



Royal College of
Obstetricians &
Gynaecologists

A new legal framework for abortion services in Northern Ireland

**RESPONSE TO THE NORTHERN IRELAND OFFICE AND THE
DEPARTMENT FOR HEALTH AND SOCIAL CARE**

DECEMBER 2019

Background

1. The Royal College of Obstetricians and Gynaecologists (RCOG) works to improve the health and wellbeing of women everywhere, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women's health globally. Founded in 1929, the RCOG now has over 16,000 members worldwide and works with a range of partners both in the UK and globally to improve the standard of care delivered to women, encourage the study of obstetrics and gynaecology (O&G) and advance the science and practice of the specialties.
2. This response has been endorsed by the Faculty of Sexual and Reproductive Healthcare (FSRH). The FSRH is the largest UK professional membership organisation working at the heart of sexual and reproductive health (SRH), supporting healthcare professionals to deliver high quality care. It works with its 15,000+ members, to shape sexual reproductive health for all. It produces evidence-based clinical guidance, standards, training, qualifications and research.
3. Earlier this year, the Northern Ireland (Executive Formation etc) Act (the Act) achieved Royal Assent in the UK Parliament. The Act requires the Secretary of State to, by secondary legislation, amend the law in Northern Ireland in order to implement the recommendations listed under paragraphs 85 and 86 of the Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women by the United Nation's Committee on the Elimination of Discrimination Against Women (CEDAW)¹.
4. We supported the aims of section 9 of the Northern Ireland (Executive Formation etc) Act 2019. Prior to this legislation, abortion in Northern Ireland was provided for in very few circumstances. Healthcare professionals were liable for a penalty of life imprisonment for providing abortion care.
5. CEDAW was correct in its assessment of the previous framework in Northern Ireland when it described it as "ambiguous" without "providing a clear pathway for the care of women requiring an abortion."²
6. We understand any future regulation must comply with those recommendations set out in Paragraphs 85 and 86 of CEDAW, if those regulations are to comply with the legal duty created by the Act.
7. We welcome this opportunity to submit our views to the Northern Ireland Office and the Department of Health and Social Care on their proposals for a new regulatory framework for abortion services in Northern Ireland.
8. In 2017, the RCOG voted in favour of the decriminalisation of abortion up until the 24th week of pregnancy (23 + 6 days). In 2018, the FSRH also voted to support decriminalisation. It is our view that abortion should be subject to regulatory and professional standards, in line with other medical procedures, rather than criminal sanctions. Abortion services should be regulated; however, abortion - for women, doctors and other healthcare professionals - should be treated as

¹ [Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women](#), UN Committee on the Elimination of Discrimination Against Women, 2018

² Ibid.

a health, rather than a criminal issue.

9. The repeal of the sections 58 and 59 of the Offences Against the Person Act 1861 achieved by the Northern Ireland (Executive Formation etc) Act 2019, and the prospect of further amendments via secondary legislation, provide a unique opportunity to establish a fit-for-purpose regulatory framework for abortion care in Northern Ireland which supports best clinical practice both now and in the future.

Question 1: Should the gestational limit for early terminations of pregnancy be:	Yes	No
Up to 12 weeks gestation (11 weeks + 6 days)		X
Up to 14 weeks gestation (13 weeks + 6 days)		X
If neither, what alternative approach would you suggest?		

10. We welcome a period of access without conditionality (i.e. without needing to meet a particular ground in law) to abortion care services for women. However, we find the proposals to limit this period to either 12 or 14 weeks inconsistent with the arguments set out by the Government in the consultation document. Particularly in that this provision seeks to protect women who have been a victim of a sexual crime, but does so insufficiently.
11. While we agree with the intention, we see no reason to limit that period to 12 or 14 weeks gestation. Restricting access to abortion care at arbitrary gestations before 24 weeks only resolves to create barriers for women.
12. Section 5 of the Criminal Law Act (Northern Ireland) 1967 states that anyone with the knowledge or belief that a criminal offence has taken place must report that offence to the police³. In order to comply with CEDAW recommendation to expand the grounds under which a woman may have an abortion following a sexual crime⁴, the Government has proposed an unrestricted access period to abortion care up until 12 or 14 weeks. This would allow girls and women access to services without mandating the need to evidence a sexual crime, if they do not wish to report that crime. Requiring women to evidence a sexual crime in order to access abortion care would lead to some women either continuing an unwanted pregnancy or seeking an unregulated and potentially unsafe abortion.
13. There is no guarantee that women who request an abortion following a sexual crime will decide to access services before either 12 or 14 weeks. In fact, any restrictions in place before 24 weeks are likely to have a detrimental impact for those women most vulnerable or disadvantaged (for instance, victims of domestic or sexual abuse, those experiencing social or economic deprivation or those women who have a disability) who are more likely to present at later gestations.

