



Northern Ireland
Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Severe Fetal Impairment Abortion
(Amendment) Bill: Amnesty International;
Informing Choices NI

3 June 2021

NORTHERN IRELAND ASSEMBLY

Committee for Health

Severe Fetal Impairment Abortion (Amendment) Bill: Amnesty International;
Informing Choices NI

3 June 2021

Members present for all or part of the proceedings:

Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Paula Bradshaw
Mr Jonathan Buckley
Mr Gerry Carroll
Mr Alan Chambers
Ms Órlaithí Flynn
Ms Cara Hunter
Ms Carál Ní Chuilín

Witnesses:

Ms Gráinne Teggart Amnesty International UK
Mr Ruairi Rowan Informing Choices NI

The Chairperson (Mr Gildernew): I welcome to the Committee Ms Gráinne Teggart, who is a campaigner with Amnesty International. Good afternoon, Gráinne. Can you hear me OK?

Ms Gráinne Teggart (Amnesty International UK): I can indeed. Thank you, Chair.

The Chairperson (Mr Gildernew): Thank you, Gráinne. We are also joined by Mr Ruairi Rowan, director of advocacy and policy with Informing Choices NI (ICNI). Can you hear us OK, Ruairi?

Mr Ruairi Rowan (Informing Choices NI): I can, Chair. Thank you.

The Chairperson (Mr Gildernew): Tá fáilte romhaibh beirt. You are both very welcome to the Committee. Please brief the Committee, and we will then go to questions and answers. Who will lead on the briefing?

Ms Teggart: Thank you, Chair. I will begin. Thank you for the opportunity to present our evidence on the private Member's Bill. Our comments will be brief. You have our evidence, and, obviously, we wish to explore in detail with you the issues that the Bill presents, and the best way to do that is through questions. I will begin by saying a few words, and I will then hand over to my colleague Ruairi to make some reflections from the Informing Choices perspective as the central access point for early medical abortions. The legislation passed at Westminster and subsequent regulations incorporate into law the findings of an inquiry undertaken by the Committee on the Elimination of Discrimination Against Women (CEDAW) into access to abortion in Northern Ireland. That inquiry found that women and girls

here were being subjected to grave and systematic violations of rights. It concluded that restrictions affecting only women from exercising reproductive choice, resulting in their being forced to carry to term almost every pregnancy, resulted in mental and physical suffering that constituted violence against women. The report made 13 recommendations, including the provision of abortion in cases where there was a severe fetal impairment. Human rights standards are resolute that women's ability to exercise reproductive autonomy, control their reproductive lives, and decide if, when and how to have children is essential to the full realisation of rights.

I will get straight to the issue that the Bill addresses. In some cases, women and girls may decide to terminate their pregnancies following a diagnosis of fetal impairment. Human rights standards are unequivocal that that must be provided for. It is important to note that UN treaty bodies have not limited their calls for access to abortion to cases in which fetal impairments such as stillbirth or death immediately after birth is a virtual certainty — what we call fatal fetal impairments.

As with all abortions, a woman's decision may be based on myriad factors, including their own physical and mental health and well-being, the fetus's chance of survival, and the options to treat and care for a child born with the anticipated health conditions. The decision to continue a pregnancy following a diagnosis of fetal impairment must lie solely with the woman, and the woman's right to health must always be at the centre of, and inform, medical decisions on terminating a pregnancy.

Treaty bodies have consistently found that denying access to abortion, including in cases of severe fetal impairment, not only undermines reproductive autonomy but violates rights to privacy and equality alongside rights to life, health and freedom from torture or ill treatment. The Convention on the Rights of Persons with Disabilities (CRPD), and, indeed, all human rights bodies, have been very clear that abortion should be available in cases where there are fetal impairments. I refer members to the joint CEDAW/CRPD statement in 2018 that:

"access to safe and legal abortion, as well as related services and information are essential aspects of women's reproductive health. Access to such services is a prerequisite for safeguarding women's human rights to life, health, equality before the law and equal protection of the law, non-discrimination, information, privacy, bodily integrity and freedom from torture and ill treatment".

In considering the impact that a proposed law such as this would have, it is important that we have conversations based on the reality of how and when women access abortions. We do not have a comprehensive picture here yet, but 91% of all abortions in England and Wales in 2019 occurred within the first 12 weeks of pregnancy, whereas abortions performed after 24 weeks accounted for 0.1% of the total figure. While that number is very small, all cases would have involved complex clinical and personal decision-making.

Any moves to deny abortions here on grounds of severe impairment would not only not be human rights-compliant or compatible with the legal obligations mandated by Parliament but would not stop them from happening. It would, however, roll back our rights and bring us back to a position where women and their families, already facing trauma and distress, are forced to travel to access essential health care, which should be available locally.

Further, at a practical level, it is often not possible to distinguish between a severe fetal impairment and one that could prove fatal. We draw members' attention to the reference in our evidence to a recent study in the South of Ireland that looked at coronial inquests into stillbirths and neonatal deaths. It concluded that:

"less than half of the congenital anomalies could be classified as an FFA; however, all were fatal".

