk725.

385 Interview with a healthcare provider, 13 September 2022.

386 Interview with Women Help Women, 4 October 2022.

387 Interview with Megan, 3 March 2023.

388 Interview with a healthcare provider, 13 September 2022; interview with a healthcare provider, 27 September 2022.



> I think that the role of the GP in provision of abortion services could change if GP attitudes changed. I think, I myself, in my own local family practice, there was a GP who was also a politician and ran on an anti-choice platform,[389] and I'm like, what advice have you been giving people? We know a lot of GPs don't want to signpost to abortion care.[390]

Susan*, from Derry, needed an abortion in summer 2022. After having a baby earlier that year, she explained that she could not handle another child at that moment, either emotionally or financially. In the end, she miscarried, but when she was seeking an abortion, she was treated disrespectfully by her GP who provided no information and refused to signpost her to abortion services.

She called her GP, and when she told the receptionist that she was calling to get an abortion, it took the GP one week to call her back. When she finally did call, the conversation lasted about five minutes where the GP initially ignored what she kept saying about wanting an abortion and instead was pushing her to make an appointment for a scan, telling her what she needs to do to have a 'healthy pregnancy and healthy baby'.

Susan said, 'The GP said something like – "Oh, you're pregnant! They'll give you a scan and then you need to take this supplement that helps the baby's bones grow, we want you to have a healthy baby, you know, you want to have a healthy pregnancy," and like, "I've done your postscript for folic acid and multivitamins."'

Her GP consistently ignored her wishes for help and then, finally, 'The doctor said something along the lines of "we can't actually facilitate abortion or anything. The GPs haven't actually got the means to facilitate it, unless extreme circumstances." Then I was left out on my own, with no information, no phone number, nothing.'

She said she felt judged by the GP, who made her feel like she was doing something wrong.

'The impression I got was, you're pregnant, you've done this. So you deal with it, more or less. There was no support at all. Like it was judgmental. Before the GP I was obviously already battling with myself because of fear. I was brought up on my own beliefs. Like I was, it was a process I was fighting with myself. And I felt that my GP would have helped me feel more easy or comfortable with it, but it just made it worse. It made me feel disgusting.'[391]

Some people Amnesty International interviewed believe that there are far more GPs supporting abortion than the general narrative presumes, but that solid data is needed as well as values clarification and guidance for GPs.[392]

389 *Belfast Telegraph*, '50 women have their say on abortion clinic', 16 October 2012 m.belfasttelegraph.co.uk/life/50-women-have-their-say-on-abortion-clinic/28875116.html

390 Interview with Dr Maeve O'Brien, Alliance for Choice Derry, 16 November 2022.

391 Interview with Susan (name has been changed), 13 January 2023.

392 For example, interview with a healthcare provider, 27 September 2022; interview with Dr Maeve O'Brien, Alliance for Choice Derry, 16 November 2022; interview with Dr Fiona Bloomer, senior lecturer in social policy, Ulster University, 12 December 2022.

### Human rights law

States have an obligation to ensure that the delivery of abortion services respects the dignity and decision-making agency and self-identified needs of persons seeking and undergoing an abortion. This includes respecting the decisions people make in accordance with their own life plans and conscience. The provision of quality abortion care requires ensuring privacy and confidentiality, and providing medically accurate, evidence-based, unbiased, and non-stigmatising information.[393]

International human rights law, in fact, does not place a positive obligation on states to guarantee a right to 'conscientious objection' for healthcare providers in the context of abortion and other sexual and reproductive healthcare services. However, they do recognise that some countries permit healthcare staff to exercise their objection. In such cases, UN and European human rights bodies have called for limitations on their use, in order to ensure that healthcare providers' personal beliefs do not hinder access to services.[394]

For example, the UN Committee on Economic, Social and Cultural Rights stated: 'Where healthcare providers are allowed to invoke conscientious objection, States must appropriately regulate this practice to ensure that it does not inhibit anyone's access to sexual and reproductive healthcare,' including abortion. They must require 'referrals to an accessible provider capable of and willing to provide the services being sought'.[395]

UN human rights bodies have also recognised that if states do allow conscience-based refusals, it is a personal, individual practice and cannot be exercised by an institution.[396]

## 4.4 Need for values clarification workshops

Many interviewees noted that such attitudes and the abuse of conscience-based refusals can be addressed through values clarification workshops with healthcare providers and other trust staff, which helps people to 'explore, question, clarify and affirm their values and beliefs about abortion and related sexual and reproductive health, such that their awareness and comfort with the provision of comprehensive, woman-centred abortion care is increased'[397] and they are able to deliver professional, non-judgmental and quality services. The World Health Organisation recommends values clarification for healthcare workers involved in sexual and reproductive health services as part of ensuring an enabling environment for abortion care.[398]

These workshops have been conducted informally since legalisation, at the initiative of individual providers and their unfaltering commitment to providing abortion care.

393 CEDAW Committee, General Recommendation 24, para 31; Human Rights Committee, General Comment 36, para 8.

394 The right to freedom of thought, conscience and religion is not an absolute right. See, for example, Human Rights Committee, General Comment 22. The manifestation of this right can be restricted to protect the rights and freedoms of others and to guarantee that there is full accessibility, availability, acceptability, and quality of services, goods, and information, and that those are enjoyed free from discrimination, coercion, and violence. CESCR Committee, General Comment 22; CEDAW Committee General Recommendation 24.

395 CESCR Committee, General Comment 22, para 43.

396 CEDAW Committee General Recommendation 24, para 11; Human Rights Committee, General Comment 34, para 8; CESCR Committee, General Comment 24, para 21.

397 Ipas, Abortion Attitude Transformation: A Values Clarification Toolkit for Global Audiences (2008) p4, ipas.org/wp-content/uploads/2020/06/VALCLARE14-VCATAbortionAttitudeTransformation.pdf

398 WHO, Abortion Care Guideline (2022) p16.



With commissioning, regional training in values clarification is being offered to staff from each trust, with the idea that these staff will become facilitators and will disseminate this training to relevant employees within their trust on an ongoing basis.[399] Having an understanding of how abortion care and treatment works, and its importance to women, amongst other things, can have a significant effect on the quality of care and the number of staff willing to provide and support the provision of abortion services.

Dr Laura McLaughlin, co-chair of Doctors for Choice, has been a leader in promoting values clarification amongst healthcare staff in Northern Ireland since decriminalisation in October 2019. She explains the recent context of why it is needed:

> Almost three years down the line, and still people don't really understand what happened on the 22nd of October 2019. It was literally thrown upon staff… And I think there was, from the anti-abortion side, a lot of scaremongering, 'You're going to be forced to do this, you know, you work in maternity, you will be forced to kill babies, whether you like it or not.' And there's still that mentality. It's less so, but it's still there.[400]

She took the lead in developing values clarification on her own initiative and on her own time, with little institutional support because of the lack of commissioning:

> I just developed it myself, based on the work of Ipas. Their values clarification workshops are one to three days, but I had to shorten it to three hours, because of the lack of support to do this. I've been delivering this within my service just to try and give the staff space to discuss their values and feelings, to make the staff feel supported, ultimately as to give our patients the best care that they should receive whenever they come through the door.[401]

To Dr McLaughlin, the benefits of even these shortened workshops have been significant.

> The introduction of values clarification around November 2020 has made a big difference in the quality of care provided. There are staff where, two years previously, would have been very reluctant to even just go in and give a woman needing to undergo an abortion at 14 weeks a plate of food, let alone hand her the medication. We have done a complete 180. More and more are willing to help with the medication. But it's through the fact that they feel supported, you know. They're not being forced. You can't drag people to the same opinion as yourself. That's where you'll get so much resistance and kick back and end up in a lot of bother. Most people will come around if you encourage them and give them space. And those that don't will never, so you just leave them. To me, gynae has been a really good example of that. They've given the staff space, time, better support. The service is talked about a lot more freely. So there's been big strides. The next step is to move on to the midwives and obstetric component of it.[402]

399 Interview with a healthcare provider, 26 April 2023; interview with a healthcare provider, 3 May 2023; interview with a healthcare provider, 3 May 2023; interview with a healthcare provider, 5 May 2023; interview with a healthcare provider, 9 May 2023; interview with a healthcare provider, 14 August 2023; interview with a healthcare provider, 15 August 2023; interview with a healthcare provider, 16 August 2023..

400 Interview with Dr Laura McLaughlin, co-chair, Doctors for Choice NI, 28 September 2022.

401 Interview with Dr Laura McLaughlin, co-chair, Doctors for Choice NI, 28 September 2022.

402 Interview with Dr Laura McLaughlin, co-chair, Doctors for Choice NI, 28 September 2022.

Providers we spoke with noted that conscience-based refusals to provide surgical abortion and later term abortions is a barrier, which is one reason why it was easier to begin service provision with early medical abortion.[403] Dr McLaughlin explained that setting up surgical services for up to 24 weeks will require values clarification workshops. She notes that values clarification should have happened much earlier and should have been ongoing.[404]

Dr Bloomer, who does research on this issue in Northern Ireland, notes:

> I think all staff need to have an opportunity to discuss what their positions are, to talk about the reality of why abortion services are needed, the experiences of women and pregnant people, so that we can deal with some of those myths. And have everybody on a broad understanding of what it's about. Because if you don't have that, there's going to be so many hurdles. And we know from research that for a woman, a private person who's going to have an abortion, her expectation is she's going to be judged. And even if one remark is made, she'll hold on to that one remark, even if everything else is fine.[405]

403 Interview with a healthcare provider, 27 September 2022; interview with a healthcare provider, 28 September 2022; interview with a healthcare provider, 16 August 2023; interview with a healthcare provider, 25 August 2023.

404 Interview with Dr Laura McLaughlin, co-chair, Doctors for Choice NI, 28 September 2022.

405 Interview with Dr Fiona Bloomer, senior lecturer in social policy, Ulster University, 12 December 2022.



# 5. Failure to provide information on abortion law and services, misinformation and stigma allowed to flourish

Until the collapse of the devolved administration in October 2022, political leaders opposed to abortion law reform in Northern Ireland set up roadblock after roadblock to implementing the new law and, in doing so, impeded abortion provision, violating the rights of people needing abortion care. In addition to failing to fund and commission abortion services, a consistent approach by the government to prevent and limit access to abortion services was a silence from the Minister of Health and, by extension, the body responsible for ensuring service provision: the Department of Health.

This failure to provide accessible information about the new abortion law or services, in this highly stigmatising and previously criminalised context, created confusion and perpetuated stigma around abortion services in Northern Ireland and prevented women, girls and other people who can get pregnant in Northern Ireland from accessing healthcare services to which they are legally entitled. Although NGOs have done their best to disseminate information and be vocal about access to abortion services,[406] and because of this people are increasingly more informed, the government has not fulfilled its duty to ensure the public is informed and knowledgeable about their human rights.

With the collapse of the obstructive devolved administration and the commissioning of abortion services, information about abortion services is now on NIDirect, the official government website for people living in Northern Ireland. However, this information is not comprehensive, nor does it clearly state the legal grounds for abortion in Northern Ireland. Moreover, a single webpage is insufficient to remedy the government's longstanding silence surrounding abortion and the pervasive abortion stigma in Northern Ireland. A public information campaign is imperative.

## 5.1 Nearly three years of silence: no information from the government to the public on how to access services (March 2020-December 2022)

From March 2020, when the new abortion regulations came into effect, until his final day in office on 27 October 2022, following the collapse of the devolved government, the then Northern Ireland health minister failed to publish accessible information about the content of the new law or where to access local abortion services. Information about where, how, and under what circumstances, someone in Northern Ireland could access abortion could not be found anywhere on the Department of Health (DOH) website or on NIDirect, the official government website for people living in Northern Ireland. There was no information campaign by the Public Health Agency.

406 See, for example, Amnesty International's online and offline ad campaign, which ran end of 2019 and early 2020; Alliance for Choice Belfast alliance4choice.com/; Alliance for Choice Derry allianceforchoiceni.org/abortion-help; Informing Choices Northern Ireland informingchoicesni.org/abortion-northern-ireland

Although Amnesty International UK undertook an online and offline ad campaign, and organisations such as Informing Choices Northern Ireland (ICNI) and Alliance for Choice posted information about the abortion law and services on their websites and social media, pregnant people in Northern Ireland who sought an abortion had no central, government-supported resource to turn to that would clearly signpost them to the services they needed and had a right to access.

In this environment, some of the Health and Social Care Trusts were initially cautious about what they put on their websites regarding their provision of early medical abortion services, and the content was not always easy to find.[407] Ruairi Rowan of ICNI helped manage the Central Access Point phone line for early medical abortion services across Northern Ireland's health trusts from April 2020 until October 2021 for people seeking abortions in Northern Ireland. He notes: 'It took some of our health trusts over a year to put information about abortion services on their websites. Even now, it's not very accessible.'[408]

Vic Young, an abortion doula – a person who provides emotional and practical support to people seeking abortion – with Lucht Cabhrach, a network of abortion doulas organised through Alliance for Choice,[409] outlined the ongoing consequences of the lack of comprehensive information.

Speaking to Amnesty International in December 2022, they noted: 'One of the most common things, whenever we're doing doula work, is very much that people are still unsure. They don't know if it's still illegal or not, they don't know if they're going to get into trouble for seeking an abortion.'

Vic Young complained that 'there is nothing on the NHS websites, or on the health and social care websites. It's very much people have to do their own digging for information.' They stated that 'one of the most common questions that I certainly get asked is, you know: Is it legal? Is this safe? And it's just a lack of information.'[410]

In their opinion, the health minister was responsible for stopping people accessing abortion services, the failure to commission services and even denying access to information about abortion services.

In addition to being unsure of the new law, most people remained unaware of how to access abortion services in Northern Ireland. An Amnesty International-commissioned survey, conducted in Northern Ireland in October 2022, found that only 47 per cent of adults and 46 per cent of women were aware that abortion is currently legal in Northern Ireland. And only a small fraction of those surveyed – 13 per cent of adults and 10 per cent of women – knew how to access abortion services.[411]

407 Interview with Ruairi Rowan, director of advocacy and policy, Informing Choices NI (ICNI), 8 September 2022; interview with a healthcare provider, 13 September 2022; interview with a healthcare provider, 29 September 2022.
408 Interview with Ruairi Rowan, director of advocacy and policy, ICNI, 8 September 2022.
409 See Lucht Cabhrach: Abortion Doulas, luchtcabhrach.com/about
410 Interview with Vic Young, abortion doula with Lucht Cabhrach, 13 December 2022.
411 Amnesty International UK, Northern Ireland: fewer than half of women realise abortion is lawful – new poll, 21 October 2022, amnesty.org.uk/press-releases/northern-ireland-fewer-half-women-realise-abortion-lawful-new-poll



Susan* recalls finding out she was pregnant in 2022 and thinking:

> I can't do this, I'm on my own. I'm a single mother, and the youngest was only a couple of months at the time. So I was like, I don't know what I'm gonna do. Like financially, it wasn't a great time. And then obviously, mentally and emotionally, myself, I just couldn't do it. It just wouldn't have been right to do it. So I was like, let me look and see what I can do. So I went online, and just on the Google, trying to do some research on it and what my options were, and there was very little information. There was a lot of information, but it was very hard to find out how you actually access it or how you actually go about doing it.[412]

She called her GP and was told they would only provide early pregnancy services and could not facilitate access to abortion services. It took her two weeks to get the information she needed, and it ultimately came from a local activist. As Susan explained, 'It does massively impact you negatively. I was seriously doubting myself for like two weeks. I wasn't sleeping. I wasn't eating. I was crying, like I was an emotional mess, because there was no support.'[413]

Nicola,* a medical doctor and Belfast resident who needed an abortion in 2021, similarly recalled:

> I wasn't really sure where to go. I had a really good friend who was a midwife and she was able to point me in the right direction, or else I'm not sure where I would have got help. It'd be nice to see information available in GP surgeries or other health environments or government buildings, you know, just about what your choices are. And if you're ever facing these choices, here's what you can do about it.[414]

Jade Cater, Senior Operations Manager at MSI Reproductive Choices (MSI) in England, periodically answers calls at the MSI booking centre. When Amnesty spoke with her in October 2022, she observed that callers from Northern Ireland seem 'a bit lost, with what's going on and what their next steps are'.[415] She recalls:

> I recently spoke to somebody who was really upset, and she was really breaking her heart on the phone because she felt that she didn't know who to call and she didn't know what to do. And she then found our number and called us, and I booked her appointment, I booked her surgical appointment as well at the same time because she was quite high gestation, she was around sort of 16 weeks. But she kept repeating and said, 'You're the only person that's helped me, you're the only person that's helped me. I just didn't know what to do.'

> She just had no idea what she needed to do to get help. And obviously, to finance it as well – she didn't know that we could support her with the financial situation and getting everything that she needed. Because, I think, especially in the economy now, and it's been like it for a little while, people don't have the money to pay for it.[416]

412 Interview with Susan (name has been changed), 13 January 2023.
413 Interview with Susan (name has been changed), 13 January 2023.
414 Interview with Nicola (name has been changed), 10 January 2023.
415 Interview with Jade Cater, senior operations manager, MSI Reproductive Choices, 3 October 2022.
416 Interview with Jade Cater, senior operations manager, MSI Reproductive Choices, 3 October 2022.

Olivia O'Neill, 26, who had an abortion herself in December 2021 and who has helped young women through the abortion process, recalls her experience of not having anywhere to turn when she was unsure if the pills worked:

> I wasn't sure if I passed the pregnancy. I've helped others through this, so I thought I knew what it was like, but it's different for everyone. I didn't have anywhere to turn to ask and I'm pretty resourceful. It was the weekend, so I had to call the off-hours GP office, and was told by the nurse on duty that I probably need to get a surgical abortion. I panicked, I was scared. Then I waited until Monday and called the Belfast clinic, and they told me not to worry. I went in for a scan just to be sure and it was all fine… It would be good if there was a place you could call with questions like this. It's all good to have a website, but you need more when you're in a crisis mode.[417]

## 5.2 Department of Health allowed local booking service to collapse in 2021

Contributing to the confusion and poor access to information for people seeking abortion services is the Department of Health's ongoing failure to provide a local helpline and booking service for abortion appointments. In 2020, when abortion services first began to be offered, Informing Choices Northern Ireland (ICNI) stepped in to fill the void left by the government's failure. ICNI provided a helpline and central booking service between April 2020 and 1 October 2021, on its own initiative and with no financial support from the government. However, realising that they did not have the resources necessary to keep pace with the demand for their services, ICNI repeatedly appealed for government funding in order to continue this work.[418]

Despite a July 2021 written directive and accompanying statement from the Northern Ireland Secretary to the Department of Health, ordering the commissioning of abortion services with 'an immediate requirement for the Department of Health to continue to support the Central Access Point provided by Informing Choices NI (ICNI) who are key to providing Early Medical Abortion services,'[419] these requests and directive were ignored and denied by the DOH. ICNI's helpline was forced to shut down due to lack of funds.[420]

The collapse of ICNI's hotline and booking service broke the local link between people in Northern Ireland who needed abortion services and Northern Ireland healthcare providers. The British Pregnancy Advisory Service (BPAS), based in England, then volunteered their services and stepped in to fill the gap but, with phone operators in England for a Northern Ireland service, Northern Ireland's government was back to exporting healthcare – and exceptionalising and stigmatising abortion services.

417 Interview with Olivia O'Neill, 20 February 2023.

418 See ICNI, *Beyond Decriminalisation: pregnancy choices and abortion care in Northern Ireland* (2021), informingchoicesni.org/wp-content/uploads/2021/06/Beyond-Decriminalisation-Report.pdf

419 The Abortion Services Directions 2021, assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005075/The_Abortion_Services_Directions_2021.pdf; Secretary of State for Northern Ireland, The Abortion Services Directions 2021, Statement UIN HCWS238, 22 July 2021, questions-statements.parliament.uk/written-statements/detail/2021-07-22/hcws238

420 ICNI, press release: Informing Choices NI Withdraw Central Access Point Into Early Medical Abortion Services, 1 October 2021 informingchoicesni.org/wp-content/uploads/2021/09/CAP-Withdrawal-PR.pdf.



To date, bookings must be made by calling either BPAS or MSI Reproductive Choices offices in England.[421] People seeking access to services in Northern Ireland have no local number to call and are unable to contact the clinics directly. Although the system has been providing much-needed support for arranging abortion care, the lack of a local contact number has made accessing care challenging for some people seeking services.

