Women's Policy Group NI

Women's Policy Group
Joint Evidence Submission
Northern Ireland Assembly
Health Committee
Severe Fetal Impairment Private Members' Bill

6th May 2021

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Abstract - Call for Evidence Information:

The NI Assembly Committee for Health would like to hear your views on the **Severe Fetal Impairment Abortion (Amendment) Bill**.

The **closing date** for written submissions is **7 May 2021**.

Overview

The Bill was introduced by Paul Givan MLA on 16 February 2021. The purpose of the Bill is to amend the Abortion (Northern Ireland) (No. 2) Regulations 2020 to remove the grounds for an abortion in cases of severe fetal impairment.

Further information on the Bill can be found below:

A copy of the **Bill** and **Explanatory and Financial Memorandum** .

The **hansard report** of the Second Stage Assembly debate on the principles of the Bill that took place on 15 March.

The **hansard report** of the briefing session on the principles of the Bill at the Health Committee meeting on 11 March.

A **research paper** prepared by the Assembly's Research and Information Service on the Bill.

How to submit your views

Your submission should be structured to address the specific clause of the Bill. If appropriate, it should include any amendments you wish to propose to the text of the Bill.

Written submissions should be sent electronically in Word format (not PDF) to: Committee.health_sfiabill@niassembly.gov.uk. If you cannot submit electronically you may send in a hard copy written submission to: The Health Committee Clerk, Room 419, Parliament Buildings, Ballymiscaw, Stormont, Belfast, BT4 3XX.

Organisations or individuals responding to this call for views should note that their written submission (either in whole or part) may be published on the Committee webpage and may be quoted in the Committee's report or referred to in Committee meetings (which are public and are broadcast).

The Committee recognises that in some circumstances people may prefer for their evidence to be treated as confidential, or published anonymously. If you wish to do this please make this clear when submitting your evidence.

Before sending us your views please read the Northern Ireland Assembly Privacy Notice. This tells you how we process your personal data.

If you have any queries or require any further information about the call for evidence or the Committee Stage of the Severe Fetal Impairment Abortion (Amendment) Bill please contact the Health Committee Clerk by email: Committee.health_sfiabill@niassembly.gov.uk or by phone: 028 9052 1787.

Many thanks,

Committee for Health

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Contents

1. Introduction:

The Women's Policy Group Northern Ireland (WPG) is a platform for women working in policy and advocacy roles in different organisations to share their work and speak with a collective voice on key issues. It is made up of women from trade unions, grassroots women's organisations, women's networks, feminist campaigning organisations, LGBTQ+ organisations, migrant groups, support service providers, NGOs, human rights and equality organisations and individuals.

Over the years this important network has ensured there is good communication between politicians, policy makers and women's organisations on the ground. The WPG is endorsed as a group that represents all women of Northern Ireland on a policy level and we use our group expertise to lobby to influence the development and implementation of policies affecting women. This group has collective expertise on protected characteristics and focus on identifying the intersectional needs of all women.

The Women's Resource and Development Agency was invited to submit evidence to the Health Committee. As WRDA is the secretariat of the Women's Policy Group, and several member organisations of the WPG also received a request for evidence, we decided it would be best to do a joint evidence submission alongside a number of other women's sector and LGBTQI+ sector organisations in the WPG membership that are experts in this field. Some of these organisations will also be submitting individual evidence submissions on behalf of their own organisations.

This joint evidence submission has been developed with input from several WPG members with expertise on different aspects of this response. This has included the following members:

- **Women's Policy Group**
- **Women's Resource and Development Agency**
- **Alliance for Choice**
- **Alliance for Choice Derry**
- **Committee for the Administration of Justice**
- **Women's Support Network**
- **Rape Crisis NI**
- **Northern Ireland Rural Women's Network**
- **Reclaim the Agenda**
- **Reclaim the Night**
- **Northern Ireland Women's European Platform**
- **Belfast Feminist Network**

Please note, not all of the organisations above have policies or positions on every aspect of this response, and each organisation has fed in with their own area of expertise where relevant throughout thus submission. Further, a number of WPG members were involved in the

development of the WPG submission to the NIO Abortion Framework Consultation in 2019 and endorsed the joint response. This evidence submission will draw on some of the evidence submitted in the 2019 response, and we would like to highlight all of the organisations that were involved in this:

- **Women's Resource and Development Agency (WRDA)**
- **Women's Support Network (WSN)**
- **Northern Ireland Women's European Platform (NIWEP)**
- **Northern Ireland Rural Women's Network (NIRWN)**
- **HERE NI**
- **Belfast Feminist Network**
- **Reclaim the Night**
- **Alliance for Choice**

2. General Comments:

Many members of the Women's Policy Group have been campaigning on matters relating to reproductive justice for decades. Whilst abortion was decriminalised in Northern Ireland on 21st October 2019, and abortion services were due to be available from the 31st March 2020, it is extremely disappointing that in May 2021, there is still extremely limited access to abortion and there has been a failure to fully commission services.

It is also extremely disappointing that within this timeframe, more debate has been had within the Northern Ireland Assembly to restrict abortion services further, than to implement the abortion framework that was due to be in place from 31st March 2020. This is particularly concerning given the fact that the St. Andrew's Veto, the cross-community veto provided under para 2.12 Ministerial Code, was used three times to block the commissioning of abortion services from the Northern Ireland Executive Agenda in 2020[1].

The WPG would like to express our disappointment that not only have abortion services still not been commissioned, but that bills such as the Severe Fetal Impairment Abortion (Amendement) Bill have been given more time and consideration by our MLAs while women and pregnant people have been forced to travel throughout a pandemic. In addition, the WPG has regularly campaigned on the rights of disabled women[2], particularly in relation to the harm of austerity on disabled women and the barriers disabled women face in accessing abortion and other forms of healthcare.

With that being said, we welcome the opportunity to respond to the request received from the Committee on Health to submit evidence on the Severe Fetal Impairment Abortion (Amendment) Bill (hereafter, 'the Bill') given our shared expertise on the matters this Bill relates to. Given that

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[1] See Amanda Ferguson (March 2021), 'Stormont Cross-Community Veto used Three Times to Block Women's Reproductive Rights', http://amanda.ie/stories/stormont-cross-community-veto-used-three-times-to-block-womens-reproductive-rights

[2] See WPG General Election Women's Manifesto Recommendations on Disabled Women - https://wrda.net/wp-content/uploads/2020/09/WomensManifesto2019.pdf;
See WPG COVID-19 Feminist Recovery Plan - https://wrda.net/wp-content/uploads/2020/07/WPG-NI-Feminist-Recovery-Plan-2020-.pdf;
See WPG Evidence Submission to the Justice Committee on the Domestic Abuse and Family Proceedings Bill - https://wrda.net/wp-content/uploads/2020/06/WPG-NI-Evidence-Submission-to-Justice-Committee-05.06.20.pdf ;
See the WPG response to the NIO Consultation on Developing an Abortion Framework for Northern Ireland 2019 - https://wrda.net/wp-content/uploads/2020/01/WPGNIOAbortionConsultation.pdf;
See WRDA Women's Sector Lobbyist Blog on Disabled Women and Discrimination - the Facts We Need You To Know - https://wrda.net/2019/11/18/disabled-women-and-discrimination-facts-we-need-you-to-know/;
See WRDA Personal Blog on the NI Assembly Motion on Disability and Abortion June 2020: https://wrda.net/2020/06/04/womens-sector-lobbyist-statement-abortion-motion-ni-assembly-2nd-june-2020/

the Bill in question only has two clauses, this response will provide an overview of the evidence we believe is crucial to this Bill, and all of this evidence should be considered as comments on the two clauses of the Bill.

In this evidence submission, the WPG will highlight the legal human rights obligations that the UK government has in relation to international mechanisms such as the Convention for Eliminating all forms of Discrimination Against Women, and how this amendment is a direct violation of the human rights of women and pregnant people in Northern Ireland. This will be supported by an overview of existing research on the human rights implications of such a Bill, including the RaISe research paper to support the bill, and we will draw the health Committee's attention to the report of the Working Group on Fetal Abnormality and the conclusions of the report that can contribute helpfully to this call for evidence.

This submission will provide an overview of work already done by the Women's Policy Group in recent years in relation to abortion access in the last few years, alongside evidence on how the restrictions on abortion for severe fetal impairment has negatively impacted women and pregnant people in the Republic of Ireland. Further, this evidence submission will look at the experiences in Great Britain and highlight that abortion for severe fetal impairment beyond 24 weeks are not usually performed for conditions such as Down's Syndrome or cleft lip/palate, in the absence of other severe abnormalities.

We will also highlight the complications raised from a medical standpoint by groups such as Doctors for Choice, particularly relating to the difficulties in being able to clearly distinguish between a "severe fetal impairment" and a "fatal fetal disability". This evidence will portray how this Bill is extremely concerning, as it seeks to remove abortion in cases of any severe impairment, despite the fact that severe impairments are wide-ranging and can include complex abnormalities that are likely to shorten lifespan or lead to significant lifelong disability with complex needs[3].

Further, we will use testimonies throughout this submission to highlight the experiences of those women who have received a severe fetal impairment diagnosis alongside the views of some disabled women. The WPG will then raise some recommendations on how the NI Executive can promote women's rights, reproductive rights and disability rights collectively.

[3] Doctors for Choice Northern Ireland (2021)

3. Human Rights Implications of this Bill and CEDAW Recommendations:

The United Nations Human Rights Committee made a 'General Comment on article 6 of the International Covenant on Civil and Political Rights, on the right to life'. Within this includes the declaration that:

> "*Although States parties may adopt measures designed to regulate voluntary terminations of pregnancy, such measures must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the Covenant. Thus, restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardize their lives, subject them to physical or mental pain or suffering which violates article 7, discriminate against them or arbitrarily interfere with their privacy.*[4]

The European Convention on Human Rights

The UK is a party to the ECHR, and bound by the judgments of its adjudicative body, the European Court of Human Rights. From the early 2000s this Court has heard a number of cases related to restrictive legal frameworks for abortion. This provides a corpus of jurisprudence determining when human rights under the ECHR are engaged and may be violated. In cases where abortion is lawful but access is prohibited in practice – for example, by health professionals, structures or unclear information – the Court has found a violation of Article 8[5] and Article 3[6]. These issues may be engaged in Northern Ireland due to a lack of appropriate and timely pathways and information on lawful abortion[7].