The legislation in the South, following repeal of the eighth amendment, only provides for fatal fetal impairments, and we can see the harm that that creates. As a consequence of that law, doctors fear getting a fatal diagnosis wrong. Ultimately, it also forces women to travel, including women with conditions that are not quite fatal enough but which may well prove to be fatal. What we have at the minute is a law that enables our clinicians to do their jobs free from the chill factor experienced under the old regime. It treats each individual pregnancy as just that: individual. It gives clinicians and the woman concerned the space in law to make very individual diagnoses and decisions. Every pregnancy is different, every diagnosis is different, and every woman's circumstance is different. There is a range of issues that will have to be considered by each woman and by each clinician. We trust our clinicians to do their jobs, and we trust each individual woman to make the decision that is right for her. It is not for any of us to prescribe an outcome based on misinformation. It is of concern, therefore, that a rollback of rights is being proposed, at a time when the priority should be — this is certainly the

priority that we are working on — the implementation of our existing law and the accompanying regulations through the commissioning of services.

Members will be aware that the UK Parliament recently gave the Secretary of State the powers to direct commissioning here. What we have at the moment is what Amnesty has termed "a postcode lottery" for access to abortion provision. That denial of healthcare is unacceptable and must be swiftly brought to an end, and we are actively working on that. I will pause there and hand over to my colleague Ruairi. Thank you.

Mr Rowan: As Gráinne said in her opening remarks, Informing Choices provides the central access point to early medical abortion services in Northern Ireland. That enables people to contact someone, via a single telephone number, from whom they can receive non-directive information. Pregnancy choices counselling is available if requested, and a referral can be made to a local health trust. Access to post-pregnancy counselling is also available through ICNI services.

What we have seen in the past 14 months since the regulations were introduced is that it has been left to individual trusts and ICNI to absorb the needs of women. For that reason, and because there has been a failure to commission services, we have seen the services that currently exist struggle to cope. In the past six months, we have seen the suspension of three early medical abortion services in our trusts. Currently, the Western Trust has no service available. From the information given by the women whom we have spoken to directly, we know that that has impacted almost 150 women, who have been unable to access local care, to which they are legally entitled under the law. I am happy to provide more information on that in answer to your questions.

Last week, the Human Rights Commission took a legal challenge on the failure to commission services. Both Amnesty International and Informing Choices jointly intervened in that case to highlight the fact that services in Northern Ireland are not only limited but highly precarious, given the suspension of services during the past year. Informing Choices has made repeated attempts, as well as joint attempts with Amnesty International, to engage the Health Minister on the central access point. To date, we have received no response from the Minister, although when he was asked in the Northern Ireland Assembly how women should access the service, he directed people to Informing Choices. The Minister has not, however, engaged with the charity directly.

We have had conversations with the Northern Ireland Office over the past year to update it on what local service provision exists. As Gráinne said in her opening remarks, the Secretary of State has now taken the power to direct local bodies and office holders to commission abortion services, and they have put it on record that they intend to make such a direction if concrete action is not taken before the summer months. That direction has not taken place yet, but we will wait to see what happens in the coming weeks.

Since we launched our service in April 2020, almost 2,500 women have self-referred to it. As Gráinne said, each will have her personal reasons for doing so. That is how many we have supported, and I am happy to expand on that. I am keen, as is Gráinne, to hear the Committee's questions on the matter, so, at this stage, I will pass over to you.

The Chairperson (Mr Gildernew): Thank you both. We appreciate your input in the form of your oral evidence and the presentation that you sent to us. My first question is to you, Gráinne. You identified, and we discussed earlier, the concerns about screening and the potential inequalities. Do we have sufficient screening at present? In relation to reproductive rights, what needs to change in the provision of screening services?

Ms Teggart: Chair, we are not a service provider, so we are not in a position to speak comprehensively to the specific points about screening. From the work that I do and the experience that I have in speaking to women who have tried to access services, I can say that we do not have screening or adequate service provision in place. We have a number of barriers, which means that the service that you receive depends on where you live in Northern Ireland. As Ruairi rightly said, the Western Trust area is where those who need access to early medical abortions will experience difficulties. As a service provider, Ruairi is probably better able to pick up on the point about screening.

The Chairperson (Mr Gildernew): Go ahead, Ruairi.

Mr Rowan: I am sure that the healthcare bodies from which you will hear will speak more extensively on this matter. A diagnosis of fetal anomaly will often be made at around the 20-week scan. That

diagnosis might not be conclusive, and future tests might be needed. That is one of the reasons why we oppose the Bill: it puts a time pressure on women who are faced with a very difficult diagnosis in what might be a planned and very much wanted pregnancy. Our experience of providing a counselling service is that people feel under time pressure to make a decision. They need to be given the space and time to have all the information so that they can make an informed choice. That is why limiting access post-24 weeks, for that very small number of cases, will have a devastating impact on those women. We come up against the general issue of time pressures currently, because our law provides for abortion on request until the 12th week of pregnancy, but, in practice, we only have abortion in place until the 10th week. That time constraint puts pressure on women to make a decision before they may have the full information and are ready to do so. We need to allow people to have the space to get all the information and testing that they need and to make that decision for themselves.