Katie Boyd described to Amnesty International that she called the BPAS-operated central booking number in England in December 2021 to book an appointment and received no follow up call from her trust-area clinic for a month, despite assurances that she would be called back in a matter of days. Increasingly distraught, she reached back out to BPAS:

> A day, whenever you're pregnant, and you don't want to be, feels like a huge amount of time. But in terms of where I was with my gestational limit, a month was the difference between being able to access an abortion in Northern Ireland via pills, or having to go to England for a procedure. So I phoned them quite a few times to say, nobody had been in touch. It's been five days, it's been six days, it's been seven days. And BPAS said, well, we can't do anything other than keep mailing the clinic asking them to contact you. And I said, well, if you even just give me the number – which I couldn't find online and I'm fairly resourceful. And they said, no, no, we can't, it doesn't work like that, there's a system whereby we email them and they then get in contact with you.[422]

Ruairi Rowan, director of advocacy and policy at ICNI, explains the importance of a local number:

> Following the decriminalisation of abortion, anti-choice groups consistently put forward the narrative that the law was being imposed on the people of Northern Ireland by Westminster and that there wouldn't be doctors willing to provide the service. So, for us, one way to dispel these myths was to ensure that it was an organisation from Northern Ireland providing the pathway into the service. I also think it was reassuring for women to see a local telephone number, hear a Northern Irish accent, and speak with someone who knew where their local clinic was. For over 50 years, the social understanding in Northern Ireland had been that you needed to travel to access abortion. So, this was essential in order to start changing that perception.[423]

In an interview with Amnesty, the Department of Health indicated that they intend to put out a UK-wide tender for a central access point sometime in 2023.[424]

## 5.3 Anti-abortion agencies, deception and delays

This lack of official and comprehensive information about abortion services in Northern Ireland allowed misinformation to flourish. Women seeking information online come across crisis pregnancy centres run by anti-abortion, rogue agencies, such

421 NIDirect, *Abortion Services* nidirect.gov.uk/articles/abortion-services#toc-1

422 Interview with Katie Boyd, 13 December 2022.

423 Interview with Ruairi Rowan, director of advocacy and policy, ICNI, 8 September 2022.

424 Interview with the director of secondary care and the head of abortion policy, Department of Health, 2 March 2023.

as Stanton Healthcare in Belfast or Advocate Women's Centre in Derry.[425] One doctor who provides abortion services explains: 'A lot of it's word by mouth for patients; or they go on the Google. But then if they Google, a good portion end up at Stanton.'[426]

Another doctor explained, in an interview prior to the commissioning of abortion services: we 'hope that [the trust website] will eventually come up higher in the Google search but, again, Stanton are paying to get up the Google list. They have more money than we have.'[427]

Healthcare providers and activists believe that places like Stanton Healthcare operate with the intention of pressuring women not to have an abortion and delaying their access to services until they are past the gestational limit where they can access them locally. One doctor who provides early medical abortions describes how it works:

> Some people are delayed by Stanton, which basically masquerades as an abortion clinic and makes women have scans every couple of weeks. So the ploy is to delay. Once the penny drops, sometimes they're actually too late by the time they come to us or too late to get treatment in Northern Ireland.[428]

Ruairi Rowan of ICNI remembers fielding calls from people seeking abortion services during the period that ICNI was running the central access point:

> When people want to find information about abortion, the first place they will go is Google. And if they search for 'abortion clinic Belfast,' Stanton Healthcare are one of the first results. We spoke with over 100 women who had gone to Stanton, as they believed they would assist them in accessing an abortion. Often, it was only after several appointments that women realised they weren't speaking to a non-directive provider [offering neutral, unbiased counselling and information]. In general, women stated that they had a horrible experience, were judged, and taken advantage of when they were at their most vulnerable. They found the experience to be very distressing and traumatising. Women frequently outlined how private scans had been arranged, having been falsely told that this was necessary, and this delayed timely access to abortion care. When you have the void created by the Department of Health in failing to provide information about services, organisations like Stanton will thrive, and women will suffer.[429]

Amnesty International was told by one healthcare provider that, prior to their trust putting information about their abortion services on the trust website, they were seeing at least two patients every month that had been misinformed and delayed by Stanton.[430]

425 See BBC News, Abortion UK: Women 'manipulated' in crisis pregnancy advice centres, 27 February 2023, bbc.com/news/uk-64751800.
426 Interview with a healthcare provider, 28 September 2022.
427 Interview with a healthcare provider, 13 September 2022.
428 Interview with a healthcare provider, 13 September 2022.
429 Interview with Ruairi Rowan, director of advocacy and policy, ICNI, 8 September 2022.
430 Interview with a healthcare provider, 8 February 2023.



## 5.4 To date, information on government and trust websites is unclear and incomplete

In December 2022, after the Secretary of State's commissioning announcement, information on the abortion law and how to access abortion services was finally made publicly available on NIDirect, the official government website for people living in Northern Ireland.[431] However, the information on the website about Northern Ireland's abortion law is unclear and incomplete, failing to specify that abortion is lawful at any gestation in cases of severe or fatal foetal impairment and to clarify the scope of the physical and mental health exception, including that it encompasses 'victims of sexual crime who present later than 12 weeks gestation'.[432] The government's website also makes no mention of abortion services being available in Northern Ireland after 12 weeks' gestation, despite the fact that trusts are providing abortion services in cases of severe or fatal foetal impairment after 12 weeks.

Information on the Department of Health website regarding where and how to access services is relegated to notes at the end of a press release, which was issued in response to the Secretary of State's legal instruction to the Department of Health to commission abortion services.[433]

Claire Hackett, a birth and abortion doula and an activist with Alliance for Choice, told Amnesty International, 'I know it's up on the NIDirect website on how to access abortion, but I would love to see a bit more awareness-raising of the fact that the service is here. Not only will people who need the service know how to get it, but I think it will raise the discussion more and it will normalise abortion. You know, if you go into your doctor's surgery and there's a poster on the wall about abortion.'[434]

Information provided by the Health and Social Care Trusts is also incomplete. As of May 2023, each of the five trusts has information on abortion services on their website; however, this information is not comprehensive, nor is it consistent across the five trusts. The extent and substance of the information provided varies significantly by trust.

All the trust websites provide phone numbers to call, depending on how many weeks pregnant the person is, and refer patients to the British Pregnancy Advisory Service in England for more information.[435] However, some trust websites don't clearly indicate that abortion services are provided within the trust.[436] Only two trust websites directly provide information about the early medical abortion procedure, what happens at an appointment, what to expect at home and afterwards, among other information.[437]

431 NIDirect, *Abortion Services* nidirect.gov.uk/articles/abortion-services
432 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, 2020 No. 503, para 7.13.
433 Department of Health, DoH Statement, 2 December 2022, health-ni.gov.uk/news/doh-statement
434 Interview with Claire Hackett, birth and abortion doula and activist with Alliance for Choice-Belfast, 17 January 2023.
435 As of 16 August 2023: Southern Health and Social Care Trust, *Sexual Health*, southerntrust.hscni.net/your-health/health-improvement/contraception-and-sexual-health/; Belfast Health and Social Care Trust, *Sexual and Reproductive Healthcare Service* belfasttrust.hscni.net/service/sexual-and-reproductive-healthcare-service/#Abortion; Western Health and Social Care Trust, *Abortion Service (Cedar Clinic)* westerntrust.hscni.net/service/abortion-service-cedar-clinic/; South Eastern Health and Social Care Trust, *Abortion Service (Tulip Service)* setrust.hscni.net/service/abortion-service-tulip-service/; Northern Health and Social Care Trust, *Abortion* northerntrust.hscni.net/services/abortion/
436 See, for example, as of 16 August 2023: Southern Health and Social Care Trust, *Sexual Health* southerntrust.hscni.net/your-health/health-improvement/contraception-and-sexual-health/; Northern Health and Social Care Trust, *Abortion* northerntrust.hscni.net/services/abortion/
437 Western Health and Social Care Trust, *Abortion Service (Cedar Clinic)* westerntrust.hscni.net/service/abortion-service-cedar-clinic/; South Eastern Health and Social Care Trust, *Abortion Service (Tulip Service)* setrust.hscni.net/service/abortion-service-tulip-service/

Four of the five trust websites fail to note that if you need to travel to England, travel costs are funded.[438] None of the trust websites include information on the abortion law or grounds on which abortion is lawful and accessible, either in Northern Ireland or the rest of the UK.[439]

## 5.5 Lack of data transparency from the DOH on Northern Ireland's abortion statistics

The former Minister of Health's failure to make available information on abortion service provision to the public extended to the publication of Northern Ireland-wide abortion data. To date, the Department of Health has failed to disclose comprehensive annual data on abortion to the public.

Although the DOH has routinely disclosed hospital-based termination of pregnancy statistics since at least 2007, this is only a small fraction of overall abortion provision in Northern Ireland since law reform in 2020.[440] In Northern Ireland, early medical abortions – which comprise the vast majority of abortions currently performed in Northern Ireland – are provided in clinics and are not hospital-based.[441]

The Department of Health has publicly provided no reasoning for this lack of data transparency except to acknowledge as recently as 2023 that 'there is currently no framework in place to report on *all* Terminations of Pregnancy carried out in Northern Ireland'.[442] This is nearly three years after the 2020 regulations and the Explanatory Memorandum, which made clear that Northern Ireland's existing system for abortion data collection and publication was inadequate to meet the needs of the new abortion service.[443] When asked by Amnesty International about the lack of data, representatives from the DOH responded that the legally mandated notifications sent to the Chief Medical Officer (CMO) have yet to be processed and that the Department is still in the process of updating their methodology for compiling annual abortion statistics to reflect the changes to the abortion law.[444]

During Minister of Health Robin Swann's tenure in office, he was pressed by members of the Northern Ireland Assembly to release abortion data in ad hoc written requests. In response, the Minister would provide more comprehensive figures by trust that included non-hospital-based abortions.[445] However, even this Assembly-compelled data was not disaggregated based on statutory grounds for termination, gestation or method of abortion – data that is mandatory to report to the DOH and is disclosed annually in national abortion statistics for Scotland, England and Wales.[446] Nor was this data disaggregated based on gender, disability, ethnicity or age. The DOH, acknowledging that this is an important issue, has expressed their intent to release interim updated statistics in 2023, noting that, eventually: 'We would hope to be able to develop a report similar or as close to a report that's developed by the other nations and from their CMO notifications.'[447]

United Nations human rights bodies that monitor state compliance with United Nations human rights treaties have made clear that the collection of disaggregated data is a human rights obligation, noting that the publication of disaggregated data is critical to effectively understand and address barriers to healthcare, including with respect to intersecting forms of discrimination.[448] In its 2019 Concluding Observations for the UK, the CEDAW Committee recommended that the government: 'Systematically collect and publish data, disaggregated by sex, gender, ethnicity, disability and age, throughout the whole of its territory to inform policymaking and assess the impact of measures taken.'[449]

A failure of the 2020 Abortion Regulations is that they do not mandate annual, anonymised public data reporting on abortion statistics.[450] The Explanatory Memorandum to the 2020 Abortion Regulations instead notes that: 'Data collection will be an operational issue for the Department of Health in Northern Ireland who will be responsible for annual publication of relevant data.'[451]

Publicly accessible disaggregated data is critical to informing policy and improving service provision and is an obligation under international human rights treaties to which the UK is party. Data transparency is also essential to dismantling the negative stigma and harmful silence that have long surrounded abortion in Northern Ireland. A failure to analyse data in a timely manner cannot be used by the government as a pretext to escape accountability for the ineffective implementation of laws and neglecting to meet the health needs of its population. The Explanatory Memorandum is clear that the regulations' mandatory notification system for abortion services 'is essential to enable scrutiny of services' and that 'in England and Wales such data has been used to support service improvement, particularly in relation to providing abortions at earlier gestations'. The memorandum notes the intention of the notification system: 'We want

438 Only the Belfast Trust includes this information. See belfasttrust.hscni.net/service/sexual-and-reproductive-healthcare-service/#Abortion

439 See Southern Health and Social Care Trust, *Sexual Health* southerntrust.hscni.net/your-health/health-improvement/contraception-and-sexual-health/; Belfast Health and Social Care Trust, *Sexual and Reproductive Healthcare Service* belfasttrust.hscni.net/service/sexual-and-reproductive-healthcare-service/#Abortion; Western Health and Social Care Trust, *Abortion Service (Cedar Clinic)* westerntrust.hscni.net/service/abortion-service-cedar-clinic/; South Eastern Health and Social Care Trust, *Abortion Service (Tulip Service)* setrust.hscni.net/service/abortion-service-tulip-service/; Northern Health and Social Care Trust, *Abortion* northerntrust.hscni.net/services/abortion/

440 See, for example, Department of Health, *Northern Ireland Hospital Based Termination of Pregnancy Statistics 2021/22*, health-ni.gov.uk/sites/default/files/publications/health/hs-termination-of-pregnancy-stats-21-22.pdf

441 NIDirect, *Abortion services*, nidirect.gov.uk/articles/abortion-services

442 Department of Health, *Northern Ireland Hospital Based Termination of Pregnancy Statistics 2021/22*, p6 health-ni.gov.uk/sites/default/files/publications/health/hs-termination-of-pregnancy-stats-21-22.pdf

443 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, 2020 No. 503, para 7.30.

444 Interview with the director of secondary care and the head of abortion policy, Department of Health, 2 March 2023.

445 See, for example, Northern Ireland Assembly, AQW 3492/22-27, Answered on 14 October 2022 (on file with Amnesty International UK) (noting that 4136 abortion notifications had been received between 31 March 2020 and 26 September 2022, and breaking down those numbers by trust).

446 See, for example, Office for Health Improvement and Disparities, *National statistics: Abortion statistics, England and Wales: 2021* https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021#:~:text=The%20age%20standardised%20abortion%20rate,the%20Abortion%20Act%20was%20introduced.&text=However%2C%20the%20abortion%20rate%20for,6.4%20per%201%2C000%20in%202021); Public Health Scotland, *Termination of pregnancy statistics: Year ending December 2021* publichealthscotland.scot/publications/termination-of-pregnancy-statistics/termination-of-pregnancy-statistics-year-ending-december-2021/

447 Interview with the director of secondary care and the head of abortion policy, Department of Health, 2 March 2023.

448 See, for example, Committee on Economic, Social and Cultural Rights, General Comment 14, paras 57, 63; Committee on Economic, Social and Cultural Rights, General Comment 20, para 41; Committee on the Rights of the Child, General Comment 5, para 48; Committee on the Rights of Persons with Disabilities, *Concluding Observations: United Kingdom*, para 19, UN Doc CRPD/C/GBR/CO/1 (2017). See also Convention on the Rights of Persons with Disabilities, article 31.

449 CEDAW Committee, *Concluding Observations: United Kingdom* (2019), para 26(d). See also, WHO, Abortion Guidance (2022) pp18-19 (recommending states disaggregate data by: ability, age, caste, education, ethnicity, gender, geography, wealth).

450 This is in contrast to the 2018 abortion regulations in Ireland, for example, that require an annual report on abortion notifications to be sent to Parliament. Ireland, Health (Regulation of Termination of Pregnancy) Act 2018, Section 20(3). ('The Minister shall, not later than 30 June in each year, prepare a report on the notifications received by him or her under this section during the immediately preceding year, and shall, as soon as may be after preparing the report, cause copies of the report to be laid before each House of the Oireachtas.')

451 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, 2020 No. 503, para 7.31.

to ensure similar data is available to monitor and provide transparency as the services develop in Northern Ireland.'[452]

### Human rights standards on access to sexual and reproductive health information

As part of their obligation to uphold the right to health, states must ensure that information about sexual and reproductive healthcare facilities, goods and services is accessible: 'All individuals and groups, including adolescents and youth, have the right to evidence-based information on all aspects of sexual and reproductive health, including… safe abortion and postabortion care.'[453]

The Committee on Economic, Social and Cultural Rights has explained, that states must 'take measures to ensure that up-to-date, accurate information on sexual and reproductive health [including abortion] is publicly available and accessible to all individuals, in appropriate languages and formats'.[454] The WHO's Abortion Care Guideline further specifies that: 'To ensure that accurate information is broadly accessible, including for those with low literacy, an enabling environment would provide that such information is shared using a variety of formats/media as appropriate for the intended audience (eg videos, social media).'[455]

In affirming state obligations, the Committee on Economic, Social and Cultural Rights has made clear that: 'States must refrain from censoring, withholding, misrepresenting or criminalising the provision of information on sexual and reproductive health, both to the public and to individuals. Such restrictions impede access to information and services, and can fuel stigma and discrimination.'[456]

The Human Rights Committee has likewise said that, as part of their obligation to uphold the right to life, states must 'ensure access for women and men, and especially girls and boys, to quality and evidence-based information and education on sexual and reproductive health and to a wide range of affordable contraceptive methods, and prevent the stigmatisation of women and girls who seek abortion'.[457]

## 5.6 Uninformed general practitioners 'a real stumbling block' to women obtaining accurate information about abortion services

Medical professionals across the board have reported challenges accessing information about abortion services and people seeking abortion services have reported the lack of effective signposting by providers. Amnesty International's interviewees have repeatedly identified general practitioners (GPs)[458] as posing a particular barrier to women's access to abortion services.

452 Explanatory Memorandum to the Abortion (Northern Ireland) (No. 2) Regulations 2020, 2020 No. 503, para 7.29.
453 CESCR, General Comment No. 22, para 18. This information must be comprehensive, non-biased and evidence-based. CESCR, General Comment 22, para 49(f). See also CESCR, General Comment 14.
454 CESCR, General Comment 22, para 63. See also CESCR, General Comment 22, para 19.
455 WHO, Abortion Care Guideline (2022), p12.
456 CESCR, General Comment 22, para 41. See also CESCR, General Comment 22, para 58.
457 Human Rights Committee, General Comment 36, para 8.
458 General practitioner practices are independent small businesses contracted by the Strategic Planning and Performance Group of the Department of Health to provide primary care services to people in Northern Ireland.



GPs are under a contractual obligation to the Department of Health to provide a range of primary care services, specifically including advice to patients who intend to have a termination of pregnancy[459] and post-abortion care, or prompt referral to another primary care provider for this care where they have a 'conscientious objection' to abortion.[460] However, GPs may also opt-out of contraceptive and abortion service provision entirely, under the terms of their contract.[461] For most people living in Northern Ireland, their GP is the first port of call with any health concerns.

The Royal College of General Practitioners Northern Ireland (RCGPNI),[462] the professional membership body for GPs in Northern Ireland, has remained silent since the Abortion Regulations came into effect, offering no information to their members on: the content of the 2020 Abortion Regulations; current pathways to access abortion services in Northern Ireland and England; current UK government policy on fully funding travel, accommodation and treatment for those who travel to England for abortion services; where to refer patients for more information; and GPs' roles in ensuring access to services.[463] As one GP put it: The RCGPNI 'haven't put out any guidance. Full stop.'[464]

One practicing GP explained in September 2022:

> I would say a good amount of the appearance of failure to direct to the right service is more ignorance of knowing where to direct. Normally, if there's a new service started, then we get a direction from the Department [of Health] telling us about the new service, so we know where to direct. So I think some of GPs who don't direct to the right place, it's just that they don't actually know where to direct, rather than choosing not to direct.[465]

Amnesty International has also received information that some GPs have failed to use the official referral pathway through the MSI Reproductive Choices booking service and instead referred patients straight into NHS hospitals. NHS hospitals have been advised to send any direct referrals from Northern Ireland back through the MSI central booking service.[466]

As a result of this failure to communicate to GPs, there is not an understanding of the extent of GPs' knowledge about how their patients might access abortion services or what services are available in Northern Ireland. The RCGPNI's silence is, in part, a product of the absence of leadership from the Department of Health and the stigma surrounding abortion – stigma that the DOH's stance has fuelled and which the RCGPNI has been reluctant to tackle, in part, because of fear of vocal anti-abortion GPs.

459 Department of Health, Default Contract (NI) 2004, para 63.5 health-ni.gov.uk/sites/default/files/publications/dhssps/GMS%20Contract%20NI%20-%20Default%20Contract%20-%20Part%201%20-%2010.pdf
460 Department of Health, Default Contract (NI) 2004, para 71.3. See also Health and Social Care, GP Contract online.hscni.net/our-work/gps/gp-contract/ (noting that all GP practices provide 'additional services').
461 Department of Health, Standard General Medical Services Contract (NI) – March 2004, p48, fn 31 and p59, health-ni.gov.uk/sites/default/files/publications/dhssps/GMS%20Contract%20NI%20-%20March%202004.pdf.
462 Amnesty International interviewed a Northern Ireland representative from the Royal College of General Practitioners (RCGP); however, they declined to be quoted in this report.
463 See for example, the RCGP website: RCGP, Abortion – guidance for GPs in Northern Ireland, 9 October 2019, rcgp.org.uk/representing-you/policy-areas/abortion-guidance-northern-ireland
464 Interview with a general practitioner, 13 December 2022.
465 Interview with a healthcare provider, 27 September 2022.
466 Interview with Jade Cater, senior operations manager, MSI Reproductive Choices, 3 October 2022.

In contrast, the Royal College of Nursing, for example, supported its members to organise a series of lectures and webinars on abortion, between September 2020 and September 2022, which about 650 nurses attended.[467] Gabrielle O'Neill, chair of the Royal College of Nursing Northern Ireland Sexual Health Network observes that, among nurses 'the appetite is out there to learn, to gain awareness, to understand the legalities'.[468] Michelle McGrath, a Nurse Specialist and member of the RCN Sexual Health Network adds 'that talking about women's stories and experiences is most powerful. Once staff hear that, they can empathise and deliver better care to those who need it.'[469]

Dr Fiona Bloomer, a researcher on abortion policy at Ulster University, underscored:

> We need GPs to know. That's been a real stumbling block. The GPs, collectively, the Royal College of GPs, has been going at a glacially slow pace on abortion, very reluctant to actually engage on it at all. The Committee of the Royal College of GPs did not want to invoke [the anti-abortion GPs'] wrath, essentially, by even consulting members on it. So, I mean, I think in terms of commissioning, GPs need to be informed and advised about what services are available. We need staff training.[470]

Not until December 2022, when services had been commissioned by the Secretary of State, did the Department of Health send a letter and fact sheet to GP practices and the Royal College of General Practitioners Northern Ireland, among other health professionals, informing them of the abortion service and pathways to care, which is normally standard procedure for the Department when a new service commences. The Department of Health noted that it did not do this earlier because services were not commissioned.[471]

Notably, the Department of Health's December 2022 letter and fact sheet do not explain the content of the new law and the grounds under which abortion is lawfully permitted, saying only that the law now allows for abortions 'in a wider range of circumstances'. Moreover, when explaining what abortion services are currently available in Northern Ireland, they note that early medical abortion services exist in all the trusts and that 'all HSC Trusts also continue to perform abortion in cases where there is immediate necessity to save the life of the woman, or due to risk of grave and serious (long-term or permanent) effect on her physical or mental health' – the more restrictive grounds that existed under NI's previous abortion law.[472]

This is inaccurate and, in the absence of any clarification of the grounds for abortion in the new law, misleading. For example, no mention is made of the right to access abortion on grounds of severe or fatal foetal impairment and that these services may be accessible locally. In addition, the fact sheet does not clarify that, under the current law in Northern Ireland, the mental and physical health grounds for abortion after 12 weeks,[473] as defined by the regulations, are where 'the continuance of the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman which is greater than if the pregnancy were terminated' and that 'account may be taken of the pregnant woman's actual or reasonably foreseeable circumstances'.[474] (See Chapter 1 for more on Northern Ireland's abortion law.) The fact sheet also does not explain that travel costs to Great Britain are covered for those who cannot access care in Northern Ireland.