³ [Criminal Law Act \(Northern Ireland\), 1967](#)

⁴ [Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women](#), UN Committee on the Elimination of Discrimination Against Women, 2018

14. An alternative approach would be to allow unrestricted access to abortion care services up until 24 weeks gestation (23 + 6 days).
15. While the latest abortion statistics from England and Wales show an increasing number of abortions take place before 10 weeks, and that in 2018, 91 per cent of abortions were performed before 12 weeks⁵, we do not believe that this is sufficient reason to restrict access to abortion care after either 12 or 14 weeks and before 24 weeks. This data should be considered inconsequential when informing legal regulation but should simply serve to inform commissioners and providers when designing a model of care.
16. Importantly, there is no legal or medical basis for introducing a restriction at either 12 or 14 weeks. There is no reason why a woman presenting at 13 weeks gestation or 15 weeks gestation should be refused abortion care. Introducing this restriction would present a series of difficulties.
17. In 2018, the Oireachtas, the Republic of Ireland's national parliament, passed the Health (Regulation of Termination of Pregnancy) Act 2018⁶. This allowed women access to abortion care up until 12 weeks gestation in the Republic of Ireland. A consequence of the limitation has meant complications for some women who have requested an abortion prior to 12 weeks, received medication prior to 12 weeks, but whose abortion has not been completed within this time limit. This has resulted in women travelling to Great Britain to complete the procedure. This situation would make it most difficult for those women who are vulnerable and disadvantaged and have found it hard to travel in the past for abortion care. Patient flow from Northern Ireland to Great Britain would demonstrate a failed regulatory framework. This is made clear by CEDAW, section 3 which describes the impact such travel can have on the mental health of women seeking an abortion.⁷
18. We also know of cases in the Republic of Ireland of women have undergone non-invasive prenatal testing prior to 12 weeks gestation and received a diagnosis of a suspected chromosomal anomaly. Some women then decide to terminate an otherwise wanted pregnancy because a confirmatory test could not be done within 12 weeks. By creating an arbitrary barrier at 12 or 14 weeks, women may feel pressured to make a decision and some may end a healthy and wanted pregnancy. For those women who do choose to end their pregnancy, they may find they are restricted from doing so.
19. The data shows that there is no reason to reconsider the established time-limit of 23+6 days (see question 3 in this document) and therefore no reason not to offer women unrestricted access to abortion care up until this point. To do so would introduce an arbitrary restriction which is not evidence-based.
20. In 2019 the National Institute for Health and Care Excellence, the body which produces evidence-based guidance and quality standards, drew no distinction between the regimen required to effect either a medical abortion or a surgical abortion at either 12 or 14 weeks [NG140]. The

⁵ [Abortion statistics for England and Wales: 2018](#), Department of Health and Social Care

⁶ [Health \(Regulation of Termination of Pregnancy\) Act, 2018](#)

⁷ [Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women](#), UN Committee on the Elimination of Discrimination Against Women, 2018

procedure remains the same at both gestations.⁸ This supports the best practice set out in our own guidance in 2011⁹.

21. Paragraph 85(d) of the CEDAW recommendations requires the State to “Adopt evidence-based protocols for health-care professionals on providing legal abortions particularly on the grounds of physical and mental health and ensure continuous training on the protocols.”¹⁰ We believe that establishing an arbitrary restriction at 12 or 14 weeks contravenes this recommendation.
22. Introducing restrictions at this gestation would further contravene Paragraph 85(a) of CEDAW. Specifically, by introducing grounds between 12/14 and 24 weeks gestation in law, the RCOG can only assume that those women who do not meet those grounds would be criminalised if they do have an abortion. And any healthcare professional who provides an abortion in these circumstances could also be prosecuted. This contravenes Paragraph 85(a) which states “no criminal charges can be brought against women and girls who undergo abortion or against qualified health-care professionals and all others who provide and assist in the abortion.”¹¹
23. If this is not the case, and if there is no intention to criminalise women or healthcare professionals after 12 or 14 weeks and before 24 weeks, the RCOG still believes it is inappropriate for restrictions to exist in law, which are likely to be interpreted via case law.
24. The law in the rest of the United Kingdom has been settled for almost 30 years following the Human Fertilisation and Embryology Act 1990 which established the time-limit as 24 weeks¹². In 2018 the Department of Health and Social Care clarified the interpretation of this time limit as “a pregnancy not exceeding 23 weeks and 6 days.”¹³
25. We therefore recommend an alternative which would be evidence-based, CEDAW compliant and in the best interests of girls and women as well as healthcare professionals. This alternative would allow women unrestricted access to abortion care up until 24 weeks (23+ 6 days).

Question 2: Should a limited form of certification by a healthcare professional be required for early terminations of pregnancy?	Yes	No
		X
If neither, what alternative approach would you suggest?		