International Human Rights Law

The UK is a signatory to all major international human rights treaties. In the past twenty years international human rights law has evolved to recognise the denial of safe abortion services as a human rights violation. **The 1994 International Conference on Population**

[4] Full text on abortion rights from UN here https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23797&LangID=E
[5] *Tysiąc v. Poland* (Application no. 5410/03) (2007); *A., B. and C. v. Ireland* (Application no. 25579/05) (2010); *R. R. v Poland* (Application no. 27617/04) (2011); *P. and S. v Poland* (Application no. 57375/08) (2012).
[6] *R. R. v Poland* (Application no. 27617/04) (2011); *P. and S. v Poland* (Application no. 57375/08) (2012).
[7] Kathryn McNeilly, 'Beyond Article 8: The European Convention on Human Rights and Abortion in Cases of Fatal Foetal Abnormality and Sexual Crime' *Stormont Knowledge Exchange Seminar Series* (2017) https://niassembly.tv/beyond-article-8/

Development and **the 1995 Beijing Declaration and Platform for Action** both outlined the importance of access to safe, legal abortion as a human rights concern.

The United Nations Human Rights Committee, the Committee on Economic, Social and Cultural Rights, the Committee Against Torture and the Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW) have stressed that states must guarantee accessible legal abortion services[8]. In particular, they have noted that criminal frameworks and punishments for abortion are not human rights compliant[9].

> **"**In 2018 the **UK Supreme Court** and the **United Nations CEDAW Committee** outlined that the current framework regulating abortion in Northern Ireland is in violation of national and international human rights commitments. These developments reflect a wider international movement conceiving access to abortion as a human rights issue[10]. Human rights are not only a transformative language which transcends the limitations of polarised debate on abortion[11], but legal imperatives which the UK has commitments to protect, respect and fulfil."[12]

Severe Fetal Impairment Abortion (Amendment) Bill, European Convention of Human Rights Compatibility and 're-criminalisation'

1. Severe Fetal Impairment Abortion (Amendment) Bill is a Private Members Bill (PMB) introduced by Paul Givan MLA which aims to "*amend the Abortion (Northern Ireland) (No. 2) Regulations 2020 to remove the ground for an abortion in cases of severe fetal impairment*".

2. In 2017 the UN Committee for the Elimination of Discrimination Against Women (CEDAW) issued its findings in an inquiry under the Optional Protocol, ratified by the UK, into NI abortion legislation. The CEDAW inquiry – in relation to NI - found the UK

[8] For example, Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 22. UN Doc. E/C.12/GC/22. The Right to Sexual and Reproductive Health. 2016CESCR, General Comment No. 14. UN Doc. E/C.12/2000/4. The Right to the Highest Attainable Standard of Health. 2000 para. 12.Human Rights Committee (HRC), Communication No. 1153/2003. UN Doc. CCPR/C/85/D/1153/2003. K.L. v. Peru. 2005 para. 7.HRC, Communication No. 1608/2007. UN Doc. CCPR/ C/101/D/1608. L.M.R. v. Argentina. 2011 para. 10.Committee on the Elimination of Discrimination against Women (CEDAW Committee), Communication No. 22/2009. UN Doc. CEDAW/ C/50/D/22/2009. L.C. v. Peru. 2011.

[9] For example, CESCR, General Comment No. 14. UN Doc. E/C.12/2000/4. The Right to the Highest Attainable Standard of Health. 2016 para. 41.CEDAW Committee, Concluding Observations on Kuwait. UN Doc. CEDAW/C/KWT/CO/3-4. 2011 para. 43(b)Concluding Observations on Hungary. UN Doc. CEDAW/C/HUN/CO/7-8. 2013 paras. 30-31.

[10] See further Rachel Rebouché, 'Abortion Rights as Human Rights' *Social and Legal Studies* (2016) 25(6): 765-782.

[11] See Kathryn McNeilly, 'From the Right to Life to the Right to Livability: Radically Reapproaching "Life" in Human Rights Politics' *Australian Feminist Law Journal* (2015) 41(1): 141-159.

[12] **Bloomer, McNeilly & Pierson, (2018)** Reproductive Health Law and Policy Advisory Group, Briefing Paper, Northern Ireland and Abortion Law Reform, September 2018

responsible for: *"(a) Grave violations of rights under the Convention considering that the State party's criminal law compels women in cases of severe foetal impairment, including FFA, and victims of rape or incest to carry pregnancies to full term, thereby subjecting them to severe physical and mental anguish, constituting gender-based violence against women; and (b) Systematic violations of rights under the Convention considering that the State party deliberately criminalises abortion and pursues a highly restrictive policy on accessing abortion…"*[13]

3. The CEDAW ruling, at paragraphs 85 & 86, provided a blueprint for the State Party to remedy the incompatibility of NI law with the international human rights obligations under CEDAW. This included the repeal of sections 58 and 59 of the Offences against the Person Act 1861 "*so that no criminal charges can be brought against women and girls who undergo abortion or against qualified health care professionals and all others who provide and assist in the abortion*". It also proscribed legislation to be adopted to provide for expanded grounds to legalise abortion in three areas, including "*Severe foetal impairment, including FFA [Fatal Foetal Abnormality], without perpetuating stereotypes towards persons with disabilities and ensuring appropriate and ongoing support, social and financial, for women who decide to carry such pregnancies to term*."[14]

4. Such matters relate to health and justice provisions, both of which are within devolved competence, and the incompatibility with CEDAW could have been remedied by the NI Assembly. In the absence of this however under the Good Friday Agreement (Paragraph 33(b) of Strand 1) the Westminster Parliament is to "legislate as necessary" to ensure the UK's human rights and other international obligations are met for NI.[15]

5. Primary legislation was consequently passed in Westminster. Section 9 of the Northern Ireland (Executive Formation etc) Act 2019 repealed sections 58 and 59 of the Offences Against the Person Act 1861 (which criminalised abortions in NI). It also placed the Secretary of State under a legal obligation to ensure that the framework under paragraphs 85 and 86 of the CEDAW report are implemented, including a continuous and ongoing duty to make changes to NI law through secondary law Regulations to ensure such implementation.[16]

6. The Secretary of State consequently introduced The Abortion (Northern Ireland) (No. 2) Regulations 2020.[17] Regulation 7 provides for termination of pregnancy in cases of "Severe

[13] CEDAW/C/OP.8/GBR/1 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, Paragraph 83.

[14] As above paragraphs 85 & 86. See also paragraph 62 for further elaboration on the on the CEDAW committee's alignment in the recommendation on severe foetal impairment with the UN Committee on the Rights of Persons with Disabilities

[15] For further information see: https://caj.org.uk/2018/05/31/is-it-westminsters-role-under-the-belfast-good-friday-agreement-to-legislate-on-northern-ireland-abortion-law/

[16] https://www.legislation.gov.uk/ukpga/2019/22/enacted

[17] https://www.legislation.gov.uk/uksi/2020/503/contents/made

fetal impairment or fatal fetal abnormality." This is consistent with what is required by the CEDAW framework and primary legislation.

7. Strictly speaking the primary legislation, in repealing the provisions of the 1861 Act, dealt with decriminalisation. However, Regulation 11 introduces an element of re-criminalisation for medical professionals who perform a termination deemed to be outside the terms of the Regulations.[18] This re-criminalisation was not recommended by CEDAW. When medical professionals conduct procedures outside of the legal framework, such issues are usually dealt with administratively or through the application of professional standards, rather than through creating a criminal offence. Re-criminalisation may constitute a chill factor to providing services to which there are entitlements, in particular in a challenge to a precise diagnosis relating to severe impairment or FFA.

8. In relation the European Convention on Human Rights (ECHR) Article 8 covers the 'right to respect for private and family life' and restrictions on same must be 'in accordance with the law'. This is the principle of 'legal certainty' which has been consistently held by the European Court of Human Rights to apply to abortion services. Put simply this means when a person has a right to an abortion in law there must be a clear way of *accessing that service in practice*.[19]

9. Whilst the Primary legislation and Regulations have been in place for some time there have been well publicised difficulties in accessing services in practice due to the failure of the NI Department of Health to commission the services required. This conflicts with the 'legal certainty' provisions of the ECHR as well as compliance with the Primary legislation. In January 2021 the NI Human Rights Commission initiated legal action over the failures to commission and fund abortion services in NI.[20] In response the Secretary of State laid the Abortion (Northern Ireland) Regulations 2021 which provide an additional power of direction that, *inter alia*, can require the commissioning of services.[21]
10. The UK has further emphasised its commitment to full sexual and reproductive rights in the Agreed Conclusions of the recently concluded CSW 65 conference, and in its commitment to the UN Generation Equality Forum initiative[22], which includes a new global Action Coalition on Bodily Autonomy and Sexual and Reproductive Rights. It should be emphasised that in its statement at the closing of CSW65, the UK stressed that action on the commitments made in the Agreed Conclusions also is required 'at home'[23]

[18] See: https://www.legislation.gov.uk/uksi/2020/503/regulation/11/made
[19] See e.g. Tysiąc v. Poland judgment (no. 5410/03) and ABC v Ireland.
[20] See: https://nihrc.org/news/detail/human-rights-commission-takes-legal-action-on-lack-of-abortion-services-in-ni
[21] See: https://www.legislation.gov.uk/uksi/2021/365/made
[22] Generation Equality Forum blueprint for Compact on women, peace and security and humanitarian action
[23] See UK statement to the closing ceremony of CSW65 in a video recording by UN WebTV; the UK statement begins at 0'22"00 of the recording.

ECHR compatibility of the PMB

11. In order to be within the legislative competence of the NI Assembly a bill, including a PMB, is to relate to a devolved competence (as health clearly is) but also be compatible with the ECHR.[24]

12. The current PMB would create a situation whereby Regulation 7 would be amended to remove reference to Severe Fetal Impairment, yet the Secretary of State would concurrently be under a binding legal duty under the Primary legislation to introduce Regulations to reinstate the provision and hence reverse the effect of the bill.

13. In addition, however the PMB, if and as long it was in place, would create a situation whereby there would still be an entitlement in NI to access abortion services in circumstances of Severe Fetal Impairment, derived from CEDAW and also from the duties under the primary legislation, yet in practice due to the absence of Regulations providing for same it would not be possible to access such a service in practice. Such a situation would conflict with the 'legal certainty' provisions of the ECHR and hence engages the question as to the PMB being outside the legislative competence of the Assembly.

14. It is essential to note that the Committee on the UN Convention on the Rights of People with Disabilities (CRPD), with the CEDAW Committee, has emphasised that using disability rights as an argument to oppose safe abortion is a misinterpretation of the Convention on the Rights of Persons with Disabilities[25]. The statement stresses that disability rights and gender equality are two components of the same human rights standard that should not be construed as conflicting, and clarifies that States must take effective measures to enable women, including women with disabilities, to make autonomous decisions about their sexual and reproductive health and ensure that women have access to evidence-based and unbiased information in this regard. It also underlines as a critical issue that all women, including women with disabilities, are protected against forced abortion, contraception or sterilisation against their will or without their informed consent.

