

NORTHERN IRELAND

**BARRIERS TO ACCESSING
ABORTION SERVICES**

**AMNESTY
INTERNATIONAL**



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“My guilt and shame was not about my decision to have an abortion; it was because society had made me feel like I was a fallen woman, dirty and criminal. That shame, that stigma was the most damaging part of my experience. Not being able to say a word in case I outed myself as some sort of perceived murderer. My silence was suffocating.”

Aoife, from County Down, who had an abortion in England when she was 17 years old

“Abortion in Northern Ireland is a criminal offence which is punishable by a maximum sentence of life imprisonment [...].”

John Larkin QC, Attorney General for Northern Ireland, in a letter to the Chairman of the Northern Ireland Assembly's Committee for Justice, 16 October 2012

EXECUTIVE SUMMARY

In recent months, the Department of Justice (DOJ) for Northern Ireland has embarked on a process of legislative consultation on the possible decriminalization and legalization of abortion in cases of “lethal foetal abnormality and sexual crime.” While this initiative is, in principle, a positive move towards removing criminal sanction for accessing reproductive health care, the underlying stigma around abortion and the lack of legal clarity on the circumstances in which abortion is permitted in Northern Ireland, continues to have a damaging impact on women and girls' human rights. Women and girls in Northern Ireland who need to access abortion services, for the most part, have to travel to another jurisdiction. Healthcare providers providing abortion information or services in Northern Ireland face harassment.

The abortion regulation in Northern Ireland is underpinned by 19th century legislation, the Offences against the Person Act 1861, which predates all the relevant international human rights treaties by a century. The Abortion Act 1967 and subsequent legislative developments which regulate abortion in Great Britain do not extend to Northern Ireland. Responsibility for healthcare and criminal justice matters has been devolved, since 1999 and 2010 respectively, to regional authorities in Northern Ireland.

The law governing abortion in Northern Ireland is one of the most restrictive in Europe both in law and in practice; only Ireland and Malta are more restrictive.¹ It also carries *the* harshest criminal penalty in abortion regulation in Europe—life imprisonment for the woman undergoing the abortion and for anyone assisting her. Abortions are only lawful in extremely restricted circumstances, namely where there is a risk to a woman’s or girl’s life or a real and serious long-term or permanent damage to the physical or mental health of the pregnant woman. Abortions procured for other reasons carry a risk and threat of life imprisonment, including abortions sought because the pregnancy is a result of a sexual crime, such as rape and incest, and in cases of fatal foetal impairment. Although that criminal sanction is not applied in practice, the risk and threat of possible severe criminal sanction continue to exert a chilling effect on women and healthcare providers alike.

In practice, the law is even more restrictive. For many women, demonstrating a long-term risk to health, particularly mental health, and overcoming barriers to access to abortion in Northern Ireland is often an insurmountable challenge. Women’s access to and experience with health services also varies depending on the attitude of and availability of services within each of Northern Ireland’s National Health Service (NHS) health trusts (i.e. the regional administrative units of the UK public health system), which leads to further inequity. Abortion remains an issue that continues to face significant social stigma. Legal abortions are infrequently carried out in Northern Ireland because of the extremely limited legal circumstances in which women are entitled to abortions: official statistics indicate that 23 lawful terminations took place in Northern Ireland in 2013/14. Most women and girls living in Northern Ireland who need to access abortion services have to take a plane or ferry to access such care in another jurisdiction; the majority travel to Great Britain, with some also travelling to other European countries, including the Netherlands and Belgium. Women and girls attending clinics and centres that provide reproductive health care and advice are regularly intimidated by anti-choice activists outside the clinics and nearby pavements. Service providers and others who work in the area of sexual and reproductive health, including family planning, and abortion, are regularly harassed publicly.

Medical providers, NGOs, civil society organizations, academics and others interviewed by Amnesty International reported a hostile environment for healthcare providers seeking to ensure women and girls’ access to abortion services.

Termination of pregnancy guidance remains unpublished by the Department of Health, Social Services and Public Safety (DHSSPS), creating significant uncertainty for medical professionals, service providers and the women and girls in their care. This lack of clarity on the law is further compounded by the threat of criminal and professional sanction.

Many interviewees also voiced concerns about a “postcode lottery” resulting in uneven care and access to abortion advice across the various NHS health trusts in Northern Ireland.

A common theme in the interviews conducted by Amnesty International was the “silence” in Northern Ireland around the issue of abortion; interviewees likened it to a wall, a conspiracy, or a stifling presence. Women and girls in Northern Ireland who have had to consider and go

¹ This statement takes account of the situation not just in the 28 European Union member states, but in all 47 Council of Europe member states.

through abortions rarely speak privately to family, friends or their healthcare providers, let alone publicly, about their decision, often referring to the pervasive stigma and the fear of punishment as their reasons for not doing so.

Amnesty International calls on the authorities in Northern Ireland to ensure access to lawful abortion in line with international human rights standards, to remove the threat of criminal sanctions from women who undergo abortion and healthcare professionals who provide termination advice and services, and to ensure the publication of clear guidelines on the termination of pregnancy which is in line with international human rights standards and best practices for the provision of reproductive and sexual health care. Amnesty International also calls on UK authorities to ensure that access to sexual and reproductive health care by devolved authorities in Northern Ireland is delivered in compliance with the UK's international human rights obligations.

METHODOLOGY

This briefing is the result of ongoing campaigning and legislative advocacy by Amnesty International UK's office in Northern Ireland (AIUK NI),² and research interviews conducted between November 2014 and January 2015 in Northern Ireland and England by Amnesty International's International Secretariat (AI IS) and AIUK NI.

Amnesty International interviewed sexual and reproductive healthcare providers, civil society and women's rights groups and academics to hear their views on the issue of access to abortion for women and girls living in Northern Ireland. Amnesty International interviewed three women who had first-hand experience of Northern Ireland's abortion regulations, and received written testimony through NGOs about six other cases (from the woman or girl, or from a family member). Most professional interviewees agreed to be identified by name (either full name or first name only) and organizational affiliation. Due to the pervasive stigma around abortion and potential harassment, only one woman who had had an abortion agreed to be identified by her real given name. Amnesty International expresses its gratitude to all those who agreed to be interviewed or provided information during this research.

This briefing focuses solely on the situation in Northern Ireland. Amnesty International is also conducting separate research into the laws regulating abortion in the Republic of Ireland, to be published later in 2015 as part of the "My Body My Rights" global campaign.³

² See AIUK NI consultation responses and related Assembly submissions available from http://www.amnesty.org.uk/resources/1629/1759/0/1610/Northern%20Ireland/0#.VOHNO_msXu1

³ See My Body My Rights: Sexual and reproductive rights under threat worldwide, Press Release, 6 March 2014, <http://amnesty.org/en/for-media/press-releases/my-body-my-rights-sexual-and-reproductive-rights-under-threat-worldwide-2014> and My life, my health, my education, my choice, my future, My body My rights, Briefing, AI Index: ACT 35/001/2014), 6 March 2014, <http://amnesty.org/en/library/info/ACT35/001/2014/en>.

A HOSTILE TERRAIN FOR REPRODUCTIVE RIGHTS

“This Act does not extend to Northern Ireland.” -- Final clause of the UK Abortion Act 1967, s 7 (3)

THE LAW REGULATING ABORTION

The central legislative plank on which abortion regulation in Northern Ireland is based is the Offences against the Person Act 1861 (the 1861 Act), which makes “procuring a miscarriage” or assisting a woman to “procure a miscarriage” punishable by life imprisonment.⁴ Abortions in Northern Ireland are currently lawful only in extremely restricted circumstances, namely where there is a risk of real or serious long-term or permanent damage to the physical or mental health of the pregnant woman.⁵ However, to date, despite a Court of Appeal judgment issued over a decade ago, no guidelines on implementation of the law exist.⁶

The UK’s international human rights obligations related to ensuring access to sexual and reproductive health care are not evenly fulfilled, given that the laws regulating abortion in the rest of the UK do not apply to Northern Ireland.

The Abortion Act 1967, passed in Westminster (the UK Parliament) to reduce the high rates of maternal mortality and morbidity arising from restrictive abortion laws, which effectively made abortion legal when carried out in compliance with the terms of the Act⁷, and the

⁴ Offences against the Person Act 1861 <http://www.legislation.gov.uk/ukpga/Vict/24-25/100>. The Criminal Justice (Northern Ireland) Act 1945, modified the 1861 Act to criminalize “child destruction,” that is the termination of a pregnancy where “a child is capable of being born alive” (see Criminal Justice (Northern Ireland) Act 1945, <http://www.legislation.gov.uk/apni/1945/15/contents>). The Northern Ireland-specific legislation in 1945 transposed legislative changes passed in Westminster in 1929, which have since become defunct in England and Wales, but which remain in force in Northern Ireland (see The Infant Life (Preservation) Act 1929, <http://www.legislation.gov.uk/ukpga/Geo5/19-20/34/section/1>).

⁵ See, *R v Bourne* - [1938], All England Law Reports/1938/Volume 3 - accessed via http://www.google.com/url?q=http://www.womenslinkworldwide.org/wl/admin/fileFS.php%3Ftable%3Ddecisions_documentos%26field%3Des_archivo%26id%3D294&sa=U&ei=Bm_RVNS3H8zIUrn3g-AH&ved=OCBQQFjAA&sig2=Te0h0sDZHTohswuWBVslsw&usq=AFQjCNFu0cpDLX9pz9ek05uotub-ZDlxqA

⁶ *Family Planning Association of Northern Ireland v Minister for Health, Social Services and Public Safety* [2004] NICA 37 (8 October 2004) http://www.courtsni.gov.uk/en-gb/judicial%20decisions/publishedbyyear/documents/2004/2004%20nica%2037/j_j_shef5066.htm.

⁷ The Abortion Act 1967 S 1 (1) stated:

1. Medical termination of pregnancy.

(1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith—

(a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or

(b) that there is a substantial risk that if the child were born it would suffer from such physical or

Human Fertilisation and Embryology Act 1990,⁸ which taken together now regulate abortion in Great Britain, do not apply in Northern Ireland. A woman or girl living in Northern Ireland is not prohibited from travelling to another country or jurisdiction to avail of an abortion, however she must access this health service through a private clinic and pay for the service herself, including in Great Britain.

LIMITED POLITICAL WILL TO LEGISLATE FOR CHANGE

“I would ask those in power to please change the law, and make it fair, and to bring Northern Ireland in line with the rest of the UK. I would ask them to make it okay for women to ask for an abortion, and not be made to feel like our reasons are frivolous and self-serving.” – A 25 year old student, originally from London, living in County Antrim who had to travel to England for an abortion.

Until the Northern Ireland Department of Justice, launched a public consultation in 2014, there appeared to be little appetite for reforming abortion laws in Northern Ireland.⁹ In fact, to the contrary, there have been proactive attempts amongst some political parties to further limit access to abortion in Northern Ireland through the introduction of increased legal restrictions. In 2013, an amendment was put forward in the Northern Ireland Assembly to the Criminal Justice Bill which would have banned abortions being performed by private healthcare clinics, such as Marie Stopes, by an Assembly member (MLA) from the Democratic Unionist Party, who was, at the time, chair of the Northern Ireland Assembly's Committee for Justice (the Justice Committee), and another from the Social Democratic and Labour Party (SDLP) also a member of the Justice Committee. The proposed amendment received majority backing from MLAs, but did not have sufficient cross-community backing to pass as a result of a “petition of concern”¹⁰ put forward by Sinn Féin, the Alliance Party and

mental abnormalities as to be seriously handicapped.

The Human Fertilisation and Embryology Act 1990 s 37 (1) amended this as follows:

37. Amendment of law relating to termination of pregnancy

(1) For paragraphs (a) and (b) of section 1(1) of the [1967 c. 87.] Abortion Act 1967 (grounds for medical termination of pregnancy) there is substituted—

“(a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or
(b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
(c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
(d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.”

⁸ Human Fertilisation and Embryology Act 1990, s37, <http://www.legislation.gov.uk/ukpga/1990/37/crossheading/abortion>.

⁹ Department of Justice NI, “The Criminal Law on Abortion: Lethal foetal abnormality and sexual crime: A consultation on amending the law by the Department of Justice,” October 2014, <http://www.dojni.gov.uk/consultation-on-abortion-2014> (referred to hereafter in footnotes as DOJ Consultation).

¹⁰ A petition of concern is a notice signed by at least 30 Assembly members and presented to the Speaker signifying concern about any forthcoming matter on which the Assembly is due to vote. The effects of a petition of concern are (a) that the vote on the matter may not be held until at least the day after the petition has been presented and (b) the vote will be on a cross-community basis, rather than simple majority. In this case it effectively blocked the amendment from passing into law. <http://aims.niassembly.gov.uk/plenary/terms.aspx>.

the Green Party. Fifty three MLAs backed the ban on private clinics, and 40 voted against it. If passed it would have prevented private clinics from carrying out lawful abortions in Northern Ireland at a time when they play an important role in ensuring access to lawful abortions, as the pathway into the NHS is severely limited by the ongoing failure of DHSSPS to publish final Termination of Pregnancy Guidance.