⁸ [Abortion care NICE guideline \[NG140\]](#), 2019

⁹ [The Care of Women Requesting Induced Abortion](#), Royal College of Obstetricians and Gynaecologists, 2011

¹⁰ [Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women](#), UN Committee on the Elimination of Discrimination Against Women, 2018

¹¹ *Ibid.*

¹² [Human Fertilization and Embryology Act 1990](#)

¹³ [Clarification of time limit for termination of pregnancy performed under Grounds C and D of the Abortion Act 1967](#), Department of Health and Social Care

- 26.** The RCOG does not believe that certification or a limited form of certification is required.
- 27.** In Great Britain, certification is a requirement of the Abortion Act 1967 (the 1967 Act). This Act does not decriminalise abortion, but instead permits it under certain grounds¹⁴. The 1967 Act amended and clarified the law in relation to abortion, which exists in the Offences Against the Person Act 1861¹⁵. The 1967 Act did not extend to Northern Ireland. The Northern Ireland (Executive Formation etc) Act 2019 repealed sections 58 and 59 of the Offences Against the Person Act 1861 in Northern Ireland, which related to the procurement of abortion services. Given the 1967 Act did not extend to Northern Ireland, there is no legal requirement to introduce certification in Northern Ireland.
- 28.** In Great Britain, certification is a mechanism for ensuring that those grounds which permit abortion, as established by the 1967 Act, have been met. It requires the completion of either the HSA1 or HSA2 forms depending on the circumstances. The form must be completed, signed and dated by two registered medical practitioners and is kept with the patient notes for 3 years.
- 29.** There is no other medical or surgical procedure which requires the signature of two doctors. In 2017 the British Medical Association explained that in the absence of criminal law and legislation, abortion would be regulated as other medical procedures are. This would include regulation set by the General Medical Council, the Nursing and Midwifery Council, the General Pharmaceutical Council, the Regulation and Quality Improvement Authority (in Northern Ireland) and civil and criminal law which apply to other aspects of healthcare¹⁶.
- 30.** The BMA are clear that criminal sanctions will continue to apply, based on existing criminal law, in cases where individuals perform an abortion without appropriate training or where an individual maliciously and covertly procures an abortion or administers an abortifacient without the woman's consent.
- 31.** In 2007 the House of Commons Science and Technology Committee considered the 1967 Act in relation to scientific and medical developments. Following evidence from a number of stakeholders with differing views, the Committee concluded that certification did not safeguard women or healthcare professionals "in any meaningful way" and instead caused delays in access to abortion care¹⁷.
- 32.** The committee concluded: "We would like to see the requirement for two doctors' signatures removed."¹⁸
- 33.** In Northern Ireland the government has proposed a period of access without conditionality to abortion care. This would mean that abortion would be decriminalised during this period. We see no reason to introduce certification which would only serve as a vestige of criminal law which does not apply.

¹⁴ [Abortion Act 1967](#)

¹⁵ [Offences Against the Person Act 1861](#)

¹⁶ [The Removal of Criminal Sanctions for Abortion](#), British Medical Association, 2019

¹⁷ [Scientific Developments Relating to the Abortion Act 1967](#), House of Commons Science and Technology Committee, 2007

¹⁸ *Ibid.*

- 34.** Many of our Fellows and Members in Great Britain feel that certification places on them an unnecessary administrative burden and one which threatens criminal prosecution if insufficiently met. As healthcare professionals, our Fellows and Members’ priority is the care of their patients, and providing that care according to clinical priorities with informed consent using the principles of patient autonomy. Certification, and signatures, can act as a barrier to providing best practice care. Introducing certification could only unnecessarily interfere with acting in the best interests of girls and women.
- 35.** In 2019 NICE recommended that assessment for abortion should take place within 1 week of a request, and that the procedure should be carried out within 1 week of the assessment. NICE also recommends greater use of telemedicine by providing abortion assessment via phone or video call¹⁹. A certification process set out in law would only interrupt abortion care which is often a straightforward procedure (where the vast majority of women have an early medical abortion.)

Question 3: Should the gestational time limit in where the continuance of the pregnancy would cause risk of injury to the physical or mental health of the pregnant woman or girl, or any existing children or her family, greater than the risk of terminating the pregnancy, be:	Yes	No
21 weeks + 6 days		
23 weeks + 6 days	X	
If neither, what alternative approach would you suggest?		

- 36.** We recommend the gestational time-limit should be set at 24 weeks (23+6 days) and that throughout these gestations women should have unrestricted access to abortion care services (see answer to question 1 in this document) without the requirement to meet specific grounds.
- 37.** The law in the rest of the United Kingdom has been settled for almost 30 years following the Human Fertilisation and Embryology Act 1990 which established the time-limit as 24 weeks²⁰.
- 38.** In 2018 the Department of Health and Social Care clarified the interpretation of this time limit as “a pregnancy not exceeding 23 weeks and 6 days.”²¹
- 39.** The stillbirth registration limit remains 24 weeks. This has recently been debated as part of the Government-sponsored Civil Partnership, Marriages and Deaths (Registration etc) Act 2019²², and has not changed.
- 40.** The clinical evidence does not support a limit of 22 weeks (21+ 6 days). The RCOG disagrees with the following statement in the consultation document: “Advances in medicine and healthcare

¹⁹ [Abortion care NICE guideline \[NG140\]](#), 2019

²⁰ [Human Fertilization and Embryology Act, 1990](#)

²¹ [Clarification of time limit for termination of pregnancy performed under Grounds C and D of the Abortion Act 1967](#), Department of Health and Social Care

²² [Civil Partnerships, Marriages and Deaths \(Registration etc\) Act 2019](#)

[mean that] it could be possible that a fetus having reached a gestation of 22 weeks (21 weeks + 6 days) is viable and thus capable of being born alive."²³