The Chairperson (Mr Gildernew): Thank you. Will you elaborate on the situation in the Western Trust? The Committee wrote to the Western Trust about the matter and wrote again following the response that we received, which, we thought, was not really sufficient. What is the impact when services do not exist or are withdrawn?

Mr Rowan: As I said, in the past number of months we have seen three trusts suspend services. The first was the Northern Trust, which suspended its services at the beginning of October last year and did not resume them until the beginning of January. There was also a short suspension in the South Eastern Trust between the beginning of January and the start of February. The Western Trust's service remains suspended. ICNI has been unable to refer into that service since 23 April, and the service remains suspended to date.

The impact on women is that, because all trusts lack resources at present due to the failure to commission services, there is no provision for a woman to access an early medical abortion in another trust area in Northern Ireland. When services are suspended, as they were previously in the Northern and South Eastern Trusts and are currently in the Western Trust, there are three options available to women if they have decided to end a pregnancy. One is to travel to Great Britain through the UK's government-funded process; the second is to travel to the South of Ireland and pay privately, which costs in the region of €450; and the third is to access the medication from an online telemedicine provider. That has been the situation to date.

Regarding the number of women impacted by that, as I said in my opening remarks, we have spoken to almost 150 people across those three trusts who requested access to abortion during the suspensions, and there was no local service that we were able to refer into. That number will continue to rise as a result of the suspension in the Western Trust.

Conversations that I have had directly with women who are in that situation show that many of them, when informed of the options, view the idea of travel, particularly during COVID, as neither practical nor feasible. The dates that were provided for the suspension of services in the South Eastern Trust date back to before Christmas, when we moved into a new period of lockdown. Moreover, when travel was discussed, to be frank, many women referred to that option as "scary". They did not wish to do it, and therefore the vast majority of people, when given the options that are now available if services are not available locally, will opt to access the medication online. That is not necessarily their preferred option, but they feel as though they have been left with no choice.

It is distressing for women when they hear information that a service is not available, because, for many of them, the first time that they will know of that information is when they speak with Informing Choices. It is upsetting to be told that, and women will often ask why, if the law has changed, services are not in place. That is the situation in the Western Trust with the suspension of the service. For the past year, the service was being sustained by a single doctor, who was working without any support, and it got to the stage at which doing that was no longer sustainable. The current situation in the Western Trust is that it is seeking to recruit additional doctors, nurses and clerical staff. I have received no information to say that the service will resume in the coming days. I am in contact with the Western Trust, but I foresee that suspension continuing for a number of weeks. If the situation changes, I will alert the Committee as soon as possible. That is the situation on the ground currently, however.

Ms Teggart: To build on and add to what Ruairi has said, that highlights the very negative position that our trusts are being left in by the lack of commissioning and the lack of action taken by the Health Minister, and it will be the position until such times as the Secretary of State exercises the powers that he now has. The reality is that those services are lawful, so people cannot lawfully be refused them,

but our trusts are not being given the resource through a commissioning process to provide the services that legally they are required to provide. It is a very precarious position that our trusts find themselves in, and that is why Amnesty and Informing Choices have been pressing the Department of Health and the NIO very hard to remedy the situation very quickly. It should not have been left to a third-sector organisation, through ICNI, working with the trusts to try very quickly in a pandemic to create some form of pathway to lawful healthcare.

As soon as the pandemic hit, we realised the impact that it would have on women, given that travel was not going to be a safe or viable option for the majority of them. Indeed, government's own advice was not to travel but to stay at home. There was therefore a direct contradiction there. Given the position that we see in the Western Trust currently and the position that we have seen in the other two trusts that Ruairi referred to, the situation will continue until such times as we get the services properly commissioned and properly resourced.

The Chairperson (Mr Gildernew): Thank you. Finally, that leads me on to post-pregnancy counselling, which was mentioned. What are the other services that need to be put in place here to provide pathways for other supports and other services that need to be addressed?

Mr Rowan: As I touched on, ICNI provides pregnancy choices counselling, so if a woman is undecided about what option to take, be it continuing with the pregnancy, adoption or abortion, and wishes to consider those options further, counselling support is available. We also provide post-pregnancy counselling, which deals with pregnancy loss, and that can cover abortion, stillbirth or miscarriage. It also deals with a traumatic birth, postnatal depression and postnatal anxiety, so any previous pregnancy experience, including the current pregnancy about which a woman may be contacting us.

We receive some funding from the Department of Health to provide counselling provision, but it is nowhere near enough to cope with the level of demand that we are experiencing, particularly following our taking on of the central access point. To update the Committee on that, the central access point launched in April 2020. After its launch, our requests for post-pregnancy counselling increased by 85%, and we are delivering at least 20 counselling sessions a week. In order to be able to provide that level of support, we have had to seek an additional grant — a community grant — ourselves. That is a short-term solution to allow us to provide additional counselling support, and that funding will run out in a number of months. That is how we have sustained the service to date. Even with the additional funding that we sought, we still have an increasing waiting list for post-pregnancy counselling. Previously, we would not have operated with any waiting list, but, after taking on the central access point, we have a waiting list in excess of 20 people. The waiting time can be between two and three months for a post-pregnancy session. We will always provide a pregnancy choices counselling session within a number of days, because that is a time-sensitive issue. Demand for post-pregnancy counselling has increased, however, and we do not have the level of funding necessary to sustain that support. Through either a commissioned service or even with short-term funding from the Department of Health, we need additional counselling support, because we are operating with one counsellor at the minute.