## 5.7 A culture of silence and caution within some trusts

Management in some Health and Social Care Trusts took a cautious approach after the legalisation of abortion in Northern Ireland. Early medical abortion services were established by individually-motivated abortion providers in each trust who were permitted to 'provide the service, but we're just not allowed to talk about it'.[475] Providers were discouraged by some HSC trusts' management from speaking to journalists and restricted in what they could say about the service on the trusts' own websites.[476]

Donagh Stenson of BPAS remembers:

> A nurse I know said something externally, about inviting a very prominent Northern Ireland politician down to come and speak to the women who are accessing their [early medical abortion] services. She told me she was threatened with the sack, by her management, because she spoke outside without permission. But that's the kind of environment they've been working within.[477]

## 5.8 'I was scared of being judged': government's failure to provide information, and politicians' anti-abortion rhetoric fuels stigma

The government's obvious reluctance and, at times, outright and vocal resistance[478] around the provision of abortion services not only creates barriers to those needing to access care, but it reinforces a climate of stigma and secrecy in Northern Ireland that has persisted for decades. Historically, women and pregnant people don't talk about the abortions they have had, even to their close family and friends.[479] Several UN treaty monitoring bodies have underlined the duty of states to address stigma related to abortion and those who seek or provide abortion services. For example, the Human Rights Committee has explicitly affirmed that states have a human rights obligation to 'prevent the stigmatisation of women and girls who seek abortion'.[480]

467 Interview with Gabrielle O'Neill, chair of the RCN NI Sexual Health Network, 8 February 2023; interview with Michele McGrath, nurse specialist and member of the RCN Sexual Health Network, 8 February 2023.
468 Interview with Gabrielle O'Neill, chair of the RCN NI Sexual Health Network, 8 February 2023.
469 Interview with Michele McGrath, nurse specialist and member of the RCN Sexual Health Network, 8 February 2023.
470 Interview with Dr Fiona Bloomer, senior lecturer in social policy, Ulster University, 12 December 2022.
471 Interview with the director of secondary care and the head of abortion policy, Department of Health, 2 March 2023.
472 Letter and Fact Sheet from the deputy secretary, SPPG, Department of Health (12 December 2022) to all GP practices, chair NIGPC, Chair RCGPNI, Community Pharmacies, NI, chair CPNI, chair Pharmacy Forum, chair Pharmaceutical Society, concerning 'Commissioning of Abortion Services, NI'.
473 Letter and Fact Sheet from the deputy secretary, SPPG, Department of Health (12 December 2022) to all GP practices, chair NIGPC, chair RCGPNI, Community Pharmacies, NI, chair CPNI, chair Pharmacy Forum, chair Pharmaceutical Society, concerning 'Commissioning of Abortion Services, NI'.
474 The Abortion (Northern Ireland) (No. 2) Regulations 2020, Sections 4(1)(b), 4(2).
475 Interview with a healthcare provider, 13 September 2022.
476 Interview with a healthcare provider, 13 September 2022; interview with a healthcare provider, 28 September 2022.
477 Interview with Donagh Stenson, innovation and marketing director, BPAS, 14 September 2022.
478 See, eg, BBC News, Abortion: New laws need full discussion says Arlene Foster, 6 April 2020 bbc.com/news/uk-northern-ireland-politics-52190465 (Foster, the then First Minister, stated: 'I don't think it's any secret I don't believe abortion on demand should be available in NI – it's a retrograde step for our society.')
479 Amnesty International, *Northern Ireland: Barriers to accessing abortion services*, EUR 45/1057/2015 (2015), pp6-7.
480 Human Rights Committee, General Comment 36, para 8.

One woman who had an abortion in 2022 explained her silence: 'If my mom and dad knew, they would never speak to me again. People are really afraid of being judged. I think that's another part of what makes it so daunting. There's stigma behind it, where a lot of women that would really need it probably are afraid. They're afraid of the judgment coming from all.'[481]

Stigma permeates all abortions and related issues, including terminations for medical reasons (TFMR). Suzie Heaney, Northern Ireland coordinator at Antenatal Results and Choices (ARC) and a midwife, notes that those who have TFMRs often 'don't say the true nature of their loss because they feel they can't sometimes with friends and family, so some might describe it as a miscarriage or a stillbirth'.[482]

Stigma, which the government has promoted, works in many ways, including through people's internalised perceptions. Many people seeking abortion services expect to be judged in the healthcare system and, when they are not, they are surprised. A nurse who works in an early medical abortion service in one of the trusts noted to Amnesty International how a recent patient expressed to her 'how nice you all are here, I thought I would be judged'.[483]

A GP explained to Amnesty International that, in their experience, some people who have needed an abortion are reluctant to speak to their GPs:

> It's stigma because it's never been talked about here. I mean, people just travel, and never told anyone outside of perhaps immediate friend and family, partner, mother. Usually that was it. And, occasionally, it might have come back to a GP, or they might have mentioned that maybe the next pregnancy, which was a happier one, but just nobody talked about it. And it's always been something here that women have sorted out themselves.[484]

Emma May of MSI in England shared with Amnesty International her experience with patients from Northern Ireland:

> It's the stigma to it. I've had conversations with Northern Irish clients, who said, 'What happens if things don't go to plan? What happens if I have complications at home? I can't tell them I've had a termination because I'll get treated so badly.' So you're kind of then thinking, you know, well you could tell them you have had a miscarriage while you were over here, you know, no one's going to know any difference, but you're then making up lies, aren't you? It's just like it starts to unravel a bit. But why should you feel that you have to lie to your healthcare provider about a decision that you're perfectly entitled to make, and now are legally entitled to make, but you feel like you can't tell them the truth?[485]

Ensuring confidentiality is another, overlapping concern, explains Karen Murray, Northern Ireland director of the Royal College of Midwives (RCM), and is why people are more likely to Google online than go to their GP:

481 Interview with Susan (name has been changed), 13 January 2023.
482 Interview with Suzie Heaney, midwife and ARC coordinator NI, 14 December 2022.
483 Interview with a healthcare provider, 8 February 2023.
484 Interview with a general practitioner, 13 December 2022.
485 Interview with Emma May, registered nurse-clinical team lead, MSI Reproductive Choices, 9 December 2022.



> Purely because of the size of Northern Ireland, where, you know, the GP has been the family GP. Plus, if you go into GP surgery, quite often the receptionists live in the community, and whilst everybody's abiding by confidentiality – you're not going to go anywhere where somebody sees you coming in, and then they say to your mum, I saw so and so in the surgery today. And then, you know what I mean? Questions.[486]

However, this secrecy and stigma is increasingly being challenged. Katie Boyd, an abortion doula, made a deliberate decision to talk about her abortion last year:

> I purposefully spoke about my abortion. When a friend asked, 'How're you doing?' I told them, 'Not great, I had an abortion.' I made a real effort to be open and honest. On quite a few occasions they responded with, 'Oh my god, yeah, I had one last year.' And I was like, wow, I mean, I was friends with this person at the time, they never spoke to me about it. Shame survives in silence. The oxygen supply gets cut off when we share our stories with each other.[487]

Claire Hackett, an abortion doula with Alliance for Choice, agrees: 'I think the more we can have these talks, even as individuals, these conversations break the binary of the abortion discussion between "right" or "wrong"' and actually [help in] seeing all the nuance in the middle, and seeing the human side of it.'[488]

Activists in Northern Ireland are among those tackling abortion stigma with facts, information and safe spaces for consciousness-raising. Bethany Moore, with Alliance for Choice Derry, organises stigma busting workshops that attract a range of people, including young people, university students, medical practitioners and politicians. As she explained:

> It's talking to people about the situation here, what has changed since decriminalisation took place in 2019, where things are right now, where people can get their abortions if they need it. Talking through the myths that are so often perpetuated about abortion. How do you debunk them? By giving people the facts and the knowledge. It's about empowering others with the knowledge to start those conversations or challenge that anti-choice rhetoric where they're hearing it in their own day to day lives.[489]

## 'Enforced ignorance': relationship and sexuality education (RSE)

Interviewees consistently expressed that the lack of comprehensive and evidence-based sexuality education in schools is a key contributing factor to the stigma around abortion and to unwanted pregnancy in Northern Ireland. Although relationship and sexuality education (RSE) is a mandatory part of the curriculum in government-funded primary and post-primary schools in Northern Ireland, there is currently no standardised RSE content for all schools. Each school has had the discretion to develop their own policy and curricular content on RSE that reflects

486 Interview with Karen Murray, Northern Ireland director, RCM, 27 September 2022.
487 Interview with Katie Boyd, 13 December 2022.
488 Interview with Claire Hackett, birth and abortion doula and activist with Alliance for Choice, 17 January 2023.
489 Interview with Bethany Moore, Alliance for Choice Derry, 26 January 2023.

their school's ethos and values, with input from parents and students.[490] Schools can decide what, how, and how much, RSE content is taught to their students.

Schools in Northern Ireland remain largely segregated by religion, with Catholics attending schools maintained by the Catholic Church and 'controlled,' or government-managed and funded, schools attended by predominantly Protestant students. Schools are managed by boards of governors, which include religious or church representatives.[491] As such, the religious ethos of these schools dictates the content of RSE, which results in a largely abstinence-based and anti-abortion curriculum[492] where students are not provided accurate and comprehensive information about contraception or abortion. The CEDAW Committee, in its inquiry report on abortion in Northern Ireland, noted that RSE 'is under-developed or non-existent'.[493]

A 2019 online survey of young people aged 14-24 carried out by Belfast Youth Forum, the youth council for Belfast City Council, found that 'while 66 per cent of the respondents had received some RSE at school, the frequency, content and delivery of this was deemed basic, unhelpful, useless and biased.' In fact, 60 per cent of young people felt that the information they received was either 'not very useful' or 'not useful at all'.'[494] The report recommended that government '[w]ork with young people to develop age appropriate, relevant and inclusive RSE programme for schools. This should be a mandatory part of the school curriculum.'[495]

Arlene McLaren, CEO of Common Youth, a non-governmental organisation that provides evidence-based RSE classes throughout Northern Ireland, acknowledges that the discretion provided to schools means that RSE is inconsistently implemented: 'It is very ad hoc. It all just depends on the school.' For example, even among schools that work with Common Youth on RSE, some schools:

> …would just want you to talk about STIs but not talk about contraception. They pick and choose. It depends on what they are comfortable with. Teachers are scared of saying something, or bringing people in [to teach RSE], of the backlash from parents or the backlash from maybe the gatekeepers of the board that are not wanting this to happen. So it really depends on the school.[496]

In McLaren's experience, very few schools are willing to discuss abortion.

Common Youth stress the need to normalise sexuality education and for teacher training to provide evidence-based, unbiased RSE, noting that teachers' values and unconscious biases impact the way they teach this subject and how they talk about abortion. 'Well, there's a lot of stigma, and you know, what we notice is that people have certain values that they never question,' observes McLaren. But, says Michele Jordan, counsellor at Common Youth, 'This has nothing to do with morals. This is a healthcare issue. We need to bring that back in Northern Ireland. This isn't about a moral dilemma. It's about health. It's about women's health.'[497]

The CEDAW Committee, in its report on abortion in Northern Ireland, emphasised the impact of the lack of RSE on the health of Northern Ireland's youth, noting that 'access to abortion services and contraceptives are not statutory requirements of the advisory curriculum. Data show that the use of contraception by NI youth is lower and their rates of sexually transmitted infections are higher in comparison to their peers in other parts of the UK. Further, the prevalence of unplanned teenage pregnancies in NI is higher in comparison to other European Union countries and six times higher in deprived areas of NI.'[498]

Women, activists, and healthcare professionals interviewed for this report consistently stressed the importance of mandating comprehensive, evidence-based, 'free-from-religious-influence'[499] RSE in addressing abortion stigma and ensuring access to services. Dr Maeve O'Brien, of Alliance for Choice Derry, remembers:

> I myself went to a convent school, you know, when there would have been young girls sitting 6-7-8-9 months pregnant, taking exams, but we wouldn't be taught anything about contraception, except that it was sinful and wrong, you know, just turning a blind eye to the realities of life and not equipping young people in Northern Ireland with the information to protect themselves and make life choices with fully informed understanding. I think it's archaic. I think we'll look back on it and just be disgusted and consider it a form of actual, you know, abuse that people who are enlisted to teach and care for children and young people in these Catholic schools and even in the controlled government schools are not providing comprehensive sex education. I mean, that's a foundational issue there. And then a lot of the stigma really springs from that.[500]

This has been a key issue for Alliance for Choice Derry, explains Dr Maeve O'Brien: 'The enforced ignorance, you know, realising that it's actually strategically done to keep people in the dark about their reproductive health, about contraception, about sexual information. So, a lot of the work we're doing now that decriminalisation [of abortion] has happened is consciousness-building, capacity-building.'[501]

The UK government is legally obligated to implement the CEDAW Committee's recommendation to make comprehensive sexuality education, 'covering early pregnancy prevention and access to abortion,' compulsory.[502] In 2022, the previous Secretary of State for Northern Ireland, Shailesh Vara, publicly declared his intent to introduce compulsory, comprehensive RSE should the Northern Ireland Department of Education fail to do so.[503] However, this was met with resistance by the Department of Education.[504]

490 Department of Education, Relationship and Sexuality Education (RSE) Guidance (2015), para 5, education-ni.gov.uk/sites/default/files/publications/de/2015%2022%20-%20Amended.pdf
491 NIDirect, *Types of School* nidirect.gov.uk/articles/types-school
492 CEDAW Inquiry Report, para 43. See, for example, Catholic Schools' Trustee Service, *Relationships and Sexuality Education, Guidance Document for Primary Schools: Northern Ireland* (NI) 2021, p29 catholiceducation-ni.org/wp-content/uploads/2021/05/RSE-Guidance-Booklet-Primary.pdf
493 CEDAW Inquiry Report, para 43.
494 Belfast Youth Forum, *Any Use? Report* (2019) belfastcity.gov.uk/documents/youth-forum/any-use-report#subjectsrse
495 Belfast Youth Forum, *Any Use? Report* (2019). (See above link.)
496 Interview with Arlene McLaren, CEO of Common Youth, 17 November 2022.
497 Interview with Michele Jordan, counsellor, Common Youth, 17 November 2022.
498 CEDAW Inquiry Report, para 44.
499 Interview with Claire Hackett, birth and abortion doula and activist with Alliance for Choice-Belfast, 17 January 2023.
500 Interview with Dr. Maeve O'Brien, Alliance for Choice Derry, 16 November 2022.
501 Interview with Dr. Maeve O'Brien, Alliance for Choice Derry, 16 November 2022.
502 CEDAW Inquiry Report, para 86(d).
503 BBC News, Sex education in schools could be made compulsory by NI secretary, 29 July 2022 bbc.com/news/uk-northern-ireland-62340425
504 BBC News, Sex education 'could bring conflict with parents and governors', 13 May 2021 bbc.com/news/uk-northern-ireland-57094099

The current Secretary of State, Chris Heaton-Harris, has sought to comply with the UK's legal obligation by issuing regulations on sexuality education for Northern Ireland. These regulations came into effect on 1 July 2023,[505] nearly four years after the UK government assumed full responsibility under the law to implement all of the CEDAW report's recommendations. The regulations make teaching on early pregnancy and abortion a compulsory component of the sex education curriculum for pupils ages 11-16, although, contrary to human rights standards (see below), parents may still opt out of having their children participate.[506] The Northern Ireland Department of Education must issue guidance to schools by 1 January 2024 on the required curriculum.[507]

**Human rights standards on sexuality education**

States have long had the obligation to provide comprehensive sexuality education in schools. It is a component of the rights to health and to information, generally, and the right to sexual and reproductive health information, in particular. The Committee on Economic, Social and Cultural Rights, for example, has made clear that states must 'ensure that all educational institutions incorporate unbiased, scientifically accurate, evidence-based, age-appropriate and comprehensive sexuality education into their required curricula,'[508] including education on abortion. The Human Rights Committee has likewise affirmed that states 'should ensure access for women and men, and especially girls and boys, to quality and evidence-based information and education on sexual and reproductive health'.[509] The Committee on the Rights of the Child, in interpreting the right to health, has also urged states to 'review and consider allowing children to consent [to education and guidance on sexual health, contraception and safe abortion]… without the permission of a parent, caregiver, or guardian'.[510] In reviewing Ireland's compliance with the Convention on the the Rights of the Child, the Committee has criticised barriers to sexual education, such as allowing parents to exempt their children from such education.[511]

At the regional human rights level, the European Court of Human Rights has addressed the related question of whether parents have a right to have their children exempted from compulsory comprehensive sexual education programmes in state primary schools. In *Kjeldsen, Busk Madsen and Pederson v Kingdom of Denmark*, the court considered the rights of parents of school-age children to ensure their children's education conforms to their religious or philosophical beliefs, and to non-discrimination, privacy, and freedom of religion. The parents had unsuccessfully sought to have their children exempted from compulsory sexual education. The court held that the parents' rights had not been violated because the sexual education information was provided in an objective and pluralistic manner. The court noted that the Danish state had a public interest in informing adolescents about sex-related issues, and affirmed that 'by providing children in good time with explanations [the state] considered useful, [it was] attempting to warn them against phenomena it viewed as disturbing,' such as high rates of adolescent pregnancy, abortion and sexually transmitted infections.[512] The court noted that the compulsory sexual education programmes did not affect the rights of the parents to provide additional teaching and information to their children in conformity with their religious and philosophical beliefs.[513]

The European Committee of Social Rights, which monitors state compliance with the European Social Charter, has established a series of standards for state parties for sex education in schools, including that it be mandatory and provided throughout schooling. The committee, in a collective complaint on the issue, held that the right to health obliges states to ensure sexual and reproductive health education 'throughout the entire period of schooling' as part of the mandatory school curriculum.[514] The committee stated that this curriculum must provide objective, scientifically based and non-discriminatory sex education without 'censoring, withholding or intentionally misrepresenting information'.[515] It added that sex education must not only address the biological functions of sexuality but also its social and cultural aspects. The committee specifically noted that sex education must be aimed at 'developing the capacity of children and young people to understand their sexuality in its biological, psychological, socio-cultural and reproductive dimensions which will enable them to make responsible decisions with regard to sexual and reproductive health behavior'.[516]

In 2023, UN experts emphasised the same in new guidelines on sexuality education, calling upon states to ensure 'that comprehensive sexuality education is a mandatory subject in school curricula' and that it is non-discriminatory, inclusive, addresses 'a breadth of topics beyond a focus on risks and disease' and 'eliminates the stigma often ascribed to sexual and reproductive health issues'.[517]

505 UK government, *Press Release: New requirements for Relationship and Sexuality Education curriculum in Northern Ireland*, 6 June 2023, gov.uk/government/news/new-requirements-for-relationship-and-sexuality-education-curriculum-in-northern-ireland; The Relationships and Sexuality Education (Northern Ireland) (Amendment) Regulations 2023, Section 1(2), legislation.gov.uk/uksi/2023/602/contents/made.

506 The Relationships and Sexuality Education (Northern Ireland) (Amendment) Regulations 2023, Sections 2 and 3. See also Explanatory Memorandum to the Relationships and Sexuality Education (Northern Ireland) (Amendment) Regulations 2023, 2023 No. 602, para 7.10 legislation.gov.uk/uksi/2023/602/pdfs/uksiem_20230602_en_001.pdf.

507 The Relationships and Sexuality Education (Northern Ireland) (Amendment) Regulations 2023, Section 2(3).

508 ESCR Committee, General Comment 22, para 63.

509 Human Rights Committee, General Comment 36, para 8.

510 Committee on the Rights of the Child, General Comment 15, para 31.

511 Committee on the Rights of the Child, *Concluding Observations: Ireland*, para 52, UN Doc CRC/C/IRL/CO/2 (2006)

512 *Kjeldsen, Busk Madsen and Pederson v Denmark*, European Court of Human Rights (ser A), para 54 (1976).

513 *Kjeldsen, Busk Madsen and Pederson v Denmark*, European Court of Human Rights (ser A), para 54 (1976).

514 European Committee of Social Rights, *International Center for the Protection of Human Rights (INTERIGHTS) v Croatia*, Complaint No. 45/2007, paras 45, 47 (2009).

515 European Committee of Social Rights, *International Center for the Protection of Human Rights (INTERIGHTS) v Croatia*, Complaint No. 45/2007, paras 47, 48 (2009).

516 European Committee of Social Rights, *International Center for the Protection of Human Rights (INTERIGHTS) v Croatia*, Complaint No. 45/2007, para 46 (2009).

517 OHCHR, *A Compendium on Comprehensive Sexuality Education*, March 2023 ohchr.org/sites/default/files/documents/issues/health/sr/Compendium-Comprehensive-Sexuality-Education-March-2023.pdf

# 6. Public persecution outside clinics and hospitals and other forms of intimidation and threatening behaviour

Various forms of intimidation and threatening behaviour against people seeking abortion, those providing abortions, and those supporting abortion rights, are present in Northern Ireland today. These tactics are at times supported by politicians and church hierarchies. Methods of intimidation and threatening behaviour include verbal intimidation and physically threatening behaviour outside trust sites providing abortion, trolling, threats by text messages, and intimidation by politicians.