On 2 July 2014, Jim Wells MLA, who was then a DUP member of NI Assembly Justice Committee, and is now Health Minister, advised Assembly members that he intended to bring forward an amendment similar to that put forward by his colleague in 2013 to the Justice Bill to restrict lawful abortions to NHS premises, except in cases of urgency when access to such premises is not possible and where no fee is paid. The amendment also sought to provide an additional option to the existing 1861 Act for a period of up to 10 years imprisonment and a fine on conviction on indictment which would apply to both women and health professionals.¹¹ AIUK NI responded to the consultation on the proposed amendment and provided evidence to the Justice Committee calling on the committee to reject the proposed amendment in its entirety, including the proposed limitation of abortion provision to NHS services alone, and for the NI Assembly and Executive to act to remove existing barriers to women accessing safe abortion services and to ensuring the issuing of guidance on the termination of pregnancy for healthcare providers without delay.¹²

In addition, there is an All Party Pro Life Group in the Northern Ireland Assembly, which exists to 'uphold the sanctity of life, including the life of the unborn child, and to promote a pro-life perspective in the Northern Ireland Assembly' and has an entirely male membership.¹³ Whilst All Party Groups do not have a statutory duty, they do exist to 'provide a forum by which MLAs and outside organisations and individuals can meet to discuss shared interests in a particular cause or subject'.¹⁴

ABORTION RIGHTS ACTIVISM OVER THE DECADES

It is important to note that much like women and girls' need for access to abortion, advocacy for reproductive and sexual health and rights – even if circumscribed by an unwillingness on the part of politicians to legislate for change – is neither new to Northern Ireland, nor has it lacked ambition.¹⁵ In the 1960s, after the Abortion Act 1967, the (first) Northern Ireland Law Reform Association (NIALRA) and the Ulster Pregnancy Advisory Association (UPAA) were formed. The former campaigned for legal reform focusing on extending the Abortion Act 1967 to Northern Ireland, while the latter provided pregnancy advice and counselling, and

¹¹ Amendment text: 'Ending the life of an unborn child,'

<http://www.niassembly.gov.uk/globalassets/documents/justice/justice-bill/amendment-by-j-wells.pdf>.

¹² Amnesty International UK NI, Justice Act – Jim Wells' amendment, Submission to the Northern Ireland Assembly Justice Committee, September 2014,

http://www.amnesty.org.uk/sites/default/files/aiuk_justice_ctte_submission_justice_act_jim_wells_amendment_2014_0.pdf

¹³ <http://www.niassembly.gov.uk/your-mlas/all-party-groups/all-party-pro-life-group/>

¹⁴ <http://www.niassembly.gov.uk/your-mlas/all-party-groups/>

¹⁵ For a brief history of the reproductive rights movement in Northern Ireland, on which this section relies, see NIALRA, *Abortion in Northern Ireland: The Report of an International Tribunal*, Beyond the Pale Publications, Belfast, 1989, in particular, Chapter 2, "The Campaign for Legal Abortion in Northern Ireland".

information about access to abortion in Britain. Despite the limited campaign success of the (first) NIALRA, the UPAA continued its work over the decades. By the mid-1970s, a feminist group set up the Northern Ireland Abortion Campaign (NIAC), which was active on a variety of abortion rights campaigns into the 1980s. NIAC's perhaps best publicized campaign was the delivery of 600 coat hangers and imitation travel tickets to parliamentarians in Westminster, to illustrate starkly the two options available to women in Northern Ireland seeking abortions: unsafe backstreet abortions or travel. In 1984, NIAC and others set up the (second) NIALRA, an organization with a wider membership, which had the sole, specific aim of extending the Abortion Act 1967 to Northern Ireland. The (second) NIALRA organized an international tribunal in Belfast in 1987, which featured domestic and international experts and heard testimony from several women from Northern Ireland who had had abortions. The (second) NIALRA assessed that testimony as confirming "the hypocrisy of society which exports its abortion problem while demanding complete silence about the issue."¹⁶ Bill Rolston, who along with his late wife Anna Eggert, was a founding member of and activist in the (second) NIALRA said: "In the end the point is not whether the law does or doesn't say this thing or that; it is a question of what is allowable. And because no one is sure what is allowable, what women have is a lottery, and not a very good one at that – there are no clear guidelines, it's been going for years and is still rolling on." The continuities between the activism and advocacy of past decades and efforts to improve access to sexual and reproductive rights and health today, by organizations such as Alliance for Choice, much like continuities in the efforts to vilify and harass advocates of reproductive rights, should not be underestimated.

IMPACT OF 'THE TROUBLES'

Northern Ireland was and remains a society deeply affected by the over three decades of serious political violence, often referred to as "the Troubles", and the legacy of significant unresolved human rights violations and abuses arising from that period.¹⁷ Some of the healthcare providers noted the importance historically of paramilitary organizations – and to a significantly lesser extent today – in exercising a degree of social control over and adding a layer of stigma to women and girls seeking abortions.

Kally, Unit Manager at the British Pregnancy Advisory Service (BPAS) Merseyside Clinic in Liverpool (England), most widely used by women and girls from Ireland and Northern Ireland has worked at the clinic for over 40 years, and spoke of a number of cases that remained in her mind from the Troubles. She recalled women from Northern Ireland who had become pregnant through relationships with soldiers, in stigmatized "cross-community" (i.e. Catholic-Protestant) relationships, or while partners involved in paramilitary organizations were serving prison sentences. In many of these cases, the women, out of fear for their own safety and that of their children and other family members, travelled to England for abortions.

Amnesty International has recently called for gender based sexual violence to form part of any thematic investigation by a single, comprehensive mechanism into patterns of human rights violations and abuses during "the Troubles", and calls for the denial of access to abortion and forced pregnancy arising from rape by members of the armed forces or armed

¹⁶ Ibid, page 49.

¹⁷ Amnesty International, Northern Ireland: Time to Deal with the Past, AI Index EUR 45/004/2013, 12 September 2013, <http://www.amnesty.org/en/library/info/EUR45/004/2013/en>.

groups as human rights violations or abuses and to be considered part of that theme.¹⁸

POLLING DATA

At the time of the DOJ's consultation in 2014, Amnesty International UK commissioned independent opinion polling indicating that approximately 70% of people in Northern Ireland supported legislative reform on abortion in Northern Ireland.¹⁹ The poll of 1013 adults, conducted by Millward Brown Ulster, showed that 69% of people thought the law in Northern Ireland should make access to abortion available where the pregnancy is the result of rape, 68% where the pregnancy is the result of incest, and 60% where the foetus has a fatal abnormality.

Successive polls conducted in recent years by Lucid Talk for the Belfast Telegraph have documented the shift in public attitudes towards broadening the grounds on which women and girls can lawfully avail of abortions in Northern Ireland, most notably an increase between 2012 and 2014 (from 26% to 58%) of respondents in favour of the proposition "abortion should be available to any woman who chooses it after being counselled on the available alternatives".²⁰

CHANGES IN PUBLIC OPINION

One important factor in Northern Ireland, however, has changed over time and continues to do so: public opinion.

Several of the people who spoke with Amnesty International, referred to the case of Sarah Ewart as a watershed moment in the public debate on abortion in Northern Ireland. In 2013, Sarah Ewart decided, along with family members, to speak publicly about her decision to terminate a pregnancy following a medical diagnosis of anencephaly, a fatal foetal impairment. Sarah Ewart spoke to Northern Irish media about the traumatic impact of the requirement to travel away from her home, family, support networks and trusted clinicians to access an abortion.²¹ Her story received wide regional and national media coverage.

¹⁸ Process on Northern Ireland's past must deal with gender violence, Amnesty International UK, Press Release, 15 October 2014, <http://www.amnesty.org.uk/press-releases/process-northern-irelands-past-must-deal-gender-violence>

¹⁹ "Amnesty launches new campaign on abortion in Northern Ireland," Amnesty International UK Press Release, 21 October 2014, <http://www.amnesty.org.uk/press-releases/amnesty-launches-new-campaign-abortion-northern-ireland> and Millward Brown, Attitudes to abortion, October 2014, http://www.amnesty.org.uk/sites/default/files/milward_brown_poll_results_october_2014_final_0.pdf.

²⁰ Liam Clarke, "Abortion: 45% want a liberalisation of the law in Northern Ireland," Belfast Telegraph, 30 November 2012, <http://www.belfasttelegraph.co.uk/news/local-national/northern-ireland/abortion-45-want-a-liberalisation-of-the-law-in-northern-ireland-28999931.html> and Liam Clarke, "Growing backing for liberalisation of abortion rules in Northern Ireland", Belfast Telegraph, 3 October 2014, <http://www.belfasttelegraph.co.uk/news/local-national/northern-ireland/growing-backing-for-liberalisation-of-abortion-rules-in-northern-ireland-30634125.html>.

²¹ BBC News Online, "Woman's abortion 'ordeal' considered by NI health officials," 9 October 2013, <http://www.bbc.co.uk/news/uk-northern-ireland-24458241>; Stephen Nolan, "Sarah Ewart's abortion journey from Northern Ireland," BBC Radio 5Live, 11 October 2013, <http://www.bbc.co.uk/programmes/p01jmx4x>; Stephen Nolan, "A devastated pregnant woman and her abortion law plea," BBC Radio 5Live, 11 October 2013, <http://www.bbc.co.uk/programmes/p01jnmbt>; Joanne Sweeney, "Mother's tragic abortion story could spark reappraisal of rules for Northern Ireland medics," Belfast Telegraph, 10 October 2013, <http://www.belfasttelegraph.co.uk/news/local->

Bill Rolston explained his perception of this shift in public attitudes against his own reticence to discuss his activism with his family during the 1980s: "I was very active in NIALRA. My parents and my siblings never knew and I would never tell them. If they'd asked me I'd have denied it. You know, I was a middle aged man at the time, and there I was worried about what my parents or my sister or brother would think. And that's sadly indicative of the atmosphere there was. And yet, when you look at some of the debate last year [2013], things have changed. I think people are now more willing to acknowledge that this thing happens. Before people wouldn't... just didn't talk about, they just wouldn't even get to the point of saying well what do you think about this?"

THE INTERNATIONAL LAW FRAMEWORK ON ACCESS TO ABORTION

International human rights bodies have repeatedly criticized the criminalization of abortion.²² They have recognized that the criminal regulation of abortion impedes women's access to lawful abortion and to post-abortion care. They have consistently called on states to amend legislation criminalizing abortion in order to withdraw punitive measures imposed on women who undergo abortion and to liberalize restrictive criminal regulation laws and to ensure access to lawful abortion.²³ **International human rights standards** oblige states to ensure access to abortion in cases when the pregnant woman or girl's life or physical and mental health is at risk, in cases of severe foetal impairment and where a pregnancy is a result of sexual crime (including rape and incest). The continuation of the status quo in Northern Ireland and its legislation that falls

[national/northern-ireland/mothers-tragic-abortion-story-could-spark-reappraisal-of-rules-for-northern-ireland-medics-29648562.html](http://www.belfasttelegraph.co.uk/opinion/columnists/jane-graham/why-sarahs-abortion-story-is-a-great-shame-on-northern-ireland-29669979.html); and Jane Graham, "Why Sarah's abortion story is a great shame on Northern Ireland," Belfast Telegraph, 18 October 2013, <http://www.belfasttelegraph.co.uk/opinion/columnists/jane-graham/why-sarahs-abortion-story-is-a-great-shame-on-northern-ireland-29669979.html>.

²² See, for example, Human Rights Committee, Concluding Observations: Argentina, para. 13, U.N. Doc. CCPR/C/ARG/CO/4 (2010); El Salvador, para. 10, U.N. Doc. CCPR/C/SLV/CO/6 (2010); Mexico, para. 10, U.N. Doc. CCPR/C/MEX/CO/5 (2010); Monaco, para. 10, U.N. Doc. CCPR/C/MCO/CO/2 (2008); Nicaragua, para.13, U.N. Doc. CCPR/C/NIC/CO/3 (2008).

²³ CEDAW Gen. Rec. No. 24, para. 31(c). See also Concluding Observations of the CEDAW Committee: Andorra, para. 48, U.N. Doc. A/56/38 (2001); Concluding Observations of the CEDAW Committee: Belize, para. 57, U.N. Doc. A/54/38 (1999); Concluding Observations of the CEDAW Committee: Burkina Faso, para. 276, U.N. Doc. A/55/38 (2000); Concluding Observations of the CEDAW Committee: Cameroon, para. 60, U.N. Doc. A/55/38 (2000); Concluding Observations of the CEDAW Committee: Ireland, para. 186, U.N. Doc. A/54/38 (1999); Concluding Observations of the CEDAW Committee: Jordan, para. 181, U.N. Doc. A/55/38 (2000); Concluding Observations of the CEDAW Committee: Namibia, Part II para. 127, U.N. Doc. A/52/38/Rev.1 (1997); Concluding Observations of the CEDAW Committee: Nepal, paras. 139 and 148, U.N. Doc. A/54/38 (1999); Concluding Observations of the CEDAW Committee: United Kingdom, para. 310, U.N. Doc. A/55/38 (1999). See e.g., Concluding Observations of the Committee on Economic, Social and Cultural Rights: Bolivia, para. 43, U.N. Doc. E/C.12/1/Add.60 (2001); Concluding Observations of the Committee on Economic, Social and Cultural Rights: Mauritius, para. 15, U.N. Doc. E/C.12/1994/8 (1994); Concluding Observations of the Committee on Economic, Social and Cultural Rights: Nepal, paras. 32 and 55, U.N. Doc. E/C.12/1/Add.66 (2001); Concluding Observations of the Committee on Economic, Social and Cultural Rights: Poland, para. 29, U.N. Doc. E/C.12/1/Add.82 (2002); Concluding Observations of the Committee on Economic, Social and Cultural Rights: Senegal, paras. 26 and 47, U.N. Doc. E/C.12/1/Add.62 (2001). See Concluding Observations of the Human Rights Committee: Ecuador, para. 11, U.N. Doc. CCPR/C/79/Add.92 (1998); Concluding Observations of the Human Rights Committee: Kenya, para. 14, U.N. Doc. CCPR/CO/83/KEN (2005); Concluding Observations of the Human Rights Committee: Paraguay, para. 10, U.N. Doc. CCPR/C/PRY/CO/2 (2006); Concluding Observations of the Human Rights Committee: Poland, para. 8, U.N. Doc. CCPR/CO/82/POL (2004); Concluding Observations of the Human Rights Committee: Trinidad and Tobago, para. 18, U.N. Doc. CCPR/CO/70/TTO (2000).

short of this minimum is in violation of the UK's international human rights obligations.