We have moved to telephone counselling, which has been beneficial, because it means that there is access for everyone across Northern Ireland. People find that to be a convenient form of counselling. We have benefited from the fact that our counselling services coordinator developed the Lifeline service and managed it for 10 years and so has vast experience of delivering telephone counselling and speaking on the telephone to people in crisis. As I said, however, we have one counsellor and growing waiting lists for that counselling support, so further funding will be needed to meet that demand. That is something that we highlighted to the Minister as far back as last summer.

Ms Teggart: We need better support services in place for women who chose to continue with a pregnancy for which there has been a severe or fatal impairment diagnosis. I worked with a woman who delivered a fetus that unfortunately died in utero, and she was referred to the Sands service. That is a fantastic service that does fantastic work, and those referred to it get some benefit from it, but it is not the same specialism as that required for someone who had a wanted pregnancy and faced a very specific set of circumstances. We therefore need something that is much more tailored to, and equipped to deal with, women who are in those very complex and difficult circumstances.

Ms Bradshaw: Thank you, panel, for your contribution today. I place on record my thanks to you both, particularly Informing Choices NI, for picking up from where others have failed over the past year. I

spoke about the Health Minister referring people to you despite knowing that you were not being properly funded and thought that his doing that was in rather bad taste.

You mentioned the post-pregnancy counselling that you provide. To what degree would the women who access it feel less sense of stigma and taboo about having access to a termination if abortion services were properly commissioned here?

Mr Rowan: The post-pregnancy counselling has raised a number of issues, Paula. I highlighted the benefits of telephone counselling, and one thing that was raised when we were working in the office and people were accessing face-to-face counselling was that our office was being picketed daily by people who are opposed to abortion. Women were having to walk through that picket to access counselling support, which may not have been about abortion, because, as I said, our post-pregnancy counselling relates to all pregnancy experiences. We know the difficulties that women faced when accessing the service, because they had to walk through protesters. That is one barrier that exists, and it exists for women who are accessing abortion services in general, because premises are picketed throughout the trust areas. That is one thing. Telephone counselling is one way around that, but there will be people who wish to access face-to-face support. We will therefore need to see movement on safe access zones to remove that stigma so that women who wish to access counselling support can access it without the fear of being re-traumatised, or of being stigmatised as a result of walking through a line of picketers while on their way to receive counselling support.

In general, the counselling services brought up the fact that, over the past year, one in 30 people who has been referred to an early medical abortion service may come back for post-pregnancy counselling. The reason for that is that a pregnancy brings to the fore other stresses in people's lives. In the past year of providing post-pregnancy counselling, we have noticed that one third of clients mentioned previous sexual assaults, and counselling for that takes long-term support over a number of sessions. We will never put a limit on the number of counselling sessions. The counselling is free to access so that women are given the space to avail themselves of the service for as long as they need it. Another reason that people may access support is that any pregnancy experience may bring up previous childhood events and relationships with their parents. Again, that is dealt with through the counselling service.

That is what we are currently experiencing, Paula. As I mentioned, demand has been increasing, and we have had to seek additional funding. Unfortunately, because the services have not been properly commissioned, we have not been able to bring in more counsellors to provide the level of support that is needed.

Ms Teggart: I will add to that point about stigma. A commissioned service will, of course, address stigma. The law changing was just the first step. A commissioned service will embed and normalise that type of healthcare in our health system. It is essential that that happen. The decision to terminate a pregnancy is just one experience that a woman will have in her reproductive lifetime. The sooner that we get to a place where that healthcare is embedded in our healthcare service and the NHS, the better, as that will send a message to society that it is a perfectly normal healthcare service for women to avail themselves of. As I said, the change to the law was the first step, but a commissioned and resourced service is essential in order to combat the stigma that has prevailed here for too long. That is particularly the case because we have just moved from a place where we had a virtual, near-total ban on abortion and all the resulting stigma around that issue for clinicians and for women who need access to the services.

Ms Bradshaw: Thank you, Gráinne. My second question relates to what you state in your paper about the commissioning of abortion services requiring "unbiased information and non-directive counselling". In the Second Stage debate on the Severe Fetal Impairment Abortion (Amendment) Bill, there were some accusations made that some healthcare professionals had almost been promoting abortion to women who had a diagnosis of severe fetal impairment and that a lot of women felt under pressure. I know that a lot of clinicians were deeply hurt when they heard that. What can we do to ensure that those sorts of accusations cannot arise again and that there are proper frameworks and guidance in place?

Mr Rowan: Will I begin, Gráinne?

