Response to

‘Northern Ireland Office consultation on a new legal framework for abortion services in Northern Ireland’

December 2019

1.0 INTRODUCTION

UNISON is the leading trade union in Northern Ireland (NI), representing over 43,000 members, and is the largest trade union in the UK with over 1.3 million members. Our membership includes public service workers in health and social care; the education and higher education services; local government; youth justice; private companies providing public services; and the community and voluntary sector. 84% of our membership in Northern Ireland are women.

UNISON represents a clear majority of healthcare workers, clinical and non-clinical, in the Health and Social Care (HSC) framework in Northern Ireland. We have a duty to protect and promote their rights as workers and to act as advocates for their health, the health of their families, and public health in all dimensions of the population. All of our members are HSC users. Consequently we respond in our capacity as representatives of both service users and the health workforce. This submission is made on their behalf.

UNISON currently chairs the Health Committee of the Northern Ireland Committee of the Irish Congress of Trade Unions.

2.0 NORTHERN IRELAND (EXECUTIVE FORMATION ETC) ACT 2019 AND CEDAW REPORT

Section 9 of the Northern Ireland (Executive Formation etc) Act 2019 places a duty on the Secretary of State for Northern Ireland to make regulations to change the law in Northern Ireland in order to comply with paragraphs 85 and 86 of the 'CEDAW

Report'.[1] Such regulations must, in particular, make provision for the purposes of regulating abortions in Northern Ireland, including provision as to the circumstances in which an abortion may take place. The Regulations must come into force by 31st March 2020. Section 9 came into force on 22nd October 2019, as a Northern Ireland Executive was not formed on or before 21st October.

Paragraphs 85 and 86 of the CEDAW report state as follows:

85. The Committee recommends that the State party urgently:
(a) Repeal sections 58 and 59 of the Offences against the Person Act, 1861, so that no criminal charges can be brought against women and girls who undergo abortion or against qualified health-care professionals and all others who provide and assist in the abortion;
(b) Adopt legislation to provide for expanded grounds to legalize abortion at least in the following cases:
(i) Threat to the pregnant woman's physical or mental health, without conditionality of "long-term or permanent" effects;
(ii) Rape and incest;
(iii) Severe fetal impairment, including fatal fetal abnormality, without perpetuating stereotypes towards persons with disabilities and ensuring appropriate and ongoing support, social and financial, for women who decide to carry such pregnancies to term;
(c) Introduce, as an interim measure, a moratorium on the application of criminal laws concerning abortion and cease all related arrests, investigations and criminal prosecutions, including of women seeking post-abortion care and health-care professionals;

[1] Report of the Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW/C/OP.8/GBR/1) published on 6 March 2018.

(d) 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;

(e) Establish a mechanism to advance women's rights, including through monitoring authorities' compliance with international standards concerning access to sexual and reproductive health, including access to safe abortions, and ensure enhanced coordination between the mechanism with the Department of Health, Social Services and Public Safety and the Northern Ireland Human Rights Commission;

(f) Strengthen existing data-collection systems and data sharing between the Department and the police to address the phenomenon of self-induced abortion.

86. The Committee recommends that the State party:

(a) Provide non-biased, scientifically sound and rights-based counselling and information on sexual and reproductive health services, including on all methods of contraception and access to abortion;

(b) Ensure the accessibility and affordability of sexual and reproductive health services and products, including on safe and modern contraception, including oral, emergency, long-term and permanent forms of contraception, and adopt a protocol to facilitate access at pharmacies, clinics and hospitals;

(c) Provide women with access to high-quality abortion and post-abortion care in all public health facilities and adopt guidance on doctor-patient confidentiality in that area;

(d) Make age-appropriate, comprehensive and scientifically accurate education on sexual and reproductive health and rights a compulsory component of curriculum for adolescents, covering prevention of early pregnancy and access to abortion, and monitor its implementation;

(e) Intensify awareness-raising campaigns on sexual and reproductive health rights and services, including on access to modern contraception;

(f) Adopt a strategy to combat gender-based stereotypes regarding women's primary role as mothers;

(g) Protect women from harassment by anti-abortion protesters by investigating complaints and prosecuting and punishing perpetrators.

The current consultation is being taken forward by the Northern Ireland Office as required under section 9 of the 2019 Act.

UNISON supports a woman's right to choose. As such we welcome the consultation being undertaken by the NIO. We provided evidence to the CEDAW Inquiry that lead to the CEDAW Report on abortion services in Northern Ireland and we wish to see its recommendations fully implemented.