A doctor that provides early medical abortions explains how she received a threatening text message and that, although she didn't feel under a direct threat, it did need a security response, for the safety of staff and patients:

> I got a text on the phone that's given to me by the trust. And it said, 'Child murderer. You killed my partner's baby,' or something like this. So I told the line management and they told me to tell the police and the police came around. I mean, they were very, very helpful, actually. The police came around to the house and sort of did an interview. And as a result of that, we were given a member of staff, a nursing auxiliary, to keep the door locked and to let people in… I didn't feel worried, but what I didn't want them doing was coming into the clinic making a scene. I think that would have been horrible.[518]

Amnesty International has received information that the Western Trust has been targeted by anti-abortion politicians. The trust has received letters and emails from public representatives involving overly detailed questioning about the services being provided. For example, some questions posed have been:

- Who provides counselling to women? Is this done by a doctor? Is this doctor their GP or is it a doctor provided by the trust? If by the trust, where are they based?
- Where do the face-to-face appointments following the initial telephone appointment take place? And are they done by the same doctor, a different doctor or nurses?
- Are women offered a scan prior to any kind of decision being made and are they offered an alternative to having an abortion?
- When women are signposted to information on counselling from different agencies, does this include any pro-life groups or agencies?
- How many doctors and nurses are employed for this service? Is there a separate ward or theatre specifically for this procedure?

These 'queries' intend to put pressure on trust administrators and managers responsible for abortion services by making clear that their every move is, and will be, monitored, causing stress in an already burdened service.

518 Interview with a healthcare provider, 29 September 2022.



Naomi Connor of Alliance for Choice described the continuing intimidation and threats against pro-choice activists over the years:

> The social media trolling, which is the obvious one. We get sent pictures of Hitler and death camps and aborted foetuses and we'll get, you know, trolled. I even got messages to say that I deserved to get breast cancer, not sure how they found out… We get called by a local priest who has a particular gift for us, he calls us satanic, like Satan's daughters or something like that, refers to us as arch feminists. Well, being an arch feminist is not an insult… Some of our activists have been attacked. I saw one of our escorts getting punched in the side of the head when they were escorting a woman when MSI used to be here. One of them came out of a sandwich shop next door and hit her on the side of the head. She didn't report it.[519]

Intimidation by anti-abortion activists outside clinics and hospitals has long been part of anti-abortion activities in Northern Ireland. This behaviour takes a significant toll on providers and women and other pregnant people seeking abortion services, as well as other patients and providers entering those buildings. Almost every single person Amnesty International has spoken to has mentioned anti-abortion activists as a significant issue and barrier to accessing abortion services. Many recounted instances in which they have been shouted at and intimidated entering their workplace or going in for services and shared their fears of their privacy being compromised on a very stigmatised issue and during a very vulnerable time for them.

As detailed below, anti-abortion organisations and activists:

- block entry into clinic buildings;
- physically chase people arriving for their EMA appointments, including all the way back to their cars in the clinic car parks;
- take videos of people entering the building and threaten to put their images online;
- force flyers filled with misinformation into peoples' hands or bags;
- shout and chant offensive statements over loudspeakers; and
- use props, such as plastic foetuses and little white coffins, and graphic images.

This behaviour and these images are disturbing and triggering, not only to some of the people seeking services and their partners or accompanying support person, but also to those who have experienced miscarriage and to broader staff and patients in the hospital or clinic.

## 6.1 Impact of anti-abortion activists on providers

Intimidation and threatening behaviour by anti-abortion protesters has taken a toll on providers and staff for many years. When Marie Stopes International (now MSI Reproductive Choices) first opened its clinic in 2012, protesters stood outside shouting and abusing staff and clients that entered the clinic. Dawn Purvis, who headed the Marie Stopes Clinic, and other staff at the clinic, experienced relentless intimidation until the clinic's closing in 2017.[520] Staff from the then Family Planning Association of

519 Interview with Naomi Connor, co-convenor, Alliance for Choice, 28 September 2022.

520 See, for example, the *Guardian*, 'Dawn Purvis Changed the Face of the Abortion Debate in Northern Ireland. So Why Is she Calling it a Day?', 10 April 2015 theguardian.com/world/2015/apr/10/dawn-purvis-abortion-debate-northern-ireland-marie-stopes-clinic-interview

Northern Ireland also experienced threatening conduct on the streets by anti-abortion 'protesters,' one incident of which led to an assault conviction.[521]

Years later, this conduct has not stopped. Without exception, every person Amnesty International spoke to who is working to ensure access to abortion or has sought reproductive healthcare services recounted instances where they experienced intimidation and threatening behaviour by anti-abortion activists. Some interviewees noted that, after the US Supreme Court's overturning of *Roe v Wade*, anti-abortion activism has got stronger and that anti-abortion activists feel validated by the Court's decision and motivated by the feeling that they are part of a global anti-choice movement that they perceive to be gaining ground with this decision.[522]

Anti-abortion protests in front of clinics and hospitals instil fear in both patients and providers, with some experiencing trauma. One provider noted that, before they relocated the clinic to a more secure hospital setting, 'It was horrible. It was upsetting. And stressful. And it kind of made me worry a bit sometimes about maybe people, protesters, knowing who I was and where I lived, and that there might be any unpleasantness for my family or anything like that, you know.'[523] Another expressed general concern about the impact of anti-choice activists on the willingness to provide services: 'That's a challenge in the Republic [Ireland] as well, we've got protesters outside, they know where we work and they know where we live.'[524]

Fear of violent protesters has been raised by numerous healthcare providers and staff we spoke with. One doctor remarked:

> I think that a lot of providers are very thick skinned. But they've got to be, you know. That must be a very unpleasant environment. How many abortion providers in the [United] States have been killed? You know, we haven't been, in the past, the most peaceful part of the UK. There's plenty of guns out there; someone could easily take a shot at you if they wanted or put a bomb under your car. I mean, those things could easily happen. So, yeah, I think it is intimidating. And for that reason, you know, people are quite cautious about the profile they have as well. So I think those things have to be recognised.[525]

Intimidation by these anti-choice activists has caused providers who otherwise would have continued to support the service to ask to be reassigned to other services. One EMA provider explained that services in their trust moved to a hospital site because of the escalation in threatening behaviours. When the services were in a clinic, 'I didn't find it particularly difficult on a personal level because I probably feel quite convinced by the reason why we do it. But I know there was other staff – we had a nurse who was invested in the work who then chose not to do it anymore because of the impact she felt from the protests. She found it very distressing.'[526]

521 *Belfast Telegraph*, 'Pro-life campaigner guilty of hitting sexual health worker with clipboard', 7 July 2015 belfasttelegraph.co.uk/life/pro-life-campaigner-guilty-of-hitting-sexual-health-worker-with-clipboard/31356836.html.
522 Interview with Donagh Stenson, innovation and marketing director, BPAS, 14 September 2022; interview with Naomi Connor, co-convenor, Alliance for Choice, 28 September 2022.
523 Interview with a healthcare provider, 30 September 2022.
524 Interview with a general practitioner, 13 December 2022.
525 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.
526 Interview with a healthcare provider, 27 September 2022.



Evidence submitted by the Royal College of Nursing, Northern Ireland, to the Assembly in respect of the Safe Access Zones Bill (see below), recognises that 'health service employers have a legal duty of care to the staff whom they employ and a broader responsibility to those members of the public who rely upon the services that they provide. At the moment, their hands are tied in terms of being able to discharge these responsibilities effectively in respect of abortion services.'[527]

Royal College of Nursing (RCN) Northern Ireland members recounted their own experiences in their submission to the Assembly. Nicola Bailey, sexual and reproductive healthcare nurse with the Belfast Health and Social Care Trust (and RCN UK Nurse of the Year 2021) stated:

> Absolutely, I have witnessed [this behaviour] and also have had patients that are in my care explain what happened to them …From my own experience, I was accessing the clinic one day and one of the protesters murmured 'murderer' under their breath as I walked by. This is not acceptable for any staff member to deal with. I am providing regulated healthcare, working within the law. I respect people have a right to their opinions, but it should not be allowed to interfere when people are trying to access healthcare facilities. Anyone has a right to confidential, safe, local, healthcare services.[528]

## 6.2 Impact of anti-abortion harassment and intimidation on patients

Many providers and patients explained to us how these protests act as a barrier to service. Dr Roberts, chair of NIACT, explains the impact:

> In Belfast, patients have been frightened off. It's very intimidating going through a line of protesters. There's no question, it's a barrier to access… We've said in our NIACT report, we're not seeking to take away people's rights to protest, but it's got to be an appropriate form of protest and jostling women and calling them murderers, and pushing leaflets on them and things like that isn't an appropriate form of protest.[529]

Healthcare providers have recounted numerous stories of women arriving to their abortion appointment distraught and in tears after encounters with anti-abortion protesters and spending the first 20-30 minutes of their appointment time comforting these women. One doctor explains, 'It's just very distressing for the patients… A lot of them come in crying and we need to spend half an hour with them to calm them down.'[530]

Carrie Montgomery, a counsellor with ICNI, tells of the impact on one of her clients:

527 RCN Northern Ireland, Call for evidence by the Northern Ireland Assembly Committee for Health in respect of the Abortion Services (Safe Access Zones) Bill, November 2021.
528 RCN Northern Ireland, Call for evidence by the Northern Ireland Assembly Committee for Health in respect of the Abortion Services (Safe Access Zones) Bill, November 2021.
529 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.
530 Interview with a healthcare provider, 13 September 2022.

> She experienced going into the clinic and what would have been said to her, and what she would have seen on the placards, and how she was treated, was so traumatic, she can't go into her own city centre any longer. The risk of maybe facing the protesters again, she completely avoids her town centre. She once had to drive past or through the town centre and, she was explaining to me, she had a panic attack. And she hasn't been able to do it since. So these are really impactful for women.

Montgomery continues:

> And also, I think, for women as well, they sort of talk about six degrees of separation. In Northern Ireland, it's more like two degrees of separation. And we're very close knit, everybody knows each other's business and somebody knows somebody that somebody else knows. It's very, very difficult to have a private life in Northern Ireland. And, you know, quite often then, again, the silencing whenever women realise that somebody was protesting they either knew or knew of. And again, you know, the realisation that that is some of the attitudes that are held by their loved ones, which silences women further.[531]

Nicola,* a medical doctor who had an abortion in 2021 at the Belfast clinic, explained the impact on her and her privacy concerns:

> There were people around, sort of protesting and sort of constantly praying outside. And that kind of really shook me and really disturbed me. It's very difficult. It's very obvious what you're going in and out for when there's people outside, shouting and handing out leaflets and things. It's very difficult… He just seemed to be like constantly praying or mumbling or jumping or something. And a few of them have banners about, you know, 'This is a centre for murder' or something like this. So it was really awful. It did bring me to tears. I thought it was a terrible thing. And the same building is used for other non-related services. It's really affecting all services.[532]

Dr Sandra McDermott recounted her experience with a patient from a rural area outside Derry who had two children and was facing a lot of family problems. Dr McDermott scheduled her for an early time, before the protesters arrived in front of the clinic, but she arrived late and when she was leaving the activists were there and had forced her to take their leaflets. She was found by another health centre staff member in the stairwell of the building, really upset and crying, so was brought back up to the clinic. The patient was so upset that Dr McDermott called the police, who arrived and spoke to the activists and to her, but they told her that they couldn't do much.[533]

A woman explained to Amnesty International the impact of these anti-abortion activists on her: 'The staff were lovely but the experience was rough because I already didn't want to be there and there was a woman outside with her "pro-life" stall and trying to give me leaflets. That obviously made it worse, not to mention my anxiety was high the whole day.'[534]

531 Interview with Carrie Montgomery, counselling services coordinator, ICNI, 8 September 2022.
532 Interview with Nicola (name has been changed), 10 January 2023.
533 Interview with Dr Sandra McDermott, retired physician, former EMA provider in the Western Health and Social Care Trust, 28 September 2022.
534 Written Testimony from Karen, 21 January 2023.



Megan, who had an abortion in May 2021, explained her experience trying to enter the Belfast Clinic:

> They were blocking me from entering, they were standing in front of the buzzer. I physically couldn't get to the buzzer that opens the door. I was already in distress, after waiting a week to get an appointment, and this made me even more anxious. And I am quite a feisty person, I have done a lot of pro-choice demonstrations. My boyfriend tried to distract them, but then someone came out and me and my best friend ran in through the door.[535]

Eventually, because of relentless intimidation and verbal attacks against patients, Dr McDermott started advising patients to enter through an underground parking area, to avoid the anti-abortion activists.[536] The protests continued in front of the building where the clinic was housed even after the services were halted in the Western Trust.[537]

Across Northern Ireland, anti-abortion activists intimidate patients entering clinics or hospitals – so much so, that patients will ask providers and staff to meet them down the road and walk in with them for support. Organisations like Alliance for Choice and Supporting Women Newry provide escort services that support women walking past the activists. Providers and women have called police and logged incidents with the trust's incident management systems, but to no avail.

Ultimately, anti-abortion protesters have forced community-based early medical abortion clinics across Northern Ireland, with the exception of the Belfast Trust clinic, to relocate to hospital settings to avoid face to face intimidation directly in front of clinics and breaches of privacy. This move has been at the expense of patient care and best practice. Some providers noted that although ideally abortion services would be offered in a community-based setting, integrated within other sexual and reproductive healthcare services, activists have made that too challenging in most trust areas, forcing services to be moved to hospitals.[538]

One doctor that provides early medical abortion services said:

> Well, I think, in some ways, being in the community was destigmatising, in the way that it was just part of general reproductive healthcare, which was quite nice, I felt, from a clinician's point of view. But to be honest, the protesters just negated all that, you know. That became a negative experience for a woman.[539]

However, moving into hospital setting does not necessarily protect against direct intimidation and threatening behaviour by protesters.

535 Interview with Megan, 3 March 2023.
536 Interview with Dr Sandra McDermott, retired physician, former EMA provider in the Western Health and Social Care Trust, 28 September 2022.
537 Interview with Bethany Moore, Alliance for Choice Derry, 26 January 2023. See section on continued protests in the Western Health and Social Care Trust, above.
538 Interview with a healthcare provider, 29 September 2022; interview with a healthcare provider, 30 September 2022; interview with a healthcare provider, 9 May 2023.
539 Interview with a healthcare provider, 30 September 2022.

**'As an employee of the hospital and a newly bereaved parent, I will be subjected to this trauma weekly until this [anti-abortion activity] is curtailed.'**

*A hospital employee who experienced pregnancy loss after many years of trying to get pregnant explains what she felt when she saw the anti-abortion activists in front of the hospital:*

I first saw the demonstration involving the coffins as I was driving into work in early August 2022, I was outraged and angry. I was shocked to see such provocative imagery used in such a callous way. As someone unaffected by infant loss at that stage, the protests only made me angry, and sympathetic to those I knew would hurt when they saw it, patients and staff included.

After years of trying to conceive, I finally became pregnant and I was so happy, an early scan showed me a healthy baby, but the next check-up was not as happy, I was told I had suffered a miscarriage. The news pierced my heart with a physical pain I had never experienced before. I lost all control of my body and wailed like a wounded animal, my body shook, the tears came and wouldn't stop. As I waited to be taken to theatre after the miscarriage, I flicked through Instagram to distract myself from my surroundings. I froze as a friend's story flashed on to my screen: 'Anti-choice presence outside the Hospital from 11am to 1pm today. Mind Yourselves.' In that moment all my emotions suddenly flipped, my sadness turned to rage, my grief was transformed into anger. How could they? I couldn't face them. I sat before my procedure, and in recovery just looking up ways that I could get rid of them, to see if, legally, there was anything I could do to get the police to move them.

After surgery, I was exhausted; emotionally and physically drained. As we left the hospital, I saw them. After everything I had been through, the protesters were there with their crosses and coffins. I couldn't let them do this. I called the police from the car and spoke to the lady on the phone. I was told that the neighbourhood policing team would be liaising with the protesters, but they couldn't do anything. But I had to do something. I got out of the car, I started removing their signs from lamp posts. One of the protesters tried to stop me but I continued regardless of her protest, I told her how hurtful their signs were, she was unapologetic and defended their actions. Members of the local pro-choice group were in attendance at the protest and their support in that very emotional time was greatly appreciated.

As an employee of the hospital and a newly bereaved parent, I will be subjected to this trauma weekly until this is curtailed. A constant reminder of the loss I have endured. These aggressive and intimidating scenes which are improperly advertised as 'prayer meetings'.

I am not the only person who has been affected by these displays. I went to a bereavement counsellor after I went through the loss, I told her about the protests and how I felt after seeing them, and she said, you're the third person this week that has come to see me that have said that they were really affected by those people standing out front.

I see them all the time going to work, it's like a rage every time I see them. I cannot express how triggering the scenes are, to be reminded of my personal loss, to know that their signs are medically inaccurate and that they will negatively affect many other people. Since experiencing this loss and encountering these protests I have joined the local pro-choice group. I didn't want to be scared of the intimidation, I wanted to stand against it, not just for what they subjected me to, but for others.[540]

Lauren McAuley, co-founder of North Coast for Choice, was 30 weeks pregnant when she first saw the protesters in front of Causeway Hospital in Coleraine. She immediately wanted to do something, angry at the insensitivity and ignorance of the anti-abortion activists in front of the hospital, 'especially after being pregnant. I don't think anybody should be forced to see or hear them.' She started counter-demonstrating in support of abortion rights, with her baby in tow, two days after giving birth in 2022. Along with others, she has been coming every week since then.

> I think if you are in a situation where you need a termination for whatever reason and there are antis protesting, trying to harass you whilst you go on this journey, and there is someone standing up for your rights, we hope that helps show they are not alone. I've had people message me, opening up to me with their stories, with some talking about how the anti-choice people make them feel. That puts a fire in my belly to keep counter-protesting against the forced birthers, to protect the people out there who really need it. We care and we want to show people they can make the choice that is right for them, no matter. We are not here to make the anti-choice bullies comfortable and we will not back down.[541]

Louise McCudden of MSI Reproductive Choices in England explained the impact of the anti-abortion protests on specific groups of people seeking abortion care:

> Many people don't understand the impact that it can have. Nobody should have to experience these behaviours but, particularly for those who are vulnerable, perhaps already experiencing some mental distress – which could be for reasons entirely unrelated to the abortion – it can have a huge impact. We hear from sexual assault survivors accessing our services, in particular, that it can be really, really, really horrible to have people in your personal space, or judging you that way. It's really important that we address this properly.[542]

Fiona Collins of Supporting Women Newry, an organisation that has escorted women seeking abortion services past the activists and monitors their conduct in front of Daisy Hill Hospital in Newry (Southern Trust), explained the disproportionate impact it can have on people with fewer financial resources:

> Women have said they're devastated having to face that kind of barrage of abuse, because that's how they see it, as abusive. We believe that it's a class issue as well, because there's a bus stop just right beside the entrance to Daisy Hill and that's where they stand. And if you're driving a car or you're in a taxi, you know, you see the protesters fleetingly. But if you can't afford a car, if you're using public transport, you get off a bus, and you're immediately confronted with them shouting and their placards. So it is a class issue as well. And, we also see it as a trade union issue, because the workers, many of whom take public transport, by the way, are being called killers.[543]

540 Interview on 15 December 2022.
541 Interview with Lauren McAuley, co-founder of North Coast for Choice, 11 December 2022.
542 Interview with Louise McCudden, advocacy and public affairs adviser, MSI Reproductive Choices, 9 September 2022.
543 Interview with Fiona Collins, Supporting Women Newry, 20 January 2023.

Activists providing pills online provide a safety net for those unable or unwilling to be abused by anti-abortion protesters. Dr Kate Guthrie of Women on Web, a service providing online abortion pills in Northern Ireland and in many other places across the globe, explained:

> We still do try really hard to get women to use local services whenever possible. But as soon as the woman says 'I'm frightened of protesters,' or anything to do with domestic violence or breach of confidentiality, we will say go ahead and Women on Web will help you access the medication. And the numbers coming to us because of fear of protesters is definitely on the increase, absolutely… Women we provide online services to are terrified, protesters carry webcams, it increases the chance of being seen. It's a small community in Northern Ireland, it is a much larger chance of somebody identifying you to friends and relatives, essentially outing you… which could be really dangerous for anyone, but especially for women in coercive relationships.[544]

### The Abortion Services (Safe Access Zones) Act (Northern Ireland) 2023

In 2022, the Northern Ireland Assembly passed a private members bill, developed by Clare Bailey, former Member of the Legislative Assembly, to create safe access zones around premises where abortions are provided. The bill is an effort to implement the UK's international human rights obligations, highlighted and reiterated by the CEDAW inquiry report, to prevent harassment outside abortion clinics.[545] It is the first piece of legislation passed of its kind in the UK. The bill became law on 6 February 2023.[546]

The Abortion Services (Safe Access Zones) Act (Northern Ireland) 2023 provides for safe access zones extending 100 meters from the entrance to the premises (and may be extended up to 150 meters), to protect people who are accessing treatment, accompanying those accessing treatment, or working in the premises, from threatening behaviour and harassment by anti-abortion protesters. The Act criminalises acts and non-consensual recordings (videos, photographs, sounds) in the safe zone that intentionally or recklessly influence, prevent or impede access to the premises, or cause harassment, alarm or distress. Those found guilty of an offence are liable to a fine.[547]

Before it could go into effect, the Safe Access Zones Bill was referred by the Attorney General for Northern Ireland to the Supreme Court to determine whether part of the bill disproportionately interfered with the rights of people protesting against abortion, in violation of the European Convention on Human Rights. In December 2022, the Supreme Court unanimously recognised that the matter referred was within the Assembly's competence and held that the bill was compatible with Convention rights to freedom of conscience, freedom of expression and freedom of assembly.[548] The bill received Royal Assent on 6 February 2023 and became enforceable on 7 May 2023.