Ms Teggart: Yes. Go ahead. That is fine.

Mr Rowan: Before the law changed, that certainly would not have been our experience about the information provided. Very often, our experience was that, because of the chill factor caused by criminalisation in law, healthcare professionals felt that they could not provide any information to women about abortion. When people came to access our counselling services, that had often been their experience as well. Our previous experience with healthcare professionals was therefore the exact opposite: that, because they were working in an environment in which a healthcare issue was criminalised, they sometimes felt that they could not give the information that was required.

Going forward with support, when I speak to women about pregnancy, I will always begin my conversation by saying that there are three options available to them: continuing with the pregnancy, adoption or abortion. I will always do that, because ICNI never wants to make assumptions about either a woman's personal circumstances or her current thinking. Over 10% of the people who come though the central access point in the first year will not be referred on to a local healthcare trust. People may initially come on to seek information, because the information about from where people can access services is not publicly available. They may initially come on to find out that information and then wish to take that information back and speak to a family member or a friend. They may then call back in several days, or they may not. They may decide to continue with the pregnancy. That non-directive information will always be at the forefront of our services. We have no investment in the decision-making process: that is entirely up to the woman.

Ms Bradshaw: Thank you. A final point, which you raised, Ruairi, is about access to information on the trusts' websites. I know that some put it up, but others do not. I think that it is deeply disappointing that not all trusts put that information up there, but that is for another day. Thank you.

Mr Buckley: Thank you, panel. I have listened, and I have heard much about being a champion of rights but little to no mention of being a champion of the rights of the unborn child. I have heard a lot about the requirements in CEDAW. It is worth remembering that the preamble to the UN Convention on the Rights of the Child (UNCRC) states:

"the child ... needs special safeguards and care, including appropriate legal protection, before as well as after birth".

When we look specifically at Northern Ireland, we see that the law recognises the specific offence of child destruction at the point of viability in section 25 of the Criminal Justice Act (Northern Ireland) 1945. We contest the ruling that an unborn child has no right to life. Our Deputy Chair asked this question in our previous session, so I now ask the panel: how does the view that the unborn child does not have any right to life under human rights law contrast with the equivalent protections under the Criminal Justice Act?

Ms Teggart: Thank you for that question. You are absolutely right to point to the preamble to the UNCRC. What has been neglected there, however, is the fact that the Committee on the Rights of the Child (CRC), like many other treaty bodies that work on the issue, has expressed concerns about lack of access to abortion services and has said that children — girls as well as women — must have full access to those services. During the negotiations when the law was being changed, Amnesty flagged the 1945 Act. Human rights law, and the law that we now have through CEDAW and the UN treaty bodies, is consistently clear that the right to life and all human rights do not extend prenatally. They apply from birth. If we look at, for example, the Universal Declaration of Human Rights (UDHR), from which all our human rights instruments are born, we will see the line:

"All human beings are born free and equal".

When attempts are made to introduce notions of fetal personhood, they invariably lead to the rights of women being denied and restricted. Our treaty bodies have been very clear that that cannot happen. We now have laws that protect, promote and respect the right of women to make what are very private and personal decisions.

Mr Buckley: Your language of "protect", "promote" and "defend" around those rights is, to me, discriminatory, in that I recognise and support the right to life of the unborn child. I say this to you: are we not sending mixed messages about the legal protections that we offer the most vulnerable in society?

Ms Teggart: No, I do not think that we are. I appreciate your position and that you are entitled to hold those views. What we have to refer to — what we as Amnesty work to — is the international human

rights instruments and what they state that access should be. At no point have any rights extended prenatally. They all apply from birth. The 1945 Act is obviously a very outdated piece of legislation, and we could talk about how that may need to be addressed as well. There is no conflict, however, between that and our most recent law, which changes legislation on abortion to provide for abortion in the circumstances that members are familiar with, including the severe impairment with which the Bill deals.

Mr Buckley: Do you support the principle of disability discrimination legislation?

Ms Teggart: Of course.

Mr Buckley: On that basis, why do you not support the principles contained in the Bill?

Ms Teggart: I work to the international human rights framework and what it says access should be. When you begin, as I said, to introduce notions of fetal personhood, you eliminate, erode and remove the rights of women. Human rights bodies are clear that we cannot allow that to happen, because, of course, that would not respect the rights of women.

Mr Buckley: On that basis, you are suggesting that those unborn children should have no right to be protected from being discriminated against on the basis of disability and have no right to life. I fail to see how that is consistent with what you outlined in your presentation, which is that you are a champion of rights. How are those two points not in conflict with each another?

Ms Teggart: I appreciate your view that you may wish to extend rights prenatally. That is not the position of Amnesty. Our position is that rights apply from birth. I have been clear and unequivocal about that. From our evidence and our submission, you will see that we are, of course, concerned about disability discrimination in our society. We have outlined clearly steps that our Governments can and should take to address that. The answer, however, is never to remove choice in what are very specific circumstances. As I have mentioned, every pregnancy and every diagnosis is different. We need to create a space in law for women to make those decisions, and that is what we have done.