41. This statement implies that fetal viability has been determined at 22 weeks gestation despite evidence to the contrary.
42. The most recent data from MBRRACE-UK concerning preterm viability was published in June 2019²⁴. This report focuses on survival up to one year of age of all babies born from 22+0 to 26+6 weeks gestational age for births from 1 January 2016 to 31 December 2016 in Great Britain.
43. The data shows that for babies born between 22+0 and 22+6, only 3 per cent survive to 1 year.²⁵
44. Given the very small numbers of babies which do survive at this gestation, the confidence interval is wider than at later gestations, but the risk of severe impairment at this gestation for survivors is considered to be 1 in 3²⁶.
45. Placing viability at 24 weeks gestation (23+6 days) does not preclude the survival of babies born before this point in time but provides an indication of the very high mortality and morbidity rate, where a small proportion of babies born before 24 weeks only survive with very intensive treatment.
46. We are also concerned that the core pathway for antenatal care in Northern Ireland does not include a combined screening test for Down's syndrome, Edwards' syndrome and Patau's syndrome between 10 and 14 weeks gestation, as is the case in Great Britain.
47. Instead, women in Northern Ireland have an ultrasonic fetal anomaly scan only during week 20 (20+0 – 20+6). In practice, this means that there could be as little as 5 working days between receiving a fetal anomaly diagnosis and procuring an abortion, should the abortion limit be set at 22 weeks (21+6 days). This would not allow time for additional tests to confirm the type or severity of the identified anomaly, and would therefore prevent a woman from obtaining sufficient information and making an informed decision.
48. The delay involved in these additional tests is shown in the 2018 England and Wales abortion figures. 552 abortions were performed under Ground E (foetal abnormality) in weeks 20 and 21 (i.e., to be allowed in a 22-week limit scenario) and 584 were performed after this point (i.e., would not be allowed in this scenario).²⁷
49. A gestational limit of 22 weeks (21+6 days) would contravene the requirements specified in the Northern Ireland (Executive Formation etc) Act 2019 and would leave open the prospect of judicial review. Paragraph 85 b(iii) recommends access to abortion care following a diagnosis of

²³ [A new legal framework for abortion services in Northern Ireland](#), HM Government 2019

²⁴ [Supplementary report on survival up to one year of age for babies born before 27 weeks gestation. For Births in Great Britain from January to December 2016](#), MBRRACE-UK, 2019

²⁵ [Perinatal Management of Extreme Preterm Birth before 17 weeks of gestation](#), British Association of Perinatal Medicine, 2019

²⁶ Ibid.

²⁷ [Abortion statistics for England and Wales: 2018](#), Department of Health and Social Care

“severe fetal impairment.”²⁸

50. A 22 weeks (21+6 days) limit would mean a continuing flow of women from Northern Ireland to Great Britain in order to access abortion care services. These women would be seeking an abortion following a diagnosis for fetal anomaly for an otherwise wanted pregnancy.
51. We also know that women who have an abortion after 22 weeks are more likely to have suffered from systemic delays within the health system in accessing abortion care, a change in circumstance in their family or social lives, or because they have been victims of physical or sexual violence.
52. A continued patient flow from Northern Ireland to Great Britain would demonstrate a failed regulatory framework and would potentially criminalise both the women and any healthcare professional involved in a referral to Great Britain.

Question 4: Should abortion without time limit be available for fetal abnormality where there is a substantial risk that:	Yes	No
The fetus would die in utero (in the womb) or shortly after birth	X	
The fetus if born would suffer a severe impairment, including a mental or physical disability which is likely to significantly limit either the length or quality of the child's life	X	
If you answered 'no', what alternative approach would you suggest?		

53. Access to abortion care for women who receive a diagnosis of a fatal fetal anomaly is an essential healthcare service. The alternative would be to force women, who know that their baby will either die in utero, during child birth, or shortly after, to carry to term. The RCOG has heard of a number of disturbing cases where this has been expected of women in Northern Ireland.
54. In England and Wales, the vast majority of diagnoses are made before 24 weeks. In 2018, only 289 abortions (0.1 per cent) were carried out after 24 weeks.²⁹
55. Until October 2019, abortion in Northern Ireland had been governed by the Offences Against the Person Act 1861 (the 1861 Act) and the Criminal Justice Act (Northern Ireland) 1945. The case law following *R v Bourne 1939* permitted abortion if the continuance of the pregnancy would result in the woman becoming “a physical or mental wreck.” The Northern Ireland (Executive Formation etc) Act 2019 repealed the sections of the 1861 Act relating to abortion.