Denying women access to abortion in these circumstances violate numerous human rights, including the right to privacy and to health and can violate the right to be free from torture and other ill-treatment.²⁴ Restrictive abortion laws are also gender-discriminatory, denying women and girls treatment only they need.²⁵ In this respect, criminal abortion laws are not gender neutral. In their intent and purpose, they enact a collective gender norm about women and their social role.²⁶ In *L.C. v. Peru*, the *Committee on the Elimination of Discrimination Against Women* acknowledged that abortion restrictions are "based on a gender stereotype that understands the exercise of a woman's reproductive capacity as a duty rather than a right."²⁷ Amnesty International has called for full decriminalization of abortion in all cases, and has demanded that states ensure access to abortion, at a minimum, in cases defined under international law.

The Parliamentary Assembly of the Council of Europe has affirmed that "the ultimate decision on whether or not to have an abortion should be a matter for the woman concerned, who should have the means of exercising this right in an effective way,"²⁸ and invited member states of the Council of Europe to "allow women freedom of choice and offer the conditions for a free and enlightened choice without specifically promoting abortion."²⁹

Northern Ireland's law continues to deny abortion in cases to protect the health of the pregnant woman, and in cases of rape and incest in fatal foetal impairment, in contravention of international standards.³⁰ Rather than restricting access to abortion, the law in effect restricts women's access to safe abortion. This is especially true when severely restrictive laws are in place, such as those in Northern Ireland.³¹ The UN Human Rights Committee has described criminal regulation as exerting a deterrent or "chilling" effect on existing lawful entitlements to abortion. Decriminalizing abortion and ensuring access to abortion on these grounds would be a critical step to ensure that women in Northern Ireland can access appropriate health care.³²

INTERNATIONAL RIGHT TO LIFE PROTECTIONS DO NOT APPLY PRENATALLY

International and regional human rights treaty provisions protecting the right to life and the official bodies that interpret articles protecting life and other human rights guarantees do not extend such protections

²⁴ Human Rights Committee, Concluding Observations: Ireland, para 9, U.N. Doc. CCPR/C/IRL/CO/4. See also Amnesty International, *El Salvador: On the brink of death: Violence against women and the abortion ban in El Salvador*, AI Index: AMR 29/003/2014, 25 September 2014, <http://www.amnesty.org/en/library/info/AMR29/003/2014/en>

²⁵ See UN Committee on the Elimination of All Forms of Discrimination against Women, General Recommendation No. 24: Article 12 of the Convention (women and health), paras. 14 and 31 (c)

²⁸ Parliamentary Assembly of the Council of Europe Resolution 1607 (2008) Access to safe and legal abortion in Europe, para.6

²⁹ *Ibid.* para. 7.3

³⁰ Human Rights Committee, Communication No. 1153/2003, K.L. v Peru, U.N. Doc. CCPR/C/85/D/1153/2003; Human Rights Committee, *LMR v Argentina* CCPR/CO/70/ARG, para. 14.

³¹ Human Rights Watch, *A State of Isolation: Access to Abortion for Women in Ireland*, January 2010; Human Rights Watch, *The Second Assault: Obstruction Access to Abortion after Rape in Mexico*, March 2006.

³² Amnesty International UK, Guidance on Termination of Pregnancy in Northern Ireland, Submission to the Northern Ireland Department of Health, Social Services and Public Safety, June 2013, http://www.amnesty.org.uk/sites/default/files/ni_submission_finalsubmittedjuly2013x.pdf

prenatally.³³ No international or regional human rights body has ever recognized the foetus as a subject of protection under international human rights treaties. International standards, do however, support numerous state measures that support the development of prenatal life through the protection of the pregnant woman.³⁴ Moreover, international human rights bodies have found restrictions on access to abortion in law or in practice to be a violation of state obligations.³⁵

TRAVEL TO ACCESS ABORTION SERVICES

“The women who have contacted us have ranged in age from 51 to 13 and they literally have every imaginable circumstance. Either they are young teens or they are mothers with children, they are married, they are not married, their pregnancies have been diagnosed with fatal foetal anomalies, they are pregnant as a result of rape. What they have in common is that they are pregnant, they don’t want to be pregnant - or in the case of fatal foetal anomaly the pregnancy has become untenable - and, above all, the women who contact us are poor. In a thousand years they would never have thought they would need to involve strangers in England in their personal decision to have an abortion.” -- Mara Clarke, Director, Abortion Support Network

“The impact of travel... well, there’s the financial aspect but that’s not always the main thing at all because really, it’s more the fact that they have to be so secretive and sneak out of the country [...] They do feel guilty anyway, and it adds to how they feel afterwards [...] Travel makes it more difficult for them. The fact that they have to travel and tell lies about where they are going, [...] No woman should feel guilty about an unwanted pregnancy in this day and age.” -- Amanda, administrative coordinator and counselor at BPAS Merseyside Clinic [referring to women both from Northern Ireland and the Republic of Ireland]

With no pathway into the NHS in Northern Ireland, each year between 1000 and 2000 women and girls have little option but to consider travel elsewhere – sometimes accompanied by a partner, supportive family member or friend – to access abortion services. They often do not know where to begin with making arrangements given that there is little public discourse about clinics providing services to women from Northern Ireland and sources of financial support for women who cannot afford either the journey or the treatment.

Helen Nela, Clinical Nurse Manager at the BPAS Merseyside Clinic recounted conversations she had overheard time and time again between Irish and Northern Irish women sitting in a quiet waiting room with a drinks machine, between the stages of the abortion process. She

³³ The Inter-American Convention on Human Rights, which is the only convention to have a provision which protects life prenatally, has been interpreted by the Inter-American commission not to confer and equivalent right to life on the foetus or require invalidation of permissive abortion laws. See *Baby Boy*, Case 2141, Inter-American Convention on Human Rights 25/OEA/ser.L./II.54, Doc. 9 Rev.1 (1981)

³⁴ See, for example, CEDAW Article 12; CEDAW General Recommendation 24 on Women and Health, 1999, para. 31(c).

³⁵ See, for example, *L.C. v. Peru*, CEDAW Committee, 2011; *KL v Peru*, Human Rights Committee, 2005; *LMR v Argentina*, Human Rights Committee, 2007.

said: “It’s sadness, more than shame or guilt, it seems to me. It’s the frustration of being made to travel. They come into the theatre one after another in a row, and you hear the conversations here in this room about their experiences.”

Aoife recalls her experience traveling when she was 17 years old: “I flew to Manchester on my own. My boyfriend made me take a pregnancy test in front of him as though somehow I had made this up and was trying to fleece [swindle] him of £500. The next morning I made my way to the clinic, I had tried to dress older, I suppose out of some sort of shame... The waiting room was full of a mixture of women and girls of all ages. All quiet, all pale, all frightened looking. It was not like people imagine, young women laughing and glad to have an abortion. Having an abortion is not a life ambition; it is just a part of some women’s lives.” She recounts how after her return her boyfriend threatened to expose her secret because he thought she was not paying back the money he had lent her quickly enough, until she confided in her mother, who intervened and paid off the money Aoife had borrowed from her boyfriend in full.

STATISTICS

Travel by women and girls—across the Irish Sea to Britain for the most part—to access abortion is neither new, nor a novel observation. In fact, its prevalence over the years places the ongoing and systemic denial of women’s access to their health and rights in stark relief. DHSSPS statistics show that in the years between 2003 and 2014, each year roughly 1000 women and girls (the lowest recorded number is 802 and the highest 1318) who gave their place of residence as Northern Ireland has received an abortion in England and Wales.³⁶ These numbers have not changed much over the past three decades. Statistics published by the Ulster Pregnancy Advisory Association in 1987, state that in 1087 women in 1985 travelled to Britain for an abortion, and 1190 did so in 1986.³⁷ Between 2010 and 2013, of the total number of abortions in England and Wales to non-residents, each year between 15% and 17% of the total number of abortions performed were for women who gave their place of residence as Northern Ireland.³⁸

Reproductive and sexual health service providers have noted that the approximate figure of 1000 women and girls per year is likely a significant underestimate, as many women give false addresses in Great Britain for fear of criminal sanction. The FPA, for instance, estimates that “the [actual] figure is probably nearer 2000 per year”.³⁹ To put these figures in even starker contrast, figures released recently by the DHSSPS illustrate how infrequently the circumstances in which lawful in Northern Ireland are carried out: in 2013/14 there were 23 terminations of pregnancy in Northern Ireland.⁴⁰ (See section on ‘lack of guidelines on abortion’ below).

³⁶ DOJ Consultation, Annex C, and Family Planning Association, Factsheet: Abortion in Northern Ireland, August 2014, <http://www.fpa.org.uk/sites/default/files/northern-ireland-abortion.pdf> – both compile tables of information from DHSSPS in a readable format allowing comparison across the years.

³⁷ UPAA Statistics, Box 3.2 in NIALRA, *Abortion in Northern Ireland: The Report of an International Tribunal*, Beyond the Pale Publications, Belfast, 1989. The UPAA was the pregnancy advice and referral provider in Northern Ireland during the 1980s; it closed in the late 1990s following an attempted arson attack on one of its clinics and sustained harassment of its staff at their homes by anti-choice activists. See “Ulster Pregnancy Advisory Association closes”, Commentary from BPAS, 23 August 1999, Archived on <http://www.prochoiceforum.org.uk/comm18.php>

³⁸ DOJ Consultation Annex c table 3.

³⁹ Family Planning Association, Factsheet: Abortion in Northern Ireland, August 2014, <http://www.fpa.org.uk/sites/default/files/northern-ireland-abortion.pdf> p. 7

⁴⁰ DHSSPS Information Analysis Directorate, January 2015, Northern Ireland Termination of Pregnancy Statistics 2013/14 <http://www.dhsspsni.gov.uk/hs-termination-of-pregnancy-stats-13-14.pdf> and

Two providers of information about clinics in Great Britain that routinely accept appointments made by women living in Northern Ireland related the way they handle the logistics and decision-making associated with travel. Both emphasized the importance of providing as much information as possible to the woman or girl, rather than referring her to a specific clinic, and leaving the decision-making about whether she proceeds, and if so at which clinic, to her.

One of them, Dawn Purvis of MSI, explained: “We don’t refer her directly to one of our clinics [in Britain]. We ask her to look at the cheapest flight available, but not to book, and then to ring up to see availability at the clinic and make sure she can get her appointment, and then book the flights. Cost is everything. We tell women to use Skyscanner [a travel comparison search engine] for the cheapest fares. Some of our centres offer a free taxi fare from the airport to the centre. Cost is a big factor for women choosing not only the type of treatment, but where they want to be treated. Women who can’t afford the treatment continue with the pregnancy. Women with money have choices, women with none have babies.”

Similarly, Audrey Simpson of the FPA said: “We really believe from the beginning to the end the decision is with the woman. The decision is in her hands from the moment she makes the call, goes to the airport, and gets in the clinic. People ask, ‘How many women that come to you get an abortion?’ I don’t know, I can tell you how many people that leave this building that might have one, but I don’t know how many people will go through with it once they leave here; it’s her decision. I’ll say ‘Do you want to make the appointment today?’ If after the counselling she decides to go ahead with it, we’ll say, ‘Here’s the phone, would you like me to stay with you while you make the appointment, or do you want to do it on your own? Or do you want to take the information away with you and make the appointment at home?’ That is the ethos of our organization. We are about empowering women the whole way through, not about making decisions for women. We facilitate the process for the woman to make the decision. What we say to women and girls is that there are four words that if you hear anyone saying you just block it out. Everyone in here is banned from saying them. Those four words are ‘I think you should.’”

FINANCIAL COSTS OF TRAVELLING FOR ABORTION SERVICES

The costs associated with travel and paying for services on a private basis are further barriers to women and girls’ access to abortion services. Most women in Northern Ireland who require access to abortion services, unlike residents of Great Britain who can access them where they live, have to incur considerable expenses for the services in another part of the UK or another country. In May 2014, the High Court of England and Wales found the (UK) Department of Health’s policy— in general – not to provide abortion services under the publicly funded health care system, the National Health Service (NHS), to “women present in England but ordinarily resident in Northern Ireland” to be lawful.⁴¹ In short, the judge found that the different regions of the UK were

DHSSPS Press Release, “The Department of Health, Social Services and Public Safety (DHSSPS) today published statistics relating to medical abortions and terminations of pregnancy during 2013/14” 28 January 2015, <http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-january-2015/news-dhssps-280115-northern-ireland-termination.htm>

⁴¹ R (on the application of A (by her litigation friend B) and B) v Secretary of State for Health, [2014] EWHC 1364 (Admin), 8 May 2014. <http://www.bailii.org/ew/cases/EWHC/Admin/2014/1364.html>. In his judgment, King J concluded: “I see nothing unlawful in the defendant [i.e. the UK Health Secretary]

entitled not to fund abortion services on the NHS for residents of Northern Ireland, given that devolved authorities in that region regarded such services as unlawful. The ruling was in response to a challenge brought by a girl who was 15 years old when she travelled to England for an abortion in 2012, and her mother, against the Department of Health's policy. In that case the costs associated with the abortion at an independent clinic had been £600 plus travel costs of £300, which had been shared between the mother and a charitable organization; the girl's mother had contended that the cost ought to have been borne by the NHS and the abortion provided free of charge.⁴²

Financial obstacles to travel and accessing treatment – and their impact on women and girls living in socioeconomically disadvantaged conditions – are particularly worth noting in Northern Ireland, where official statistics estimate that up to 20% of the population lives in relative deprivation.⁴³

Women and families without the funds to arrange for travel have limited sources from which to seek such funding, or accommodation while in England. Abortion Support Network (ASN) is a widely used source of such assistance at the moment. Mara Clarke, Director of Abortion Support Network, described the role of ASN in assisting women facing financial hardship in travelling to Britain and paying for abortion services, return tickets and accommodation:

“We started with a handful of volunteers and now we have 60 who are involved to varying degrees and we provide three main services. The first is provision of practical information about how to arrange the least expensive abortion. There is so much misinformation on the internet. The second thing is if people don't have the money, ASN does a financial assessment. We explain to them that we are a volunteer run organization and we are almost entirely funded by private individuals, that we would love to fund a first class ticket and send someone to hold your hand all the way through the process but the fact of the matter is we have ten other women who have called today already. [...] So we do a financial assessment and then we award grants if we have money in the bank [...] Our only criteria is financial need and availability of funds. The third thing we provide is accommodation. Which means that for the women and girls who come over and need to stay overnight, we have volunteers in West London, South London, Birmingham, Manchester and Liverpool who put them up in their homes. Most women don't need to stay over and most want to come in and out in a day but for women who have to take the ferry or for women who are further along and for women that live in parts of Ireland with no airports they need to stay overnight.”