Mr Buckley: I respect the fact that we can have this discussion in a respectful forum in a Committee meeting, but I believe, and it is the position of my party and that of many people in my community who have lobbied me heavily on the issue, that it is completely wrong to say that the issue of discriminatory provisions permitting abortions in cases of severe disability can be resolved by full decriminalisation of abortion. What is your view on that?

Ms Teggart: Decriminalisation was necessary, because we do not criminalise healthcare. We had a situation in which our healthcare professionals were operating in a climate of fear, under the threat of criminal sanction and prosecution, and women were faced with the prospect of life imprisonment. By not decriminalising that healthcare, we would therefore have created a situation in which the chill factor that was experienced by healthcare's being criminalised would have continued. We are the first part of the UK and Ireland that has had that healthcare decriminalised. That was absolutely the right approach to take. Human rights bodies have called for that. What we now have is legislation that does not discriminate. What it does is chime with human rights instruments that state that, where there are cases of severe — not just fatal — impairment, we need to provide access to those services. The ways in which you get to that point can vary, but what has to be at the centre of all of it is the woman's right to health.

Mr Buckley: You may have listened in to the previous presentation and the debate on conscientious objection. I am keen to hear your opinion on the Human Rights Commission's desire to see the definition of "conscientious objection" defined. Do you, as an organisation and, indeed, personally, recognise that the risk of restricting the exemption to direct abortion services only rather than to auxiliary functions may unduly infringe on freedom of conscience and, indeed, freedom of religion and thus impact on members of the health service and place them in an extremely difficult position, given their own viewpoints?

Ms Teggart: I have not watched the previous session. I therefore cannot comment on what the Human Rights Commission said until I see and consider it myself. What I can say on conscientious objection, however, is that it is right that that attach only to the procedure itself. Not only is that the view of Amnesty, but it has already been tested in the courts. I am not sure whether you were referred to what is commonly known as the "Glasgow midwives' case", in which the Supreme Court was very

clear that conscientious objection should be attached to the procedure itself, not to the administrative end of the procedure, such as booking appointments, or to managerial aspects, such as the management of wards.

We absolutely recognise that there are people who will want to object for reasons of conscience to taking part in a procedure. They should absolutely be protected in doing that, and they are protected. What we have here on conscientious objection is in line with what exists in the rest of the UK.

Mr Buckley: You may have listened to —.

The Chairperson (Mr Gildernew): Jonathan, before you go any further, I want to bring matters back to the submission on the Bill, rather than the earlier session with the Human Rights Commission, because we have other members waiting to come in. Have you a final question on the Bill?

Mr Buckley: If other members are waiting, I am happy to allow them to come in now, Chair. Thank you.

Mr Carroll: Gráinne and Ruairi, thanks for your presentation. I echo Paula's comments about your work. I put on record once again my total opposition to people picketing or protesting at services and centres that provide access to terminations or advice on how people can access them.

I find it quite hypocritical and ironic that parties that were integral to implementing the vicious welfare programme that targeted people with disabilities have the gall to talk about standing up for people with disabilities, but I will perhaps leave that for another day.

If the Bill passes, it aims to criminalise abortion in cases of fetal impairment. Perhaps Gráinne can answer this question. What other countries globally have such policies and practices in place? We are often told that we live in a modern, forward-looking and brilliant country, but this form of legislation smacks of something that is reminiscent of or in line with that in countries that are not compliant with or respecting of human rights and that are instead quite repressive and regressive. I appreciate that it may be a question for Amnesty International beyond the North, but any indication of where the legislation would fit in globally would be helpful.

Ms Teggart: Previously, our law was among the most restrictive globally. It carried the harshest criminal penalties in the whole of Europe. Different countries, particularly European countries, provide abortion, such as that which we have now provided for here, in cases of serious impairment and fatal impairment and without gestational limits. We now have much stronger and robust legislation, in line with many other European countries. There is always the exception to that, and countries such as Poland and others are rolling back rights, making abortion more restrictive and having near-total or total bans, which is the experience that we have just come from. We are now much more in keeping not only with European countries but with global efforts to realise women's full reproductive rights. We are in a much stronger position than we were when we had among the most restrictive laws globally.

Mr Carroll: Thanks for that, Gráinne. Is there any evidence or anecdotal indication that putting a 24-week limit in place may force women to proceed with terminations when they otherwise may not have wanted to? If that time limit is in place, they may not be aware of the severity or detail of the diagnosis or of the support mechanisms that are in place should they decide that they want to continue with their pregnancy. Its sponsor is presenting the Bill as a way of reducing or stopping terminations. Is there any indication that installing that time limit may lead to an increase in them?

Ms Teggart: That goes back to the points that I made in my opening comments, to some of what Ruairi said and to our written evidence. We have to look to England and Wales as the nearest comparator, because we do not have the complete picture for here yet, but abortions beyond 24 weeks there account for 0.1% of all abortions. A very small number of abortions happen beyond 24 weeks.