3.0 PROPOSALS

We note and are aware of the engagement of the Northern Ireland Office (NIO) with the Royal Colleges in relation to these proposals. Given our position as the largest trade union across the health and social services system in Northern Ireland, we are disappointed that similar engagement was not undertaken with UNISON, despite our clear requests to meet NIO officials.

These proposals will clearly have a significant impact for our members, particularly our nurse members who form our single biggest block of membership. We would demand that the NIO engage with us as a matter of urgency before the regulations required under section 9 come into force. If the NIO is genuine in its desire to ensure that healthcare professionals clearly understand their legal rights, obligations and responsibilities it cannot limit engagement to the Royal Colleges alone.

We have responded to those proposals we consider to be most relevant below:

Should the gestational limit for early terminations of pregnancy be:

Up to 12 weeks gestation (11 weeks + 6 days)

Up to 14 weeks gestation (13 weeks + 6 days)

If neither, what alternative approach would you suggest?

UNISON does not support either proposed gestational limit here.

We believe that abortion should be regulated in the same way as any other healthcare treatment and that women should have choice and control over their own bodies. In line with the principles of informed consent, individuals should have autonomy over decisions relating to their healthcare.

Unrestricted early access to abortion services is important and will meet the needs of around 90% of woman who require access to terminations. Restricting access on the grounds of pregnant people being the victims of rape or incest would be unacceptable, impossible to regulate and liable to cause further trauma and harm.

Given that the NIO appears to accept this point, we are challenged as to why an arbitrary limit of 12 or 14 weeks would be imposed instead. The CEDAW report recommendations do not specify such a gestational limit. If these gestational limits were to prevent persons from being able to access terminations if they became pregnant as a result of rape or incest, this would result in a grave violation of their human rights under both the European Convention on Human Rights, CEDAW, the UN Convention on the Rights of the Child and the Convention against Torture.

Experience from Canada, where there have been no legal restrictions on abortion for more than 20 years, is that there is no difference in how women present for abortion care – the vast majority will present early in pregnancy, with those few presenting at higher gestations being the most vulnerable (e.g. mental health issues, abuse, trauma, younger age).[2] This also means the imposition of an arbitrary limit of 12 or 14 weeks will have an overwhelmingly negative and disproportionate effect on these most vulnerable women.

[2] Abortion Rights Coalition of Canada (2019) *Statistics - Abortion in Canada.* Retrieved 6 December 2019 from http://www.arcc-cdac.ca/backrounders/statistics-abortion-in-canada.pdf

It should be noted that those made pregnant as a result of rape or incest are likely to face considerable barriers in accessing abortion services. Those who have become pregnant as a result of rape or incest are more likely to be in domestic violence situation. These women may have their movement restricted; and/or they may feel that they are required to conceal the pregnancy for their own safety. Similarly, those who have become pregnant as a result of incest are more likely to be underage. This means they are less likely to notice the early signs of pregnancy. These factors are likely to cause delayed presentation.[3]

We are also concerned that as first trimester screening generally occurs at around 12 weeks, a lower gestational limit may force women into rushing important decisions.

Evidence from Alliance for Choice, BPAS, the Abortion Support Network and many other sources who regularly support victims of sexual crime, highlights that victims of sexual crimes can have complex reasons for being unable to access an abortion until the second trimester. Among these reasons domestic abuse and coercive control can prevent victims from being able to access an abortion. Disabled women, who are likely to be more vulnerable to domestic abuse and who face barriers to accessing healthcare will also be negatively affected by these shorter gestational limits.

UNISON believes that the timeframe of unrestricted access to abortion until the point of viability (currently 24 weeks in England and Wales) would be much more appropriate to ensure that the CEDAW recommendations are enacted. This will ensure that no victims of sexual crime will be forced to travel to Britain to access a termination.

Should a limited form of certification by a healthcare professional be required for early terminations of pregnancy?

[3] See for example: Amnesty International (2019). *She is not a criminal.* https://www.amnestyusa.org/pdfs/Ireland_She_Is_Not_A_Criminal.pdf; *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27

If no, what alternative approach would you suggest?

UNISON does not believe that any form of certification should be required for early terminations of pregnancy.

Requiring certification by a healthcare professional is clinically unnecessary and provides no additional safeguards for women or doctors. The provision of medical and surgical treatments, including abortion, is heavily regulated. The independent regulators of the healthcare professions,[4] as well as the independent regulators of healthcare services,[5] ensure that all medical and surgical procedures, including abortions, are performed in safe, appropriate locations, by appropriately qualified professionals adhering to clinical best practice. Where practice falls outside of regulations, regulatory bodies retain the authority to take action against the individual or service responsible, for example by imposing restrictions on, or cancelling their registration. No additional form of oversight is necessary or justified in the case of abortion.