²⁸ [Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women](#), UN Committee on the Elimination of Discrimination Against Women, 2018

²⁹ [Abortion statistics for England and Wales: 2018](#), Department of Health and Social Care

56. It is important to note that before the repeal of sections 58 and 59 of the 1861 Act, the High Court of Justice in Northern Ireland ruled the restriction on abortion in Northern Ireland for women who did receive a diagnosis of a fatal fetal anomaly incompatible with the Human Rights Act 1998^{30,31}. This was made in response to an application by Sarah Jane Ewart for a judicial review by the Queen’s Bench Division.
57. For those women who receive a diagnosis of a life-limiting anomaly and choose to have an abortion after 24 weeks, this may be due to results of invasive tests not being available or, in fewer cases, due to late presentation. Recent advances in genetic testing has allowed for more detailed information and often a longer time interval until those results are available. Significant maternal comorbidities may also influence decision-making.
58. These rare late cases should be discussed by a multidisciplinary team (to include fetal medicine specialists, neonatologists, medical geneticists, paediatric surgeons, fetal cardiologists and others) to include discussion of all available options to allow informed decision-making.
59. Many women who receive a diagnosis of a fatal or severe life-limiting anomaly may wish to continue the pregnancy to term. There should be adequate social and financial support for women and girls in these circumstances and adequate financial support for those teams (e.g. counselling services, bereavement midwifery support, hospice care) who play a vital role in providing care and support for families before and after birth.
60. Paragraph 85(b)(iii) of CEDAW states that any regulation must provide access to abortion care for women who receive a diagnosis of “severe fetal impairment” as well as “fatal fetal abnormality.”³²
61. Ultimately we support abortion care for women who receive a diagnosis of a life-limiting anomaly, which should be judged on a case-by-case basis by experts. If a future regulatory framework does not allow abortion in these circumstances, we expect women will continue to travel to Great Britain to access care. This will create legal and professional barriers for healthcare professionals who should recommend care based on clinical priorities, unburdened by the prospect of criminal prosecution for both themselves and their patients.

Question 5: Do you agree that provision should be made for abortion without gestational time limit where:	Yes	No
There is a risk to the life of the woman or girl greater than if the pregnancy were terminated?	X	
Termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman or girl?	X	
If you answered ‘no’, what alternative approach would you suggest?		

³⁰ [2019] NIQB 88

³¹ Human Rights Act 1998

³² [Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women](#), UN Committee on the Elimination of Discrimination Against Women, 2018

62. It is inconceivable that regulations would not protect girls and women if there is a risk to their life.

63. *R v Bourne 1939* states:

“If the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are entitled to take the view that the doctor is operating for the purpose of preserving the life of the mother”³³

R v Bourne predated the Abortion Act 1967 and subsequent jurisprudence has permitted abortion in Northern Ireland in a small number of cases beyond risk to life where “the continuance of the pregnancy will be to make the woman a physical or mental wreck.”

64. Paragraph 85(b)(i) of CEDAW recommends that abortion is available for women where there is a threat to their physical or mental health “without conditionality of “long and permanent” effects.”³⁴ By producing regulations that do not provide abortion care for women in these circumstances, the government would contravene the requirements under the Northern Ireland (Executive Formation etc) Act 2019 to implement the recommendations made by CEDAW.

65. By producing regulations which do not provide abortion care for women in these circumstances, the regulatory framework would leave women in a worse position than before and women will continue to access services in Great Britain, potentially facing the prospect of criminal prosecution.

Question 6: Do you agree that a medical practitioner or any other registered healthcare professional should be able to provide terminations provided they are appropriately trained and competent to provide the treatment in accordance with their professional body’s requirements and guidelines?	Yes	No
	X	
If you answered ‘no’, what alternative approach would you suggest?		

66. We support the inclusion of other healthcare professionals in providing abortion care services and believe that the legal framework should not specify which healthcare professionals should be able to provide abortion services. Professional bodies should determine if a healthcare professional is trained and competent in this area. In Great Britain nurses and midwives care for women who have experienced a miscarriage but are restricted from performing the same procedures for a woman who has requested an abortion due to the legislation. This situation is anomalous and

³³ *R v Bourne 1938 1 KB 687*

³⁴ [Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women](#), UN Committee on the Elimination of Discrimination Against Women, 2018

unhelpful.

67. Abortion care has, like all other medical procedures, changed considerably since the Abortion Act 1967 (the 1967 Act) which only permitted doctors to provide services to women. Legislation, which is often difficult to change, does not keep pace with medical practice, which is partly why the 1967 Act is considered anachronistic in many ways.
68. This is demonstrated by the shift towards early medical abortion. In 2018, 83 per cent of abortions in England and Wales under 10 weeks were medical abortions³⁵. For those women who choose a medical abortion, the regimen does not necessarily require a doctor, and this role can be performed by other trained healthcare professionals. Other trained healthcare professionals are also perfectly able to perform a majority of surgical abortion as evidenced by the many senior nurses who provide surgical management of miscarriage.
69. Restrictions in place in Great Britain created by the Abortion Act 1967 should not be replicated in Northern Ireland. The inclusion of trained and competent healthcare professionals in delivering these services will reduce delay and provide a better service for women.
70. In 2019 NICE recommended a greater role for nurses and midwives in providing abortion care. NICE recommended that all nurses and midwives should have the chance to gain experience in abortion services during their training. There is some evidence, according to NICE, that women prefer care led by nurses or midwives, but the legal restrictions prevent them from providing some elements of abortion care.³⁶
71. This position is supported by the Royal College of Midwives³⁷ and the Royal College of Nursing³⁸, who are also in favour of the decriminalisation of abortion and recognise the important role that their members have in providing these services.
72. Paragraph 85(d) of CEDAW recommends that the state adopts evidence-based protocols for healthcare professionals on providing abortion care. Restricting those able to provide abortion care services in legislation is likely to contravene this requirement because restrictions are not evidence-based³⁹.