In its decision, the Supreme Court held that the bill had legitimately aimed to ensure both 'that women have access to premises at which treatment or advice concerning the lawful termination of pregnancy is provided, under conditions which respect their privacy and their dignity, thereby enabling them to access the healthcare they require, and promoting public health' and 'that the staff who work at those premises are also able to access their place of employment without intimidation, harassment or abuse, thereby ensuring that the healthcare services in question continue to be provided.'[549]

The Court reasoned, citing to *P and S v. Poland*, a case decided by the European Court of Human Rights, that:

> The right to access healthcare in conditions of privacy and dignity, and the right to pursue employment, are protected by article 8 of the Convention. Indeed, it has been established that states are under a positive obligation, under article 8, to create a procedural framework enabling a pregnant woman to exercise effectively her right of access to a lawful abortion: P and S v Poland (2012) 129 BMLR 120, para 99. The same principle would appear to entail that there is also a positive obligation on states, under article 8, to enable a pregnant woman physically to access the premises where abortion services are lawfully provided, without being hindered or harmed in the various ways described in the evidence before the court.[550]

In upholding the bill, the Court further emphasised, 'A measure that seeks to ensure that women seeking a safe termination of pregnancy have unimpeded access to clinics where such treatment is provided, and are not driven to less safe procedures by shaming behaviour, intrusions upon their privacy, or other means of undermining their autonomy, is a rational response to a serious public health issue'[551] and that 'there is a pressing social need for such restrictions to be imposed, in order to protect the rights of women seeking treatment or advice, in particular, and also in the interests of the wider community, including other patients and the staff of clinics and hospitals.'[552]

Many interviewees Amnesty International spoke with expressed hope in the Safe Access Zones Act but some also recognise that this may not be enough. Naomi Connor of Alliance for Choice-Belfast explains:

544 Interview with Dr Kate Guthrie, Women on Web, 5 October 2022.
545 CEDAW Inquiry Report, para 86 (g).
546 Abortion Services (Safe Access Zones) Act (Northern Ireland) 2023 legislation.gov.uk/nia/2023/1/contents/enacted
547 Abortion Services (Safe Access Zones) Act (Northern Ireland) 2023 legislation.gov.uk/nia/2023/1/contents/enacted
548 Judgment, Reference by the Attorney General for Northern Ireland-Abortion Services (Safe Access Zones) (Northern Ireland) Bill (2022) UKSC 32, Judgment given on 7 December 2022, paras 156 and 157.
549 Judgment, Reference by the Attorney General for Northern Ireland-Abortion Services (Safe Access Zones) (Northern Ireland) Bill (2022) UKSC 32, Judgment given on 7 December 2022, para 114.
550 Judgment, Reference by the Attorney General for Northern Ireland-Abortion Services (Safe Access Zones) (Northern Ireland) Bill (2022) UKSC 32, Judgment given on 7 December 2022, para 115.
551 Judgment, Reference by the Attorney General for Northern Ireland-Abortion Services (Safe Access Zones) (Northern Ireland) Bill (2022) UKSC 32, Judgment given on 7 December 2022, para 118.
552 Judgment, Reference by the Attorney General for Northern Ireland-Abortion Services (Safe Access Zones) (Northern Ireland) Bill (2022) UKSC 32, Judgment given on 7 December 2022, para 154.

> What you have to remember is, how is this going to be implemented? I mean, the anti-choice lobby have said that we are going to ignore it anywhere, so how is that going to be policed? And are they going to just give them fines? Because, I mean, they have money to pay fines. Are they going to put them in jail? And I think what we're working towards – we do want buffer zones [safe access zones], obviously, and we are in favour of them, but I think what we have to do is also work to destigmatise abortion through education and services that meet the needs of women and pregnant people through training and health professionals, who deserve to work in an environment that isn't cloaked.[553]

The Act requires the Department of Health to 'publish an annual report, setting out whether, in the opinion of the Department, each safe access zone has been effective in protecting the safety and dignity of protected persons'.[554] Monitoring the effectiveness of the safe access zones will be important to ensure that the responsibilities of the various actors, including police, are effectively discharged.

The Department of Health has noted that the Safe Access Zones Act is a 'welcomed development' and that it intended to issue policy guidance to trusts on safe access zones before it became an enforceable offence in May 2023, to ensure consistent implementation across the trusts. However, as of August 2023, no policy guidance has been issued and no safe access zones have been created[555], despite information received from some trusts through Freedom of Information Act requests that notifications were sent to the DOH requesting such zones.[556]

The DOH also informed Amnesty International that the safe access zone 'will be a 100-meter zone around the perimeter of the trust site. So not just the building with the services being provided in. If they then want to extend that, they can do so up to a further 150 meters.' The Department of Health noted that all requests for a further 150 meters will be granted.[557] The Department of Health has informed Amnesty that it is working with trusts on mapping the zone areas, ensuring appropriate signage and working with the police on implementation, noting that the Police Service of Northern Ireland (PSNI) will have 'a separate protocol of their own, about how they respond to any calls a trust might place… What we're developing is a policy for the health service and for the Department to follow.'[558]

In response to an FOI request submitted in June 2023, the PSNI noted:

> There are currently no Safe Access Zones in Northern Ireland, therefore this legislation is not yet enforceable. Duty and power to designate them lies with Department of Health & Social Care. Once the DoH designates SAZs, the Police Service of Northern Ireland will be able to respond and develop its processes, policies and training. Further information may become available once this progresses.'[559]

As of August 2023, no formal policies or protocols have been issued by the DOH or the PSNI.[560]

553 Interview with Naomi Connor, co-convenor, Alliance for Choice, 28 September 2022.

554 Abortion Services (Safe Access Zones) Act (Northern Ireland) 2023, Section 8.

555 Interview with the Department of Health, 17 August 2023.

556 Belfast Health and Social Care Trust, response 20 July 2023 FOI/29464; Southern Health and Social Health Care Trust, response 13 July 2023, CR/gf/FOI 1760.

557 Interview with the Department of Health, 17 August 2023.

558 Interview with the director of secondary care, Department of Health, 2 March 2023; interview with the Department of Health, 17 August 2023. See also BBC News, Abortion: Protest exclusion zones become enforceable by PSNI, 7 May 2023 bbc.com/news/uk-northern-ireland-65497779

559 FOI request response from PSNI, FOI-2023-02031, received by email 4 July 2023.

560 Interview with the Department of Health, 17 August 2023; FOI request response from PSNI, FOI-2023-02031, received by email on 4 July 2023.

# 7. A longstanding neglect of sexual and reproductive health services

The Northern Ireland Executive, Department of Health, and the Health and Social Care Trusts have a long history of failing to prioritise sexual and reproductive healthcare. Sexual and reproductive health has been neglected at the policy level, underfunded and undervalued as a service, and currently faces a workforce crisis that, although felt across all areas of care in the Health and Social Care service, reflects the particular lack of investment in sexual and reproductive health. As a result, people in Northern Ireland face challenges accessing the full range of modern contraception. The abortion service presents an opportunity to strengthen both contraceptive and abortion services by offering comprehensive, integrated care.

## 7.1 Neglected at the policy and career pathway level

At present, Northern Ireland lacks a current sexual health strategy, with the Department of Health's last Action Plan expiring in 2015 and no new strategy in place.[561] Recommendations from a 2013 review of sexual health services by the Regulation and Quality Improvement Authority (RQIA), which assures the quality of services provided by the trusts, have been largely ignored. Moreover, Northern Ireland is currently the only place in the UK and Ireland that does not have a dedicated women's health strategy that addresses the inequalities women face in accessing healthcare.

Dr Cubitt, chair of the Faculty of Sexual and Reproductive Healthcare (FSRH) Northern Ireland Committee, notes:

> The RQIA did a report on sexual and reproductive healthcare in Northern Ireland in 2013. And the recommendations in that report, we're still waiting for [them to be implemented]… They recommended consultant leadership within reproductive healthcare, good integration of sexual health and contraception care, wider provision of LARC [long-acting reversible contraception], even outside specialist services. There has also been no update of the sexual health strategy in Northern Ireland for a long time. And it needs updating.[562]

NIACT's 2021 Report on Sexual and Reproductive Health in Northern Ireland reiterated many of the RQIA's recommendations, concluding that without an updated sexual health action plan from the DOH, this 'out-of-date strategy… has left current provision struggling without direction, but with ever increasing demands'.[563]

A significant issue raised by both the RQIA and NIACT is the lack of consultant leadership within sexual and reproductive health (SRH). Historically, SRH provision has instead been done by GPs with a faculty qualification in SRH.[564] Without SRH consultants, one EMA provider observes, 'It's very hard then at service planning level to be represented. I think that lack of consultant leadership within SRH, especially, has been very negative and has allowed SRH to be overlooked at the commissioning level.'[565]

The lack of SRH consultants has also meant that a Northern Ireland-based specialty training programme could not be established. Dr Cubitt explains, 'You need a consultant for governance to set up a specialty training program.'[566] Instead, to become an SRH consultant, Northern Ireland-trained doctors must apply for a certificate of equivalent specialist training, which takes six years to complete and requires travel to other parts of the UK. In 2023, Northern Ireland saw its first two doctors complete this training and become locum SRH consultants.[567] Dr Cubitt said: 'Hopefully, soon, the full range of training right up to consultant level in SRH will be available in Northern Ireland, if we have a good abortion service.'[568]

The lack of a specialty training pathway has also impacted recruitment to SRH, as the opportunities for career advancement are limited: 'Most young doctors who would love to work in SRH, from an OB/GYN or GP background, tend to stick with obs and gynae or general practice because they have a career path. So [not having the SRH consultant pathway has] been a big barrier to encouraging staff,' explains Dr Cubitt.[569]

## 7.2 Underfunded and understaffed: lack of resources impacts availability and accessibility of contraceptives

Staffing shortages are a significant problem in sexual and reproductive health. The RQIA flagged this issue in its 2013 report, noting 'significant pressures on staff providing specialist sexual health services in meeting the demand for services' and that, '[i]n general, staffing levels appear to be lower than for comparative services in other parts of the United Kingdom.'[570] The report also pointed out the lack of a regional workforce plan for SRH services in Northern Ireland.[571]

Dr Cubitt, an SRH provider, notes that in many trusts 'senior SRH doctors retired and were never replaced. Services have just been allowed to go down.'[572] This problem is particularly acute in the Western Trust, which has difficulty recruiting doctors, generally, to work in the trust, particularly in the rural parts of the trust.[573] Professor Louise Dubras, Foundation Dean of the new School of Medicine at Ulster University's

561 Department of Health, *Sexual Health Promotion Strategy and Action Plan 2008-2013* (November 2008) (and an addendum which expired in December 2015) health-ni.gov.uk/sites/default/files/publications/dhssps/sexual-health-promotion-strategy-and-action-plan-2008-13.pdf

562 Interview with Dr Eveane Cubitt, chair, Faculty of Sexual and Reproductive Healthcare (FSRH) NI Committee, 30 September 2022. See RQIA, Review of Specialist Sexual Health Services in Northern Ireland (2013).

563 NIACT, *Report on Sexual and Reproductive Health in Northern Ireland* (March 2021), p30.

564 Interview with Dr Eveane Cubitt, chair, Faculty of Sexual and Reproductive Healthcare (FSRH) NI Committee, 30 September 2022.

565 Interview with a healthcare provider, 30 September 2022. See also RQIA, *Review of Specialist Sexual Health Services in Northern Ireland* (2013), p53 (noting that 'With the absence of any consultant presence, Northern Ireland cannot provide training places and there is no one with consultant status to participate in discussions about the future development of services').

566 Interview with Dr Eveane Cubitt, chair, Faculty of Sexual and Reproductive Healthcare (FSRH) NI Committee, 30 September 2022.

567 Interview with a healthcare provider, 14 August 2023.

568 Interview with Dr Eveane Cubitt, chair, Faculty of Sexual and Reproductive Healthcare (FSRH) NI Committee, 30 September 2022.

569 Interview with Dr Eveane Cubitt, chair, Faculty of Sexual and Reproductive Healthcare (FSRH) NI Committee, 30 September 2022.

570 RQIA, *Review of Specialist Sexual Health Services in Northern Ireland* (2013), p52.

571 RQIA, *Review of Specialist Sexual Health Services in Northern Ireland* (2013), p52.

572 Interview with Dr Eveane Cubitt, chair, Faculty of Sexual and Reproductive Healthcare (FSRH) NI Committee, 30 September 2022.

573 Interview with Dr Louise Dubras, Dean, Ulster University School of Medicine, 13 February 2023.

Derry-Londonderry campus, noted that the school was created to help fill this gap, with an emphasis on education in General Practice.[574]

### 7.2.1 Unable to meet the sexual and reproductive health needs of the population

After years of neglect and underfunding, SRH services in Northern Ireland are entirely insufficient to meet the needs of the population. Interviewees for this report noted the impact this has had on establishing SRH-led abortion service provision: 'SRH has been chronically underfunded for decades in Northern Ireland. So if you're trying to get a chronically underfunded service to add in another service, that's really hard.'[575]

It has also had a significant impact on contraceptive access. There are long waiting lists and a lack of access to the full range of contraceptive choices in most trusts. For example, Amnesty was informed that in the Southern Trust, the waiting list for implants is eight weeks, and for coils is 12 weeks. In Western Trust, as of October 2022 there was 'an eight-week waiting list for the contraceptive implant, and 6-9 month waiting list for the coil.'[576] Dr Sandra McDermott, a former early medical abortion provider and SRH specialist in the Western Trust, notes that in the Western Trust, in particular, 'our contraceptive services have been poor for a long time, particularly in the more rural areas.'[577]

Another early medical abortion provider underscores this:

> Access to postpartum contraception is a big thing. You know, a good 20 per cent of the women that come through my [EMA] clinic are pregnant within a year of giving birth and are using our services. That's a failing on our behalf. You throw women out there and not give them any sense of power over what they can do with themselves, you know, and then they end up pregnant again. Especially in this day and age, where we are facing financial struggles, the only option is to end their pregnancy, you know, instead of having something on board before they leave the hospital that they can then, when the time is right, make the decision, do they want to broaden their family further or not.[578]

The 2018 CEDAW inquiry report underscored the challenges women face in accessing contraception in Northern Ireland[579] and called on the UK government to 'ensure accessibility and affordability of… safe and modern contraception and adopt a protocol to facilitate access at pharmacies, clinics and hospitals.'[580] For NIACT, the early medical abortion services represent an opportunity to do just that.

574 Interview with Dr Louise Dubras, Dean, Ulster University School of Medicine, 13 February 2023.
575 Interview with a healthcare provider, 27 September 2022.
576 Alliance for Choice Derry quoted in *Belfast Live*, 'Early abortion services reinstated in the Western Trust after "staff resourcing issues"' belfastlive.co.uk/news/northern-ireland/early-abortion-services-reinstated-western-25175890
577 Interview with Dr Sandra McDermott, retired physician, former EMA provider in the Western Health and Social Care Trust, 28 September 2022.
578 Interview with a healthcare provider, 28 September 2022.
579 CEDAW Inquiry Report, para 46.
580 CEDAW Inquiry Report, para 86(b).



#### Human rights standards on contraception and a sexual and reproductive health strategy

Human rights treaty monitoring bodies have consistently found that states must ensure the availability and accessibility of the full range of good quality, modern, and effective contraceptives to all individuals, without discrimination,[581] 'including those from disadvantaged and marginalised groups'.[582] The Committee on Economic, Social and Cultural Rights states that, as a matter of gender equality, 'Preventing unintended pregnancies and unsafe abortions requires states to adopt legal and policy measures to guarantee all individuals access to affordable, safe and effective contraceptives.'[583]

States must also ensure that contraceptive use is voluntary, fully informed, and occurring 'free from violence, coercion or discrimination'.[584] Where violations of informed consent occur, states must ensure access to 'meaningful and effective' remedies.[585]

States also have a core obligation '[t]o adopt and implement a national strategy and action plan, with adequate budget allocation, on sexual and reproductive health, which is devised, periodically reviewed and monitored through a participatory and transparent process, disaggregated by prohibited ground of discrimination.'[586]

## 7.3 Integrated service provision: 'The Gold Standard'

NIACT members and abortion providers feel strongly that integrated contraceptive and abortion services are the ideal model of care. Dr Cubitt, chair of FSRH NI, underscores: 'Contraception provision within the same service as the termination of pregnancy. That would be a standard that would be endorsed by all the professional bodies, you know, that's really the gold standard.'[587]

581 CESCR Committee, General Comment No. 22, paras 13, 28, 45, 57, 62; Human Rights Committee, General Comment 36, para 8; CEDAW Committee, General Recommendation 24, paras 12(d), 17; CEDAW Committee, General Recommendation 34, paras 38, 39(a); Committee on the Rights of the Child, General Comment 15, paras 31, 70; Committee on the Rights of the Child, General Comment 20, paras. 59, 63; Committee on the Rights of the Child, *Concluding Observations: Argentina*, para 32, UN Doc CRC/C/ARG/CO/5-6 (2018); CEDAW Committee, *Concluding Observations: Mozambique*, para 36(c), UN Doc CEDAW/C/MOZ/CO/3-5 (2019).
582 CESCR, General Comment 22, para 45.
583 CESCR, General Comment 22, para 28. See also Committee on the Rights of the CHild, General Comment 15, para 56; CEDAW Committee, General Recommendation 24, para 17; Committee on the Rights of the Child, *Concluding Observations: Kyrgyzstan*, paras 51-52, UN Doc CRC/C/KGZ/CO/3-4 (2014); CEDAW Committee, *Concluding Observations: Angola*, para 31(c), UN Doc CEDAW/C/AGO/CO/6 (2013); Human Rights Committee, *Concluding Observations: Malawi*, para 9, UN Doc CCPR/C/MWI/CO/1/Add.1 (2014); CESCR Committee, *Concluding Observations: El Salvador*, para 23, UN Doc E/C.12/SLV/CO/3-5 (2014).
584 CESCR, General Comment 22, paras 5, 29, 49(d), 57, 59.
585 CESCR, General Comment 22, para 64.
586 CESCR, General Comment 22, para 49(b). See also CESCR, General Comment 14, para 21.
587 Interview with Dr Eveane Cubitt, chair, Faculty of Sexual and Reproductive Healthcare (FSRH) NI Committee, 30 September 2022.

One early medical abortion provider explains:

> So because our EMA ladies are being looked after in SRH, we're in a perfect position to provide their contraception of choice at the same time as they come see us for EMA. So I think that's really very positive and that's something we would hold on to with great passion. Because a lot of those ladies have been interested in a long-acting method of contraception but have had difficulty accessing it and then they present for EMA.[588]

Where abortion services have already been integrated within SRH or contraceptive service provision, there has been significant uptake of contraception. One healthcare provider notes that, in their trust, 'Our waiting times have gone from six months down to two to four weeks. So not only have we introduced the EMA service, but we've also really improved access to contraception. But that is not the same everywhere. Some trusts don't even have a doctor working in contraception.'[589]

In another trust that is able to offer contraception, an early medical abortion provider notes that their clinic has 'about 99 per cent uptake, and about 60 per cent take LARC [long-acting reversible contraception]. It's really high. We prioritise contraceptive access and usually have it in anywhere between 10 days to three weeks after, or if they want an implant or depo, or pill, they get that on the day of the [EMA] treatment.'[590]

Commissioning of abortion services offers an opportunity to provide quality integrated SRH services. 'But,' says Dr Roberts, 'it needs money and it needs people being serious about it.'[591]

588 Interview with a healthcare provider, 30 September 2022.
589 Interview with a healthcare provider, 13 September 2022.
590 Interview with a healthcare provider, 27 September 2022.
591 Interview with Dr Ralph Roberts, chair, NIACT, 27 September 2022.



# 8. Conclusion

More than three and a half years have passed since abortion was decriminalised in Northern Ireland and a legal duty was imposed on the Secretary of State to implement the recommendations in the CEDAW inquiry report, including to ensure expanded access to abortion services. These duties were to be carried out 'expeditiously, recognising the importance of doing so for protecting the human rights of women in Northern Ireland'.[592] Yet, to date, access to abortion services in Northern Ireland remains limited and unequal.

The Department of Health's failure to commission abortion services, and the Secretary of State's failure to act promptly and decisively to ensure the timely, adequate, quality and accessible provision of the full range of lawful abortion services, has meant the continued 'systematic denial of equal rights for women' in Northern Ireland.[593] Although services have finally been commissioned, ongoing barriers to abortion access in Northern Ireland include: a failure to provide for telemedicine; a failure to ensure comprehensive abortion service provision after 10 weeks' gestation; lack of adequate staffing for existing abortion services; lack of monitoring and oversight over the practice of conscience-based refusals; a failure to provide accessible and comprehensive information about the new law and available services; the absence of guidance and training for healthcare professionals, particularly on surgical abortion; ongoing intimidation by anti-choice protesters; and the long-term neglect of sexual and reproductive health services.[594]

Pregnant people are legally entitled to access timely abortion care and information in Northern Ireland. Forcing people living in Northern Ireland to travel to England for essential healthcare, or to carry an unwanted pregnancy to term, violates their human rights, including their right to make autonomous decisions about their sexual and reproductive health.

592 Northern Ireland (Executive Formation etc) Act 2019, Section 9(7).
593 CEDAW Inquiry Report, para 80.
594 The Department and the former minister deny responsibility for these failures. Their positions are recorded in Annexes 2 and 3 respectively.

# 9. Recommendations

## To the Department of Health and the Secretary of State for Northern Ireland:

- Ensure the full provision of abortion services, including that abortion is available locally, in Northern Ireland, across all health trusts and at all gestations, and that patients have a choice of abortion method.
- Ensure that all abortion service provision respects patients' rights to physical and mental health and autonomy in decision-making, including informed choice.