In addition, requiring certification by a healthcare professional is likely to cause unnecessary barriers to access. In England, Wales, and Scotland the requirement that two doctors certify the need for an abortion is known to have caused delays in access to abortion services. These delays occur where women struggle to make prompt GP appointments or where they face negative attitudes and struggle to get a referral.

The regulatory system for abortion in Northern Ireland should avoid implementing clinically unnecessary, obstructive and administratively burdensome requirements for

[4] These include the Nursing and Midwifery Council, the General Medical Council, and the Pharmaceutical Society of Northern Ireland.
[5] In Northern Ireland, the Regulation and Quality Improvement Authority.

certification, and instead aim to facilitate access and timely treatment. Ensuring access and timely treatment is particularly important where time limits are placed on the availability of abortion, to ensure procedural delays do not interfere with women's ability to access legal, safe abortion services. Timely access can also lead to a decrease in adverse events. This is because although abortion is a safe procedure, it is safer the earlier it is performed.

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

21 weeks + 6 days gestation

23 weeks + 6 days gestation

If neither, what alternative approach would you suggest?

UNISON would reiterate our view here that unrestricted access to abortion up to 24 weeks should be the minimum.

The RCM cautions very strongly against setting a gestational time limit in circumstances where the continuance of the pregnancy would cause risk of injury to the physical or mental health of the pregnant woman or girl, or any existing children or her family at 21 weeks + 6 days gestation.

They argue that this proposed time limit is based on the incorrect assumption that 'due to advances in medicine and healthcare, it could be possible that a fetus having reached a gestation of 21 weeks + 6 days is viable and thus being capable of being

born alive.' While survival rates have improved for extremely premature births, most babies born at 22 weeks sadly do not survive. The most recent paper on this issue, published by the British Association of Perinatal Medicine, using data from MBRRACE, found that if a woman goes into spontaneous labour at 22 weeks, there is only a 3 per cent chance that the baby will survive to its first birthday. For spontaneous labour during week 23, less than 20 per cent of babies survive to their first birthday.[6]

Even though doctors will attempt to save the lives of some babies born before 24 weeks, where that is what parents wish, the very high risk of mortality or very serious complications means that intensive care treatment is not always provided. If parents do not wish for their baby to receive intensive treatment it is ethical to provide palliative care at delivery, and the revised framework supports this.[7]

As prominent medical ethicist Dr Dominic Wilkinson notes, 'this reflects the ethical importance of respecting the wishes of parents when it comes to treatment that is so risky and uncertain. Arguably, if a woman decides not to continue a pregnancy at 22 or 23 weeks' gestation, and obstetricians support this choice, that is completely consistent with the ethical framework that applies in newborn care.'[8]

The NIO must also consider here that the failure to make provision for the availability of abortion in circumstances of rape or incest at all gestations fails to fulfil the obligations set out under Section 9 (1) of the Northern Ireland (Executive Formation) Act 2019, which requires that the recommendations in paragraphs 85 and 86 of the CEDAW report are implemented in respect of Northern Ireland. Limiting the availability

[6] British Society of Perinatal Medicine (2019) *Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation*. https://hubble-live-assets.s3.amazonaws.com/bapm/attachment/file/176/Extreme_Preterm_22-10-19_FINAL.docx.pdf.
[7] Wilkinson, D. (2019) *Lifesaving Treatment for Babies Born at 22 weeks Doesn't Mean Abortion Law Should Change*. http://blog.practicalethics.ox.ac.uk/2019/10/lifesaving-treatment-for-babies-born-at-22-weeks-doesnt-mean-abortion-law-should-change/.
[8] Ibid.

of abortion where there is a threat to the woman's physical or mental health to 22 or 24 weeks gestation will open the Government to the possibility of judicial review.

Therefore the law in Northern Ireland should at a minimum equal the provisions in England and Wales, or follow best practise for abortion care such as the Canadian model described above. If the NIO were to follow the Canadian model as a result of the responses to this consultation, it must move however to urgently repeal or amend section 25 of the Criminal Justice (Northern Ireland) Act 1945.

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

The fetus would die in utero (in the womb) or shortly after birth

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

If you answered 'no', what alternative approach would you suggest?

UNISON supports the proposal to allow abortion in cases where the fetus would die in utero or shortly after birth, and where the fetus 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, without gestational limit. This is in line with the legal obligations set down by section 9 Northern Ireland (Executive Formative etc) Act 2019 to implement the recommendations made by paragraphs 85 and 86 of the CEDAW report.