Question 7: Do you agree that the model of service delivery for Northern Ireland should provide for flexibility on where abortion procedures can take place and be able to be developed within Northern Ireland?	Yes	No
	X	
If you answered 'no', what alternative approach would you suggest?		

³⁵ [Abortion statistics for England and Wales: 2018](#), Department of Health and Social Care

³⁶ [Abortion care NICE guideline \[NG140\]](#), 2019

³⁷ [Position Statement: Abortion](#), Royal College of Midwives, 2016

³⁸ [Decriminalisation of Termination of Pregnancy](#), Royal College of Nursing, 2018

³⁹ [Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women](#), UN Committee on the Elimination of Discrimination Against Women, 2018

- 73.** A flexible model for where procedures can take place is important. We recommend that any future legal framework for abortion care is not restrictive, and that services are commissioned to meet the needs of women, rather than to meet legislative requirements.
- 74.** In England and Wales, 72 per cent of abortions are performed by independent sector providers under NHS contract⁴⁰.
- 75.** In 2018, the Department of Health and Social Care legalised the home use of misoprostol, the second drug used to affect a medical abortion⁴¹. This allowed women to avoid the distress of bleeding or pain on the journey home and prevented an unnecessary second trip to a clinic or hospital.
- 76.** Given the safety of mifepristone (the first drug used to affect a medical abortion), we have asked the Department of Health and Social Care to allow its home-use too⁴². This demonstrates the changing practices associated with abortion care, and why fixing in legislation restrictions on service delivery can pose barriers now and in the future.
- 77.** We have also recommended⁴³, along with NICE in their recent guidance to professionals⁴⁴, the greater use of telemedicine (i.e. video conferencing). This could significantly improve access to medical abortion, especially in remote and rural locations, and is already utilised in other countries^{45, 46, 47, 48, 49, 50}.
- 78.** Like any other healthcare procedure, decisions concerning where and how services are delivered should be made by commissioners and regulated in Northern Ireland by the Regulation and Quality Improvement Authority. There is no reason why restrictions on place specific to abortion care should exist in legislation.
- 79.** Paragraph 85(d) of CEDAW recommends that the state adopts evidence-based protocols for healthcare professionals on providing abortion care. Any restriction is likely to contravene this requirement.

⁴⁰ [Abortion statistics for England and Wales: 2018](#), Department of Health and Social Care

⁴¹ [The Abortion Act 1967 – Approval of a Class of Places](#), 2018

⁴² [Better For Women – Improving the health and wellbeing of girls and women](#), Royal College of Obstetricians and Gynaecologists, 2019

⁴³ Ibid

⁴⁴ [Abortion care NICE guideline \[NG140\]](#), 2019

⁴⁵ [A direct-to-patient telemedicine abortion service in Australia: Retrospective analysis of the first 18 months](#), Aust N Z J Obstet Gynaecol. 2018 Jun;58(3):335-340, 2018

⁴⁶ [Online access to abortion medications: a review of utilization and clinical outcomes](#), Best Pract Res Clin Obstet Gynaecol. 2019 Jul 2. pii: S1521-6934, 2019

⁴⁷ [Medication Abortion Provided Through Telemedicine in Four U.S. States](#), Obstet Gynecol. 2019 Aug;134(2):343-350, 2019

⁴⁸ [TelAbortion: evaluation of a direct to patient telemedicine abortion service in the United States](#), Contraception. 2019 Sep;100(3):173-177, 2019

⁴⁹ [Acceptability and feasibility of 400 µg buccal misoprostol after 200 mg mifepristone for early medical abortion in Georgia](#), Eur J Contracept Reprod Health Care. 2016 Oct;21(5):367-71, 2016

⁵⁰ [Prospective study of home use of mifepristone and misoprostol for medical abortion up to 10 weeks of pregnancy in Kazakhstan](#), Int J Gynaecol Obstet. 2016 Sep;134(3):268-71, 2016

Question 8: Do you agree that terminations after 22/24 weeks should only be undertaken by health and social care providers within acute sector hospitals?	Yes	No
		X
If you answered 'no', what alternative approach would you suggest?		

- 80.** In some cases an acute hospital setting is appropriate for abortion care services, for instance where there is a complex co-morbidity which may require co-location with other specialists. However, we would not wish to see legislation restricting the provision of abortion services when these decisions are best made by commissioners and regulators and informed by clinicians.
- 81.** In 2018, 147 abortions between 22+0 and 23+6 took place in the independent sector in England and Wales⁵¹.
- 82.** As stated previously, legislation does not keep pace with medical practice. Restricting provision to acute sector hospitals should not be defined in legislation, which could hamper the development of both an immediate and a future model of care.
- 83.** Paragraph 85(d) of CEDAW recommends that the state adopts evidence-based protocols for healthcare professionals on providing abortion care. This restriction is likely to contravene this requirement.

Question 9: Do you think that a process of certification by two healthcare professionals should be put in place for abortions after 12/14 weeks gestation in Northern Ireland?	Yes	No
		X
If you answered 'no', what alternative approach would you suggest?		