15. Specifically, the comment states that 'States parties should fulfill their obligations under articles 5 and 8 of CEDAW and CRPD Conventions respectively by addressing the root causes of discrimination against women and persons with disabilities. This includes challenging discriminatory attitudes and fostering respect for the rights and dignity of persons with disabilities, in particular women with disabilities, as well as providing support to parents of children with disabilities in this regard. Health policies and abortion laws that perpetuate deep-rooted stereotypes and stigma undermine women's

[24] See NI Act section 6(2)(c) with reference to Convention (ECHR) rights https://www.legislation.gov.uk/ukpga/1998/47/section/6

[25] CEDAW and CRPD Committees (August 2018). 'Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities': Joint statement by the Committee on the Rights of Persons with Disabilities (CRPD) and the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW)

reproductive autonomy and choice, and they should be repealed because they are discriminatory'.

Amending the bill to remove the 'recriminalisation' provision

16. Should the PMB nevertheless proceed it would be open to MLAs to amend the bill to remove the 'recriminalisation' provisions of Regulation 11.

17. Given the drafting of the bill only relates to Regulation 7, it is possible that such an amendment in this instance may have to only relate to this provision rather than to other grounds for abortions under regulations 3-6. This would nevertheless sit within the intention of the CEDAW ruling and remove a potential chill factor for medical professionals, in relation to this specific area.

4. Human Rights Implications and NI Assembly Existing Research

As highlighted by Alliance for Choice[26], there are many existing research reports and consultation responses on abortion law in NI, including the briefing paper for this Bill. Prior to the 2020 Regulations, the NI Assembly Department of Justice and Department of Health had commissioned a working group on Termination of Pregnancy for Fatal Foetal Abnormality. This lead to the proposal of the The Abortion (Fatal Foetal Abnormality) Bill which ultimately collapsed along with the Assembly. Many of the points made by the working group[27], which was limited in scope to FFA, can be applied to SFI.

In particular, comments from healthcare professionals that 'there are woman who face risks to their physical health, mental health including acute trauma and distress and possible financial hardship, because they cannot access the health service they require in this jurisdiction'[28] is true for many people who need abortion care for SFI.

Healthcare professionals also highlighted that where women and pregnant people travel to access abortion care in GB, they had serious concerns 'about the increased risk of harmful physical and mental health outcomes for women who travelled to other jurisdictions'[29]. This is the experience of many people who travel to GB for abortion care that is not available locally. Currently travel includes an additional health risk of Covid-19. Where someone has to travel to GB for an abortion for a SFI, they are less likely to be able to access support services such as bereavement care. Additionally, it is less likely that they will be able to have tests, or a post-mortem, carried out on the fetus, unless they travel home without the remains.

These risks are the same for someone travelling to GB for an abortion after a SFI diagnosis, not only those traveling for care after a FFA diagnosis.

Further, in the RAISE paper accompanying this Bill many of the human rights implications of the law are clearly set out, as well as a number of comments from healthcare professionals[30]. We would urge members of the committee to consider the research produced by the Assembly which

[26] Alliance for Choice have contributed to this joint WPG submission, and the WPG fully endorses their individual submission.
[27] See Department for Health (2019) Report of the Working Group on Fatal Fetal Abnormality: https://www.health-ni.gov.uk/sites/default/files/publications/health/report-fatal-fetal-abnormality-April-2018.pdf
[28] Ibid, p.6.
[29] Ibid, p.26.
[30] See Raise Paper (2021) here: http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2017-2022/2021/health/1621.pdf

summarises not only the relevant human rights instruments relating to this Bill, but also the potential impacts of the Bill in exacerbating inequalities.

The paper is right to draw attention to the fact that were SFI abortions not provided for, NI would be out of step with GB. Should someone choose to terminate a SFI pregnancy, they would have to travel to GB for treatment, which currently would be funded by the UK Government. However, while the treatment would be funded, this would be in an unfamiliar location, away from support structures and their care team, with a limited referral pathway for aftercare. This is entirely at odds with the requirements. contained in 2018 UN-CEDAW, which are now law as outlined above. The paper states 'Such a scenario would be a return to 'exporting the problem' of abortions, which are unlawful in Northern Ireland, to other jurisdictions.', which is the crux of the issue.

Finally, the RAISE report highlights access to reproductive health services 'is closely linked to socioeconomic status and educational attainment – enactment of the Bill as introduced could therefore cause inequalities in these areas'. This Bill would impact not only the human rights of those who need an abortion following an SFI diagnosis, but would also seep into other areas.

5. Existing and Ongoing Women's Policy Group Work:

The Women's Policy Group and our members have undertaken a significant amount of work in relation to abortion in Northern Ireland. In the past two years in particular, we have made a number of submissions and recommendations in relation to the Northern Ireland Executive Formation Act and the urgent need for the full commissioning of abortion services in Northern Ireland. We have also undertaken a significant amount of lobbying in relation to the attempts by MLAs to restrict abortion services further, before they have been fully commissioned. We would like to take this opportunity to share some of this evidence again with members of the Health Committee.

5.1 Recommendations Relating to Abortion in the WPG COVID-19 Feminist Recovery Plan:

As many members of the Health Committee will be aware, the WPG published a COVID-19 Feminist Recovery Plan in July 2020 that provided a comprehensive roadmap on how the NI Executive could not only addressed the disproportionate impact of COVID-19 on women, but actually address the structural inequalities existed before the pandemic that led to such a disproportionate impact on women. Here we would like to reiterate our recommendations in relation to abortion, maternal health and bodily autonomy.

The full Feminist Recovery Plan is available here, and we would recommend that members of the Committee also note the various recommendations we have made on how to better support disabled women too.

Health Pillar - Section 2.5 - Abortion, Maternal Health and Bodily Autonomy:

The availability and access to sexual and reproductive healthcare services are crucial to women's health and well-being. We believe that free, non-directive sexual and reproductive healthcare should be made available to all women who wish to avail of it. Women must also be able to access sexual and reproductive health services, including contraception, emergency contraception and the means to access safe abortion care. International human rights law explicitly recognises the rights to sexual and reproductive health and bodily autonomy. These rights give rise to positive

state obligations to ensure abortion-related information and services and to remove medically unnecessary barriers that deny practical access[31].

Introducing additional barriers to abortion and/or failing to ensure abortion access during the COVID-19 pandemic contravenes UN treaty bodies' consistent critique of states' denial of safe abortion services, and recommendations that states both refrain from introducing new barriers and eliminate existing barriers to abortion[32]. Women should not, and may not be able to, travel to access an abortion and healthcare workers should not be put at risk by requiring pregnant people to physically attend healthcare premises, this has been made clear by WHO advice. The Northern Ireland Office have so far implemented an abortion framework that is inadequate.[33]

Further, the Department of Health has failed to commission the full abortion services provided for in the NIO regulations and has failed to enable women, girls and pregnant people to safely manage an abortion at home through telemedicine services. We need an abortion provision that is evidence-based, relies on best medical practice, and is fully implemented in the safest manner to address the difficulties around and barriers created by COVID-19. This includes telemedicine for self-managed abortions to reduce risk, provisions for those unable to take misoprostol, and full, accessible provisions for those accessing an abortion after 10 weeks gestation. The women of Northern Ireland have travelled to Great Britain to access abortions for too long, travel was considered an unviable solution by CEDAW,[34] therefore they should be able to fully access healthcare at home during this global pandemic.[35]

The Government has an obligation to take effective measures to protect and guarantee women, girls and pregnant persons' right to health, physical integrity, non-discrimination and privacy as they seek healthcare information and services, free of harassment and intimidation amounting to obstruction of their access to that healthcare. As access to abortion is often timebound and urgent, it is vital that exclusion / safe access zones are introduced.

Other areas of reproductive healthcare, including access to fertility treatments for lesbian and bisexual women, as well as access to timely and human rights compliant gender affirming care, are not currently guaranteed by the Department of Health and are often held behind long waiting lists and/or gatekeeping. The constraints on bodily autonomy imposed by the Department of Health on LGBT+ women must be addressed and rectified, in close partnership with organisations working directly with those communities.

In recovery planning, we recommend that the Government:

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[31] Center for Reproductive Rights, Breaking Ground: Treaty Monitoring Bodies on Reproductive Rights 12-14, 2020

[32] Abortion in the context of COVID-19: a human rights imperative, Jaime Todd-Gher &Payal K Shah https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1758394

[33] For details on the best provision for NI, see the WPG response to the NIO Abortion Framework Consultation here: https://wrda.net/wp-content/uploads/2020/01/WPGNIOAbortionConsultation.pdf

[34] For more information on the heavy financial, emotional and logistical burden of travelling to GB on women, see the CEDAW Committee comments here: https://undocs.org/CEDAW/C/OP.8/GBR/1

[35] For more information, see: https://www.who.int/reproductivehealth/publications/self-care-interventions/en/

- Ensure Relationships and Sexuality Education (RSE) is standardised, starts early, is relevant to pupils at each stage of their development and maturity and is taught by people who are trained and confident in talking about the course content, in line with CEDAW recommendations,
- Set up a dedicated fund specifically for organisations who offer contraception and nondirective information,
- Extend sexual and reproductive healthcare services across Northern Ireland to ensure equal access for all women, particularly those in rural areas,
- Ensure there are free, safe, legal and local abortion services accessible to all who want or need them,
- Introduce telemedicine for early medical abortions,
- Introduce safe access/buffer zones,
- Ensure there is funded assisted fertility treatment for everyone who wants or needs it, including same sex couples and single women,
- Ensure there is funded perinatal mental health provision.

5.2 Content from WPG Response to A New Legal Framework for Abortion in Northern Ireland 2019:

In 2019, the WPG submitted an extensive response to the NIO Consultation on an Abortion Framework for Northern Ireland. Many of the recommendations we made throughout this are of relevance to the PMB in question. As the Bill in question disregards medical evidence and human rights obligations, we would like to share some of this evidence and recommendations again in this evidence submission to the Committee on Health. This full consultation response can be seen here[36]*.*

Intro:

It is crucial that the voices of women, girls and pregnant people are heard when creating a framework for abortion provision in Northern Ireland. The organisations represented in this response have extensive experience and expertise through working with a range of groups impacted by the upcoming legislation including; women, girls, trans men, non-binary people, disabled people, bisexual and lesbian women, victims of domestic abuse, victims of rape and sexual assault, rural women, those with dependants, migrant women and more. All of these

[36] WPG Response to the NIO Consultation on a New Legal Abortion Framework for Northern Ireland (2019): https://wrda.net/wp-content/uploads/2020/01/WPGNIOAbortionConsultation.pdf

groups mentioned are set to benefit from the introduction of an abortion framework in Northern Ireland; if the legislation is accessible and takes the concerns of these groups into account.