## To the Northern Ireland Executive (when devolved Government is restored):

- Ensure that a budget with adequate funding for abortion services is allocated annually.
- Ensure that the Department of Health comprehensively implements the Commissioning Framework and Service Specification for abortion services by exercising scrutiny and oversight through the Health Committee.
- Exercise scrutiny and oversight through the Education Committee to ensure that the Department of Education implements the Relationship and Sexuality Education (Northern Ireland) (Amendment) Regulations 2023 in compliance with international human rights norms and as provided in UNESCO's latest International Technical Guidance on Sexuality Education.

## To the Secretary of State for Northern Ireland:

- Ensure the availability and accessibility of the full range of abortion services in Northern Ireland, across all trusts and at all stages of gestation.
- Ensure that all abortion service provision respects patients' rights to physical and mental health and autonomy in decision-making, including informed choice.
- Amend The Abortion (Northern Ireland) (No. 2) Regulations 2020 to:
  - Remove all penalties (fines).
  - Remove the requirement of multiple provider authorisations.
  - Remove the certification and notification requirements.
  - Provide for abortion to be delivered by telemedicine. The World Health Organisation recommends that individuals in the first trimester (up to 12 weeks pregnant) can self-administer mifepristone and misoprostol medication without the direct supervision of a healthcare provider, and that individuals should have a source of accurate information and access to a healthcare provider should they need or want it at any stage of the process.
  - Legally mandate the annual disclosure of comprehensive, disaggregated abortion statistics by the Department of Health.
- Ensure that the Department of Health (DOH) provides evidence-based guidance on abortion to healthcare professionals in Northern Ireland that includes a comprehensive explanation of the circumstances under which abortion is lawful, the lawful scope of conscience-based refusals and provider obligations, and that clarifies the requirements for trusts to effectively monitor conscience-based refusals. Should the DOH fail to act, issue interim guidance to healthcare professionals – similar to the 2019 interim guidance issued by the NIO to healthcare professionals in Northern Ireland on the abortion law and service provision[595] – that will remain in effect until the devolved government acts to issue guidance.
- Create an 'appropriate monitoring mechanism for failure to facilitate quality care, including regular review and reform of law and policy to recognise and remove barriers to quality abortion care'.[596]
- Ensure that the Department of Education implements the Relationships and Sexuality Education (Northern Ireland) (Amendment) Regulations 2023 and provides quality, comprehensive and scientifically accurate education on sexual and reproductive health and rights, covering early pregnancy prevention and access to abortion, is a compulsory curriculum component for all learners, in compliance with the Secretary's legal obligations under the Northern Ireland (Executive Formation etc) Act 2019 to ensure the CEDAW report recommendations are implemented in Northern Ireland.
- Ensure that the curriculum is available in accessible forms and languages.
- Ensure compliance with international human rights law by rescinding the provision in section 2(3) of the Relationships and Sexuality Education (Northern Ireland) (Amendment) Regulations 2023 that amends Article 10A(5) of the Education (Northern Ireland) Order 2006, which currently allows for parents to excuse their child from such education.
- Ensure the accessibility, including affordability, of the full range of contraceptive services and products, and conduct awareness-raising campaigns on access to the full range of modern contraception, in compliance with the Secretary's legal obligations under the Northern Ireland (Executive Formation etc) Act 2019 to ensure the CEDAW report recommendations are implemented in Northern Ireland.

## To the Home Office:

- Ensure that people who are seeking asylum who need to travel for time-sensitive abortion services are able to do so without delay and without loss of eligibility for asylum accommodation support in Northern Ireland.
- Ensure that people seeking asylum who seek assurances that they can travel are made aware that their reasons for travel will be kept confidential and that travel for abortion will not impact their asylum application.
- Ensure that people seeking asylum who are required to stay away from their accommodation for longer than expected owing to recovery or complications are assured that their asylum support is not at risk during this absence.

## To the Department of Health:

### Accessible and comprehensive abortion services

- Ensure that women and girls and other people who can get pregnant can access abortion services in Northern Ireland in all circumstances permitted under the law.
- Ensure the full provision of abortion services, including that abortion is available locally, in Northern Ireland, across all health trusts and at all gestations.
- Ensure the provision of medical and surgical abortion services for all gestations.
- Ensure that all abortion service provision respects patients' rights to physical and mental health and autonomy in decision-making, including informed choice.

595 NIO, UK Government Guidance for Healthcare Professionals in Northern Ireland on Abortion Law and Terminations of Pregnancy in the Period 22 October 2019 to 31 March 2020 in Relation to the Northern Ireland (Executive Formation Etc) Act 2019 (October 2019).

596 WHO, Abortion Care Guideline (2022), p6.

- Ensure that provision is made for effective access for all to any centralised later term surgical services. This may require the provision of transportation for those traveling from rural areas or from farther away.
- Ensure that an adequate number of healthcare providers are trained to offer the full range of abortion services.
- Ensure that trusts, particularly rural trusts, such as the Western Trust, have an adequate number of locations where they provide abortion services so that they are accessible to people living in those trust areas.
- Ensure easy or self-referral to any trust area for provision of abortion services.
- Provide and publish written approval for medication abortion to be delivered by telemedicine, as the department is authorised to do under Section 8 of The Abortion Regulations 2020, and as allowed in other parts of the UK and Ireland and recommended by the World Health Organisation (WHO). The WHO recommends that individuals in the first trimester (up to 12 weeks pregnant) can self-administer mifepristone and misoprostol medication without the direct supervision of a healthcare provider, and that individuals should have a source of accurate information and access to a healthcare provider should they need or want it at any stage of the process.
- Designate safe access zones as per the Abortion Services (Safe Access Zones) Act (Northern Ireland) 2023 and cooperate with the PSNI to ensure effective implementation, including through supporting development of protocols and training of relevant staff.

### Data transparency

- Annually publish comprehensive, disaggregated data on abortion that includes information on all abortions provided by healthcare services in Northern Ireland, disaggregated by statutory/regulatory grounds for termination, gestation, method of abortion, trust location, age, ethnicity, disability and gender identity, and any other relevant ground.
- Annually publish data on the number and types of healthcare workers who have registered their objection to participating in abortion treatment in each HSC Trust.

### Guidance

- Issue clear directives to all healthcare providers on all pathways for abortion care. Reissue a letter and fact sheet to all healthcare providers and professional bodies that includes a full and accurate explanation of Northern Ireland's abortion law.
- Issue clear guidelines and regulations on conscientious objection in line with national case law and international law. This guidance should include a comprehensive explanation of the lawful scope of conscience-based refusals and provider obligations, and clarify the requirements for trusts to effectively monitor conscience-based refusals.
- Comply with the Abortion Services Directions 2022 to:
  - 'review, and endorse with any appropriate caveats, NICE guidelines relevant to the treatment for the termination of pregnancy, including in particular NICE guideline NG140.'
  - 'issue guidance for registered medical professionals replacing the guidance entitled "Guidance for Health and Social Care Professionals on termination of pregnancy in Northern Ireland" issued by the Department in March 2016.' This clear guidance should include, among other things, a comprehensive explanation of the circumstances under which abortion is lawful and the lawful scope of conscience-based refusals and provider obligations.
- Adopt and implement the World Health Organisation's Abortion Care Guideline (2022).



- Adopt and implement the UK National Screening Committee recommendations for first trimester screening, to bring Northern Ireland in line with the rest of the UK. Recommended screening tests should be available in each trust, as part of routine antenatal care.
- Ensure that the 2023-2030 Domestic and Sexual Abuse Strategy contains clear information about: the abortion law – including that 'victims of sexual crime' may lawfully access abortion services until 24 weeks' gestation; the availability of abortion services in Northern Ireland; and information for health and social care professionals about how to refer and signpost to abortion services.
- Develop and issue a Sexual Health Promotion Strategy and Action Plan.

### Access to information and counselling

- Ensure that clear, accessible, accurate, comprehensive and evidenced-based information on the abortion law, the abortion procedure, the abortion services available, and how to access those services is posted on the DOH website and on NIDirect. This information should be prominent and easy to find. Information should be available in multiple and accessible formats and technologies appropriate to different kinds of disabilities and in relevant languages.
- Initiate a public information campaign to inform people living in Northern Ireland of the abortion law and how to access services in Northern Ireland. Ensure this awareness campaign tackles abortion stigma.
- Ensure that non-directive, 'non-biased, scientifically sound and rights-based'[597] pregnancy counselling is available and accessible, and that women and girls and other people who can get pregnant are made aware of counselling services and are facilitated to access these services, when requested.
- Ensure 'accurate, non-biased and evidence-based SRH information, including on abortion and contraceptive methods, is widely available in multiple and accessible forms and languages'.[598]
- Initiate a public information campaign to inform people living in Northern Ireland of the full range of available contraceptive methods, including long-acting reversible contraception, and how and where to access contraception.

### General practitioners

- Issue a clear, updated directive to GPs informing them of all available abortion services, the circumstances under which abortion is lawful, where to refer women and girls and other people who can get pregnant for abortion care, and clarifying the scope of conscience-based refusals and their obligations should they object to providing abortion services.
- Ensure the distribution to general practitioners (GPs) of information leaflets and signs that they can post in their offices about abortion services.
- Encourage GPs to be trained in and to provide abortion services.

### Central Access Point

- Reinstate, as soon as possible, a local Central Access Point in Northern Ireland to ensure timely referral to local provision across all health trusts.

597 CEDAW Inquiry Report, para 86(a).
598 CEDAW Inquiry Report, para 86(a).

### Clarification that mifepristone is not a controlled drug, nor should it be treated exceptionally

- Immediately issue a directive that clarifies that mifepristone and misoprostol are not controlled drugs and are therefore not subject to any additional administrative restrictions specific to controlled drugs and should not be treated exceptionally. Ensure that this information is disseminated to all trusts, providers and to pharmaceutical staff. Monitor the implementation of this directive

### Values clarification

- Ensure that trusts and the department hold periodic values clarification workshops for all staff providing information and services that relate to or affect, directly or indirectly, the provision of abortion services.
- Ensure that current, and any future, providers of telephone interpreting for HSC Trusts in Northern Ireland understand that conscience-based refusals do not extend to translation services and include translators in values clarification sessions.

### Integrated SRH provision and contraception

- Implement comprehensive, integrated SRH service provision, to include early medical abortion and contraceptive provision.
- Ensure the availability and accessibility of the full range of contraceptive methods and counselling and information services on SRH, as required by the CEDAW Committee report recommendations.

### Monitoring and accountability

- Comply with the UK parliamentary report recommendation that: 'In the absence of a separate regulatory body overseeing the provision of abortion services, the Department of Health acting as a regulatory body should have a duty to regularly review consistency of services between trusts, training of the profession and facilities so that all women and girls have the same access to treatment within the law.'[599] Ensure that the department's Abortion Oversight Board exercises robust monitoring and oversight to guarantee equal access in all trusts to: contraception; EMA services; MVA services; antenatal screening; and pathways to abortion treatment after 12 weeks' gestation.
- Ensure that the Department of Health exercises continuous oversight over and monitoring of conscience-based refusals in all trusts.
- Ensure that medical practitioners who fail to maintain professionalism (for example, by disrespectful care and mistreatment, such as engaging in abusive or derogatory rhetoric, refusing to provide advice or care, including where conscience-based refusal is not permitted, and intentionally misleading patients about their treatment options and care) are held accountable.[600]
- Create 'accessible mechanisms for women to challenge denial of abortion in a timely manner'.[601]
- Monitor to ensure that, in all private and public health settings, the information provided to patients on abortion is accurate and evidence-based and where misinformation is deliberately given and/or delay tactics are used, there is accountability, including potential closure. Rogue agencies, such as Stanton and Advocate Women's Centre and all others, should be mandated to make clear to the public and to those coming in for services that they are anti-abortion, and be held to account if they do not, including by closure.
- Engage with civil society organisations who monitor human rights compliance of abortion provision, and support people in accessing abortions, to understand the barriers that women, girls and other pregnant people face in accessing abortion services, in order to continually improve services.

599 House of Commons Women and Equalities Committee, *Abortion Law in Northern Ireland: Eighth Report of Session 2017-2019* (2019), p50, para 158.

600 WHO, Abortion Care Guideline (2022), pp11-12.

601 WHO, Abortion Care Guideline (2022), p6.



## To the Public Health Agency:

- Create, in consultation with healthcare providers and civil society organisations, a public information campaign about Northern Ireland's abortion law, existing services and how to access those services, so that abortion becomes normalised as a healthcare service.
- Create, in consultation with healthcare providers and civil society organisation, a public information campaign about all forms of contraception, including long-acting reversible contraception, and how and where to access contraception in Northern Ireland.
- Ensure that clear, accessible, accurate and evidenced-based information on the abortion law, the abortion procedure, the abortion services available, and how to access those services is posted on the Sexual Health NI website, operated by the Public Health Agency, and across all other relevant webpages. This information should be prominent and easy to find. Information should be available in multiple and accessible formats and technologies appropriate to different kinds of disabilities and in relevant languages.

## To the Regulation and Quality Improvement Authority (RQIA):

- Undertake a review and audit of the abortion services provided in all the trusts. Advise the DOH on improving gaps in abortion service provision, including on addressing unequal access to services across the five HSC Trusts and on exercising effective oversight over and monitoring of conscience-based refusals.

## To the Department of Justice and the Police Service of Northern Ireland (PSNI) in implementing the Abortion Services (Safe Access Zones) Act (Northern Ireland) 2023:

- Ensure that police protect the rights of women, girls and other pregnant people, including their rights to health, physical integrity, non-discrimination and privacy, as they seek healthcare information and services at clinics, free of harassment and intimidation.
- Ensure that police receive training (including values clarification training) on, and that relevant operational protocols fully reflect, the rights of women, girls and other pregnant people to access abortion care in an effective, safe, timely and respectful manner in accordance with the UK's international human rights obligations.
- Guarantee the safety of human rights defenders and providers who support access to abortion by responding to threats, intimidation and other forms of abuse in an effective manner.
- The Department of Justice should work with the Department of Health to ensure a robust monitoring system that includes an assessment of the effectiveness of measures taken by the police in implementing the Act.

## To the Department of Education:

- Ensure the implementation of the Relationships and Sexuality Education (Northern Ireland) (Amendment) Regulations 2023 and provide good quality, comprehensive and accurate education on sexual and reproductive health and rights, covering early pregnancy prevention and access to abortion, as a compulsory curriculum component for all learners. Ensure that the curriculum is available in accessible forms and languages.
- In accordance with UNESCO recommendations, invest in quality curriculum reform and teacher training and strengthen monitoring of the implementation of comprehensive sexuality education.
- Ensure that the curriculum is available in accessible forms and languages.

## To the HSC Trusts:

### Conscience-based refusals, judgmental care and values clarification

- Collect data on the number and scope of refusals, disaggregated by job position, to ensure effective and quality abortion service provision and inform staff shift planning.
- Ensure that all trust staff are provided with clear guidelines and education about the scope and limits of conscience-based refusals, including that it applies only to direct provision of treatment and not to any ancillary care, that there is an obligation to ensure effective referrals for providers who refuse to provide care, and that conscience-based refusals do not apply to the provision of information and booking appointments or other related administrative tasks.
- Ensure that guidance and monitoring of conscience-based refusals is in line with human rights obligations and WHO recommendations, including ensuring that a person's right to access lawful services is not hindered, delayed or denied due to the practice of conscience-based refusals.
- Exercise continued monitoring of conscience-based refusals to ensure timely, effective and quality provision of abortion services.
- Provide values clarification training for all levels of health workers, from administrative assistants to obstetrician gynaecologists, to ensure respectful and quality service provision. Ensure that such values clarification includes an understanding of the reasons why persons seek to undergo abortions and how safe and common it is in society.
- Ensure that current, and any future, providers of telephone interpreting for HSC Trusts in Northern Ireland understand that conscience-based refusals do not extend to translation services and include translators in values clarification sessions.
- Enhance training on ethical issues and on respectful, non-judgmental communication for providers, including respect for patients' autonomous decision making.
- Ensure that abortion care meets the needs of all individuals and that gender identity or its expression does not lead to discrimination.

### Accountability

- Make patients aware of complaints mechanisms within the trust to address instances of unsatisfactory care and denials of abortion care.[602]
- Create 'accessible mechanisms for women to challenge denial of abortion in a timely manner'.[603]

602 WHO, Abortion Care Guideline (2022), pgs. 11-12.

603 WHO, Abortion Care Guideline (2022), p. 6. See also, *Tysiac v. Poland*, European Court of Human Rights, (App. No. 5410/03) (2007), paras. 117-118.



### Training

- Provide clinical training on the provision of abortion services for a range of health providers, as per WHO recommendations on task sharing on abortion, including for nurses and midwives.
- Train healthcare professionals to meet the needs of women, girls and other people who can get pregnant and their partners having to undergo a termination for medical reasons (TFMR). This must include system infrastructure, as well as appropriate training and support for health professionals to develop their knowledge and skills.

### Accessibility of services and service provision pathways

- Ensure an adequate number of clinics within the trust to guarantee accessibility of services, taking into account rural areas and financial and other barriers that people face with travel.
- Ensure that all university sexual health clinics controlled by an HSC Trust provide early medical abortion services.
- Ensure the provision of MVA services in all abortion settings, as an option for all women and girls and other people who can get pregnant, as per the WHO Abortion Care Guideline,[604] without non-medical restriction or limitation.
- Develop aftercare pathways to support the needs of people who have a TFMR.
- Until full implementation of commissioned services, as people continue to travel, ensure pathways and communication between providers in Northern Ireland and England are robust to ensure continuity of care.
- Promote nurse- and midwife-led services for abortion, as permitted under law, to relieve pressure on existing services and enhance service provision. Hire independent nurse prescribers for the EMA services and ensure nurses are trained on MVA for abortion and to do pregnancy scanning/ultrasounds.
- Ensure all levels of trust management understand their obligation to provide supportive services, which requires robust staffing levels to ensure continuity of care without relying on one or two individuals to manage and run the entire service. Ensure that an adequate number of providers are available, within each trust, to offer both EMA and surgical abortion services.

### Access to information

- Ensure clear, accessible, easy-to-find information on abortion, the abortion law, and abortion services, that is accurate and evidenced-based, on all trust websites. Information should be available in accessible formats and technologies appropriate to different kinds of disabilities and translated into relevant languages.
- Issue clear guidance to trust pharmacies that mifepristone is not a controlled drug and should not be treated as such or in any other exceptional manner.

## To the healthcare professional bodies:

- Ensure that members are aware of how to access abortion services, have the information necessary to signpost their patients and are kept apprised of developments in abortion services as commissioned services are rolled out.
- Ensure that members are aware of the scope of conscience-based refusals and their professional obligations in that regard. In particular, raise awareness of their legal obligation to disclose their conscience-based refusal to the patient and to refer them to another healthcare provider in a timely manner.

604 WHO, Abortion Care Guideline (2022), p. 64, Recommendation 24.

- Support values clarification workshops on abortion for members. Ensure that pharmacists are aware that mifepristone and misoprostol are not controlled drugs and should not be treated as such, nor in any other exceptional manner. Support members who are interested in providing abortion services to offer these services within their practices.
- Ensure that medical practitioners who fail to maintain professionalism (for example, by engaging in abusive or derogatory rhetoric, refusing to provide advice or care in contexts where conscience-based refusal is not permitted, and intentionally misleading patients about their treatment options and care) are held accountable.

### To healthcare educational institutions, including medical, nursing and midwifery schools:

- Ensure education on abortion for students in all healthcare fields as well as in clinical training.
- Ensure training is non-discriminatory and destigmatises abortion, including by integrating abortion into education as a critical element of reproductive healthcare.



# Annex 1: Detailed historical context of abortion law reform

## Political dynamics: Westminster, Stormont and public opinion

Devolution in the UK[605] figures prominently in the story of abortion law reform in Northern Ireland and continues to play a significant role in efforts to ensure implementation of the law.

### Westminster

Historically, the UK government's approach to the issue of abortion in Northern Ireland was largely one of avoidance and ostensible neutrality. Whereas the rest of the UK introduced legislation in 1967, legalising abortion on broad grounds, Northern Ireland was excluded from that statutory reform, with little debate. The UK government (Westminster) maintained this non-interventionist position until law reform, in 2019.[606]

Fearful of a backlash from Northern Ireland elected officials and of jeopardising a fragile peace in Northern Ireland, Westminster justified their position and Northern Ireland's outlier status by framing it as an issue to be resolved locally. They pointed to the region's distinct cultural, moral and religious values, relying on claims by Northern Ireland politicians of strong public opinion in opposition to abortion. Eager to avoid 'controversy', and concerned that an intervention could exacerbate tensions and herald a return to political violence, referred to as 'The Troubles', Westminster was long content to hide behind devolution and exceptionalise Northern Ireland when it came to abortion.[607]

With the formal devolution of legislative authority over criminal justice to Northern Ireland (Stormont) in 2010, the responsibility for criminal law reform was firmly Stormont's, and Westminster could point to devolution as a reason for inaction.

### Stormont

Political leaders in Northern Ireland have historically been staunchly opposed to abortion law reform. With political parties deeply intertwined with religion[608] and patriarchal norms, one point of consistent agreement among the parties, including the Democratic Unionist Party (DUP) and Sinn Féin, was an anti-abortion stance. Relying on claims that they represented an overwhelming majority of the people of Northern Ireland who did not want a change in the abortion law, political leaders consistently thwarted efforts at reform. They also leveraged to their advantage the UK government's concerns that law reform would damage the peace process and

605 Civil Service, Devolution Factsheet assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770709/DevolutionFactsheet.pdf

606 When additional legislation concerning abortion was debated and passed in the rest of the UK in 1990, an amendment to extend the Abortion Act to Northern Ireland was defeated. A 2008 update by the UK parliament to the 1990 legislation similarly yielded no abortion law reform for Northern Ireland, with proposals either blocked or voted down. See also, for example, CEDAW Inquiry Report, para 82.