- 84.** We support the decriminalisation of abortion and consider the certification process an artefact of criminal law. The Northern Ireland (Executive Formation etc) Act repealed sections 58 and 59 of the Offences Against the Person Act 1861. Therefore there is no requirement or necessity to introduce certification in Northern Ireland which often only causes delay for women seeking access to abortion care.
- 85.** There is no other medical or surgical procedure which requires the signature of two doctors. In 2017 the British Medical Association explained that in the absence of criminal law and legislation, abortion would be regulated as other medical procedures are.
- 86.** Regulation of abortion could be achieved through those requirements already set by the General Medical Council, the Nursing and Midwifery Council, the General Pharmaceutical Council, the

⁵¹ [Abortion statistics for England and Wales: 2018](#), Department of Health and Social Care

Regulation and Quality Improvement Authority (in Northern Ireland) and civil and criminal law which apply to other aspects of healthcare.

- 87.** The BMA are clear that criminal sanctions will continue to apply, based on existing criminal law, in cases where individuals perform an abortion without appropriate training or where an individual maliciously and covertly procures an abortion or administers an abortifacient without the woman's consent.
- 88.** In 2007 the House of Commons Science and Technology Committee considered the Abortion Act 1967 in relation to scientific and medical developments. Following evidence from a number of stakeholders with differing views, the Committee concluded that certification did not safeguard women or healthcare professionals "in any meaningful way" and instead caused delays in access to abortion care⁵².
- 89.** The committee concluded: "We would like to see the requirement for two doctors' signatures removed."⁵³
- 90.** Many of our Fellows and Members in Great Britain feel that certification places on them an unnecessary administrative burden and one which threatens criminal prosecution. As healthcare professionals, our Fellows and Members' priority is the care of their patients, and providing that care according to clinical priorities and with informed consent using the principles of patient autonomy. Certification, and signatures, can act as a barrier to providing best practice care. Introducing certification could only unnecessarily interfere with acting in the best interests of girls and women.
- 91.** In 2019 NICE recommended that assessment for abortion should take place within 1 week of a request, and that the procedure should be carried out within 1 week of the assessment. NICE also recommends greater use of telemedicine by providing abortion assessment via phone or video call⁵⁴. A certification process set out in law would only interrupt routine abortion care which is often a straightforward procedure (where the vast majority of women have an early medical abortion.)
- 92.** We trust healthcare professionals and people to make complex decisions in every other aspect of healthcare. In all circumstances, detailed notes are kept and procedures are followed. We do not believe that abortion care should require different practices.

⁵² Scientific Developments Relating to the Abortion Act 1967, House of Commons Science and Technology Committee, 2007

⁵³ Ibid.

⁵⁴ Abortion care NICE guideline [NG140], 2019

Question 10: Do you consider a notification process should be put in place in Northern Ireland to provide scrutiny of the services provided, as well as ensuring data is available to provide transparency around access to services?	Yes	No
		X
If you answered 'no', what alternative approach would you suggest?		

93. A requirement in law is not necessary for data collection.
94. Data collection is good governance and is incredibly valuable for commissioners, providers and policymakers. Data collected on abortion care should be used alongside other data on reproductive health provision to evaluate current services with a view to improving them. This is the case for all other healthcare procedures where routine data collection is the norm.
95. We do not support a form of notification which would gather identifiable information for the purposes of prosecuting criminal law. The Northern Ireland (Executive Formation etc) Act repealed sections 58 and 59 of the Offences Against the Person Act 1861. Therefore there is no requirement or necessity to introduce this form of notification in Northern Ireland.
96. A notification process which would seek to enable the prosecution of women and healthcare professionals is likely to contravene Paragraph 85(a) which states "no criminal charges can be brought against women and girls who undergo abortion or against qualified health-care professionals and all others who provide and assist in the abortion."⁵⁵

Question 11: Do you agree that the proposed conscientious objection provision should reflect practice in the rest of the United Kingdom, covering participation in the whole course of treatment for the abortion, but not associated ancillary, administrative or managerial tasks?	Yes	No
	X	
If you answered 'no', what alternative approach would you suggest?		

97. We agree that conscientious objection should cover participation in the course of treatment for the purpose of the abortion but should not include any ancillary, administrative and managerial tasks which might be associated with the treatment.
98. The provisions made for conscientious objection by the Abortion Act 1967⁵⁶ serve as a good template for conscientious objection in Northern Ireland.

⁵⁵ [Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women](#), UN Committee on the Elimination of Discrimination Against Women, 2018

⁵⁶ [Abortion Act 1967](#)

99. Currently there exists clear guidance on conscientious objection from the General Medical Council and the Nursing Midwifery Council. There is an argument that existing guidance and regulation is sufficient, without the need for legislation. Evidence from a number of other countries supports this (for example Finland, Iceland and Sweden have no clause within their abortion laws.)
100. Existing guidance is also clear with regards to emergency situations where there is a risk to the life of the mother or to prevent grave permanent injury to the physical or mental health of a pregnant woman or girl.

Question 12: Do you think any further protections or clarification regarding conscientious objection is required in the regulations?	Yes	No
		X
If you answered 'yes', what alternative approach would you suggest?		