Mara shared a message sent to the ASN by an 18 year old student who had traveled to England to access abortion services. She said: “The abortion was done and was only possible because of the help we received. Having an abortion is hard enough emotionally without the

adopting the express policy *'that in general the NHS should not fund services for residents of Northern Ireland which the Northern Ireland assembly has deliberately decided not to legislate to provide, and which would be unlawful if provided in Northern Ireland'*. This is no more than paying respect in the context of the devolution of powers, for the approach deliberately adopted by the responsible authorities in Northern Ireland and there can be nothing unlawful in that in my judgment” (para 58, emphasis in original).

⁴² By way of comparison, at least one health trust in Northern Ireland – the Belfast Health and Social Care Trust – appears to have an arrangement with a hospital in England for cancer patients in its care who require liver transplants, a surgery not currently carried out in Northern Ireland (see <http://belfasttrust-cancerservices.hscni.net/LiverCancer.htm>).

⁴³ Department for Social Development NI, http://www.dsdni.gov.uk/poverty_bulletin.htm

added stress of trying to arrange travel and money.” Mara also related another story of a young single mother who had recently been laid off and was pregnant as the result of rape. She had sold her car and cut off her telephone line to save money for travel to England, but still did not have enough to pay for the travel and the procedure. Out of desperation, she considered contacting the man who raped her to ask for money towards the abortion. To add to her distress, Mara related, the counselling service she contacted after she was raped was not supportive of her decision to have an abortion, telling her that if she had an abortion she would be “committing a worse crime than that of her rapist, because he was a rapist but she would be a murderer”. She was eventually able to travel to Britain with ASN support.

MARGINALIZED COMMUNITIES AND GROUPS

Some of the service providers interviewed raised concerns about additional financial and social obstacles for women and girls from marginalized communities and groups in being able to afford or access the means of travel to England.

Donagh Stenson, Associate Director of Marketing at BPAS, whose role includes signing off on grants for Irish and Northern Irish women unable to otherwise afford travel to BPAS centres in England, noted the differential impact on marginalized communities on both sides of the border in Ireland. As an illustrative example, Donagh referred to cases from Traveller communities, where BPAS tends to receive a phone call from a support or social services agency because the woman or girl cannot ask for support from within her community, and usually the abortion has to be done very quickly in order for her absence not to be noticed.

Similarly Mara Clarke of ASN explained her organizations experience dealing with some requests for financial assistance in relation to crisis pregnancies from women and girls from marginalized Traveller and migrant communities: “There have been some Traveller women who have contacted us from Northern Ireland. One in particular haunts me to this day because she disappeared – she was 16 and she said that if her family found out that she had had sex they would kill her, I talked to her on the phone a couple of times and then I could never reach her again. Another Traveller woman, again from the North, couldn’t read and went to an internet café and asked the manager to read out the information about abortion [...] We got a call from a women’s refuge about a non-Irish woman living in the North with her two teenage daughters and her 16 year old daughter was pregnant as a result of rape. So where do you start with that one? And when the refuge called on their behalf, we had about £11 for grants in the bank. So we called in some favours and were able to get them to England for the procedure.”

INTERNATIONAL HUMAN RIGHTS CRITICISM OF REQUIRING WOMEN TO TRAVEL ABROAD TO ACCESS ABORTION SERVICES

The Human Rights Committee has criticized the Republic of Ireland for sending women abroad to access abortion services. (2008, para. 13) In 2010, *in A.B. & C. v. Ireland*, the European Court assessed the ‘psychological impact’ of women travelling abroad for services in cases of risk to health and well-being, acknowledging that:

[Women] felt the weight of a considerable stigma prior to, during and after their abortions. They travelled abroad to do something ... [that] went against the profound moral values of the majority of the Irish people

... and which was ... a serious criminal offence in their own country punishable by penal servitude for life. Moreover, obtaining an abortion abroad, *rather than in the security of their own country and medical system, undoubtedly constituted a significant source of added anxiety.* (para 126).

STIGMA AND STEREOTYPING

“When I asked my GP about abortion he said that he didn’t know anything about it and gave me a family planning clinic number. As I got up to leave he said, “I can see you are getting a good Catholic education, I hope you know what you are doing.” I have never felt so judged in my life. I was so angry that a grey, old man could make such nasty value judgements about me and my life.” -- Aoife, from County Down, who had an abortion in England when she was 17 years old

In their intent and purpose, criminal abortion laws conscript women into a gender-stereotyped reproductive role,⁴⁴ perpetuating stigma. Experiences of sadness, shame, guilt and being judged by others arose repeatedly in Amnesty International’s discussions of women and girls’ experiences of obtaining advice relating to abortion, travel to access abortion, and returning to Northern Ireland after having had an abortion. These themes were raised by healthcare providers, and women and girls themselves speaking directly to Amnesty International or in testimony previously recorded by reliable sources. Several of them raised concerns both about women and girls’ inability to discuss reproductive choices openly with their family doctors, particularly in rural communities, and many of them also pointed to inconsistencies in the delivery of sex and relationship education programmes in schools, some of which openly stigmatize abortion.

THE MORAL STANDING OF PHYSICIANS

Dawn Purvis, Director of Marie Stopes International⁴⁵ in Belfast like others interviewed, remarked on the barriers and stigma women associated with discussing abortion options with their general practitioner (GP), both on the basis of the standing enjoyed by doctors in local, and especially rural, communities and the perception on the part of women that their doctor holds an anti-abortion position. She said: “In some of the worst cases, the GPs have said they are ‘pro-life’ and have kicked the woman out without referring her on [which they are obliged to do]. It is very distressing, there are women who come from small rural communities who will not attend a family GP and many women absolutely refuse. Or if we would like to inform

⁴⁴ UN Special Rapporteur on the Right to Health. *Interim report to the General Assembly*. UN Doc. A/66/150 (2011), para. 16.

⁴⁵ MSI stated at the time it opened its Belfast centre, that it would provide:

- family planning and contraception – providing short term methods such as the pill, injection and condoms, and long-acting options including implants and intrauterine devices (IUD)
- STI testing and treatment
- HIV counselling, testing and referral
- termination of pregnancy up to nine weeks gestation
- 24 hour information, advice and ongoing support for all of its services

See Marie Stopes Northern Ireland to open Belfast centre, 10 October 2012, Press Release, <http://mariestopes.org/media/marie-stopes-northern-ireland-opens-belfast> and Media backgrounder, http://mariestopes.org/sites/default/files/originals/Media%20backgrounder%20-%20MSI%20NI_0.docx

their GP they absolutely refuse. On a rare occasion we'll be given the details. And that certainly has implications if a woman has an adverse reaction to treatment or takes ill. It has implications for the woman physically and mentally if she can't be open with her GP."

Kellie O'Dowd of Alliance for Choice, has researched aspects of abortion in Northern Ireland.⁴⁶ Kellie said, "In terms of the research I carried out with people who worked with GPs -- I didn't work with GPs directly -- there was that moral standing in the community. I think it's the god complex, because of their moral standing in the community. They don't want to rock the boat either. I mean if you're getting paid 80 or 90 grand a year to be a GP why would you put your head above the parapet. For example, we've got this pro-choice doctor and I suggested to the other women at the clinic, 'He can talk to women and students,' and they said 'Oh no, he'll not put his head above the parapet', so you're left in the vacuum again."

Aoife⁴⁷, who had an abortion in England when she was 17 years old, relates her experience of seeking advice from a local GP: "Eventually I decided that I better go to my doctor. But I am from a rural area and I couldn't face my own doctor so I went to a doctor in the practice that none of my family went to. I went on my own after school in my school uniform, feeling completely lost and overwhelmed. I told him that I was pregnant. He didn't even do a test to confirm it. I asked him what my options were. He looked at me blankly. I knew that abortion was illegal and knew that women and girls had to travel to Britain. When I asked him about that option he said that he didn't know anything about it and gave me a family planning clinic number. As I got up to leave he said, "I can see you are getting a good Catholic education, I hope you know what you are doing." I have never felt so judged in my life. I was so angry that a grey, old man could make such nasty value judgements about me and my life."

Kally, who has worked at the BPAS Merseyside Clinic for over 40 years said in her experience many women from Ireland and Northern Ireland, return home after their abortions with two stories – a Story A and a Story B – one for themselves about the actual circumstances of their pregnancy and/or the reason for their travel and a second one with another explanation for their absence or loss of their pregnancy, in order to avoid the stigma associated with abortion.

COMPREHENSIVE SEXUALITY EDUCATION

Some interviewees, particularly those who had worked with young people – boys and girls, and young men and women – on issues of sexual and reproductive health, such as Mary Crawford, Director of the Brook Charity in NI, raised concerns about inconsistent delivery of relationship and sex education in Northern Ireland schools. Given that most children in Northern Ireland still receive an education from a faith-based school, sex and relationship education often has to fall within the ethos permitted by the school's leadership and board of governors. Mary Crawford stated: "We find that when we do community outreach and discuss

⁴⁶ See Bloomer, Fiona and O'Dowd, Kellie (2014) Restricted access to abortion in the Republic of Ireland and Northern Ireland: exploring abortion tourism and barriers to legal reform. *Culture, Health & Sexuality*, 16 (4). pp. 366-380.

⁴⁷ Aoife asserted that she was willing to use her real given name, but asked that her surname be withheld to protect her identity.

abortion with young people under the age of 18... we tend not to do it because they have very strong views primarily against abortion and until they actually find themselves in the situation, or their parents find themselves with a daughter who is pregnant they aren't open to looking at the discussions and the debates around it. Relationship and sex education is compulsory in schools in Northern Ireland but that doesn't mean to say that it is consistently well done. It is inconsistent and therefore what you might be taught about abortion may be very limited and is within the context of the ethos of the school." These underlying concerns about the sex and relationship education are borne out by official statistics gathered by the Education Training Inspectorate (ETI) in its 2011 evaluation of such programmes in post-primary education in Northern Ireland.⁴⁸ The ETI evaluation found that almost all schools (over 97%) used external agencies to provide the sex and relationship component of their curriculum; of these schools, about 75% had support from an independent Christian charity with a stated core belief in the "value and dignity of human life from conception to natural death," which would appear to be a position strongly opposed to abortion on any grounds.⁴⁹

Kellie O'Dowd, of Alliance for Choice, states that the myths around abortion received in sex and relationship education, along with the broader societal pressure to brush discussions about abortion under the carpet have led to a situation where "the level of debate and discussion is very different in the North [Northern Ireland] than it is in the South [Republic of Ireland], because of the referendum in the South, because of Savita Halappanavar and because of other things as well. I think in the South the public have had a discourse about it, here we don't."

INTERNATIONAL HUMAN RIGHTS OBLIGATIONS TO ADDRESS GENDER STEREOTYPES AND TO ENSURE ACCESS TO COMPREHENSIVE SEXUALITY EDUCATION

The Human Rights Committee has long acknowledged the critical role of culture and other social structures such as gender has had on women's full enjoyment of Covenant rights. In its General Comment No. 28, the Human Rights Committee elaborated: 'Inequality in the enjoyment of rights by women throughout the world is deeply embedded in tradition, history and culture, including religious attitudes. ... States parties should ensure that traditional, historical, religious or cultural attitudes are not used to justify violations of women's ... equal enjoyment of all Covenant rights.'⁵⁰ In *L.C. v. Peru*, the Committee on the Elimination of Discrimination Against Women described abortion restrictions as "based on a gender stereotype that understands the exercise of a woman's reproductive capacity as a duty rather than a right."⁵¹

Under the rights to health and to education, as well as to non-discrimination, States must ensure that individuals have access to comprehensive sexuality education, both in and outside formal education

⁴⁸ Education Training Inspectorate, "Report of an Evaluation of Relationships and Sexuality Education in Post-primary Schools," 11 January 2011, <http://www.eti.gov.uk/index/surveys-evaluations/surveys-evaluations-post-primary/surveys-evaluations-post-primary-2011/report-of-an-evaluation-of-relationships-and-sexuality-education-in-post-primary-schools.htm>, paragraph 4.15 and Figure 6.

⁴⁹ Love for Life Charter, <http://www.loveforlife.org.uk/love-for-life-charter/>.

⁵⁰ Human Rights Committee, *General Comment No. 28: Equality of rights between men and women (article 3)*, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000), para 5.

⁵¹ *L.C. v. Peru*, CEDAW/C/50/D/22/2009 (2011), para 7.7.

systems.⁵² Under these rights, States must ensure that curriculum materials do not perpetuate harmful or discriminatory stereotypes, and should pay special attention to diversity and gender issues, including ensuring that there is no gender role stereotyping, such as portraying women's primarily role as being a mother.⁵³ Treaty bodies, including the Children's Rights Committee, have noted that States should make comprehensive sexuality education programs part of the standard school curriculum, provided throughout schooling in an age-appropriate manner and without parental consent.⁵⁴ States should also develop public education campaigns to raise awareness about sexual and reproductive health issues, such as risks of early pregnancy and prevention of STIs, thorough medical and other alternative forums.⁵⁵ All sexuality education programs, both in and out of school should not censor or withhold information or disseminate biased or factually incorrect information, such as inaccurate information on contraceptives or abortion.⁵⁶ The content should also not be discriminatory, including on grounds of gender and sexual orientation, both in content and in teaching methodologies.⁵⁷

HARASSMENT

Abortion stigma is not just an amalgamation of intangible expressions of deeply held and pervasive set of sociocultural beliefs and practices. Abortion stigma also finds expression in regular public demonstrations—and in some instances harassment—outside sexual and reproductive health clinics in Northern Ireland, and takes the form of both veiled and open threats to healthcare providers working in these organizations and the women who use their services. Without exception, the interviewees working in this area of healthcare advice and information provision recounted instances in which they had been harassed by anti-choice activists. Some also recounted instances in which women and girls visiting their premises—both to access abortion advice and for other reasons, and in some instances women visiting other organizations in the same building—had been pursued down the street by anti-choice activists and harassed. Those providing services to pro-choice organizations, such as a hotel, have also been targeted. Service providers have also been the subject of official complaints by anti-choice activists to the police, resulting in intimidating police investigations.