We have the knowledge, experience and expertise needed to assist NIO in creating a truly accessible abortion provision that will benefit the lives of those who need to access it. By taking our expertise and guidance into account, Northern Ireland could be leading with best practice for abortion services across the UK. Our response and recommendations are based on extensive research and expertise. **The recommendations that me make throughout this response will ensure that the UK Government is abiding by CEDAW recommendations, respecting the human rights of women, girls and pregnant people and creating an abortion provision that is truly compassionate, accessible and fit for purpose.** We have collectively campaigned on abortion access for decades, and our recommendations come from that experience, and through lessons learned on the barriers that still exist in other jurisdictions such as the Republic of Ireland or the US.

Q.1 Early Termination of Pregnancy - Should the gestational limit for early terminations of pregnancy be:

- ***Up to 12 weeks (11 weeks + 6 days)***
- ***Up to 14 weeks (13 weeks + 6 days)***

WPG welcomes the recognition of the trauma women, girls and pregnant people who are victims of sexual violence and crime. As outlined in CEDAW recommendations, it is necessary that every person who becomes pregnant as a result of sexual crime should have the option to access an abortion. As this is difficult to legislate for without causing additional trauma for victims, it is widely understood that a period of unrestricted access to abortion works best[37] .

WPG also welcomes the approach to avoid the requirement of having to declare or certify being the victim of a sexual crime as a precondition of accessing an abortion. WPG supports a period of unrestricted access to abortion, as this is necessary in order to meet CEDAW recommendations to ensure all victims of sexual crime have access to abortion. As outlined in the consultation document notes, early termination will meet the needs of the vast majority of care seekers (up to 90% of care seekers in England and Wales).

However, WPG does not believe that 14 weeks is a long enough period of unrestricted access to abortion. Evidence from Alliance for Choice, BPAS, the Abortion Support Network, and many other sources who regularly support victims of sexual crime, highlights that victims of sexual crimes can have complex reasons for being unable to access an abortion until the second trimester. Among these reasons, domestic abuse and coercive control can prevent victims from being able to access an abortion. WPG believes that the timeframe of unrestricted access to abortion until the point of viability (currently 24 weeks in England and Wales) would be much more appropriate to ensure CEDAW recommendations are enacted.

[37] Centre for Reproductive Rights – Law and Policy Guide: Rape and Incest https://reproductiverights.org/lawand-policy-guide-rape-and-incest

This will prevent victims of sexual crime being forced to travel to GB to access a termination. In addition to this, very young people and menopausal women are more likely to not realise they are pregnant; especially in cases of rape or sexual assault. Disabled women also are more likely to be victims of domestic abuse and face additional barriers of being able to access support or healthcare. For these women, the best service that can be offered is, at minimum, an unrestricted limit of 24 weeks.

Q.2 Should a limited form of certification by a healthcare professional be required for early terminations of pregnancy? (No)

As abortion is decriminalised in Northern Ireland, it is unnecessary to abide by the conditions of the 1967 Abortion Act where two doctors have to certify that the woman or pregnant person has met the conditions of the act.

WPG does not support certification as it treats abortion different from other medical procedures and can increase stigma. As there is no clinical evidence to suggest that certification assists with abortion services or provides safeguards for patients, certification could lead to unnecessary delays in accessing abortions. In addition, introducing certifications may deter particular individuals, such as victims of sexual crime, from seeking care and support. Introducing unnecessary conditions such as certifications, which may lead to delays and act as a deterrent.

Abortion should be considered a part of sexual and reproductive healthcare, therefore, an informed consent model should be applied. Pregnant people should be enabled to come to the decision of having an abortion after consulting with medical professionals, this should not require the 'permission' of medical professionals; women and pregnant people should be trusted to make the decision that is best for them.

Q.3 Should the gestational time limit in circumstances where the continuance of the pregnancy would cause risk of injury to the physical or mental health of the pregnant woman or girl, or any existing children or her family, greater than the risk of terminating the pregnancy, be:

- ***21 weeks + 6 days gestation***
- ***23 weeks + 6 days gestation***

WPG would also like to reference the Concluding Observations of the most recent CEDAW examination of the UK; whereby it was stated that the **'State Party should ensure that protections for women and girls be put on an equal footing with those elsewhere in the UK'.** In order to ensure consistency of rights of women across the UK, this recommendation should also be considered in creating a legislative and medical framework for abortions in Northern Ireland. On that basis, a lower gestational time limit than England and Wales would be unacceptable in Northern Ireland as it would continue to force some women, girls and pregnant people to travel to access an abortion.

In order to meet the recommendation for equal footing of rights across the UK, WPG believes at the very minimum, terminations need to be available until at least 24 weeks, with the removal of

time restrictions on terminations related to the grounds of physical or mental health. As is widely recognised, and acknowledged in the consultation document notes, it is extremely likely that third trimester terminations will be an extremely low proportion of all terminations.

For those accessing an abortion after 20 weeks, it is highly likely that they are presenting later for care due to extremely complex reasons. Therefore, a time restriction is likely to increase the long term, permanent harm for this often very vulnerable group and further infringe upon their human rights. As the consultation document gives extremely limited detail on how physical or mental health would be assessed, this is very concerning. There is existing evidence of GPs and other healthcare providers not being well trained in mental health, dealing with those with existing disabilities or conditions, or taking women's mental health concerns seriously.

Further, while the majority of those accessing abortion will identify as women and girls, these services nevertheless must be accessible to all, especially considering the acute mental health impacts of pregnancy on many transgender men and non-binary people. Trans men and non-binary people face major barriers when accessing healthcare, and are often denied treatment, misgendered and re-traumatised based on health professionals not being well trained. Therefore, it is completely vital the assessment of physical or mental health is clearly set out, to ensure consistent, evidence-based practice across services in Northern Ireland.

Without this, it is possible that criteria could be interpreted very conservatively and inconsistently by service providers and this could lead to heavily restricted access to second trimester abortions. Furthermore, as domestic abuse and coercive control is not well understood by professionals here, and we have no legal protection against this crime, training is necessary to ensure care includes termination counselling where needed, alongside signposting to other services as appropriate. This is particularly prudent for victims of sexual crime, reproductive coercion, those with mental health issues, disabled people, those who are homeless or people with addiction or substance use issues.

To conclude on this point, **WPG believes that decisions regarding later terminations should be made between pregnant people in consultation with medical professionals (that are appropriately trained) to enable women, girls and pregnant people to make an informed choice. The majority of abortions in GB are following a diagnosis of a serious fetal abnormality happen before 24 weeks. Third trimester abortions are extremely rare and most families receiving this difficult news about a fetal abnormality decide whether or not to continue the pregnancy by 24 weeks. Under the current system, fetal anomaly screening takes place at the 20 week scan, with any detected abnormalities requiring a referral to the Fetal Medicine Unity; which can take a week to 10 days to secure an appointment. Further, specialist testing may be required which adds an additional amount of time to the wait for results. With all of this evidence, it is clear that a time limit of 21 weeks + 6 days cannot meet the needs of families in these circumstances and can lead to additional stress, trauma and in some cases, the violation of human rights.** WPG believes legislation in Northern Ireland should, at a minimum, equal the provisions in England and Wales.

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

- ***The fetus would die in utero (in the womb) or shortly after birth (Yes)***
- ***The fetus if born would suffer a severe impairment, including a mental or physical disability which is likely to significantly limit either the length or quality of the child's life (Yes)***

WPG would like to refer to comments made already in relation to question 3 on accessing terminations after 24 weeks. In addition, **WPG would like to note that experience from the Republic of Ireland shows that the definition of 'severe impairment' or 'fatal fetal abnormality' may not provide health professionals with the certainty that they need to perform terminations on the above grounds.**

Based on the experience of those in the Republic of Ireland, where only 'fatal' abnormalities are covered, many families receiving devastating news still have to travel outside of Ireland to access a termination due to the restrictive definition of 'fatal' within the regulations. Removing rigid definitions that do not encompass the full spectrum of health care issues is essential to providing best practice abortion care.

WPG agrees that no limit should be placed on terminations on the grounds of severe or fatal fetal abnormality and that it is important to remember that CEDAW requires access to abortion where the abnormality is 'severe' and not just 'fatal'. This is significant for those who have received such a diagnosis that brings difficult conversations relating to the odds of survival or the possibility of serious impact on the length or quality of life. **CEDAW recommendations also state that women, girls and pregnant people faced with such a diagnosis need sufficient time and support to reach an informed decision.**

Families in this situation are experiencing the difficulty of grief and loss which can complicate decision making and require additional support through counselling and other relevant services. It has already been highlighted, in both the consultation document notes and this consultation response, that third trimester abortions are a very low proportion of all abortions, with these figures being likely to be reduced as further diagnostic services are developed over time. **WPG believes it is necessary to develop specialist support provisions for these families, such as the models of support available in Iceland to ensure families can make an informed choice and feel support afterwards; regardless of the decision they make.**

WPG also recognised the separate issues of stigma around disability more generally; and particularly in relation to reproductive healthcare. **Disabled women and people can become pregnant and face additional barriers in accessing the reproductive healthcare that they need.** There is a legacy of abusive reproductive policies whereby disabled people have faced forced sterilisation. It is vital that disabled women and people are seen as respected, autonomous individuals and that barriers to reproductive healthcare are removed. **Disabled people's groups have spoken out against the co-option of disabled people's human rights, lives and identities by extreme anti-choice groups. For example, Down's Syndrome**

Ireland publicly supported the 'yes' campaign in the referendum to repeal the eighth amendment in the Republic of Ireland.

When respecting reproductive justice as a human right, it is necessary that abortion rights are not viewed in isolation to the inequalities and barriers other people can face. Disability discrimination, stigma around disability and the further decreasing levels of state support for disabled people, can make it extremely difficult to make a decision around some pregnancies. **Particularly for disabled pregnant people who get the diagnosis of a fetal disability and feel they are unable to continue with the pregnancy due to a lack of financial support[38] due to austerity.** WPG believes that doctors and other healthcare professionals need to be better educated on the impact of different disabilities on the lives of individuals and provide families with balanced, evidence-based information about the quality of life implications. For example, every family that received a Down's Syndrome diagnosis in Iceland is given evidence-based support and real life experiences from families with disabled children and meets with health professionals that work in this field. This approach helps remove some of the stigmas associated with having a disabled child allows families to make a truly informed choice.