607 See, eg, Sally Sheldon et al, '"Too Much, too Indigestible, too Fast"? The Decades of Struggle for Abortion Law Reform in Northern Ireland', 83(4) *Modern Law Review* (2020).

608 The DUP was founded by Ian Paisley, a protestant fundamentalist minister; the DUP has strong links to Paisley's church, the Free Presbyterian Church of Ulster. Sinn Féin's membership is mainly Catholic.

perhaps lead to continued political violence, thereby preventing meaningful debate in Westminster.[609]

In 2018, with Ireland's successful constitutional referendum and subsequent abortion law reform, Sinn Féin in Northern Ireland further shifted its political platform to support the legalisation of abortion. This left the DUP as the largest political party opposing abortion law reform in Northern Ireland. The DUP has been an obstructive force against abortion law reform for decades, a role they have continued to play throughout the implementation phase of the new abortion law.

## Public opinion in support of law reform

Despite elected leaders' claims to represent a strong majority of staunchly anti-abortion constituents in Northern Ireland, public opinion data demonstrates otherwise. Surveys conducted throughout the early 1990s demonstrated 'growing support for liberalising reform amongst both doctors and the general population in Northern Ireland'.[610] Amnesty International commissioned independent polling in 2014, to coincide with the launch of Amnesty's report, *Northern Ireland: Barriers to Accessing Abortion Services*,[611] which indicated that approximately 70 per cent of people in Northern Ireland supported legislative reform on abortion. Polling done by researchers at Ulster University in 2016 also found that well over 70 per cent of people, across all political parties, believed abortion should definitely or probably be legal in a range of circumstances;[612] additional polling in 2018 showed that public support for decriminalisation had increased since 2016.[613]

### Human rights advocates and the push for law reform: CEDAW, advocacy, litigation and tackling abortion stigma[614]

Civil society in Northern Ireland, active in campaigning for abortion law reform and access to abortion since the 1960s,[615] for decades focused their efforts on Westminster as the most viable path to law reform. However, after years of failed engagement, and with Stormont viewed as a dead end upon the devolution of criminal justice in 2010, some advocates focused their efforts internationally and in the courts.

In 2010, following longstanding engagement with the Committee on the Elimination of Discrimination against Women (CEDAW Committee), the body charged with monitoring implementation of the Convention on the Elimination of all forms of Discrimination against Women, the Family Planning Association (now Informing Choices NI), Northern Ireland Women's European Platform and Alliance for Choice submitted a collective request for an inquiry into the criminalisation of abortion in Northern Ireland.[616] It would take six years for the inquiry to materialise and until 2018 for the CEDAW Committee's report to be issued, with profound impact for law reform efforts in Northern Ireland (see below).

In 2013, Sarah Ewart decided, along with family members, to speak publicly about being forced to travel to terminate a pregnancy following a medical diagnosis of anencephaly, a fatal foetal impairment. Sarah Ewart spoke to Northern Irish media about the traumatic impact of the requirement to travel away from her home, family, support networks and trusted clinicians to access an abortion.[617] Her story received wide regional and national media coverage. Sarah Ewart and her mother, Jane Christie, would go on to work very closely with Amnesty International.[618] A high-profile public campaign with Amnesty combined with political advocacy and litigation ensued,[619] helping to dramatically shift public opinion and the terms of the debate.

The Northern Ireland Human Rights Commission (NIHRC) launched legal proceedings in 2014 in the High Court, challenging the criminalisation of abortion in cases of fatal foetal impairment or where the pregnancy results from rape or incest as a violation of international human rights law.[620] Amnesty International and Sarah Ewart were intervenors in this case from lower courts to the Supreme Court. At the Supreme Court, further evidence from other women impacted, such as Denise Phelan, was also presented.[621]

Although the case was ultimately lost at the Supreme Court on technical grounds, the Supreme Court's 2018 decision was nonetheless an important development. The Court took the unusual move of issuing a judgment, regardless of its findings on the NIHRC's 'standing,' and concluded that the criminalisation of abortion in the contexts of rape and foetal anomaly violated women's rights to private and family life under the European Convention on Human Rights.[622]

609 See, eg, Sally Sheldon et al, '"Too Much, too Indigestible, too Fast"? The Decades of Struggle for Abortion Law Reform in Northern Ireland', 83(4) *Modern Law Review* (2020).

610 Sally Sheldon et al, '"Too Much, too Indigestible, too Fast"? The Decades of Struggle for Abortion Law Reform in Northern Ireland', 83(4) *Modern Law Review* (2020), p771.

611 Amnesty International, *Northern Ireland: Barriers to Accessing Abortion Services* (2015) EUR 45/1057/2015, amnesty.org/en/documents/eur45/1057/2015/en/

612 Ann Marie Gray, *Research Update: Attitudes to Abortion in Northern Ireland* (June 2017), ark.ac.uk/ARK/sites/default/files/2018-07/update115.pdf.

613 Ann Marie Gray and Goretti Horgan, *ARK Feature: Northern Ireland Supports Abortion Law Reform* (October 2019), ark.ac.uk/ARK/sites/default/files/2019-10/feature13_0.pdf.

614 This section contains a very brief summary of key events, recognising that advocates have been working tirelessly on this issue for decades and it is impossible in a report such as this one to capture in detail all the efforts of all the people and organisations who have been advocating for decades on this issue.

615 Amnesty International, *Northern Ireland: Barriers to Accessing Abortion Services*, EUR 45/1057/2015 (2015), pp10-11 amnesty.org/en/documents/eur45/1057/2015/en/

616 CEDAW Inquiry Report, para 1.

617 BBC News, Woman's abortion 'ordeal' considered by NI health officials, 9 October 2013 bbc.co.uk/news/uk-northern-ireland-24458241; Stephen Nolan, 'Sarah Ewart's abortion journey from Northern Ireland', BBC Radio 5Live, 11 October 2013 bbc.co.uk/programmes/p01jmx4x; Stephen Nolan, *A devastated pregnant woman and her abortion law plea*, BBC Radio 5Live, 11 October 2013 bbc.co.uk/programmes/p01jnmbt; Joanne Sweeney, 'Mother's tragic abortion story could spark reappraisal of rules for Northern Ireland medics', *Belfast Telegraph*, 10 October 2013 belfasttelegraph.co.uk/news/local-national/northern-ireland/mothers-tragic-abortion-story-could-spark-reappraisal-of-rules-for-northern- ireland-medics-29648562.html; and Jane Graham, 'Why Sarah's abortion story is a great shame on Northern Ireland', *Belfast Telegraph*, 18 October 2013, belfasttelegraph.co.uk/opinion/columnists/jane-graham/why-sarahs-abortion-story-is-a-great- shame-on-northern-ireland-29669979.html

618 Susan McKay, 'The supreme team', in Fiona Bloomer and Emma Campbell, eds, Decriminalizing Abortion in Northern Ireland (2022) pp84-88; see also, for example, BBC News, NI abortion law: Jane Christie says she is devastated by first minister's comments, 1 May 2015, bbc.com/news/uk-northern-ireland-32551326

619 This began with the launch of Amnesty International UK's 2015 report, *Northern Ireland: Barriers to Accessing Abortion Services*, and included Amnesty International UK and FPA NI and others' work organising a 64,000 strong petition to the NIO in Westminster and a 'suitcase march'. See for example, Amnesty International UK, press release, Derry Girls and MPs call on Northern Ireland Secretary to decriminalise abortion, 26 February 2019, amnesty.org.uk/press-releases/derry-girls-and-mps-call-northern-ireland-secretary-decriminalise-abortion; ICNI, Beyond Decriminalisation: pregnancy choice and abortion care in Northern Ireland (June 2021) pp8, 17, and 21, informingchoicesni.org/wp-content/uploads/2021/06/Beyond-Decriminalisation-Report.pdf

620 *In the Matter of an Application by the Northern Ireland Human Rights Commission for Judicial Review* [2015] NIQB 96, judiciaryni.uk/sites/judiciary/files/decisions/The%20Northern%20Ireland%20Human%20Rights%20Commission%E2%80%99s%20Application.pdf

621 A full list of intervenors, including Amnesty International UK and Sarah Ewart, as well as the FPA NI, BPAS, ASN RCM, Alliance for Choice, ARC, and Birthrights, can be found here: supremecourt.uk/cases/docs/uksc-2017-0067-judgment-accessible.pdf

622 *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review* [2018] UKSC 27.

Media coverage[623] of the proceedings strengthened the campaign at Westminster for law reform and Sarah Ewart, supported by Amnesty International, filed another case before the courts, this time in her own name and with Amnesty International as an intervenor. NIHRC and others would later join this challenge.[624] In 2019, the High Court in Belfast found that Northern Ireland's law, criminalising abortion in cases of fatal foetal abnormality, violated the right to private and family life and was in breach of the UK government's obligations under the European Convention on Human Rights.[625]

Throughout this period, in the years preceding law reform, organisations continued to fight for abortion rights and access. Alliance for Choice and others tackled abortion stigma and worked to help women access abortions. Civil society continued to campaign for the decriminalisation of abortion in Northern Ireland in many ways, including by getting Belfast City Council to pass a motion for the decriminalisation of abortion pills, signalling to Westminster that political support existed for change.[626] There were also solidarity efforts in Ireland to repeal the 8th [Amendment of Irish Constitution], the success of which added to the momentum for change in Northern Ireland.

Together, advocates, organisations and individuals made clear that access to abortion is a human right issue and that the UK government could not escape its obligations under international human rights law to ensure access to abortion in Northern Ireland.[627]

## Law reform: abortion as a human rights issue

The momentum behind law reform grew in 2018 and 2019, after a series of key legal and political developments and public campaigning. Notably, these occurred during a period where the Northern Ireland Assembly was suspended (January 2017-January 2020). Calls for law reform were therefore targeted at Westminster, in the absence of a devolved assembly in Northern Ireland.

In 2018, the CEDAW Committee published a report on its inquiry on access to abortion in Northern Ireland. The Committee found that the UK government was responsible for grave and systematic violations of the rights of women in Northern Ireland under the Convention.[628] The Committee's report called upon the UK government to, among other things, decriminalise abortion and adopt legislation allowing for abortion in a wide range of circumstances.[629]

Also in 2018, Ireland's successful constitutional referendum, which paved the way for the legalisation of abortion, and the UK Supreme Court decision finding Northern Ireland's abortion law violated the European Convention on Human Rights, helped support efforts to firmly frame abortion as a human rights issue – and increased the pressure to reform Northern Ireland's laws.[630] In October 2018, there were 'several UK parliamentary attempts' made to change NI's abortion law, including a private members bill introduced by Diana Johnson that sought to decriminalise abortion in England, Wales and Northern Ireland.[631] As a result of sustained advocacy,[632] this was the first time that Northern Ireland was included in UK-wide legislation on the decriminalisation of abortion and, although it failed to pass, marked an important milestone after decades of exclusion from abortion legislation at Westminster.

In April 2019, the House of Commons Women and Equalities Committee published a comprehensive report on its 2018-2019 inquiry into the abortion law in Northern Ireland, calling for law reform in Northern Ireland by the UK government, noting that 'devolution does not remove the UK Government's own responsibilities to comply with its international obligations and internal laws cannot be used to justify a failure to comply with human rights standards.'[633]

These events culminated in July 2019: Westminster, determining that a human rights issue such as abortion, was a valid exercise of authority by the UK Parliament in the absence of a sitting Northern Ireland Assembly, passed the Northern Ireland (Executive Formation etc) Act 2019. The Act included provisions decriminalising abortion in Northern Ireland and halted all ongoing prosecutions relating to abortion.[634] The Act further obligated the Secretary of State to 'expeditiously' 'ensure that the recommendations in paragraphs 85 and 86 of the CEDAW report are implemented in respect of Northern Ireland'.[635] All of the Northern Ireland MPs present during the vote on this amendment voted against it[636] and last minute efforts to restore Stormont to block the law taking effect failed. The law to decriminalise abortion took effect on 22 October 2019.[637]

623 See, for example, Amnesty International UK, Supreme Court judges find Northern Ireland abortion law in breach of human rights, 7 June 2018 amnesty.org.uk/press-releases/supreme-court-judges-find-northern-ireland-abortion-law-breach-human-rights; see also, *The Journal*, '"All eyes are on the UK government": Who'll be the first to make moves to change NI's abortion laws?', 7 June 2018 thejournal.ie/northern-ireland-abortion-law-4057624-Jun2018/; the *Guardian*, 'The UK supreme court abortion ruling offers another fragment of hope', 7 June 2018 theguardian.com/commentisfree/2018/jun/07/uk-supreme-court-abortion-ruling-northern-ireland-women.

624 For a complete list of intervenors, see judiciaryni.uk/sites/judiciary/files/decisions/Ewart's%20(Sarah%20Jane)%20Application_0.pdf

625 *In the Matter of an Application by Sarah Jane Ewart for Judicial Review* [2019] NIQB 88, para 37. See also, Amnesty International UK, Abortion ban in Northern Ireland found to breach human rights, 18 May 2020 amnesty.org.uk/abortion-law-northern-ireland-sarah-ewart-human-rights

626 The *Guardian*, 'Belfast council passes abortion pills motion against prosecutions', 10 April 2018 theguardian.com/world/2018/apr/09/belfast-council-to-debate-abortion-pills-motion-northern-ireland; Amnesty International UK, Belfast Council to debate 'abortion pills' ahead of court case, 9 April 2018 amnesty.org.uk/press-releases/belfast-city-council-debate-abortion-pills-ahead-court-case

627 Grainne Teggart and Ruairi Rowan, 'Law reform and decriminalization delivered: Westminster and strategic litigation', in Fiona Bloomer and Emma Campbell, eds, *Decriminalizing Abortion in Northern Ireland* (2022) pp91-99.

628 CEDAW Inquiry Report, paras 81-82.

629 CEDAW Inquiry Report, paras 85-86.

630 Amnesty International UK, Ireland: Abortion ref outcome 'sends message to Northern Ireland', 26 May 2018 amnesty.org.uk/press-releases/ireland-abortion-ref-outcome-sends-message-northern-ireland

631 BBC News, Abortion decriminalisation bill tabled in Commons, 23 October 2018 bbc.com/news/uk-politics-45955492.

632 For example, in 2018, Amnesty International and the FPA NI held briefing events in Parliament, including on 18 July 2018, to support decriminalisation and law reform in Northern Ireland.

633 House of Commons Women and Equalities Committee, *Abortion Law in Northern Ireland: Eighth Report of Session 2017-2019* (2019), p25 publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/1584/1584.pdf (see references to submissions from Amnesty International UK, Alliance for Choice and others, throughout this report).

634 As a result of this Act, the charges against a mother being prosecuted for buying her daughter abortion pills were dropped. Amnesty International UK, Northern Ireland: court drops charges against mother prosecuted for buying daughter abortion pills, 23 October 2019 amnesty.org.uk/press-releases/northern-ireland-court-drops-charges-against-mother-prosecuted-buying-daughter

635 Northern Ireland (Executive Formation etc) Act 2019, Section 9. Paras 85 and 86 of the CEDAW recommendations relate to abortion law reform.

636 UK Parliament, Votes in Parliament, 9 July 2019 votes.parliament.uk/Votes/Commons/Division/700#noes.

637 Amnesty International UK, Northern Ireland: Campaigners mark end of Victorian era abortion ban at Stormont, 21 October 2019 amnesty.org.uk/press-releases/northern-ireland-campaigners-mark-end-victorian-era-abortion-ban-stormont

## The politics of implementation

The Northern Ireland Assembly was restored in 2020, just months prior to Westminster's 2020 Abortion Regulations, which legalised abortion in Northern Ireland on a wide range of grounds, coming into effect. The political dynamics between Stormont and Westminster that had historically frustrated law reform continued to impact every aspect of the implementation of Northern Ireland's abortion law.

### March 2020: service provision halted by the Department of Health

Despite the new law and subsequent abortion regulations, which came into force on 31 March 2020, the Northern Ireland Department of Health (DOH) provided no funding or support for the establishment of abortion services. Instead, once some of the Health and Social Care Trusts began offering early medical abortion services on their own initiative, the DOH instructed them to stop over concerns that approval by the Northern Ireland Executive was required before services could be provided or commissioned.[638] Pro-choice activists threatened legal action against the DOH, alleging that anti-choice politicians were blocking service provision as required under the regulations.[639]

Goretti Horgan, a long-time pro-choice activist and a senior lecturer in social policy at Ulster University, recalls that in early April 2020:

> The Department of Health said that they couldn't do it. And we kept on going: 'Yes, they can. Why can't they do it?'. And then, in the course of one week, two hospitals in Belfast each had a case of a young woman who was booked on a flight to go to England. And the flight was cancelled at the last minute [because of Covid-19]. And those young women tried to take their own lives. And as soon as that happened, really that kind of galvanised everybody. The doctors put a lot of pressure on the Chief Medical Officer to come through and admit that they had a right to go ahead with the service. And he finally did. And so that's really how the EMA [early medical abortion] service got to be set up.[640]

Ultimately, after receiving legal advice, the DOH allowed abortion provision in the trusts to proceed on 9 April 2020.[641]

### NIHRC judicial review proceedings concerning the failure to fund and commission abortion services

Nine months later, after continued DOH failure to fund or commission services, and limited intervention by the Secretary of State, the Northern Ireland Human Rights Commission commenced judicial review proceedings against the Secretary of State, the Northern Ireland Executive and the Minister of Health.[642] The proceedings concerned their ongoing failure to provide abortion and post-abortion care services

638 BBC News, NI health trusts 'stopped from carrying out early abortions', 9 April 2020 bbc.com/news/uk-northern-ireland-52221872

639 The *Guardian*, 'Northern Ireland confirms abortions can now be carried out', 9 April 2020 theguardian.com/world/2020/apr/09/northern-ireland-confirms-abortions-can-now-be-carried-out

640 Interview with Goretti Horgan, Alliance for Choice Derry and senior lecturer in social policy, School of Applied Social and Policy Sciences, Ulster University, 29 September 2022.

641 The *Guardian*, 'Northern Ireland confirms abortions can now be carried out', 9 April 2020 theguardian.com/world/2020/apr/09/northern-ireland-confirms-abortions-can-now-be-carried-out

642 Northern Ireland Human Rights Commission, Annual Statement (2021), p256 (proceedings commenced in December 2020, Amnesty International and ICNI jointly intervened).



'in all public health facilities expeditiously' and to provide 'relevant guidance' to healthcare professionals.[643]

Although the High Court nonetheless dismissed the claims against the DOH and Northern Ireland Executive and declared that the Secretary of State failed to act 'expeditiously as required by section 9 [of the 2019 Act],'[644] the judge did note: 'It is most dispiriting to learn that it appears to be the view of the Minister [of Health in NI] that the Executive Committee will simply not make a decision unless forced to do so by way of direction or judicial review.'[645] He also found that 'those in public office are not prepared to comply with their legal obligations because they disagree with the relevant law.'[646]

In response, the Department of Health issued a statement setting out it and the minister's position for not commissioning services: 'Department and Minister have received clear legal advice that NI Executive approval is required on the commissioning of abortion services.'[647] It cited the following from Mr Justice Colton's verdict:

> It [the Department of Health] will further be constrained by the fact that ultimately the Executive Committee will have to agree to the commissioning proposals [for abortion services] when complete. This is because the introduction of any new service would require Executive approval, in accordance with sections 20 and 28A of the Northern Ireland Act 1998 and the Ministerial Code contained in the Act.[648]

A representative of the Royal College of Nursing Northern Ireland recalls conversations with colleagues at the Department around the time of the judicial review:

> Their attitude varied between this NIO legislation's got nothing to do with us, and being obstructive and not wanting to talk to the NIO. You had a Minister of Health claiming that he couldn't commission what at that point were perfectly legal healthcare services.[649]

The representative expressed the view that the Minister of Health had abdicated responsibility: 'It was his job as minister once that legislation had been passed to commission services and he refused to do that for reasons that remain unclear.'

### Abortion (Northern Ireland) Regulations 2021

In response to the ongoing delays and commencement of judicial review proceedings, the Secretary of State issued new regulations, which came into force on 31 March 2021,[650] giving the Secretary power to direct the DOH to take action to ensure the provision of abortion services in NI. The DOH was given a few months to voluntarily commission services. However, without meaningful progress by the DOH, in July 2021

643 *Re Northern Ireland Human Rights Commission* [2021] NIQB 91, para 8 judiciaryni.uk/sites/judiciary/files/decisions/Application%20by%20The%20NIHRC%20for%20JR%20-%20In%20the%20matter%20of%20the%20failure%20by%20the%20SoS%20and%20others.pdf

644 *Re Northern Ireland Human Rights Commission* [2021] NIQB 91, para 112.

645 *Re Northern Ireland Human Rights Commission* [2021] NIQB 91, para 103.

646 *Re Northern Ireland Human Rights Commission* [2021] NIQB 91, para 104.