INTIMIDATION OF HEALTH CARE PROVIDERS

A prominent anti-choice protester was convicted in November 2014 of harassing Dawn Purvis

⁵² Committee on the Rights of the Child, General Comment 15: On the Right of the Child to the highest attainable standard of Health (2013); Committee on the Rights of the Child, General Comment 4 on Adolescent Health paras 26, 28, 39(b) (2003); CEDAW General Recommendation 24 on Women and Health, Article, para 18 (1999).

⁵³ Report of the UN Special Rapporteur on the Right to Education, paras. 21-23, 87 (d), Doc. /A/65/162 (2010).

⁵⁴ Ibid. paras. 87 (c), Doc. /A/65/162 (2010); Committee on the Rights of the Child Concluding Observations: Ireland, para. 52, (2006).

⁵⁵ Committee on the Rights of the Child, General Comment 15: On the Right of the Child to the highest attainable standard of Health, para. 28 (2013); Committee on the Rights of the Child, General Comment 4 on Adolescent Health para. 28, (2003)

⁵⁶ Committee on the Rights of the Child, General Comment 3 HIV and the rights of the Child, para 16 (2003); Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health*, para. 34 (2000). Report of the UN Special Rapporteur on the Right to Education, para. 39, Doc. /A/65/162 (2010)

⁵⁷ Report of the UN Special Rapporteur on the Right to Education, para. 63, Doc. /A/65/162 (2010). The UN Special Rapporteur on the Right to Education has noted that states take steps to ensure that programs are free from harmful sex or gender based or heteronormative stereotypes of those based on mental of physical ability. (para 63)

of Marie Stopes International outside the organization's Belfast clinic. Bernadette Smyth, who leads the anti-choice group Precious Life, was found guilty of harassing Dawn Purvis on two dates in 2014.⁵⁸ The sentence—currently subject to appeal—handed down in December 2014 included 100 hours of community service, and compensation of £2000, and was accompanied by a five year restraining order.⁵⁹ Anti-choice campaigners have gathered at the MSI's Belfast centre since it opened in October 2012, targeting centre staff as well as women and girls they believe to be attending the clinic to avail of abortion advice and services. Dawn Purvis said she had been frightened for her safety following two incidents. She described these incidents to Amnesty International in the context of a pattern of harassment of MSI staff, volunteers and service users by protestors assembled on the street outside their clinic over several months. On 9 January 2014, she said that when she asked protestors to stop harassing her, Bernadette Smyth replied in an exaggerated drawl: "You ain't seen harassment yet, darling." In an incident in February 2014, Dawn Purvis said that after she left her son and his female friend at the front door of the MSI clinic, one of the protestors followed the girl up the street. She said that when she shouted to the protestors to "leave them alone", Bernadette Smyth began to cackle and laugh in an exaggerated way.

The district judge who heard the case said anti-choice campaigners stationed outside the clinic had been forcing any women of child-bearing age to identify their reasons for entering. In his judgment, as reported by media, he said: "I want to make it absolutely clear that I do not feel it's appropriate for anyone to be stopped outside this clinic in any form, shape or fashion and questioned either to their identity, why they are going in there and being forced to involve themselves in conversation at times when they are almost certainly going to be stressed and very possibly distressed."

Responding publicly to the sentence, Dawn Purvis stated: "[the] sentence is important not just for me, but for all the women who have been subjected to abuse and intimidation since the clinic opened two years ago. I fully respect people's right to peaceful protest, but it is totally unacceptable to intimidate women accessing a legal health service or the staff that provide their care. Today the judge has issued a clear message that this sort of behaviour is intolerable and that harassing people who provide legal healthcare services is not acceptable."⁶⁰ She had earlier stated, following the verdict, that she felt "relieved and heartened that [...] women's wellbeing and rights have been respected and upheld."⁶¹

⁵⁸ Alan Erwin, "Precious Life chief Bernie Smyth convicted of harassing Marie Stopes abortion clinic director," Belfast Telegraph, 19 November 2014, <http://www.belfasttelegraph.co.uk/news/local-national/northern-ireland/precious-life-chief-bernie-smyth-convicted-of-harassing-marie-stopes-abortion-clinic-director-30757557.html>; BBC News, "Anti-abortion protester Bernadette Smyth guilty of harassing Dawn Purvis," 19 November 2014, <http://www.bbc.co.uk/news/uk-northern-ireland-30116191>.

⁵⁹ BBC News, "Bernadette Smyth: Anti-abortion protester given community service," <http://www.bbc.co.uk/news/uk-northern-ireland-30513682> and BBC News, "Bernie Smyth: Anti-abortion protester cautioned," 19 December 2014, <http://www.bbc.co.uk/news/uk-northern-ireland-30550741>. For details on the appeal, see: Alan Erwin, "Appeal date set for Bernie Smyth: Anti-abortion campaigner to fight Marie Stopes harassment conviction, court hears," Belfast Telegraph, 16 January 2015, <http://www.belfasttelegraph.co.uk/news/local-national/northern-ireland/appeal-date-set-for-bernie-smyth-antiabortion-campaigner-to-fight-marie-stopes-harassment-conviction-court-hears-30913769.html>.

⁶⁰ MSI, Media statement - Sentencing passed on Northern Irish abortion protester, 17 Dec 2014, <http://mariestopes.org/media/media-statement-sentencing-passed-northern-irish-abortion-protester>

⁶¹ MSI, Media statement - Northern Ireland harassment case, 19 Nov 2014,

Mary Crawford from Brook NI, which provides sexual health and contraception (but not abortion) services to young people, told Amnesty International about a smear campaign directed against her personally at the time the clinic opened in Northern Ireland, and about pickets and protests outside the clinic over the years. She said: “Sixteen years ago every person in my street got a letter posted to them saying I sent 17 women a week to England to get abortions. That weekend was unbelievable because people came to my door and handed me the letter saying ‘I think this is for you,’ not realizing that it was for them and it was about me. Copies were sent to the whole street from top to bottom, almost a hundred houses. The intent was to intimidate me, to say this woman is a terrible woman. At the bottom, it said ‘Where good people remain silent, evil triumphs.’ So they used that quote to say that I was the most evil woman in Northern Ireland at that time. [...] One person in particular had said that they were going to put me out of a job and had made veiled kind of death threats with it. I did have a fair idea of who it was that did it and I went to the police; they talked to me about security, about what I needed to do to my house, about changing my route to work. [...] The whole idea was to intimidate me and our senior doctor, they had our names on placards so we challenged that as well. Just after that they were chanting outside the clinic saying our names [...] it was particularly harrowing, it was intimidatory and they were personalizing it in order to let me know they knew exactly who I was, who my family was. You know my mother at the time was 80 and people were coming up to her and saying, ‘You know I always thought well of your family until I found out about your Mary.’ They personally said things to my family so there was a huge amount of animosity around the situation and working in that environment was difficult.”

INTIMIDATION OF WOMEN SEEKING CLINIC SERVICES

Kellie O’Dowd, who volunteers as an escort for women and girls attending the MSI clinic in Belfast explained why she decided to be an escort and outlines the sort of harassment and intimidation that women attending the clinic face:

“Every Thursday and Friday women come to the [MSI] clinic, they are asked when they phone if they would like an escort into the building because of the protestors outside. As a human rights advocate and activist I think that it is extremely important that people have the right to protest, but I think it is absolutely disgusting and abominable that protestors chase women the whole way up the street. In fact we were chased last week to the steps of the Europa bus station. They shout at women, holding a plastic foetus in front of the women saying ‘This is your baby, you’re already a mother, what you are doing is murder, these women don’t care about you, don’t do it, please don’t do it, we’ll be able to help you.’ It doesn’t matter what those women are in the clinic for, which is even more interesting, it’s a reproductive clinic, it’s not just an abortion clinic, but if they see a young woman coming into the building, they chase her. [...] By the time women get into the building they’re shaking. Really, really disturbed. Really, really harassed... on leaving the building something like I’ve just described to you happens. They also have a guy... there’s two men that are there all the time, one is really intimidating, he’s about six foot two and just hangs about all the time. And they’ve got another wee guy who hangs about and films us on a handheld video camera, who films all the women coming into the building and all the women coming out. The other week we had a horrendous situation where a young woman had come to the clinic, and as we were leaving she was being filmed and started freaking out. She ran out into the middle of the road into

<http://mariestopes.org/media/media-statement-northern-ireland-harassment-case>

open traffic, she was so frightened. She could have been killed.”

Audrey Simpson of the FPA told Amnesty International of efforts by anti-choice activists to bring pressure on a hotel, which the FPA and the Irish FPA had chosen to host an all-Ireland clinical conference on abortion in 2010 to cancel the event.⁶²

“Some of the doctors attending must have spoken to Precious Life [an anti-choice group], who then started a campaign against the hotel. They told the hotel staff, receptionists, that they were facilitating murder. They then wrote to the chief executive and told him that his staff would be liable for prosecution. Sent horrible photographs, the Catholic church said they would never, ever use the hotel again for any of their events.”

POLICE INVESTIGATIONS

Audrey Simpson believes when those efforts were unsuccessful, anti-choice activists lodged a complaint against her to the PSNI. She expressed her frustration that because abortion is something that is subject to criminal regulation, and which carries such a stiff potential sentence, the police have no option other than to follow up on such complaints. She recalls,

“The evening before the conference, I got a phone call from the banqueting manager who said ‘Audrey there is a police officer downstairs who wants to have a word with you.’ I thought ‘Okay, we know there are a lot of protests, a lot of security and dogs.’ So I thought he was coming to talk to me about security. It was a Chief Inspector and his sergeant, who had driven 40 miles, saying that they had received an official complaint that we were running a conference that was inciting murder, and could I please give him a copy of all the presentations. So I said to him, ‘Gosh you’ve had a long journey for nothing’. He wanted full copies. But I said, ‘No, we will not be giving you full copies, this is a clinicians conference about good practice, they happen every day regularly in the rest of the UK. Northern Ireland is no different.’ He said to me, ‘You know there could be repercussions Audrey. You’re making things very difficult for yourself Audrey.’ He rang me up three months later asking for the contact details of all the presenters. I said ‘Oh sorry I’m not able to pass on that information to you.’ He said again, ‘You know there could be repercussions.’ He then rang me up two months later and said we’re not taking any further action. So that is the problem. Whenever somebody here makes a complaint, because abortion is criminalized the police can’t just tell them to wind their neck in.”

Breedagh Hughes of the RCM recalled being reported to the PSNI by a representative of Precious Life in 2007, on the basis of an interview she had given to the Sunday Times, over

⁶² Statement by the Catholic Bishops of Northern Ireland on the ‘First All-Ireland Conference on Abortion and Clinical Practice, 7 October 2010, <http://www.catholicbishops.ie/2010/10/07/statement-by-the-catholic-bishops-of-northern-ireland-on-the-first-all-ireland-conference-on-abortion-and-clinical-practice/>
The Christian Institute, Pro-lifers outraged at first ever NI abortion conference, 8 October 2010, <http://www.christian.org.uk/news/pro-lifers-outraged-at-first-ever-ni-abortion-conference>
Abortion seminar provokes anger, News Letter, 7 October 2010, <http://www.newsletter.co.uk/news/regional/abortion-seminar-provokes-anger-1-1851373>
SPUC, Health minister should end public funding of abortion advocates, 6 October 2010, <https://www.spuc.org.uk/news/releases/2010/october06>
Outcry at abortion conference in NI, UTV, 8 October 2010, <http://www.u.tv/News/Outcry-at-abortion-conference-held-in-NI/4f92a3e6-394b-4b80-8d27-03a73626f601>

three years prior to the complaint being made, about abortions in which she had taken part when still a practicing midwife. The PSNI interviewed her under caution, and Breedagh recalls the stress caused to her – and her concern for other midwives who carried out their work on a daily basis fearing a similar situation – for a period of over a year until the complaint was eventually dismissed. She discussed the effect on her, in addition to the stress arising from the police investigation, of being smeared in public and having complaints made to the leadership of the RCM to have her dismissed.

CONSULTATION ON LEGISLATIVE REFORM BY THE DEPARTMENT OF JUSTICE

The DOJ has acknowledged that the story of Sarah Ewart (described above in the section on 'public opinion'), along with that of another family who were expecting twins where both foetuses were diagnosed with anencephaly, as a precipitating factor for the ongoing process of consultation launched in 2014.⁶³

The DOJ's consultation is narrow in its definition and is restricted to examining whether the criminal law regulating abortion "should enable abortion in cases where there is a diagnosis in pregnancy that the foetus has a lethal abnormality," and "whether abortion should be available to women who have become pregnant as a result of sexual crime."⁶⁴ Amnesty International has made a formal submission in response to this consultation.⁶⁵ The DOJ's consultation stated explicitly that it was not about, nor would it entertain responses setting out, broader positions for and against abortion. This narrow approach to potentially expanding the permissible grounds reflects the limited political will and lack of consensus across the board for wider change in line with public opinion. In an indication of the strong feeling and activism by religious authorities, even this narrow consultation came under significant public attack, from Archbishop Eamon Martin, Primate of All Ireland in January 2015.⁶⁶ It should be noted that opposition to these narrowly defined changes to the law are not confined to the

⁶³ DOJ Consultation, Chapter 1.

⁶⁴ A note on terminology: The DOJ Consultation refers to lethal foetal abnormality. Amnesty international uses the term fatal foetal impairment to describe the same condition. The consultation refers to sexual crime by which it means rape and unlawful familial sexual activity. Amnesty International uses the terms 'rape and incest', in line with international human rights language.