This practise needs to be embedded into healthcare in Northern Ireland, to respect the autonomy of disabled pregnant people, remove some of the stigma associated with having a child who is disabled to ensure parents are able to make an informed choice that they are supported through; regardless of what that choice is. **To further remove the stigma disabled women, pregnant people and disabled children face, WPG believes the horrific programme of austerity cuts to the living allowances of disabled children and adults needs to end and appropriate investments into support services are necessary.** The human rights of disabled people need to be fully recognised and respected, therefore, access to information and support is vital to ensure disabled women, children, pregnant people and their families can live their lives with dignity and as independently as possible. By incorporating this into reproductive healthcare, disabled people's lives, identities and human rights will no longer be co-opted by groups opposed to abortion and barriers for disabled people and their families making informed choices around reproductive healthcare will be removed.

[…]

Q.6 Do you agree that a medical practitioner or any other registered healthcare professional should be able to provide terminations provided they are appropriately trained and competent to provide the treatment in accordance with their professional body's requirements and guidelines? (Yes)

WPG agrees with the World Health Organisation and NICE guidelines that early medical abortions can be safely provided by nurses, midwives, auxiliary midwives and doctors. A multi-disciplinary approach to abortion provision will be the most appropriate for Northern Ireland. Abortion care should be treated like all other forms of sexual and reproductive healthcare and be

[38] Disabled mothers with disabled children are set to lose 32% of their income by 2021 due to Austerity: https://wbg.org.uk/analysis/2018-wbg-briefing-disabled-women-and-austerity/

framed within an informed consent model. Abortion care in countries such as Sweden and Scotland are led by nurses and midwives, which can lead to a more efficient use of staffing resources and can overcome any shortages of appropriately trained doctors.

Given the fact that nurses and midwives are currently trained to provide care in circumstances of miscarriage, it is appropriate that they are also trained to provide care relating to abortion. With this approach, it is likely that abortions will be more accessible, which is particularly important for people living in rural areas, those with disabilities and those with dependants. **Creating an accessible service has been emphasised as essential in CEDAW recommendation.** There is a need for a change in medical, nursing and midwifery education to reflect the provision on abortion care as a part of sexual and reproductive healthcare services.

Finally, WPG believes that providers should be protected by their healthcare trust and union against any discrimination. Conscientious commitment to providing services should be promoted as providing holistic care for women, girls and pregnant people.

[…]

Q.8 Do you agree that terminations after 22/24 weeks should only be undertaken by health and social care providers within acute sector hospitals?

WPG recognises that terminations at this stage involve reduced grounds on which an abortion can take place alongside higher risk of complications for the patient. **Therefore, WPG believes any decisions regarding where a termination should take place after 24 weeks should be a clinical decision rather than a legally mandated restriction.**

Legally stipulating the type of setting abortions can take place in through regulations is potentially stigmatising and could create an inequality with other types of sexual and reproductive care. Therefore, WPG believes the legislation should remain flexible, while it is accepted that services in practice will focus on provision in acute sector NHS hospitals. Care should always be provided in a facility able to cater for complex needs and address any complications that may arise. All services should be available in NHS hospitals to ensure cost is not an additional barrier to accessing an abortion.

Q.9 Do you think that a process of certification by two healthcare professionals should be put in place for abortions after 12/14 weeks gestation in Northern Ireland? Alternatively, do you think that a process of certification by only one healthcare professional is suitable in Northern Ireland for abortions after 12/14 weeks gestation?

WPG does not accept that certification is required at any stage. As the Executive Formation Act 2019 decriminalised abortion in Northern Ireland, **certification is redundant, administratively burdensome, invasive and against the spirit of CEDAW**

recommendations which provide a clear roadmap to develop an appropriate legislative framework.

This is separate from ensuring all women, girls and pregnant people are given the opportunity to consult with medical professionals about their pregnancy and options for termination; which is essential to creating an informed choice and providing safe access to abortion. There is no clinical evidence available to suggest certification assists with abortion services or provides any safeguards for patients; in fact evidence suggests that it can lead to unnecessary delays.

If the government decides, against the suggestions from the women's sector, to introduce certification, this will make some women (especially rural) vulnerable to being refused care from doctors.

[…]

Q.11 Do you agree that the proposed conscientious objection provision should reflect practice in the rest of the United Kingdom, covering participation in the whole course of treatment for the abortion, but not associated ancillary, administrative or managerial tasks? (Yes)

WPG believes that the provision for conscientious objection in Northern Ireland should be equal to the rest of the UK. This will ensure consistency in how health workers are treated and how care seekers can access treatment. By having consistency across the UK, it will create clarity for both providers and care seekers.

[…]

Q.13 Do you agree that there should be provision for powers which allow for an exclusion or safe zone to be put in place? (Yes)

Protesters outside of clinics and healthcare facilities are extremely distressing and a large invasion of the private life of a woman/pregnant people seeking an abortion and their families. Protesters further enhance the extreme stigma surrounding abortion and they have no place in anyone's healthcare experience.

Given past experiences in NI through the Marie Stopes Clinic, Brook clinic and the Family Planning Association, protesters were so distressing to those accessing healthcare that a volunteer clinic escort service was required for patients; with many patients and escorts facing verbal abuse, harassment, threats and, on occasion, physical assault.

For some leaving maternity hospitals, they are leaving without their babies and face being re-traumatised by protesters who attack each woman to looks to them as one who is of a child-bearing age. These protesters seek to humiliate these women, and further stigmatise them, this should not be tolerated nor enabled.

For context on Northern Ireland, Belfast City Council supported a motion calling for exclusion zones to reproductive healthcare facilities in 2017 and this gained cross-party support; including the DUP.

[...]

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

- WPG believes it is **necessary to deliver on all CEDAW recommendations** to achieve full sexual and reproductive rights in Northern Ireland. For too long, women, girls and pregnant people have faced archaic laws, impossible barriers and immense stigma when it comes to abortion. Too many people have had to travel or continue with unwanted/forced pregnancies due to the 1861 Offence against the Person Act and it is a relief to the women, girls and pregnant people of Northern Ireland that abortion has finally been decriminalised. With all of this in mind, it is absolutely crucial that the new abortion framework in Northern Ireland is fit for purpose and fully accessible to all who need to access an abortion. We would like to address/suggest the following:

    - **Addressing remaining criminal provisions/ Section 25 Criminal Justice (Northern Ireland) Act 1945:** It will be necessary for the new regulations to repeal s.25 of the Criminal Justice (Northern Ireland) Act 1945, in order to comply with s.9(1) of the NI (EF) Act 2019 read with paragraph 85(a to c) of the CEDAW report.

- **Non-discrimination in accessing services:**

    - ***Trans Men and Non-Binary People:*** Throughout the consultation document, as well as the equality screening itself, those who may require access to abortions are referred to solely as 'women and girls', leading to the exclusion of many transgender men and non-binary individuals and the potential exclusion of those groups in any services developed. While the majority of those accessing abortion will identify as women and girls, these services nevertheless must be accessible to all, especially considering the acute mental health impacts of pregnancy on many transgender men and non-binary people. The exclusion of those whose legal documents, physiology and/or expression may be gendered differently from the specific wording of the legislation will lead to the creation of barriers to accessing abortion services. Therefore, the legislative framework - as well as any services developed from that framework - must be inclusive and mindful of those experiences directly in the language used, and be developed in collaboration with trans civil society organisations to ensure all needs can be met within these services.

    - ***Lesbian and Bisexual (L&B) Women:*** Firstly, the CEDAW report particularly highlights the need to provide abortion care where there pregnancy is a result of a

sexual crime. Lesbian and bisexual women are more likely to experience sexual violence than their heterosexual counterparts, and consequently a pregnancy as a result of a sexual crime. The Guttmacher Institute found in a 2018 US study of people who had had an abortion, 15% of Lesbians said their pregnancy was because of forced sex compared to 1% of heterosexuals and 3%of bisexuals. Bisexuals (9%, 7%) and Lesbians (33%, 35%) were also more likely to report that the man who impregnated them had physically or sexually abused them, compared to 4%/ 2% of heterosexuals. It is likely that there are similar trends consistently identified in international research in the UK, as ONS and other research highlights that L&B women experience proportionately higher levels of sexual crime and domestic abuse. Given that access to abortion in cases of sexual crime is specially a recommendation of CEDAW which must be complied with, and the L&B women are more likely to need access in this circumstance, the introduction of abortion care will positively impact L&B women.

- ***Adolescent Bisexuals and Lesbians:*** A systematic worldwide study (Hodson et al 2018), including reports from the UK, found that there was a statistically significant higher rate of pregnancy in adolescent lesbians and bisexual women. This was particularly found in bisexual adolescents where the rate was twice that found in the heterosexual adolescent cohorts. It is currently unclear as to why there is a higher rate of pregnancies in teenage L&B women than their heterosexual peers and the reasons need to be established. Higher rates of pregnancy in L&B adolescents might follow their being more adventurous or sexually active in general, more forced or unplanned sex without contraception, or if they experiment with heterosexuality to persuade themselves that they are heterosexual. L&B teenagers are more likely to experience an unplanned pregnancy, which some will choose to terminate. This higher rate of L&B teen pregnancy also highlights the need for more comprehensive sex and relationships education, which is also recommended by the CEDAW report, as well as ensuring that measures are put in place to make abortion services accessible to lesbian and bisexual pregnant people. This raises further concerns on the need for adolescents being able to access abortion care without the consent of guardians.

- ***Minority Ethnics, Migrants, Asylum Seekers and Refugees:*** Ensuring equal access to abortion services for racialised groups, especially migrants (documented or undocumented) and asylum seekers, is essential for fulfilling the NIO's duty under Section 75. Many migrants, asylum seekers and racialised groups struggle to access mainstream health care services due to issues with ID, documentation, and/or for fear of the 'hostile environment' policy enforced by the UK government. These issues need to be considered by the NIO and an awareness of the needs of these groups needs to be established. We would recommend engagement with with migrant/refugee groups to ensure equal access to abortion and that all barriers are removed for these groups.

- ***Disabled People:*** For disabled people, accessing healthcare often raises issues regarding the lack of agency afforded to them in the decision-making process. Often, ableism is rife in healthcare services, with many disabled people accessing care being treated as though they don't have autonomy over their own bodies. **This intersects with how society views disabled people, in an infantilising and dehumanising way, creating unconscious bias amongst healthcare providers and a lack of cultural competency leading to barriers to accessing care.** Given the widespread issues experienced by disabled individuals in accessing care in mainstream healthcare services, it cannot simply be assumed that these individuals will be able to access abortion services - it must be guaranteed in the language of the legislative framework and in any guidelines provided to healthcare practitioners. Issues regarding legal capacity and supported decision-making for people with learning disabilities also needs to be urgently addressed.