101. The Abortion Act 1967 (the 1967 Act) strikes a good balance between the rights of healthcare professionals and women requesting an abortion⁵⁷. It is clear as to the circumstances when conscientious objection is appropriate and when it is not.
102. We do not support any further protections for conscientious objection other than the protections modelled by the 1967 Act.

Question 13: Do you agree that there should be provision for powers which allow for an exclusion or safe zone to be put in place?	Yes	No
	X	
If you answered 'no', what alternative approach would you suggest?		

103. Paragraph 86(g) of CEDAW recommends the state investigates complaints of harassment of women and prosecutes them.
104. We understand that there have been several prosecutions in Northern Ireland against protestors outside of abortion care providers in the past. Despite this, CEDAW found that the UK failed to protect women from harassment when seeking sexual and reproductive healthcare services.
105. We believe that that no girl or woman should be subject to fear, intimidation or harassment and support the introduction of safe zones around abortion care providers.
106. In England, the use of Public Space Protection Orders have provided some protection for women seeking an abortion, however these measures are neither efficient nor sufficient.

⁵⁷ Ibid.

107. We also understand that the right to protest is important, however we consider harassment outside of abortion care providers to be harmful to the women seeking care and to the healthcare professionals involved in providing that care.
108. We would welcome legislation which provides a safe access zone for women seeking abortion care.

Question 14: Do you consider there should also be a power to designate a separate zone where protest can take place under certain conditions?	Yes	No
		X
If you answered 'no', what alternative approach would you suggest?		

109. We consider designating a separate zone for protests unnecessary. Protestors would be able to gather outside of the safe access zone.

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

110. The repeal of the sections 58 and 59 of the Offences Against the Person Act 1861 achieved by the Northern Ireland (Executive Formation etc) Act 2019, and the prospect of further amendments by secondary legislation, provide a unique opportunity to establish a regulatory framework for abortion care in Northern Ireland can allow best practice now and in the future.
111. Any future abortion care service in Northern Ireland should be commissioned to meet the best-practice guidance issued by NICE earlier this year⁵⁸.
112. Both the combined test (1st trimester screening) and Non-invasive Prenatal Testing (NIPT) are not available within NHS maternity services in Northern Ireland. In the rest of the UK, these tests allow for earlier diagnosis of some fatal and life-limiting fetal anomalies. Both of these tests are only available in Northern Ireland within the private sector, leading to an inequality in access to important maternity care.
113. We recommend that 1st trimester screening / NIPT should be available in Northern Ireland to minimise the need for later terminations in those cases where a fetus would die in utero or shortly after birth and where the woman decides that she does not wish to continue with the pregnancy.
114. We recognise that a well-trained workforce is an essential enabler for high quality abortion care. It is paramount that the Northern Ireland Health and Social Care Board prioritises, plans and budgets for training of sufficient healthcare professionals to deliver this service.

⁵⁸ [Abortion care NICE guideline \[NG140\]](#), 2019

- 115.** Establishing a new framework for abortion care must be accompanied by a sexual and reproductive healthcare strategy for Northern Ireland, which provides medically accurate information to girls and women as well as easy access to contraception and other services.
- 116.** We know that promoting health literacy and healthy behaviours makes an important contribution to preventing avoidable ill-health and encouraging women to take control of their own future health. There is clear evidence that preventative strategies can help to improve health outcomes for women and their families throughout their life course.
- 117.** Contraception is the single most cost-effective intervention in healthcare. Public Health England estimate that for every £1.00 spent on contraception, there is a £9.00 saving across the public sector.
- 118.** Education about women’s health must start from a young age so that all girls and women better understand their bodies, are informed of where and when to get help and feel confident to talk about any health issues. Women can take control of their own health with easily accessible and reliable information, which should be available in a variety of forms suitable for all women of all ages.
- 119.** Effective relationships and sex education leads young people to making informed choices about when to have sex for the first time. Unsurprisingly this reduces the numbers of unplanned pregnancies and abortions.
- 120.** Paragraph 86 of CEDAW and the Northern Ireland (Executive Formation etc) Act 2019 places a legal duty on the Secretary of State to provide better sexual and reproductive health rights and services to girls and women in Northern Ireland.⁵⁹
- 121.** We would like to see these requirements met as soon as possible in order to provide comprehensive and high quality sexual and reproductive education and healthcare.
- 122.** Our most recent report, *Better For Women*, provides a number of recommendations which can improve sexual and reproductive healthcare for women. This includes the reclassification of the progesterone-only pill from ‘prescription-only’ to ‘pharmacy product’ and the reclassification of oral emergency hormonal contraception from ‘pharmacy product’ to the ‘General Sales List’⁶⁰.
- 123.** *Better For Women* recommends each UK nation develops a national women’s health strategy. A full list of recommendations can be found [here](#).

For further information please contact:

Stephen Hall

Political Adviser to the President, Royal College of Obstetricians and Gynaecologists

policy@rcog.org.uk

⁵⁹ [Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women](#), UN Committee on the Elimination of Discrimination Against Women, 2018

⁶⁰ [Better For Women – Improving the health and wellbeing of girls and women](#), Royal College of Obstetricians and Gynaecologists, 2019