⁶⁵ Amnesty International UK, Submission to the Department of Justice consultation, The Criminal Law on Abortion: Lethal foetal abnormality and sexual crime," January 2015, http://www.amnesty.org.uk/sites/default/files/aiuk_doi_ni_submitted_copy.pdf

⁶⁶ Archbishop criticises proposed changes to Northern Ireland's abortion law Catholic Herald, 13 January 2015, <http://www.catholicherald.co.uk/news/2015/01/13/archbishop-criticises-proposed-changes-to-northern-irelands-abortion-law/>. See also "Archbishop in Stormont abortion row," Belfast Telegraph, 12 January 2015, <http://www.belfasttelegraph.co.uk/news/local-national/northern-ireland/archbishop-in-stormont-abortion-row-30898541.html> and "Archbishop Eamon Martin meets David Ford over abortion laws," BBC News, 15 January 2015, <http://www.bbc.co.uk/news/uk-northern-ireland-30831196>.

Catholic Church; the Evangelical Alliance in Northern Ireland, which describes itself as 'offer[ing] a prophetic and evangelical voice to those at Stormont and in the media' has opposed any change to the law on abortion in Northern Ireland.⁶⁷

The consultation document also sought responses on setting on an explicit statutory footing the right to conscientious objection to participation in a procedure for termination of a pregnancy in Northern Ireland.

ABORTION IN CASES OF FATAL FOETAL IMPAIRMENT

"My husband and I have been trying for years to get pregnant. I've had two miscarriages and we were so excited when we finally fell pregnant. However, we've had antenatal testing and the baby has severe foetal malformations and may not live until birth and certainly won't live for long after if it's even born [alive] at all. This is completely breaking both our hearts and because of this backwards country we live in we have nowhere to turn. At the hospital they wouldn't even talk to us about abortion, they just kept saying 'if you choose to travel' – as if we were planning a holiday! It makes this situation even more difficult." -- A woman from Northern Ireland who travelled with the assistance of the ASN to England to terminate a pregnancy with a diagnosed fatal foetal impairment.

From Amnesty International's own research and leading studies, women invariably experience a diagnosis of fatal foetal impairment differently, depending on a number of factors and circumstances. Nevertheless there is a commonality: women experience a traumatic and devastating loss. Reactions to diagnosis include intense sadness, anger, loneliness, and hopelessness. Women experience deep grief for multiple losses: loss of their child, loss of the joys of a normal, pregnancy experience, and of future parenting of their child.

Against these circumstances, a criminal prohibition on abortion perpetuates severe suffering as it prolongs the traumatic and devastating sense of loss by forcing a woman to endure pregnancy, with the full knowledge that it will ultimately end in death rather than life. Many women describe this experience as a near unbearable state of being. Moreover, criminalization denies women the empathetic compassion of a health provider in the face of their profound tragedy.

In many cases, fatal foetal impairments cannot be detected accurately until later in the pregnancy, past the first trimester.

The DOJ consultation process currently underway has asked whether the law regulating abortion "should enable abortion in cases where there is a diagnosis in pregnancy that the foetus has a lethal abnormality". Public opinion, as shown above, widely supports such a change and international human rights law requires it. The case of Sarah Ewart, mentioned above, is widely documented. It is worth noting that where the fatal foetal impairment places the life or health of the pregnant woman or girl at risk, abortion is technically permissible under law and in theory may be available in Northern Ireland. Fatal foetal impairment is not grounds for a termination in itself. All the medical practitioners and reproductive health care and advice providers interviewed, referred to differential access in Northern Ireland between

⁶⁷ See <http://www.eauk.org/northern-ireland/> and <http://www.eauk.org/northern-ireland/briefings/abortion-in-northern-ireland.cfm>.

health care trusts, and along urban/rural or East/West divides. A number of them spoke persuasively about how access to abortion in Northern Ireland in cases of fatal foetal impairment presenting a risk to the life of the woman is effectively something of a “postcode lottery”, that is an arbitrary luck of the draw depending on one’s place of residence within the region.

Dr Samina Dornan, a consultant in Maternal and Foetal Medicine at the Royal Maternity Hospital in Belfast (the Royal), one of four specialists to whom high risk pregnancies are referred from across Northern Ireland, said, speaking based on her individual professional experience rather than as a representative of the Royal:

“The atmosphere in hospitals has changed since the 2013 guidelines [see section on lack of health guidance below]. The atmosphere in the Royal has changed even though the services we provide have not. Our management team have been excellent and have fully supported our approach to these difficult cases. We therefore have continued to function under the 2009 guidelines and will do so until the DHSSPS tables new ones in a non-draft form. We have though found it increasingly difficult to work in this atmosphere, since the new draft guidelines which are “out there” are quite intimidating. But we are professionals and so just get on with it. Some of the other trusts and clinicians in Northern Ireland were told categorically by their management teams that they should not procure [terminations] on mental health grounds in their units. However some of them carried on referring these tragic cases [to us] for a second opinion, and were then sending the women across the water but at their own expense, which in many cases is formidable. Termination of pregnancy is legal in Northern Ireland where the medical team have determined that there is a serious and long term risk to the mental or physical health of the mother. I, and the colleagues I work with closely, feel strongly that we are well-equipped to make the appropriate mental health assessments in these mothers who have no psychiatric medical history. We think it is plain wrong to suggest that a psychiatric opinion be required in cases where there is a serious or lethal fatal anomaly. We also think it unfair to have this ‘postcode lottery,’ and so those who can’t afford are doomed. The ethos of the NHS is that equal treatment is available for all and that is not what has been happening in Northern Ireland in recent times.”

The Abortion Support Network has supported a number of couples who have needed to travel outside Northern Ireland to access abortions in cases of fatal foetal impairment. Mara Clarke of ASN shared details of one such case:

“A married couple with four children, living in Northern Ireland, found out at 20 weeks gestation that there were severe problems with their very much wanted pregnancy. The foetus was diagnosed with Edwards’ syndrome and a heart condition and was not expected to survive past birth. When they contacted Abortion Support Network, the woman was 23 weeks pregnant and the couple had spent their already limited resources travelling to foetal heart specialists to get a second and third opinion and to determine the exact nature of the problem so that they could make an informed decision as to what to do. After they exhausted all of these options, this couple made the decision to come to England for an abortion, a decision that was complicated with the woman’s ill health from the stress of the situation. When they called ASN, they only had £200 left, not even enough to cover the two last minute plane tickets required to travel before she passed the 24 week time limit. The combined cost of travelling and the procedure was more than £2000.”

THE INTERNATIONAL LAW AND STANDARDS ON FOETAL IMPAIRMENT

The criminal prohibition of abortion in cases of fatal foetal impairment has increasingly been raised as a concern within international human rights law, including under the prohibition of torture and other ill-treatment.

In its 2005 decision in *K.L. v. Peru*, the Human Rights Committee found that compelling a 17-year-old girl to carry an anencephalic foetus to term violated her right to be free from cruel and inhuman treatment, arbitrarily interfered with her private life, and failed to provide her with the special care she needed as a child.⁶⁸ In finding a violation of torture and other ill-treatment, the Committee recognized that KL suffered deep depression which was found to have severely affected her development and future mental health. The Human Rights Committee rooted the violation of Article 7 in the State party's denial of abortion and utter disregard for the woman's mental health, despite the foreseeability of the harm.

It also found the state arbitrarily interfered with her private life, and failed to provide her with the special care she needed as a child. In finding the right to privacy violated, the Committee recognized that the existing provision of the law allowing for abortion on health grounds (there is no explicit foetal impairment ground in Peru's law) entitled her to a lawful abortion.⁶⁹ Anencephaly, the absence of a major portion of the brain during embryonic development, nearly always results in stillbirth or death within hours or days of birth.

The UN treaty bodies have not limited their calls for access to abortion to cases in which foetal impairments are such that stillbirth or death immediately after birth is a virtual certainty. The CEDAW has called for access to abortion in cases of "severe" (rather than "fatal") foetal impairment in recent concluding observations. In its July 2014 concluding observations on Peru, for example, the committee recommended that the state "[e]xtend the grounds for legalization of abortion to cases of rape, incest and severe foetal impairment."⁷⁰

PREGNANCIES RESULTING FROM SEXUAL CRIME

The DOJ's consultation also examines "whether abortion should be available to women who have become pregnant as a result of sexual crime." Unlike fatal foetal impairment the DOJ makes no specific recommendations for legislative change; instead it merely seeks views on whether and how the law ought to be changed. As with cases of fatal foetal abnormality, such a change is supported by public opinion and international human rights law and standards. All the reproductive and sexual health service and advice providers interviewed in Northern Ireland and England related their experiences of addressing the needs of women who had become pregnant as the result of rape or incest, and some raised cases where

⁶⁸ Human Rights Committee, *Views: K.L. v. Peru*, Communication No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (22 November 2005), para 6.2, 6.4, 6.5, available at <http://reproductiverights.org/sites/crr.civactions.net/files/documents/KL%20HRC%20final%20decision.pdf> (viewed 24 October 2014).

⁶⁹ Ibid.

⁷⁰ Committee on the Elimination of Discrimination against Women, *Concluding Observations on the Combined Seventh and Eighth Periodic Reports of Peru*, U.N. Doc. CEDAW/C/PER/CO/7-8 (24 July 2014), ¶ 36(a).

women were forced to continue with pregnancies in a situation of domestic violence.

Given the additional level of stigma attached to rape, incest and domestic violence, it is perhaps unsurprising to learn from abortion service providers that many women do not report these issues. Dawn Purvis of MSI said; “We probably see at least six women a month who have been raped and none of them have reported it [to the police]. Now if we have concerns about an under 18-year-old who we think has been raped and is in danger, we’ll contact social services. Below 13 it’s statutory rape and we would have to refer to the police. We see women who have been forcibly made pregnant. Especially those in abusive relationships where the abusive partner had physically removed their contraceptive device whether that be an IUS [intrauterine system], an IUD [intrauterine device] or an implant. We’ve had a woman whose partner has used a pair of pliers to pull out her IUD and she got pregnant. We’ve had a woman whose partner has used a razor blade to cut the implant on her arm to force her into pregnancy.”

Mara Clarke of Abortion Support Network shared some stories and messages from women and girls – or their supporting family member – about accessing abortion services in England in cases where the pregnancy was the result of a sexual crime.

For instance, she related the story of one woman who had obtained support from ASN to travel for an abortion but had not disclosed at the time of doing so that her pregnancy was the result of a rape by a family member and his friends. The woman wrote several months later to say; “when everyone else refused to help me you went above and beyond and I will be eternally grateful for everything you’ve done for me. If you had not helped me, I would be dead either by my own hand or by theirs”.

In a second case of sexual crime, Mara told Amnesty International about a teenager who had been drugged and gang raped at a birthday party. Her family was faced with a number of hardships in addition to this crime, and while they were able to raise a small amount of money, this was used to pay for a passport for the young woman. Before they found out that Abortion Support Network might be able to help them with the costs, she was so desperate to end her pregnancy that she tried to self-abort and, when that failed, attempted suicide.

Of a third such illustrative case, Mara said: “ A 19 year old pregnant from rape and her father travelled to England to a clinic seeking an abortion only to find out that she was further along than originally thought – 15 weeks instead of 12. There was no appointment available at that clinic on that day for a later procedure, and the increase in gestation also raised the cost of the abortion from £350 to £600. Their two options at that point were to fly home and come back to England again – paying for two additional set of flights - or find another clinic in England with an open appointment. ASN was able to find a nearby clinic able to do the procedure, and also covered the price increase. The girl’s father wrote to say: “Now we can all get on with our lives after weeks of torment I will never forget what you have done to help us through this process thank you so much.”

Interviewees with whom Amnesty International raised the suggestion made by some commentators that victims of rape and sexual violence should be required to report the incident to the police (in order to then engage with the Rowan Sexual Assault Referral Centre (SARC), located in Antrim, funded by the DHSSPS and the PSNI and operational since

2013) in order to lawfully access abortion services expressed grave concern that such a position exhibited a fundamental misunderstanding about the reporting of rape by many victims.

One said, "Why does a woman have to prove she was raped? [...] The numbers of women we see who have been raped or become pregnant as the result of sexual abuse, the majority have not reported that rape. It's like saying you have to prove this and jump through so many hoops in order to access these services. Women will not go near it, they'll not. You know how many women report a rape end up going to the Rowan centre? That SARC should be open to any woman, any woman who has been raped ... but it's not. It's all about reporting rape to the police and all these women don't report it."⁷¹

A statutory inspection of the various criminal justice mechanisms' collective response to sexual crimes in Northern Ireland further supports such observations about the underlying stigma associated with reporting sexual violence, and also document high rates of attrition in sexual crimes progressing through the justice system. In 2010, Criminal Justice Inspection Northern Ireland found that only between 5 and 25% of rapes were reported. Only 25% of sexual crimes reported proceeded to trial; of those, the conviction rate was 57%. The conviction rate for rape in Northern Ireland in 2010 was 7%. In his introduction to these findings, the then Chief Inspector alluded to societal stigma, stating that "reasons for non-reporting are extensive and relate to many issues outside the control of the criminal justice system," and further noted that it was "incumbent on society in general to encourage victims and survivors to seek help and tackle barriers that currently stop them from doing so".⁷²

⁷¹ The Rowan SARC, by contrast, states clearly that it can provide help and support either through a referral by police following a formal complaint, or by direct self-referral (i.e. without police involvement) to the SARC (see <http://therowan.net/about-us/how-do-i-access-help/>). The latter possibility, perhaps given the SARC's recent establishment, did not appear to be well-known in the reproductive health services sector. The SARC's website – both under sections providing information to women and to children and young people – states clearly that its services include emergency contraception and pregnancy testing, but does not make any explicit reference to signposting rape victims to information about accessing terminations. Additionally, a report published by *The Detail*, in February 2015, has documented that the Rowan SARC has clarified that in the initial three months referrals were only by the PSNI, and only since then have self-referrals and third-party referrals been possible, and that over 1100 people have been supported by the Rowan SARC since its opening in May 2013. See Kathryn Torney, "15,000 victims of rape and sexual assault receiving support in NI," *The Detail*, 11 February 2015, <http://www.thedetail.tv/issues/369/the-rowan/15000-victims-of-rape-and-sexual-assault-receiving-support-in-ni>.