- ***People with Dependants:*** Many of those currently seeking abortions abroad find themselves struggling to cover the costs of childcare and/or making alternative arrangements for their dependants. It is absolutely essential that the barriers people with dependants face are considered and overcome in the creation of a new abortion framework; including providing localised services across Northern Ireland (including telemedicine), alongside support with alternative care arrangements for dependants.

- ***Minors Accessing Abortions:*** For under 18s, especially for those in abusive or dangerous living situations, access to abortion can be lifesaving. Access to this lifesaving care can be called into question due to a lack of agency provided to young people in those kinds of situations. There has been no information provided in the NIO's equality screening or consultation documentation as to what measures will be put in place to ensure confidentiality and access to services for minors who are in abusive or dangerous situations, which - if handled poorly - could put young people's lives at risk. WPG would like the NIO to consider this when creating an abortion framework for NI.

- **Developing Integrated Sexual and Reproductive Health Services:**

This consultation on a new legal framework for abortion services in Northern Ireland should be seen as a unique opportunity to develop a fully integrated sexual and reproductive health service. **This would be in line with CEDAW recommendations that note:**

> *'Women attested to difficulties in obtaining modern forms of contraception, inter alia, emergency (morning after pill), oral, long term and permanent. Testimonies revealed that women were refused sterilisation if deemed too young or unmarried, including pharmacists' reluctance to dispense or provide information about emergency contraception'* (CEDAW 2018, para 46).

By removing barriers to contraception, the numbers of unplanned or unwanted pregnancies will fall. Despite this, cuts to the public health budget have affected access to contraceptives across the UK. With the introduction of abortion in Northern Ireland, this is the ideal opportunity to seek greater resources for integrated sexual and reproductive health services as a whole across Northern Ireland.

- **Relationships and Sexuality Education (RSE):**

RSE in schools across Northern Ireland is largely dominated by religious and antiabortion organisations. The current provision of RSE is failing children across all of Northern Ireland, who are taught faith-based RSE[39] . RSE should teach children about abuse, consent, boundaries, contraception and respect. It should move beyond heteronormative views of relationships and this should be standardised across Northern Ireland. It is critical that age-appropriate RSE is developed with factual information on sexual and reproductive rights. This is crucial to ensure women and girls are able to fully understand, enjoy and exercise their rights while contributing to addressing other issues such as violence against women, girls and gender non-conforming people. RSE should not be taught by external, antiabortion or religious groups and it should be standardised, and regulated, across all schools in Northern Ireland.

[39] Faith-based RSE in Northern Ireland includes Love for Life and the Evangelical Alliance. Read more here: https://www.eauk.org/news-and-views/inspiring-choice

6. Personal Testimonies from Women:

We would like to take this opportunity to share some anonymous testimonies received by the women's sector over the past number of years. These testimonies are from women and their families who have experienced a severe fetal impairment diagnoses, alongside the views of disabled women who find this narrative of using disability to restrict abortion as distressing:

Testimony 1:

> *"**Restricting access will not prevent those of us with the privilege of freedom and means to travel from making our own choices.** It will hurt those who cannot travel at an incredibly vulnerable and traumatic time. Those people without the money, support, physical ability, access to childcare, or freedom to travel. Including the community the amendment claims to wish to protect."*
>
> - A woman who travelled after an SFA diagnosis

Testimony 2:

> ***"My wife had a termination after severe foetal defects were discovered in a series of scans at 21 weeks**. Our choices were limited. The thought of placing my already distressed wife on a plane to England was not only unthinkable but a denial of her basic human right to make a decision about her own body or face a humiliating, medically dangerous and deeply upsetting journey to another country and a strange hospital with little or no support as I would have had to remain at home with our other child. That the laws surrounding this issue are determined by faith and politics, rather than science and simply providing a choice to women, is still thoroughly shocking and archaic. Northern Ireland is embarrassingly behind the rest of the UK which the loudest of our politicians claim to demand parity with in all cases except providing a choice to women over their own bodies. A hypocritical disgrace."*
>
> - Testimony for Women and Equalities Committee Inquiry

Testimony 3:

> ***"I am in my 40s, live in Belfast and am married with one child.** At the end of 2014 I was ecstatic to find out I was pregnant. We had been trying for a while for a brother or sister for my daughter and I had already been through a devastating and painful miscarriage. At the 20-week scan (which took place a week late due to scheduling problems) I was told that there appeared to be fluid*

on the brain. It took a week to get a cancellation with a foetal medicine consultant and she carried out an amniocentesis which showed a severe chromosomal disorder.

As you can imagine, this was utterly devastating for us. She gave us some information on the condition and suggested Googling it to learn more about the prognosis, which is that 80-90% of babies with the condition do not survive the birth and the rest die within days or weeks. We said we wanted to consider termination but the only thing they were able to offer us was a cardiac scan later in the pregnancy as many of the babies have heart conditions.
I have since learned that previously families in NI diagnosed with a fatal foetal abnormality (FFA) diagnosis were offered induction[40].

However, in 2013 DUP health minister Edwin Poots published revised abortion guidelines which threatened 10 years' imprisonment for medical staff who carried out abortions that were not in line with the very strict laws in NI. My consultant has since told me that following legal advice on those guidelines, medical staff were not allowed to provide any information that would help anyone to get an abortion, including recommending organisations that could help or advising on the most appropriate procedure.

We felt utterly cut adrift from any medical support and left to fend for ourselves at the worst moment of our lives. At this stage, we only had a week and a half before the 24-week cut-off point."

- Testimony for the Women and Equalities Committee Inquiry

Below is a personal testimony from a disabled woman in relation to the NI Assembly Motion to *'reject the imposition of abortion legislation which extends to all non-fatal disabilities, including Down's syndrome'* on 2nd June 2020:

Testimony 4:

"As a disabled woman, this was an extremely distressing debate to watch, especially as **this was the most that I have ever heard disability being mentioned in the Assembly and it was only in the context of limiting hard-won reproductive freedoms.**

[…]

Disabled people were described as being "treated poorly" because of "their imperfections" rather than due to entrenched systemic discrimination; this in itself

[40] *See more here from Gerry Edwards's experience - http://www.thejournal.ie/readme/terminations-medical-reasons-experience-3233583-Feb2017/*

shows the ignorance towards disability activism by the speakers in question. Not once did any of these members discuss the history of parties in the Executive stripping away the human rights of disabled people through their support of welfare reform and austerity; nor did any of these members once consider the needs of disabled women themselves who face even greater barriers to accessing much needed reproductive healthcare.

[...]

Most significantly, **I want to address the view that Northern Ireland is incapable of being allowed to lead the way when it comes to modern legislation**. Why do we need to have the worst aspects of the 1967 Act and the abortion provisions in the Republic of Ireland added to our own regulations here? Why is it not possible to learn lessons from other areas that gained access before us, to assess what we need to do better to ensure an accessible provision that is fit for purpose? In relation to the specific use of disability in this context, clarification is needed that unfortunately was not provided in the debate in the Assembly. **For those who are in the heart-breaking position of facing a foetal abnormality, it is extremely unlikely that a doctor can give a clear fatal diagnosis**. Instead, you will be told the nature of the anomaly, the consequences of this, the survival rate of the condition and other reasons that this rate could be lowered. The term 'fatal foetal abnormality' has had an extremely narrow criteria attached to it, and as a result, many Irish women are forced to travel to Great Britain to access an abortion.

[...]

A much-broader discussion of how disability is treated in Northern Ireland needs to be had and the debate held was Stormont is a far, far way from how the disabled community deserves to be treated. We, as a society, need to make a total cultural shift to how disabled people are treated. That includes our fair access to healthcare, education, housing, social benefits, human rights, and a life free from stigma. Disabled people across the UK have begged both the Westminster government and the NI Assembly to not implement welfare reform, and despite the new-found disability activism from certain parties, our pleas were ignored and thousands of disabled people died as a result. Where was the concern for our lives then? **Why do certain parties only discuss disability when it is in the context of restricting our right to choose?** Why have our voices not been listened to in the past but suddenly certain parties became our apparent advocates overnight? It is not good enough, and we should never be used as a political football.

[...]

I am a disabled woman and I will always support the right to choose. I am a disabled woman and I want to see all parties put actions behind their words

and scrap all discriminatory policies they have introduced in the past decade that have killed many disabled people. I am a disabled woman and I am sick of us not being included in debates about disability. We are a broad community, with a diverse range of views, please do not only use disability when it suits your agenda."

7. Existing Medical Evidence

The WPG would like to highlight the wide-ranging medical evidence that exists that demonstrates the harms of restricting abortion on the grounds of severe fetal impairment.

For instance, the Royal College of Obstetricians and Gynaecologists produced a report for the Working Party regarding Termination of Pregnancy for Fetal Abnormality[41]. This report acknowledged the difficulty in providing an accurate prognosis regarding a pregnancy when the anomaly is more likely to result in morbidity rather than mortality, and that specialist advice is required, meaning these abortions may occur post-24 weeks. This report further highlights that one third of all terminations made post-24 weeks were for central nervous system anomalies, indicating that these pregnancies are the most difficult to provide an accurate diagnosis and prognosis for. Choosing to restrict these abortions further for those in this group is to make women and pregnant people for vulnerable to a lack of options.

In addition, research from Crowe *et. al.*[42] highlights the wide variation in healthcare provider options regarding abortion for non-lethal fetal anomalies, and that the lack of medical definitions for legal terms providing restrictions creates differences in opinion across the professional field, however, more restrictive definitions are not necessarily welcome or needed in order to provide high quality support and care to parents with a fetal anomaly diagnosis. This is also raised by Lotto *et. al.*[43] stated that definitions of severity of fetal anomaly are often unclear and thus difficult to determine, leaving medical staff to interpret the law with low levels of consensus even among medical staff, while also being subject to harsh legal scrutiny and high levels of vulnerability as a result. This has led to a difficult situation whereby clinicians face a challenge between their role as a facilitator to provide information and support to their patients, and dealing with the legal constraints and scrutiny they face which restricts the options provided to women and impacts on the ability to support patients.