Nonetheless, the reason that we need access beyond 24 weeks is that those cases will be very complex. They will involve a lot of complex clinical decision-making as well as personal decision-making. As Ruairi mentioned, the way in which it works here is that, with the available scans, it is usually at the 20-week scan that some diagnosis will be made, based on what our clinicians can see. It is often the case that further diagnostic tests will be needed, however, and we need to allow the time for those to happen. It is only once those diagnostic tests have taken place, when women and clinicians have a full picture of the diagnosis, that a woman can ultimately decide what is best for her

in those circumstances. If we restrict that to 24 weeks, we will effectively force women to make those decisions a lot quicker, when they might otherwise want to wait for the results of those further diagnostic tests and also get a better understanding of the support services that are available in the community, such as the healthcare that would be available to treat the fetus if carried to term and delivered. All those complex issues have to be considered. That is why we, our human rights standards and our legislation all push so strongly for there not to be a 24-week limit in cases of severe or fatal impairment. I am not sure whether Ruairi wants to add something.

Mr Rowan: I want to just comment briefly on the broader point around decriminalisation and why it was so vital. I touched earlier on the impact that the suspension of early medical abortion services is having. If abortion had not been decriminalised, think of the situation that people who live in the Western Trust area would face. People have previously faced that in the Northern Trust and South Eastern Trust areas. They have said, as I highlighted, that travel has been impractical. Sometimes, during COVID, travel would have been near impossible, so their only option, because a service has not been available locally, has been to access the medication online. They would be criminalised for doing so if that law was still in place, yet provision should be available in Northern Ireland.

That was always something that we came up with in our counselling service, because, in a position where abortion was criminalised, section 5 of the Criminal Law Act (Northern Ireland) 1967 meant that if you were aware of a crime that had a penalty of over five years' imprisonment, there was a duty to report that to the police. If a woman had taken abortion pills and wished to discuss that confidentially with a counsellor, there could be an obligation to report that woman to the police. We felt that, while the availability of abortion pills online was often discussed during pregnancy choices counselling, until the decriminalisation of abortion, it was rarely, if ever, discussed in post-abortion counselling, and that was because women felt silenced and felt that they could not access support. That is why it was so vital and why it was needed. If it was not in place, how would people currently access services? They would have to do so outside of the law.

Ms Teggart: Also, in a situation where healthcare is criminalised, our clinicians are compromised between a position of wanting to do what is best by their patient while looking over their shoulder and being conscious of the risk of prosecution, and that will have affected the information that they give. We needed to have this healthcare decriminalised so that there is space for our clinicians to freely do their jobs. That is the bottom line.

Mr Carroll: Thanks for that. I have a quick final point. The lack of guidance poses a further problem for medical practitioners. If the Bill is passed, what impact will it have on people with disabilities who have abortions? They face greater barriers in society generally, but also in getting access to health services. Gráinne said that it is not an either/or; people should have a right to termination but also a right to proper support services based on what they decide. If the Bill is enacted, what impact will it have on pregnant women who are disabled?

Mr Rowan: You alluded to it in your previous question, Gerry. It would lead to rushed decision-making and people being forced to make a quick decision without the full information and, potentially, without further tests being done. You said that the Bill could actually increase the number of abortions taking place at 23 weeks. That could be an unintended consequence of the Bill, and you will have people forced into making that decision when they may not be ready to. They may end up regretting that decision if they do not have the full information, and, even if they have, it will constantly be in the back of their mind — "What if I was able to receive more information? What if I had the opportunity to receive those results?" As I said, we have highlighted that this is a very small number — 0.1% in England. We are dealing with those decisions that should be left to women and their clinicians. They should be given the best possible advice and support, and we should not be forcing people into rushed judgements.

Ms Teggart: Ultimately, it will result in our being in the position that we were in before, where women who are experiencing extreme distress and vulnerability are forced to travel. Once again, we would be in a position where we are exporting healthcare. If the Member who has proposed the Bill and other Members are committed to addressing disability discrimination, there are a number of ways that that can happen, and we have included some examples in our submission. You are absolutely right: this is often a neglected part of the debate here. Women who have disabilities access abortion services as well, and, depending on the nature of the disability and the support that that woman will need, those aspects can delay decision-making. All of that has to be considered. If we are giving women a window between 20 weeks and 24 weeks, we can see the obvious pressures that women and clinicians are going to come under. The bottom line is that, if we restrict the law and try to roll back on what we have

secured via Westminster, we will ultimately be in a position where we are exporting healthcare again, and that is not acceptable.

Mr Carroll: Thank you.

Ms Ní Chuilín: Thank you, Gráinne and Ruairi, for your presentation today and your written evidence. Unless abortion services are commissioned, we will, effectively, be exporting people. That is the bottom line.

Ruairi, you said that you were not listening to the previous session, but I raised the issue of the protests. What measures will the Department need to take to prevent women who are accessing healthcare from being harassed? That is my first question. Second, what else can be done to ensure that these services are commissioned? My last question is about conscientious objection. You used the Glasgow example. Have you had any feedback at all, even from the Department, on any of that? We have just been through a Budget exercise and a June monitoring exercise. There is absolutely nothing identified in there, and there is no intention either. I am keen to hear your thoughts on that.