⁷² Criminal Justice Inspection Northern Ireland, *Sexual Violence and Abuse: A thematic inspection of the handling of sexual violence and abuse cases by the Criminal Justice System in Northern Ireland*, July 2010, <http://www.cjini.org/CJNI/files/0a/0ad6b7e4-0810-4151-8bb0-e28789591efc.pdf>. In its follow up, Criminal Justice Inspection Northern Ireland, while noting significant progress by criminal justice agencies, the establishment of the Rowan SARC and some PSNI pilot projects, emphasized the "need to continue to focus on the reasons why cases drop out of the criminal justice process at all stages in order to increase the number of cases which ultimately result in a conviction in court, and to ensure that vulnerable victims are neither re-victimised nor inappropriately dissuaded from giving evidence". See Criminal Justice Inspection Northern Ireland, *Sexual Violence and Abuse: A follow-up review of inspection recommendations*, October 2013, <http://www.cjini.org/CJNI/files/d1/d1c3dab5-25f3-45a4-9e19-4f7ed8a0c9fc.pdf>.

THE INTERNATIONAL HUMAN RIGHTS AND HEALTH STANDARDS ON SEXUAL CRIME AND ABORTION

Violence against women is a violation of fundamental human rights, including right to life, health and the right to be free from torture and other ill-treatment.

Violence against women also constitutes a form of discrimination against women.⁷³ Treaty bodies widely agree that abortion should be legal when a pregnancy results from rape and have repeatedly urged countries to amend their laws to this effect.⁷⁴ They have also urged states to take measures to provide for implementation mechanisms to ensure availability and accessibility of abortion on rape and incest grounds and to also adopt relevant medical standards.⁷⁵

The CEDAW Committee, in a case of denial of abortion to a suicidal young girl who had been raped, recommended that the state take measures to ensure access to abortion in cases of rape and that the life and health of a pregnant woman or girl are prioritized over protection of the foetus.⁷⁶

The World Health Organization (WHO) has clearly indicated that women who become pregnant as a result of rape should have access to safe abortion services.⁷⁷ To facilitate access to abortion services in such cases, the WHO advises that states should elaborate standards and guidelines for both police and healthcare providers, including referrals to abortion services.⁷⁸

International human rights bodies have called on states to remove unnecessary barriers to women and girls access to abortion services. The WHO, for example, recommends that women should be provided safe, legal abortion services based on their complaint of the rape,⁷⁹ and should not be compelled to undergo unnecessary administrative or judicial procedures, such as pressing charges against the perpetrator, identifying the rapist

⁷³ CEDAW Committee, General Recommendation. no. 19 on Violence Against Women, 1992, para. 6.

⁷⁴ See, e.g., CRC/C/ARG/CO/3-4, para. 59 (2010) ("The Committee recommends that the State party. Take urgent measures to reduce maternal deaths related to abortions, in particular ensuring that the provision on non-punishable abortion, especially for girls and women victims of rape, is known and enforced by the medical profession without intervention by the courts and at their own request"); E/C.12/PER/CO/2-4, para. 21 ("it recommends that the criminal code be amended so that consensual sexual relations between adolescents are no longer considered as a criminal offence and that abortion in case of pregnancy as a result of rape is not penalized."); E/C.12/KEN/CO/1, para. 33 ("The Committee recommends that the State party ensure affordable access for everyone, including adolescents, to comprehensive family planning services, contraceptives and safe abortion services, especially in rural and deprived urban areas, by ... decriminalizing abortion in certain situations, including rape and incest."); CCPR/C/GTM/CO/3, para. 20 ("The State party should, pursuant to article 3 of its Constitution, include additional exceptions to the prohibition of abortion so as to save women from having to resort to clandestine abortion services that endanger their lives or health in cases such as pregnancy resulting from rape or incest .").

⁷⁵ CEDAW Committee, Concluding Observations: Kuwait, para. 43(d), U.N. Doc. CEDAW/C/KWT/CO/3-4 (2011).

⁷⁶ L.C. v. Peru, CEDAW Committee, 2011, para. 8.15; see also, CEDAW Concluding Observation to Hungary, 2013, para. 30.

⁷⁷ WHO Safe Abortion Guidance at 92 ("The protection of women from cruel, inhuman and degrading treatment requires that those who have become pregnant as the result of coerced or forced sexual acts can lawfully access safe abortion services.").

⁷⁸ Ibid. page. 69, 92-93.

⁷⁹ Ibid. page 92-93.

or providing forensic evidence of the rape.⁸⁰

The WHO has noted that such requirements can delay access to abortion services, or may prevent access to services altogether, such as where there are gestational limits for the abortion and women cannot meet the requirements in time and in instances when women do not want to report the rape due to fear of stigma.⁸¹

CONSCIENTIOUS OBJECTION

The practice of conscientious objection arises in the field of care when healthcare providers refuse to provide certain health services based on religious, moral or philosophical objections. Conscientious objection is not uncommon in reproductive health care settings because of beliefs on when life begins and the religious or moral values placed on those beliefs. It is often invoked in the context of abortion.

The DOJ consultation considers introducing a right to conscientious objection on a statutory footing to Northern Ireland. Were such a provision to be introduced, Amnesty International considers it essential to make unequivocally clear in law, and accompanying guidance, that a right to conscientious objection is not absolute and that Northern Ireland has an obligation to ensure that the practice does not hinder women's reproductive rights, including access to lawful abortion services. Conscientious objection should only be permitted insofar as the person seeking care can still be guaranteed timely and appropriate quality care. In addition, that the right to conscientious objection would not apply in cases where there is a risk to the woman's life or an immediate risk to her health. A woman's right to life, health and dignity must always take precedence over the right of a health care professional to exercise conscientious objection to participation in an abortion procedure.

The right to conscientious objection should also only apply to the abortion procedure itself – not pre and post care, as confirmed by a recent UK Supreme Court judgment.⁸² The European Court of Human Rights has also confirmed that where states allow abortion they must ensure its access, including by regulating the practice of conscientious objection. The Court, in two separate cases where a woman and a girl faced barriers in accessing abortion, in part because of the practice of conscientious objection, noted that the Convention does not protect every act motivated or inspired by religion and that '...States are obliged to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation.'⁸³ The Court found violations of Article 8 of the Convention for failing to do so.

Similarly the UN CEDAW Committee has stated, with regard to reproductive health services generally, "If health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative

⁸⁰ Ibid. page. 69, 92-93.

⁸¹ Ibid. page 92-93

⁸² *Doogan and Wood v NHS Greater Glasgow and Clyde Health Board*
https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0124_Judgment.pdf

⁸³ *RR v Poland*, para 206 (2011); *P and S v Poland* (2012, para 106).

health providers.”⁸⁴ And further, the Special Rapporteur on the right to health has cited inadequate regulation of conscientious objection as a legal restriction that contributes to making legal abortions inaccessible. “Conscientious objection laws create barriers to access by permitting health-care providers and ancillary personnel, such as receptionists and pharmacists, to refuse to provide abortion services, information about procedures and referrals to alternative facilities and providers.⁸⁵ He has recommended that states “ensure that conscientious objection exemptions are well-defined in scope and well-regulated in use and that referrals and alternative services are available in case where the objection is raised by a service provider.”⁸⁶

LACK OF ABORTION GUIDANCE TO HEALTHCARE PROVIDERS: THE CHILLING EFFECT

In addition to broader underlying societal stigma associated with abortion, and the chilling effect that criminal regulation continues to exert over healthcare providers, and women and girls, there is a lack of clear guidelines for healthcare professionals in Northern Ireland on termination of pregnancy. The ongoing failure of the DHSSPS to publish such guidance has given rise to a widespread reluctance among healthcare providers to provide abortion services, which are lawful in Northern Ireland. The courts have found that doctors have expressed unwillingness, in some instances, notwithstanding an express judicial declaration stating that in the particular circumstances abortion was lawful, on the basis of medical professionals’ “perceived uncertainty as to the law” governing abortion in Northern Ireland.⁸⁷

THE FAMILY PLANNING ASSOCIATION CASE

The FPA has led the charge in litigating and campaigning for the publication by DHSSPS of guidance on medical practices relating to abortion and the provision of abortion services. Since 2001, the FPA has challenged the DHSSPS through judicial review proceedings to publish official guidance to healthcare professionals on termination of pregnancy in Northern Ireland. Audrey Simpson of the FPA explains the organization’s decision to pursue the DHSSPS for clear guidelines: “We knew we’d built a good strong case. We felt the DHSSPS were failing their statutory duty in not providing guidance to health care professionals on the

⁸⁴ CEDAW Committee General Recommendation 24 on women and health (1999), para. 11

⁸⁵ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, U.N. Doc. A/66/254, para.24

⁸⁶ *Ibid.*, para 65 (m)

⁸⁷ See Sheil LJ’s discussion of the facts of his own decision a decade earlier in *Northern Health and Social Services Board v F and G* [1993] NI 268, at paragraph 10 of *Family Planning Association of Northern Ireland v Minister for Health, Social Services and Public Safety* [2004] NICA 37 (8 October 2004) http://www.courtsni.gov.uk/en-gb/judicial%20decisions/publishedbyyear/documents/2004/2004%20nica%2037/j_j_shef5066.htm

provision of termination of pregnancy services in Northern Ireland. There was guidance on getting your tooth out, toenail sorted out or whatever, but there was no guidance at all in existence on the provision of abortion in Northern Ireland. That's the case that we built up. It took 15 months for the case to be heard, 16 months to get judgment which we spectacularly lost, and then appealed and won.”

The case, *Family Planning Association of Northern Ireland v Minister for Health Social Services and Public Safety*, was eventually won on appeal in 2004.⁸⁸ The Court of Appeal of Northern Ireland held that the Department of Health, Social Services and Public Safety of Northern Ireland failed to perform its statutory duties to provide women seeking to undergo lawful abortion with satisfactory integrated health services. Specifically, the Court found that the Department failed to provide guidelines on local availability of legal abortion services and to investigate whether women were receiving satisfactory abortion-related services. As a result, medical providers were confused on the status of abortion in Northern Ireland and fearful of being held liable for potentially breaking the law, and thus women were being denied access to abortion services to which they are legally entitled. The Court required that the state investigate whether guidelines on the lawfulness of abortion should be issued to mitigate the chilling effect of the criminal law.⁸⁹

In the judgment, Lord Justice Sheil noted: “Considerable assistance could be given to those members of the medical profession, doctors and nurses, who have to decide these difficult cases if clear guidelines were set out in print by [the DHSSPS]. Such guidelines would also remove the concern of members of the medical profession that they might be liable to prosecution in carrying out a particular pregnancy termination as they could refer to such guidelines as part of their defence that they acted in good faith in accordance with those guidelines [...] there is still uncertainty on the part of many, including members of the medical profession and associated services, as to what is the law in Northern Ireland relating to termination of pregnancy. They should not be left in a position where they have in effect to go and read for themselves the various decisions of the courts in Northern Ireland on this subject, some of which are not reported.”⁹⁰

After significant delay, in 2009 the DHSSPS issued a consultation draft guidance document for healthcare providers.⁹¹

WHO RECOMMENDATIONS ON IMPLEMENTING NATIONAL STANDARDS AND GUIDELINES ON SAFE ABORTION CARE

In *Safe abortion: technical and policy guidance for health systems*, the World Health Organization (WHO) presents recommendations for use by health ministries, program managers and providers around the world for providing safe abortion services within existing laws. The updated 2012 Guidance incorporates the evolving human rights rationale for providing safe, comprehensive abortion care, along with current clinical and public health evidence. WHO recommends that national standards and guidelines for safe abortion services be

⁸⁸ Ibid.

⁸⁹ Ibid. paragraphs 27-339, 42, 44, 115.

⁹⁰ Ibid. paragraphs 9 & 10.

⁹¹ DHSSPS, *Guidance on the Termination of Pregnancy: The Law and Clinical Practice in Northern Ireland*, March 2009, Archived at http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/20_03_09_ninursing.pdf

developed. The guidance identifies an end result to which laws and services should be directed: the protection and promotion of the health and human rights of women.⁹²

Planning and managing safe, legal abortion care requires consideration of a number of health system issues, including the development of national standards and guidelines on safe abortion services. WHO recommends the establishment of national standards and guidelines facilitating access to and provision of safe abortion care to the full extent of the law. Standards and guidelines should cover: types of abortion service, where and by whom they can be provided; essential equipment, instruments, medications, supplies and facility capabilities; referral mechanisms; respect for women's informed decision-making, autonomy, confidentiality and privacy, with attention to the special needs of adolescents; special provisions for women who have suffered rape; and conscientious objection by health-care providers. National standards and guidelines for safe abortion care should be evidence based and periodically updated, and should provide the necessary guidance to achieve equitable access to good-quality care. They apply whether services are public, private or not-for-profit. UN human rights bodies have recommended that states implement these WHO guidelines.⁹³

UNCERTAINTY ARISING FROM 2009 AND 2013 DRAFT GUIDANCE DOCUMENTS

The 2009 consultation draft guidance document was withdrawn the following year after a judicial review by the anti-abortion group, Society for the Protection of Unborn Children (SPUC), succeeded on limited grounds, with the High Court judge ordering that the guidance be withdrawn and reconsidered by DHSSPS.⁹⁴ Media reports and anecdotal information from interviewees, however, suggest that Northern Ireland gynaecologists and obstetricians have continued to rely on the draft guidelines despite government officials declaring that it has 'no status'.⁹⁵ In March 2013, the then Health Minister published revised draft guidelines for consultation, which included sections on conscientious objection and the collection of data on abortions.⁹⁶ This draft guidance was criticized by Amnesty International and several other bodies, on a number of fronts, including that it reinforced a climate of fear and threat of prosecution to the medical profession, rather than being an enabling document which effectively clarified the law in Northern Ireland.⁹⁷ His successor as Health Minister has, however, failed to publish the revised guidance in final form and as a result a great deal of

⁹² WHO Safe Abortion Guidance, 2012, pages 63-85; Erdman, J., DePiñeres, T., Kismödi, E. Updated WHO Guidance on Safe Abortion: Health and Human Rights, *International Journal on Gynecology and Obstetrics*, 120 (2013) 200-203.