[41] RCOG (2010), 'Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales': https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport18may2010.pdf

[42] British Medical Journal (2018), 'Negotiating acceptable termination of pregnancy for non-lethal fetal anomaly: a qualitative study of professional perspectives', : Crowe L, Graham RH, Robson SC, et al. Negotiating acceptable termination of pregnancy for non-lethal fetal anomaly: a qualitative study of professional perspectives. BMJ Open 2018: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5855171/pdf/bmjopen-2017-020815.pdf

[43] British Medical Journal (2017), 'Clinicians' perspectives of parental decision-making following diagnosis of a severe congenital anomaly: a qualitative study'; : Lotto R, Smith LK, Armstrong N. Clinicians' perspectives of parental decision-making following diagnosis of a severe congenital anomaly: a qualitative study. BMJ Open 2017

7.1 Endorsement of Statement from Doctors for Choice NI and the Royal College of Obstetricians and Gynaecologists

We would like to endorse the comments made by Doctors for Choice NI, together with the Royal College of Obstetricians and Gynaecologists, in a recent statement sent to MLAs in relation to the Severe Fetal Impairment Abortion Bill[44]. Doctors for Choice NI asked MLAs to vote **against** the Bill for the following reasons:

> "It is the view of Doctors for Choice Northern Ireland, together with the Royal College of Obstetricians and Gynaecologists, that women should be supported in difficult circumstances during pregnancy, and this is best accomplished by permitting decisions to be taken by women in discussion with an expert and multidisciplinary clinical team on a case-by-case basis.
>
> Removing these provisions in law will ultimately put women with much wanted pregnancies under pressure to make decisions before they are ready to. All women in these very sad circumstances deserve to be looked after locally with their family and friends nearby and access to bereavement support and counselling as required.
>
> **Abortion following the diagnosis of a severe fetal impairment is usually undertaken in the context of a much-wanted pregnancy. The decision-making process for the women and their partners after a diagnosis of fetal abnormality is a difficult one. They must try to absorb the medical information they have been given, while in a state of emotional shock and distress, and work out a way forward that is best for them and their families.**
>
> This bill seeks to remove abortion in cases of any severe impairment. Severe impairments are wide-ranging and can include complex abnormalities that are likely to shorten lifespan or lead to significant lifelong disability with complex needs.
> From a medical standpoint, it is not always possible to clearly distinguish between a "severe fetal impairment" and a "fatal fetal disability". Most severe abnormalities are only diagnosed at the 20-week scan or later, and women and their partners need time to reflect with all the facts and information available to them.
>
> **NOTE: Abortions for severe fetal impairment beyond 24 weeks are not usually performed for conditions such as cleft lip/palate, club foot or Down's Syndrome in the absence of other severe abnormalities.**
>
> If this Bill passes:

[44] Doctors for Choice NI (2021) Statement to MLAs Asking to Vote Against the Severe Fetal Impairment Abortion Bill.

- **Women will be rushed to terminate their pregnancy before 24 weeks.** Preventing access beyond 24 weeks is not workable because most serious abnormalities are only detected at the 20-week scan or later. Women need time for diagnostic tests and specialist advice in order to decide what is best for them and their families. Only women will know what they can manage within their individual set of circumstances.

- **Women will be forced to travel but without the proper support and aftercare they need.** This is a very distressing experience for people, who by the nature of the context and diagnosis, are already in a very difficult situation.

- Doctors for Choice Northern Ireland believe that Stormont should focus their efforts on improving support for women: including the commissioning high-quality services, an NHS screening programme in line with GB, ensuring women do not have access to support whether they choose to continue the pregnancy or not - as well as better social support for disabled children and their families."

We would also like to highlight and endorse the Doctors for Choice UK statement on abortion for fetal abnormality, which states the following[45]:

> "Despite advances in antenatal screening and diagnostic tests, most fetal abnormalities are not detected until the 18–20-week scan, with some serious conditions not being diagnosed until the third trimester.
>
> Doctors for Choice UK are opposed to removal of fetal abnormality as grounds for abortion or any restriction on time limits for fetal abnormality.
>
> We believe that:

- Women and their partners do not take the decision to end, what in most cases is a wanted pregnancy, lightly. They make the painful choice to do so after careful consideration of what the diagnosis may mean for their child's quality of life as well as for themselves and their family's future.

- Following the diagnosis of a severe fetal abnormality, women and their partners should have access to all relevant information necessary for them to make the decision to continue with the pregnancy or seek an abortion.

- Women and their partners should be treated in a sensitive and non-judgmental manner and have access to specialist support (including the offer of counselling) whether they decide to continue with the pregnancy or seek an abortion.

[45] Doctors for Choice UK Position Statement on Abortion for Fetal Abnormality: https://www.doctorsforchoiceuk.com/our-work

- Any time limit for abortion in the case of serious fetal abnormality would cause additional distress at what is already a difficult time and risk rushed decision-making, which may even lead to some fetuses being aborted when more time, information and support might have resulted in a decision to continue the pregnancy. Furthermore, for conditions not diagnosed until the third trimester; a 24-week abortion time limit would mean forcing women to carry these pregnancies to term.

- Having the choice to decide to have an abortion following a diagnosis of severe or fatal fetal abnormality does not discriminate against persons with disabilities[46]:

    - When women and their partners decide to have a termination for fetal anomaly, they do not seek to denigrate those living with disabilities, but are making the decision for their own reasons and individual circumstances,
    - Anti-discriminatory legislation is applicable to born persons, not the fetus in utero, with birth being the start-point of human rights,
    - It does not violate the right of a person with a disability to not face discrimination and to have access to the care resources they need."

[46] In 2016 the disabled political journalist Dr Frances Ryan stated that, "forcing a woman to bring to term a disabled foetus against her will is not the way to support disabled people" and that "any progress made in disability rights should never be off the back of women's".

8. Experiences in the Republic of Ireland and Great Britain

Later in this evidence submission, the WPG will discuss the case of Iceland, in the effort to debunk some myths that are often perpetuated in relation to abortion and disability alongside recommendations on how to better support those who receive a fetal anomaly diagnosis. However, we would like to take this opportunity to look closer at our neighbouring jurisdictions.

8.1 Experiences in Great Britain:

We have already highlighted existing medical evidence for England, Scotland and Wales earlier in this response. The WPG would like to again stress that in Great Britain, the majority of conditions are detected before 24 weeks, with many more now being detected through first trimester screening. However, it is widely known that the major anomaly scan is around 20 weeks gestation, and a number of structural conditions will not be detected until this point. Necessary follow-up scans and genetic testing can take women close to, or beyond, the 24-week point, as highlighted previously within both the existing medical evidence and within the personal testimonies.

In addition, despite the narrative surrounding this Bill has suggested, we would like to reiterate the fact that in Great Britain, abortions for severe fetal impairment beyond 24 weeks are not usually performed for conditions such as cleft lip/palate, club foot or Down's Syndrome in the absence of other severe abnormalities.

This Bill will lead to women and pregnant people being rushed to terminate pregnancies before 24 weeks, which removes the time needed for diagnostic tests and specialist advice needed.

8.2 Experiences in the Republic of Ireland:

If this Bill is introduced, it will lead to women and pregnant people being forced to travel to Great Britain without the support and aftercare that they need, as has been the case in the Republic of Ireland. This is a very distressing experience to force people to go through, who are already in an extremely difficult situation. As highlighted repeatedly by abortion campaigning groups, evidence from the Republic of Ireland shows that narrowly defined "fatal" fetal anomaly is causing

unnecessary levels of pressure towards clinicians, whist forcing women and pregnant people in these situations to travel to Great Britain for the care they need.

The WPG would like to endorse the following comments from the Alliance for Choice individual evidence submission:

> The current law in Ireland allows for abortion on request up to 12 weeks, or for limited reasons at a later gestation; SFI is not a permitted reason for an abortion after 12 weeks. Figures published by Westminster show that while abortions for people normally resident in Ireland decreased by 87% overall following the change in legislation, the proportion of abortions performed under 'Ground E' increased. This demonstrates that where abortion for SFI is not provided for locally, people will continue to travel to GB for legal care. [47]
>
> Legislation which allows abortion only in cases of narrowly defined "fatal" fetal anomaly exerts too much pressure on clinicians to produce indisputable evidence that a fetus will not survive after 28 days of birth. This strict legal definition does not comport with medical understandings and results in many women and pregnant people with a heartbreaking diagnosis being exiled to England for treatment.
>
> There is clear evidence from the Health (Regulation of Termination of Pregnancy) Act 2018 in the Republic of Ireland that restricting abortion access to fatal diagnosis only means that families are forced to travel to England to access abortion after receiving the heartbreaking news. Restrictive definitions create high legal thresholds for abortion access which act as a barrier to healthcare, meaning travel to England remains the most common route to access abortion for SFA in the whole island of Ireland.
>
> There is clear evidence from Ireland that any abortion provision policy including only fatal fetal anomaly means that many families are forced to endure the additional heartbreak of travel after a diagnosis of anomaly. As the Abortion Rights Campaign in Ireland has said in its report to CERD[48]:
>
> *"Fear of criminal penalties hangs over doctors' decision making. Pregnant people given diagnoses of catastrophic but not necessarily "fatal" foetal anomalies have no choice but to travel abroad for abortion care, just as they did before Irish voters changed the Constitution."*

[47] See more: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf

[48] See more: https://www.abortionrightscampaign.ie/wp-content/uploads/2019/12/ARC-ASN-CERD-SUBMISSION-2019-1.pdf

The Abortion Rights Campaign commented in 2020:

> *"The figures from the UK Department of Health (DOH) demonstrate clearly to those of us in the South that the compassionate care promised by politicians during the 2018 referendum has not materialised. On the contrary, we have heard heartbreaking stories from those who believed they were entitled to a legal abortion in Ireland being forced to travel. Our new law puts doctors in the position of making impossible distinctions between "fatal" and all other severe, complex, or life-threatening foetal anomalies, distinctions that are not rooted in medicine. With the threat of prosecution still hanging over them, many doctors are hesitant to make that distinction and so, as illustrated here by the UK DOH figures, many are still forced to travel to access the compassionate care we voted for in 2018."*[49]

If Severe Fetal Impairment is removed as a permitted reason for abortion, medical professionals in NI will be operating in a climate where they risk criminalisation as they decide whether a condition satisfies the fatal requirement, rather than being severe.

[49] https://www.abortionrightscampaign.ie/2020/06/11/abortion-figures-show-hundreds-still-travel/

9. Myth-Busting, the Use of Disability and Disabled Women:

9.1 The Use of Disability to Restrict Abortion:

For years, anti-abortion groups have used disability as a defence for their positions as they argue that their support for an abortion ban protects the lives of disabled people that would otherwise have been aborted. Rarely, when thinking of this topic does the narrative focus on disabled people themselves, and what they think about abortion. This has been evidenced in both Northern Ireland and in the Republic of Ireland.

In the lead up to the referendum on repealing the eighth amendment, anti-repeal groups 'Love Both', 'Life Institute' and 'Save the 8th' were heavily criticised for their use of images of disabled people to support their campaign. Down's Syndrome Ireland criticised 'Love Both' for using images of a little girl with Down's syndrome on campaign leaflets alongside the caption of '90 percent of babies diagnosed with Down's syndrome in Britain are aborted[50]'. Down's Syndrome Ireland went further to state:

> *'This is very disrespectful to both children and adults with Down syndrome and their families. It is also causing a lot of stress to parents. People with Down syndrome should not be used as an argument for either side of this debate … we would like to remind campaigners on both sides of the campaign debates, all political parties and any other interested groups to stop exploiting children and adults with Down syndrome to promote their campaign views.[51]'*

The disabled population in Northern Ireland is broad and diverse, and with that, they have broad and diverse views. Disabled women in particular face additional discrimination and marginalisation, and it cannot be assumed that all disabled people will support the Bill in question.