647 Department statement on High Court judgment, Department of Health (NI), 14 October 2021.

648 Cited in Department statement on High Court judgment, Department of Health (NI), 14 October 2021.

649 Interview with RCN NI, 8 February 2023.

650 Abortion (Northern Ireland) Regulations 2021, 2021 No. 365, legislation.gov.uk/uksi/2021/365/made

the Secretary issued a Direction to the Department of Health and the First and Deputy First Ministers ordering them to provide guidance to providers and to commission abortion services in Northern Ireland by 31 March 2022.[651]

In response, 'First Minister Paul Givan… vowed to resist the government order forcing Stormont to commission abortion services in Northern Ireland. He warned he was prepared to go to court to block the move.'[652] Subsequently, Givan's bill to remove the foetal impairment ground for abortion was rejected by the Northern Ireland Assembly, indicating momentum on this issue.[653] The Society for the Protection of Unborn Children Pro-life Limited (SPUC), an anti-choice organisation, then launched judicial review proceedings challenging the lawfulness of the 2021 regulations and direction. The Belfast High Court found against SPUC.[654]

In the judgment, issued on 8 February 2022, the judge commented:

> There can be no doubt that the commissioning of abortion services in Northern Ireland is a controversial and significant matter and one which excites deeply held opposing views. However, it seems to the court that the implementation of the law should not be regarded as a significant or controversial matter in the legal sense… As indicated in this judgment the existing law in relation to abortion services in Northern Ireland is clear. That can only be changed by the UK Parliament or the Northern Ireland Assembly… Ultimately as we approach two years after the law on this issue was changed, no provision for commissioning abortion services in Northern Ireland, in accordance with the 2020 regulations, has been implemented. As was said in the NIHRC application the court expects that in accordance with the rule of law the Minister of Health and the Executive Committee will carry out their legal obligations on this issue.[655]

## Abortion (Northern Ireland) Regulations 2022

The 31 March 2022 deadline for commissioning abortion services passed without any meaningful action being taken by the MOH. In May 2022, the Secretary of State issued new regulations, giving the Secretary the power to 'do anything that a Northern Ireland Minister or Northern Ireland department could do for the purpose of ensuring that the recommendations in paragraphs 85 and 86 of the CEDAW report are implemented in respect of Northern Ireland.'[656] The regulations also state explicitly that Northern Ireland Executive discussion or agreement is not required to implement a directive to commission abortion services.[657]

651 Abortion Services Directions 2021, Section 3(4) assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005075/The_Abortion_Services_Directions_2021.pdf

652 BBC News, NI abortion: Givan vows to resist commissioning order, 29 July 2021 bbc.com/news/uk-northern-ireland-58018850

653 Northern Ireland Assembly, Bill Number 15/17-22, Severe Fetal Impairment Abortion (Amendment) Bill, niassembly.gov.uk/assembly-business/legislation/2017-2022-mandate/non-executive-bill-proposals/severe-fetal-impairment-abortion-amendment-bill/

654 *Re SPUC Pro-Life Ltd's Application for Judicial Review* [2022] NIQB 9 judiciaryni.uk/sites/judiciary/files/decisions/Spuc%20%28Society%20for%20the%20Protection%20of%20Unborn%20Children%29%20Pro%E2%80%93Life%20LTD%27s%20Application_0.pdf.

655 *Re SPUC Pro-Life Ltd's Application for Judicial Review* [2022] NIQB 9, paras 199-200 judiciaryni.uk/sites/judiciary/files/decisions/Spuc%20%28Society%20for%20the%20Protection%20of%20Unborn%20Children%29%20Pro%E2%80%93Life%20LTD%27s%20Application_0.pdf

656 The Abortion (Northern Ireland) (No. 2) Regulations 2022, Section 4(1), legislation.gov.uk/uksi/2022/554/regulation/4/made

657 The Abortion (Northern Ireland) (No. 2) Regulations 2022, Section 4(2)



The new regulations were followed by the Abortion Services Directions 2022, which instructed the DOH to commission abortion services 'as soon as reasonably practicable'.[658]

## Northern Ireland Office commences commissioning process

Finally, on 2 December 2022, the Secretary of State announced the formal commissioning and funding of abortion services in Northern Ireland and instructed the Department of Health to commission services.[659]

658 The Abortion Services Directions 2022, Section 3(4) assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1079095/Abortion_Services_Directions_2022.pdf

659 NIO, press release: Secretary of State for Northern Ireland Instructs the Department of Health to Commission Abortion Services, 2 December 2022, gov.uk/government/news/secretary-of-state-for-northern-ireland-instructs-the-department-of-health-to-commission-abortion-services

# Annex 2: Response from the Department of Health

**From the Permanent Secretary and HSC Chief Executive**

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Tel: [redacted]

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Your Ref:

Our ref: [redacted]

Date: 18 September 2023

Dear Grainne

**Amnesty International's Report on Barriers to Abortion in Northern Ireland: Policy and Practice**

Thank you for your correspondence of 4 September 2023 regarding the above report.

It is evident that significant work has been undertaken by Amnesty International to develop the report and the Department will carefully consider the findings and recommendations upon final publication. Indeed, many of the recommendations reflect the work already underway within the Department on abortion commissioning as well as related work, such as the development of a Sexual Health Action Plan due to be published later this year. You will also be aware that some recommendations cannot be progressed in the absence of a Minister including the introduction of telemedicine and first trimester screening.

Further detail is outlined below on the up-to-date position regarding service provision. I have also briefly outlined some of the background that led to the Secretary of State's instruction on 2 December which I trust demonstrates that neither the Department nor the then Health Minister, Robin Swann MLA deliberately or intentionally withheld access to or information on lawful abortion services in Northern Ireland. The Department strongly refutes this allegation. The Department also does not accept that its actions amount to a breach of the Article 8 human rights of any woman or girl[1] in Northern Ireland. As set out in the judgment of the High Court in *Re NIHRC* [2021] NIQB 91[2] the Court found that the Department's actions did not amount to a breach of Article 8 and it was entitled to a reasonable period of time to introduce services in Northern Ireland, following the introduction of the Abortion (Northern Ireland) (No 2) Regulations 2020 (the 2020 Regulations).

[1] For simplicity of language this correspondence uses the term women and girls, but this should be taken to also include people who do not identify as women but who are pregnant.
[2] In the matter of the failure of the Secretary of State, Executive Committee and Minister of Health to provide women with access to abortion and post abortion care in all public health facilities in Northern Ireland

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**Background**

The 2020 Regulations came into force on 31 March 2020, legalising abortion in Northern Ireland, under the conditions as laid out in the Regulations[3]. Upon the introduction of the 2020 Regulations, the Health Minister wrote to the NI Executive on 3 April 2020 outlining his original intention to bring a paper to the Executive later that year setting out the Department's proposals for commissioning abortion services and addressing the other health and wellbeing recommendations in the report of the Committee for the Elimination of Discrimination Against Women (CEDAW)[4].

At the same time in April 2020, uncommissioned early medical abortion (EMA) pathways were put in place by Health & Social Care (HSC) Trusts starting from April 2020 in line with their statutory duties and functions to provide medical care and treatment in accordance with the needs of patients and subject to the law.

Acknowledging the difficultly that COVID-19 travel restrictions placed on women and girls requiring access to abortion services, the Health Minister brought forward two Executive Papers to the NI Executive in April and May 2020 for a decision on the introduction of telemedicine services during the pandemic. The Department was clear at the time that, until the Executive comes to an agreement on the provision of this important health service, women who require access to services should use the non-commissioned EMA services provided by Trusts in Northern Ireland, or those commissioned by the UK government and provided by the British Pregnancy Advisory Service in England. The use of unregulated services was strongly discouraged given the serious risks to women's lives and health. An agreement on the way forward could not be reached by the Executive and the second paper was not discussed.

The easing of COVID-19 pressures enabled the Department to restart the abortion services commissioning project in June 2021[5]. The aim of the project was to develop a commissioning model and service specification for abortion services in NI. The project timeline was adapted to meet the requirements of the Abortion Services Direction 2021, brought forward by the then Secretary of State (SoS), the Rt Hon Brandon Lewis MP, which required the Department to commission services by 31 March 2022. The First Minister and deputy First Minister were also directed to include proposals on the commissioning of abortion services on the agenda at the next meeting of the Executive Committee once they were brought by the Department of Health. The draft Service Specification was signed off by the Project Board in December 2021 and a draft Executive Paper was prepared for the Minister to issue to the Executive in early 2022. The resignation of the First Minister in February 2022 meant that the Health Minister was no longer able to fulfil this obligation.

Despite the absence of the Executive, the Department and the then Health and Social Care Board[6] continued to prepare for the implementation of services and directed Trusts to prepare for the introduction of services, although this could only be taken so far in the absence of additional funding and a commissioning decision.

[3] Prior to April 2020, abortion was lawful in Northern Ireland where it was necessary to preserve the life of the woman, or there is a risk of real and serious adverse effect on her physical or mental health, which is either long term or permanent
[4] The Department had received legal advice which stated that as abortion is a cross cutting and controversial matter, the Health Minister is required by the Ministerial Code to bring it for discussion and agreement by the NI Executive
[5] This was originally established in anticipation of the 2020 Regulations but had to be stood down due to resource implications within the Department because of COVID-19.
[6] On the 31 March 2022, the HSCB was dissolved as a corporate entity and its functions were transferred to the Strategic Planning and Performance Group (SPPG) within the Department. Any reference to the Department throughout this correspondence relates to both policy and commissioning functions (which now sit within SPPG)

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In May 2022, the current SoS for NI, the Rt Hon Chris Heaton-Harris MP, laid further regulations[7] that removed the need for the Department of Health to seek Executive Committee approval to commission abortion services in NI. These new Regulations also conferred on the Secretary of State the power to do anything that a Northern Ireland Minister could do for the purposes of ensuring that paragraphs 85 and 86 of the CEDAW report are implemented. The SoS used this power under Regulation 4 to instruct the DoH to commission and fund abortion services on 2 December 2022.

In his letter, the SoS instructed the Department to commission services in line with the agreed commissioning framework and service specification for 2022 - 2025. This service specification, which was previously shared with Amnesty, sets out the model for a fully resourced service. It was developed following extensive engagement with HSC Trusts to understand the full requirements to provide the abortion services. It was signed off by the Departmental Project Board and endorsed by the Northern Ireland Office (NIO) as being CEDAW compliant.

Funding allocation letters were issued by the Department to HSC Trusts in January 2023 and the implementation of services has been ongoing since then. As well as implementing services, this decision meant that the Department could publish information regarding service provision on NI Direct and could proceed with endorsing NICE guidance relevant to abortion services.

**Commissioning / Service Provision**

A formal programme for implementation and service mobilisation has been developed by commissioners within the Department. A series of workstreams have been established to take forward certain elements of implementation, and an Abortion Implementation Board (AIB), comprising Departmental, Trust, Public Health Agency and NIO representatives meets monthly. An Abortion Oversight Board, chaired by the Deputy Secretary of the Strategic Planning & Performance Group within the Department has also been established and deals with any issues that are escalated from the AIB. The Oversight Board provides assurance to both the Permanent Secretary of DoH and Permanent Secretary of NIO. Permanent Secretaries also meet on a regular basis to discuss progress.

It should be recognised that establishing any new service can take time. A series of steps are required including staff recruitment, identification of appropriate training programmes and available and suitable premises, procurement and the development of policies and care pathways. Despite some delays due to different operational challenges across HSC Trusts, significant progress has been made in the past nine months. HSC Trusts are progressing with recruitment and training; premises have largely been identified and equipment is being acquired. The Department is closely monitoring demand across the HSC Trusts and the number of women continuing to travel for abortion care in Great Britain.

As at September 2023, abortion services are available up to 11 weeks and 6 days in three out of five Trusts. In addition, the Southern, Belfast and Northern HSC Trusts offer surgical abortion up to 11 weeks and 6 days gestation. Commissioners are actively working with those remaining Trusts to expand early medical abortion service provision from 9 weeks and 6 days to 11 weeks and 6 days and to offer surgical services up to 11 weeks and 6 days. Commissioners are committed to ensuring that sustainable services are provided in NI. Furthermore, the expectation is that during periods of leave, a Trust

[7] The Abortion (Northern Ireland) Regulations 2022





Regional multi-disciplinary conscientious objection training facilitated by the Clinical Education Centre (CEC) has also taken place and CEC facilitate ongoing “Termination of Pregnancy regulation of care” training in relation to abortion services.

**Public Awareness**

Immediately upon the commissioning instruction in December 2022, the Department initiated a communications campaign. Information on abortion services was uploaded to the NI Direct website and several support networks have the appropriate web links to NI Direct, BPAS and MSI. These are updated on an ongoing basis. Letters were also sent to the Royal College of General Practitioners, General Practitioners (GPs) and GP Federations with a factsheet providing information for GPs should their patients approach them for advice on how to access services. The Department also directed funding to ensure google search optimisation resulted in appropriate pregnancy advice services being displayed.

The Department does, however, recognise that there is a requirement for further public awareness as services continue to roll out. There are plans in place to progress this with a specific Task & Finish Group considering this workstream under the Abortion Implementation Board.

There has also been engagement between the Department and the Department of Education given its role in delivering against the statutory requirement for all post-primary schools in Northern Ireland to provide age-appropriate, comprehensive and scientifically accurate education on sexual and reproductive health and rights.

**Safe Access Zones**

The Department of Health is aware of the impact that anti-abortion protestors can have on women who are accessing legally available abortion services and staff who work at locations where these services are provided. Department officials worked closely with the Bill Sponsor in development of the legislation and since the Abortion Services (Safe Access Zones) Act (Northern Ireland) 2023 was introduced by the NI Assembly, the Department has been working with the Trusts and the PSNI to develop a regional approach to the introduction of safe access zones.

Detailed preparation work has been ongoing to ensuring that appropriate steps are taken to inform members of the public that they are in a protected zone, for example, through adequate signage, boundary identification and published maps. Trusts have also worked with Ordnance Survey NI and local Councils to tailor signage and maps to their specific localities and to plan for their display in line with planning requirements. All Trusts have developed standard operating procedures and training to ensure that staff are aware of the safe access zones and how to manage a suspected breach. Until safe access zones are established existing public order protections remain in place if there is any threat or risk of harm to staff or service users. HSC Trusts remain on course to introduce Safe Access Zones this month and will be fully supported by a suite of communication and engagement to help bring the existence of the zones to the attention of the public and service users. Northern Ireland will be the first nation in the UK and Ireland to establish a regional approach to Safe Access Zones with all five Health and Social Care Trusts in Northern Ireland establishing zones at locations where abortion services are provided.

In summary, the commissioning of abortion services in NI has been a complex and challenging journey to date. Significant work has been undertaken by the Department and

will support other Trusts as required to ensure that women and girls have timely access to services in NI. In time, the aim is that a new Central Booking System will be introduced with open access to services across Trusts regardless of post-code.

The Department does acknowledge that there has been a delay in establishing abortion services post 12 weeks gestation. These delays primarily relate to training which in some cases must be provided outside of Northern Ireland.

Abortion is available in all HSC Trusts in cases of immediate necessity. Abortion is also available on the grounds of risk to life or grave permanent injury to the physical or mental health of the pregnant woman or severe fetal impairment and fatal fetal abnormality. The Belfast Trust offers a regional feticide service for all patients in Northern Ireland requiring access to this service. The Department is aware of the importance of first trimester screening in this context. In Northern Ireland, a fetal anomaly ultrasound scan is offered to all pregnant women at 18-20 weeks of pregnancy as part of routine antenatal care. The Department has commissioned work to assess the actions required and costs of offering antenatal screening for fetal anomalies and inherited conditions in Northern Ireland, as recommended by the UK National Screening Committee. This work will inform a future policy decision for a Minister on antenatal screening for fetal anomalies and inherited conditions in NI.

The implementation of telemedicine is also a policy decision for a Minister. The Department is focussed on implementing the current service specification for 2022 – 2025 as instructed by the SoS. Services will be monitored during this period and the current aim is that an external review of services will be undertaken in 2025. At that stage, any proposed changes to the service model will be brought forward to a Minister and for public consultation.

**Conscientious Objection**

Regulation 12 of the 2020 Regulations provides for staff to conscientiously object to participation in treatment authorised by the regulations. Staff members who have a conscientious objection are obliged to discuss this with their Trust management. As explained in earlier correspondence, the professional regulatory bodies set practice standards in relation to personal beliefs held by regulated professionals. The operation of this is a matter for HSC Trusts. The Department regularly receives assurance that conscientious objection is being managed and is not impacting on service delivery. Trusts, as employers, should have relevant policies and procedures in place and provide training to staff in relation to conscientious objection.

Values Clarification Abortion Training (VCAT) sessions were delivered in Trusts in May-July 2023. These sessions included one 'standard' values clarification workshop as well as a 2-day 'values clarification facilitator training'. These sessions were attended by staff working within abortions services and staff working within surgical services, as well as by a member of staff from the NI Clinical Education Centre. The rationale for having the facilitator training sessions was to develop in-house capacity within trusts to take forward further VCAT training sessions with staff both within their services as well as trust staff working in other services (e.g. pharmacy).

It should be recognised that given capacity and where the need for training is greatest, this is focussed initially on those services delivering or directly involved in abortion care. The training sessions were delivered by Abortion Talk, an advocacy organisation focused on reduction of abortion stigma. Commissioners have offered to arrange for further VCAT sessions and discussions are ongoing.





Trusts in the lead up to the SoS instruction, and in the nine months since. There remains a number of challenges to work through in order to deliver the full suite of abortion services as set out in the service specification and the Department and HSC Trusts remain committed to delivering for women and girls in NI.

Thank you for sharing a copy of the Executive Summary to Amnesty's report. We look forward to engaging with you further upon publication of the full report.

Yours sincerely

[redacted]

Working for a Healthier People

**From the Permanent Secretary and HSC Chief Executive**

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Your Ref:

Our ref: [redacted]

Date: 11 October 2023

Dear Gráinne

Thank you for your recent updates. I note that a revised publication date will be advised in due course, and also note that you have revised the report having considered the Department's response of 18 September. However, based on our reading of the most recent draft Executive Summary which you shared on 6 October, we continue to have concerns about how information provided by the Department has been presented, or not as the case may be, and would ask that you give further consideration to these concerns in the additional time available.

I am aware that Amnesty's research commenced prior to the Secretary of State authorising the commissioning of abortion services from December 2022, and while the experiences of service users and staff recorded during that period are of course valid and valuable in shaping the service model which is currently being implemented, the Executive Summary fails to mention that the Department has developed a comprehensive service specification to deliver the statutory requirements of the 2020 Regulations, and continues to work closely with Trusts to oversee its implementation. It also continues to criticise the Department for alleged failures to act during the period prior to the 2022 Regulations, when it was clear that Executive agreement was required under the terms of the Northern Ireland Act 1998, and fails to take cognisance of the High Court's position on this specific point in 2021, as I explained in my previous reply. You will be aware that Departmental officials serve under the direction and authorisation of Ministers, and in the absence of Executive agreement it was only possible to commission these services upon the subsequent instruction of the Secretary of State in December 2022. The suggestion that Departmental officials could have acted differently in those circumstances is therefore, in my view, misleading to potential readers as currently drafted. It would also be more accurate/informative if the report reflected the work that the Department was leading during this time prior to the Secretary of State's instruction to prepare the ground for a fully commissioned service model to be introduced.





While I acknowledge that the period of reporting goes only as far as August 2023, it would seem unfortunate in the extended publication period if the successful establishment of Safe Access Zones across all HSC sites from 29 September were not to be noted as a major accomplishment in terms of removing barriers to access to abortion services. As far as I am aware, Northern Ireland has been acknowledged as the first region of these islands and beyond to have implemented complete protection under the law of all health service locations providing abortion services. You will be aware that the Department has played a very active role in shaping the legislation during its passage through the Assembly to ensure it was human rights compliant, through its work with the Bill sponsor and the Office of Legislative Counsel, and through its briefing of the Health Committee during 2021-22. Since Royal Assent in February 2023, officials have also coordinated the regional implementation of this legislation by working closely across all Trusts, the PSNI and other partners to ensure preparations were completed in line with the planned operational date of September 2023. We acknowledge that monitoring the effectiveness of the zones is now an important focus for the period ahead, however their establishment through Department-led collaboration across multiple organisations and sectors should be noted as an important milestone in any assessment considering the rights of service users/staff or the removal of access barriers.

Officials will be happy to meet with you to discuss these and other issues once we have received the full report and had an opportunity to consider it in detail. You can arrange this through [redacted].

Yours sincerely

[redacted]

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# Annex 3: Response from the former Minister of Health

The former Minister of Health was provided with an opportunity to respond to the issues raised in this report by provision of a draft copy of the Executive Summary of the report on 6 October and 25 October 2023.

The former Minister of Health disputes that he is responsible for the failures set out in this report and asserts that the report 'negates and ignores' a legal opinion he received. While this legal opinion has not been shared, it is claimed that the minister was advised that any decision on the commissioning of services required Executive approval. Accordingly, the former minister claims that he would have breached the Ministerial Code if he had acted otherwise than he did. The former minister asserts that the requirement for Executive Committee approval of commissioning proposals for abortion was recognised by the High Court.[660] The former Minister of Health emphasises that this was an area that was not within his 'sole remit'.

660 The Northern Ireland Human Rights Commission (abortion services) [2021] NIQB 91 para. '[68]….It will further be constrained by the fact that ultimately the Executive Committee will have to agree to the commissioning proposals when complete. This is because the introduction of any new service would require Executive approval, in accordance with sections 20 and 28A of the Northern Ireland Act 1998 and the Ministerial Code contained in the Act. I should add that none of the parties in this application disputed this contention. For the purposes of these proceedings the court has proceeded on the basis that this is an accurate statement of the law.'

# LEGAL BUT NOT LOCAL

## Barriers to accessing abortion services in Northern Ireland

Abortion has been decriminalised in Northern Ireland since 2019. Yet, those seeking abortion care in continue to face significant barriers.

Why do so many barriers to accessing abortion remain?

Multiple failings by devolved government, limited, under-resourced and understaffed services, conscience-based refusals, misinformation and pervasive stigma are among the many remaining obstacles.

This report is based on desk research, Freedom of Information Act requests, and more than 60 in-depth interviews with women, members of the healthcare profession, healthcare professional bodies, civil society representatives, academics, and government representatives, which show that, almost four years after abortion was decriminalised, Northern Ireland's abortion services are unfit for purpose.

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