Mr Rowan: I will begin with interaction with the Department. As we outlined, we have made several attempts to engage the Minister on the issue, both when the regulations came into force and in terms of the ongoing funding difficulties. It is an unfunded service. ICNI is running it with a very small number of staff. That cannot continue indefinitely, which we have mentioned to the Department several times. We put that in writing on three occasions last year and again this year, but we have received no response. There has been no engagement with the Minister on the matter.

A private Member's Bill from Clare Bailey is in the works on this issue. Hopefully, that will come before the Assembly in the coming weeks. We are not currently experiencing protests outside our office because most members of staff are working from home, but trusts are experiencing protests outside their facilities. Those protests make it difficult for women to access services. One of the benefits of the early medical abortion service is the availability of contraception afterwards. For example, on the same day that a woman receives an early medical abortion, an implant can be inserted. If she wishes to access a coil, an appointment can be made to come back three weeks later. You might find that a woman who experienced protests going in does not come back for follow-up appointments and so may not come back to gain access to contraception which could prevent a further unintended pregnancy. That is the impact that it is having. Women are being extremely distressed by those protests when going into the buildings. As I mentioned, a private Member's Bill on the issue is in the offing. We support that. We have made several reports to the police, and we gained one conviction against a protestor who followed a former member of staff out of our office and assaulted them. We gained a criminal conviction, but, even after that conviction, that protestor was still able to stand outside our building each day. We need added legislation. It is impacting women every day. No one should face those barriers when accessing healthcare. As I said, it is about the consequences afterwards; women may not wish to attend follow-up appointments, which denies them access to follow-up contraception.

Ms Teggart: We hope that the private Member's Bill will be passed in this mandate. We absolutely need to see safe access zones or buffer zones — they go by different terms — as urgently as possible. We have to begin to remove the barriers to that provision. As Ruairi mentioned, those protests have an off-putting effect. Ultimately, however, those protests amount to harassment and intimidation of people seeking that healthcare. Our Government do have obligations to address that harassment and intimidation and ensure that there are not barriers to accessing that healthcare. The Department of Health, the Department of Justice and others could move swiftly and proactively to bring in those safe access zones.

It also raises, though, some of what Ruairi was saying. It goes back to something that we called for at the beginning of the COVID pandemic, which was the introduction of telemedicine. There are the consequences, as Ruairi mentioned, of how that might be off-putting to some women. However, there are, for example, women from an area where protestors are from the same local area. They might be in a domestic abuse situation and need to access early medical abortion services. The safest way for them to do that may be through telemedicine, taking the pills at home at a time that is safe for them.

In terms of steps that can be taken now, and arguably should *[Inaudible owing to poor sound quality]* sooner as well. We were the only part of the UK and Ireland during the COVID pandemic where that was not in place, and that is a damning indictment of the failure to prioritise women's healthcare during the pandemic.

Ms Ní Chuilín: Ruairi, I am thinking that it is the harassment of workers as well. I am sure that you have done this, but complain as often as possible. People should be able to work and live free from harassment and access health and social care free from harassment as well. Thank you.

Mr Rowan: Finally on that point, Carál, we have seen the impact of protests, particularly on one trust. They were a factor in the Southern Health and Social Care Trust moving its early medical abortion service to a different location. That put added pressures on staff who were already under-resourced having to find new premises. It is having that added impact.

Ms Hunter: I have a follow-up question about adequate screening and equipment here in the North. Where do you feel we are in Northern Ireland, compared with other parts of these islands, with regard to availability of modern facilities, systems and screening? Issues were raised in the previous discussion about access to non-invasive prenatal testing — the IONA test, for example — and how financial barriers and socio-economic status impact on the ability to access the test. as it can cost anywhere between £300 and £570. How can improved screening and access to screening help women to make informed choices earlier? What more can be done here in the North on that matter?

Mr Rowan: As I said — apologies for this — because we are not healthcare professionals, I will admit that my in-depth knowledge of the screening process is limited. I am part of the Northern Ireland Abortion and Contraception Taskgroup. which recently produced a comprehensive report that deals with not only abortion services and conscientious objection but also contraception and relationships and sexuality education. This was one of the issues raised in that report and one of the recommendations. It is not currently in place in Northern Ireland. We do not want to be putting financial barriers in place whereby someone with means can access a service privately whereas those who do not have the means cannot.

You mentioned the importance of making informed choices. To do that, you need access to all the information. Therefore, we would not want to see barriers in place in terms of people who have the means being able to access that information, and those who do not have the means not being able to access it. Hopefully, the Committee will be hearing from medical professionals in the coming weeks who may be able to speak more extensively on that point.

Ms Teggart: We expect that the commissioning process will deliver the full suite of screening that will be needed as early as possible in a pregnancy.

Ms Hunter: That is great, Gráinne. Thank you, Ruairi, for your contribution.

The Chairperson (Mr Gildernew): On behalf of the Committee, I thank Amnesty and Informing Choices for your written evidence, your attendance to draw that evidence out, and taking questions from members. Thank you very much for attending the Committee meeting this afternoon, and please take care in the time ahead.