⁹³ Committee Against Torture, Concluding Observations: Poland, para. 23, UN Doc. CAT/C/POL/CO/5-6 and CEDAW Concluding Observation to Hungary, 2013.

⁹⁴ *Society for the Protection of Unborn Children, Re Judicial Review* [2009] NIQB 92 (30 November 2009) <http://www.bailii.org/nie/cases/NIHC/QB/2009/92.html>

⁹⁵ BBC News, Draft NI abortion guidelines published by minister, 8 March 2013, <http://www.bbc.co.uk/news/health-21712388>

⁹⁶ DHSSPS, The Limited Circumstances for a Lawful Termination of Pregnancy in Northern Ireland: A Guidance Document for Health and Social Care Professionals on Law and Clinical Practice (Draft), April 2013, <http://www.dhsspsni.gov.uk/guidance-limited-circumstances-termination-pregnancy-april-2013.pdf> and Amnesty International UK, Guidance on Termination of Pregnancy in Northern Ireland, Submission to the Northern Ireland Department of Health, Social Services and Public Safety, June 2013, http://www.amnesty.org.uk/sites/default/files/ni_submission_finalsubmittedjuly2013x.pdf.

⁹⁷ DHSSPS, Draft Termination of Pregnancy Guidance, Summary of consultation responses received, October 2013, <http://www.dhsspsni.gov.uk/termination-pregnancy-responses-2013.pdf>

uncertainty still surrounds the issue for healthcare providers working in this area.⁹⁸

Professor Jim Dornan, a retired obstetrician, has gone on the record to state: “the new [2013] guidelines [...] bore no resemblance to the previous guidelines. Two areas [...] were particularly offensive to those of us who have been providing this very sensitive care for over 50 years. Firstly, the assessment of mental health; it was suggested that this should be by a psychiatrist and not by the team of geneticists, paediatricians, obstetricians and midwives. Secondly, they said that any healthcare worker, including non-clinical healthcare workers, if they suspected that something illegal was going on in their unit, they must report it to the PSNI or risk ten years in jail.”⁹⁹ Following the issuing of the new guidelines, Professor Dornan has stated, further emphasizing the very real ‘chilling effect’ of unclear guidelines coupled with criminal regulation, “Some of the trusts went to their legal teams at that stage and were advised to stop giving advice on what to do in these situations.”¹⁰⁰

Breedagh Hughes serves as Director of the Royal College of Midwives (RCM) Northern Ireland, the professional association and trade union representing midwives. Breedagh spoke to Amnesty International both in her capacity as a midwife who used to practice in hospitals where terminations took place and as the leader of a representative organizations for midwives in active practice. She expressed the view that the lack of clear guidelines was inhibiting midwives from doing their work with confidence and was an obstacle to providing women and girls with quality care. Breedagh explained the RCM’s decision to support the FPA’s call for guidelines from the DHSSPS, notwithstanding strong differences in views towards abortion within the RCM’s membership.

“When the FPA brought its judicial review, I consulted with my board here in Northern Ireland and my colleagues elsewhere; we decide to support a campaign for the publication of guidelines. [...] Every step of the way I was conscious that the makeup of the RCM represents society generally from one extreme to the other, from the person who says ‘I don’t give a toss, it’s the woman’s right the choose in every circumstance’, to those who say ‘I don’t believe pregnancy should ever be terminated for any reason’, to people in the middle who have their own little personal sliding scale. But what we were all agreed on were the issues for midwives in the absence of any guidance [...] *If there is no guidance, and there isn’t, midwives’ understanding of the law is such that they may not be able to make any judgments themselves as to whether or not the termination is lawful. If they are involved in the termination of a pregnancy which subsequently turns out to be unlawful they are at risk of prosecution. If they are prosecuted and found guilty they will be referred to the Midwifery Council and are most likely to be dismissed. If on the other hand, they refused to participate*

⁹⁸ Amnesty International has written to the DHSSPS seeking clarification on the Minister of Health’s timeline for publication of the Termination of Pregnancy Guidance (Letter of 28 October 2014). A representative of the Family Policy Unit of the DHSSPS responded in writing on 3 November 2014 stating: “[The Minister] has indicated that he is keen to resolve the matter without undue delay. However, due to the contentious nature of the subject, it is not possible to confirm a date for publication. Once the Minister is content with the draft guidance, he will bring it to the Northern Ireland Executive. Publication would follow Executive consideration and agreement that the guidance should be released.” At the time of this briefing, the guidance remains unpublished. Copies of correspondence can be made available on request.

⁹⁹ BBC. Draft abortion guidelines ‘causing fear among NI health staff’, 18 October 2013, <http://www.bbc.co.uk/news/uk-northern-ireland-24550586>

¹⁰⁰ Ibid.

in the termination whether or not it is lawful, they are likely to be disciplined by their employer for insubordination and failure to provide care to a woman. And if they are disciplined potentially they can be dismissed. If they are dismissed they can automatically be referred to the Nursing and Midwifery Council where they may be struck off for refusing to provide care. So basically they are damned if they do and damned if they don't. There is great inconsistency in Northern Ireland. The practice has changed now [after the 2013 guidelines] and has become much more guarded because everyone's is operating in a climate of fear."[emphasis added]

A POSTCODE LOTTERY?

Audrey Simpson of the FPA, Dawn Purvis of MSI and Breedagh Hughes of the RCM all stated that there are significant divides within Northern Ireland—notably on rural/urban and east/west axes—for women seeking abortions. All three suggested based on their professional experience and anecdotal knowledge over the years, that women and girls seen in some parts of Northern Ireland, were more likely to be able to access abortion permitted under local law than women in other areas. Additionally, all three expressed the view that since the 2009 and 2013 guidance documents, doctors in some NHS trust areas have been less sure about the parameters within which abortion is permissible or have held a conscientious objection to performing one, and have resultantly been unwilling to perform abortions or to signpost women towards accessing abortion services in Great Britain.

Dawn Purvis of MSI said, "We know for example that women from Fermanagh, South Tyrone who would have previously attended their local hospital, but because the doctors there were refusing to carry out terminations, well not refusing, they just wouldn't do them basically. It comes down to individual doctors whether they do it or not. There's no uniform access across hospitals or across the different hospital trusts. Women from Fermanagh were being sent to the Royal Victoria hospital for a test, which is well within the rights of other trusts to do. But that was essentially just shipping out the problem to Belfast knowing that there may be an obstetrician who would perform a termination on that woman."

The barriers or rights infringements arising from the postcode lottery, and the resulting delays—while a woman is first seen by one trust, referred to another, and then sent back to the original trust—can have a seriously damaging impact on the health and life of the pregnant woman, and push women beyond time limits for abortion under the law.

Recent survey research among all NHS gynaecologists practising in Northern Ireland, with a response rate of 88%, found that 57% favoured a liberalization of the law regulating abortion, and 78% were in favour of free abortions for women travelling from Northern Ireland to Britain for abortions.¹⁰¹ These views, while perhaps held privately in many cases, are still inhibited in practice by the threat of criminal sanction and the lack of clear guidelines. Professor Jim Dornan, has made this point unequivocally, stating publicly: "The mood is fear within the health care professionals because of these [2013] guidelines."¹⁰²

¹⁰¹ Colin Francome and Wendy Savage, Attitudes and practice of gynaecologists towards abortion in Northern Ireland, *Journal of Obstetrics and Gynaecology*, 2011, 31(1):50-3.

¹⁰² BBC. Draft abortion guidelines 'causing fear among NI health staff', 18 October 2013,

The Royal College of Obstetricians and Gynaecologists has also noted the lack of professional guidance from the DHSSPS to healthcare providers, and raised concerns about its impact on delays women are subject to when obtaining an abortion, which in turn increase the risk to women and costs associated with the procedure.¹⁰³ A recently formed chapter of Medical Students for Choice at Queen's University Belfast has also raised concerns publicly and with Amnesty International, about the lack of provision of training in Northern Ireland for medical students in abortion procedures.¹⁰⁴

CONCLUSION

**"I felt like a criminal, having to do all the travel in secret. It seems silly but I felt the airport staff would recognize me. I wanted to take my partner, but we couldn't afford it, and our boys needed him here. I didn't want to have to do it alone, I should have been able to come home after it, to my boys."
— A 25 year old student, originally from London, living in County Antrim who had to travel to England for an abortion**

Northern Ireland's antiquated and draconian abortion laws fall significantly short of the standards required by the United Kingdom's international human rights obligations. This report details the many barriers that women and girls living in Northern Ireland face in accessing abortion services. The barriers include, inter alia, severely restrictive laws, which include the threat of criminal sanction for unlawful abortion; limited political will to legislate for change; deep underlying stigma and stereotyping; a lack of comprehensive sexuality education; and the financial costs and additional burdens of travel to another jurisdiction to access abortion services. Healthcare providers and women and girls attending reproductive and sexual health clinics face regular harassment. Medical professionals lack clear guidance on abortion, despite a court judgment ordering the DHSSPS to publish such a document. Despite a significant shift in recent years in public opinion towards removing restrictions on access to abortion and to bring the law in Northern Ireland into line with other parts of the United Kingdom, and efforts by the DOJ to embark on legislative consultation towards decriminalization of abortion in specific circumstances of fatal foetal impairment and sexual crime, much work remains to be done. Northern Ireland's devolved authorities need to redress historical inequality, discrimination, limited choices and restricted freedoms for the region's women and girls. In failing to live up to its international human rights obligations, the United Kingdom government is also responsible for the human rights violations experienced by women and girls living in Northern Ireland who seek abortion services. The following recommendations outline what the devolved authorities in Northern Ireland and the government of the United Kingdom must do to ensure a society that respects and upholds sexual and reproductive rights, instead of restricting and repressing them.

<http://www.bbc.co.uk/news/uk-northern-ireland-24550586>

¹⁰³ Royal College of Obstetricians and Gynaecologists, Q&A: Extending the Abortion Act to Northern Ireland, July 2008, <https://www.rcog.org.uk/en/news/campaigns-and-opinions/human-fertilisation-and-embryology-bill/qa-extending-the-abortion-act-to-northern-ireland/>

¹⁰⁴ Jason Ashford, "Medical Students for Choice hold panel discussion in Belfast – 'It's not about being pro abortion'," Off the Record NI, 4 December 2014, <http://offtherecordni.com/2014/12/its-not-about-being-pro-abortion-medical-students-for-choice-hold-panel-discussion-in-belfast/>

RECOMMENDATIONS

Amnesty International recommends to the following authorities:

To the Northern Ireland Assembly and Executive

- Place a gender perspective at the centre of all legislation, policies and programmes affecting women's health and involve women in the planning, implementation and monitoring of such legislation, policies and programmes and in the provision of women's health services.
- Instigate legislative reform, in coordination with the Department of Justice, to remove criminal sanctions imposed on women who undergo abortion and healthcare professionals providing termination advice and services.
- Ensure access to lawful abortion in line with international human rights standards.

To the Department of Health, Social Services and Public Safety:

- Publish, without further delay, human rights compliant Termination of Pregnancy Guidance which uses language that is in line with international human rights standards and best practices for the provision of reproductive and sexual health care. The guidance should enable clinical decision-making providing women with the quality care they choose, in particular with regard to access to lawful abortion and other relevant pregnancy and abortion related care.
- Ensure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health.
- Ensure that all health services are consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice;
- Prioritize the prevention of unwanted pregnancy through access to modern contraception and sexuality education.
- Make available and accessible the full range of quality modern contraceptive methods, including those listed in national formularies and on the World Health Organization's Model List of Essential Medicines;¹⁰⁵
- Ensure that emergency contraceptives are available to all women, especially women and girls who have been raped;¹⁰⁶

¹⁰⁵ Committee on Economic, Social and Cultural Rights, *General Comment 14: the right to the highest attainable standard of health*, Article 12, paras 11, 12, and 21 (2000).

¹⁰⁶ CEDAW Committee, Concluding Observations to Mexico, para. 33, (2006); Committee on Economic,

- Take steps to ensure wide dissemination of information about the multiple referral pathways by which victims of rape and sexual violence can access the Rowan Sexual Assault Referral Centre.

To the Department of Justice :

- Legislate to make abortion services available where pregnancy is result of a 'sexual crime'. This service should be offered to any woman presenting herself to medical staff requesting a termination of pregnancy on these grounds, without being compelled to undergo unnecessary administrative or judicial procedures, such as pressing charges against the perpetrator or identifying the rapist.
- Ensure that the conscientious objection does not inhibit women's access to timely and appropriate quality care, including ensuring that it would not apply in cases where there is a risk to the woman's life or an immediate risk to her health;
- Ensure that a woman's right to life, health and dignity always takes precedence over the right of a healthcare provider to exercise conscientious objection to participation in an abortion procedure;
- Restrict the right to conscientious objection strictly only to the abortion procedure itself – not pre- and post-abortion care.

To the Department of Justice and the Police Service of Northern Ireland:

- Ensure adequate protection to staff and volunteers associated with reproductive and sexual health care and advice clinics, and to people accessing such clinics to avail of lawful health services;
- Issue consistent instructions to all police officers on the handling of complaints of harassment by protestors outside reproductive and sexual health care and advice clinics.

To the Department of Education:

- Ensure age-appropriate comprehensive sexuality education is provided throughout schooling. Ensure the curriculum is evidence-based and non-discriminatory and promotes gender equality.

To the Secretary of State for Northern Ireland:

- Ensure that all aspects of healthcare and criminal law in relation to the provision of information about and access to abortion services in Northern Ireland– including those devolved to regional authorities – are brought into compliance with the United Kingdom's human rights obligations.

Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health*, (2000) .



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