9.2 Myth-Busting - Abortion and Down's Syndrome in Iceland

As stated earlier in this response, in the UK, abortions for severe fetal impairment beyond 24 weeks are not usually performed for conditions such as cleft lip/palate, club foot or Down's

[50] Down Syndrome Ireland, 2018, 'Statement on the topic of the upcoming referendum', available online via <https://downsyndrome.ie/statement-on-the-topic-of-the-upcoming-referendum/> [Accessed on 22.05.20].
[51] Ibid n4.

Syndrome in the absence of other severe abnormalities. Despite this, Down's Syndrome is often used by groups opposed to abortion as a justification for further restricting abortion access.

The frequent debate about Down Syndrome (DS) and abortion is emotive and personal. Evidence from Iceland is often cited with regards to no babies with DS being born after specific tests. This is misleading as Iceland is a small country with a current population of 334,252 (the population of Belfast is approx. 311,500).

Further, World Health Organisation data from the last 10 years, taking account of yearly variations, shows Iceland's rates are approximately 10% lower than other European countries. Scientifically, this is considered random and not significant in contradiction to the suggestions from many anti-abortion groups. The chief of obstetrics at Iceland's National University Hospital stated:

> *"the truth is that one third of mothers-to-be choose not to have more (prenatal) tests done after the first indication of DS. 80 – 85% of women chose to have the screening so 15 – 20% of women don't."*[52]

In Iceland, in the cases of a prenatal diagnosis women and parents are offered the opportunity to meet with doctors and nurses who work with people with DS and the parents of children with DS. This creates an opportunity of truly informed choice, which is entirely absent from Northern Ireland. There is the issue in Northern Ireland about how women are informed of screening results and pervasive medical model attitudes of health care professionals. The issue is with the screening process and attitudes to disability not a woman's right to choose. We need to reform how society treats disability in order to support families with disabled children, rather than focusing on pervasive medical models and austerity that makes it extremely difficult to support disabled children.

9.3 Supporting Collective Women's Rights, Reproductive Rights and Disability Rights

Abortion has been decriminalised in Northern Ireland, yet the Abortion Framework has still not been commissioned. Despite this, more work has been done publicly in the NI Assembly to further restrict abortion access that has not yet been fully available. The issue of restricting abortions for severe fetal impairment have been highlighted throughout his response, but it is worth nothing that this would also negatively impact disabled women as well. Disabled women are also autonomous people who need access to reproductive healthcare and face greater barriers than non-disabled women in accessing it.

The WPG would like to encourage the Health Committee to look at alternative means of supporting disabled people in our society rather than rolling back the hard-fought, yet still inaccessible, rights of women and pregnant people in Northern Ireland.

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[52] Abortion Rights Campaign (2017), 'Let's Talk About Iceland': https://www.abortionrightscampaign.ie/2017/11/28/lets-talk-about-iceland/

WRDA has published an article in the past on 'Disabled Women and Discrimination: The Facts We Need You to Know[53]' and there are some shocking statistics from UK-wide data that we could suggest the Executive works to immediately address:

- Disabled women earn 22.1% less than non-disabled men, and 11.8% less than disabled men.
- 26% of households with a disabled person are in poverty, compared to 22% of overall households in the UK (pre-COVID). This is likely an underestimation, as it does not take into account the estimated £570 per month of additional costs associated with a disability.
- Women make up 55% of claimants for disability benefits and have been disproportionately impacted by the narrowing of scope in disability support entitlements. As a result, benefit sanctions, degrading PIP assessments, lost income and the removal of any independence has been a reality for many disabled women.
- Disabled people, in general, have been disproportionately impacted by austerity cuts since 2010. Disabled women are set to lose 13% of their annual income by 2021 due to austerity and cumulative tax-benefit changes.
- Disabled single mothers are losing out the most from these tax and benefit changes since 2010. By 2021, they will have lost 21% of their net income if they do not have a disabled child and 32% if they do have a disabled child too. 1/3 of this loss is due to a shift to Universal Credit.
- Disabled people experience domestic violence at TWICE the rate of non-disabled people. ONE IN TWO disabled women experience it and face many additional barriers in seeking support.
- Spending cuts to adult social care and housing support has also disproportionately impacted disabled people.

Disabled women are losing their independence, are living in poverty and are being actively discriminated against, abused and underpaid. We all need to be aware of this wide-spread systemic abuse. The WPG would welcome action taken by the wider NI Executive to address these issues facing disabled women in particular. Further, we would like to emphasise again that disabled women need access to abortions too, and restricting abortion on the grounds of severe fetal impairment will negatively impact disabled women needing access to abortion healthcare.

[53] WRDA (2020), Bold Women Blogging: "A Personal Perspective on the Abortion Motion NI Assembly 2nd June 2020': https://wrda.net/2020/06/04/womens-sector-lobbyist-statement-abortion-motion-ni-assembly-2nd-june-2020/

10. Women of Colour and Migrant Women

The WPG has been raising concerns about the additional discrimination and systemic barriers that women of colour and migrant women in Northern Ireland face. It is crucial that the Health Committee considers the ramifications for migrant women and women of colour of restricting abortion further.

The WPG would like to echo the following points from our member Alliance for Choice:

> *Accessing abortion in Northern Ireland requires complicated navigation of the health system. Most GPs and hospital staff are too afraid to even recommend travel to England and the Dept. Of Health have as yet, refused to publish any information about abortion services anywhere on their site, the PHA site or any of the Health Trust's websites. These complications make it difficult for women who speak English and have access to the internet or networks of women who have had the same experience. Women who are new to the country will not have the same access to this information, or even know where to get help.*
>
> *Travel to England becomes intensely more complicated when your migration status is at risk or you have a complex visa arrangement. Similarly, students who are from overseas often find travel difficult due to the restrictions of their travel visa.*
>
> *Expectant parents often have optimistic expectations of the obstetric ultrasound examination and are unprepared for a diagnosis of foetal anomaly. Research that gives voice to the experiences of immigrants faced with a prenatal diagnosis is scarce, and there is a need for more exploratory research that provides insights into the experiences of these persons.*
>
> *The analysis resulted in three themes: (1) an unexpected hurricane of emotions, (2) trying to understand the situation though information in an unfamiliar language, and (3) being cared for in a country with accessible obstetric care and where induced abortion is legal.*
>
> *Immigrant women described an unexpected personal tragedy when faced with a prenatal diagnosis of foetal anomaly and emphasised the importance of respectful and empathic psychological support. Their experiences of insufficient and incomprehensible information call attention to the importance of tailored approaches and the use of adequate medical interpreting services. There is a need for more descriptive studies that investigate decision-making and preparedness for induced abortion among immigrants faced with a prenatal diagnosis.*

11. Clause by Clause Comments and Concluding Remarks:

11.1 Clauses

At Introduction the Member in charge of the Bill, Mr Paul Givan, had made the following statement under Standing Order 30:

"In my view the Severe Fetal Impairment Abortion (Amendment) Bill would be within the legislative competence of the Northern Ireland Assembly."

Amendment of abortion on the grounds of disability

Clause 1:
1.—(1) Regulation 7 of the Abortion (Northern Ireland) (No. 2) Regulations 2020 (Severe fetal impairment or fatal fetal abnormality) is amended as follows.

(2) In the heading, omit "Severe fetal impairment or".

(3) In paragraph (1)(a), omit the second "or".

(4) Omit paragraph (1)(b).

Short title and commencement

Clause 2:
2.—(1) This Act may be cited as the Severe Fetal Impairment Abortion (Amendment) Act (Northern Ireland) 2021.

(2) This Act comes into force on the day on which this Act receives Royal Assent.

11.2 Comments and Concluding Remarks:

Given that this PMB only has two clauses, the evidence presented throughout this submission should be considered as comments on both of the above clauses.

The WPG wholly disagrees with the Bill in question, as it violates the human rights of women, girls and pregnant people, as highlighted comprehensively throughout this evidence submission.

Further, the WPG is gravely concerned with how this Bill disregards the existing medical evidence on the matter, and how this Bill would increase the legal and political scrutiny on abortions for fetal impairment. This would have an extremely negative impact on both the ability of medical professionals to fully do their job while also limiting the support provided to families dealing with a diagnosis of severe fetal impairment.

The WPG has advocated for many actions to be taken by the NI Executive to advance the rights of disabled women, and disabled people more generally, and we would suggest that the Committee focuses instead on the impact of welfare reform and austerity on the health and wellbeing of disabled people in Northern Ireland rather than further restricting the rights of women which have yet to be implemented or made accessible.

Finally, we would recommend that the Committee becomes familiar with some of the ongoing discrimination women have faced in Northern Ireland as highlighted in the following Women's Resource and Development Agency Article on 'Disabled Women and Discrimination: The Facts We Need You to Know'[54] as well as this personal perspective from a disabled woman in Northern Ireland on how disability should not be used as a means of restricting abortion[55].

The WPG have also made a wide range of health and economic recommendations in the comprehensive COVID-19 Feminist Recovery Plan that would assist greatly in tackling discrimination that disabled people face; particularly in relation to welfare reform and the health impacts of austerity[56]. We have also made a bespoke summary of the Feminist Recovery Plan in relation to all recommendations for the Department of Health and would like to encourage the Health Committee to reach out to the WPG to discuss the evidence and recommendations within this report[57].

The WPG hopes that this Bill does not proceed for all of the reasons outlined in this evidence submission.

ENDS

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[54] WRDA (2019)' Disabled Women and Discrimination: The Facts We Need You to Know': https://wrda.net/2019/11/18/disabled-women-and-discrimination-facts-we-need-you-to-know/
[55] WRDA (2020), Bold Women Blogging: "A Personal Perspective on the Abortion Motion NI Assembly 2nd June 2020': https://wrda.net/2020/06/04/womens-sector-lobbyist-statement-abortion-motion-ni-assembly-2nd-june-2020/
[56] WPG (2020) COVID-19 Feminist Recovery Plan: https://wrda.net/wp-content/uploads/2020/07/WPG-NI-Feminist-Recovery-Plan-2020-.pdf
[57] WPG (2020) NI COVID-19 Feminist Recovery Plan Recommendations for the Department of Health (2021): https://wrda.net/wp-content/uploads/2021/02/Department-of-Health-WPG-FRP-Summary.pdf

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