Here we would highlight the importance of the CEDAW recommendations specifically stating that terminations should be available in such circumstances where the

abnormality is both 'severe' and 'fatal'. CEDAW recommendations also state that women, girls and pregnant people faced with such a diagnosis need sufficient time and support to reach an informed decision.

We would caution against any attempt to adopt overly-prescriptive or rigid definitions in relation to both 'fatal' and 'severe' abnormalities which may be problematic for healthcare professionals in practice. Medical evidence shows that determinations of which conditions will constitute a 'fatal' abnormality are complicated and can leave doctors and women in difficult situations, particularly where the threat of criminal law still applies.

Do you agree that provision should be made for abortion without gestational time limit where:

There is a risk to the life of the woman or girl greater than if the pregnancy were terminated?

Termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman or girl?

If you answered 'no', what alternative provision do you suggest?

UNISON notes here that as a result of the legal precedent set in *R v Bourne*,[9] abortion is already legal in the above circumstances in Northern Ireland, that is, in circumstances in which there is a risk to the life of the pregnant person greater than if the pregnancy were terminated, or where necessary to prevent grave permanent injury to their physical or mental health.

However, concerns exist as to the lack of clarity surrounding this precedent and the lack of clear guidance for health professionals following it. As a result doctors and

[9] *R v Bourne* [1939] KB 687.

health professionals can be unwilling to provide legal abortion services or referrals for fear of prosecution.[10]

As such, UNISON agrees that provision should be made for abortion in the above circumstances within the regulatory framework for abortion in Northern Ireland, to assist in providing clarity to women and healthcare professionals.

However, it should be considered that the continued criminalisation of abortion after the fetus is 'capable of being born alive' pursuant to section 25 of the Criminal Justice (Northern Ireland) Act 1945 will continue to have a 'chilling effect' on the provision of abortion at or after the fetus has reach 'viability'. UNISON recommends that the government repeal section 25 to ensure this does not occur.

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?

If you answered 'no', what alternative approach do you suggest?

UNISON agrees with this proposal. We believe that by allowing flexibility in relation to the healthcare professionals who can perform terminations, timely access to treatment will be improved.

UNISON recommends that determinations as to which healthcare professions are competent to perform medical or surgical procedures, including abortion, are left to the regulatory bodies responsible for regulating the medical professions and healthcare services,[11] just as they would be for any other treatment. These bodies are responsible for ensuring that all medical and surgical procedures, including abortions,

[10] Women and Equalities Committee (2019). *Abortion law in Northern Ireland* https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/1584/158402.htm.

[11] These include the Nursing and Midwifery Council, the General Medical Council, the Pharmaceutical Society of Northern Ireland and the Regulation and Quality Improvement Authority.

are performed in safe, appropriate locations, by appropriately qualified professionals adhering to best clinical practice. Where practice falls outside of regulations, regulatory bodies retain the authority to take action against the individual or service responsible, for example by imposing restrictions on, or cancelling their registration.

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?

If you answered 'no', what alternative approach do you suggest?

As is stated in the consultation document, the majority of abortions performed in England and Wales are performed by the independent sector under contract from the NHS. In general terms, UNISON believes that healthcare should be provided free at the point of need, should be publically-funded and that treatment and care should be given by health workers directly employed within the public health system. We are opposed to outsourcing and privatisation of healthcare services, which we view as problematic with regards to ensuring equality of access, and which bring risks with regards to sustainability and capacity.

However we agree fully that the model of service delivery for Northern Ireland should provide for flexibility on where abortion procedures can take place. The model that is developed must be suitable to the particular circumstances of Northern Ireland, taking into account existing health inequalities, our large rural population which can already experience difficulties in accessing services, and our underdeveloped transport and roads infrastructure.

It is vitally important that abortion care services are accessible to women, including women in vulnerable circumstances and those from geographically isolated communities. Provided safety standards are met, it is entirely appropriate for abortion

care services to be extended to a range of services. By allowing for flexibility on where abortion procedures can take place, access can be improved.

We note the In England, Wales, and Scotland, the Abortion Act 1967 requires that abortions be performed in a hospital or other premises approved by the Secretary of State. These restrictions are unsupported by any current medical evidence base.[12] At the time these restrictions were written into law - in the late 1960's - abortion was a far more technically demanding and risk procedure.[13] Conversely, today abortion is a very safe procedure and in 2018, 83 per cent of abortions in England and Wales were early medical abortions.[14]

UNISON recommends that determinations as to where medical or surgical procedures, including abortion, can take place are left to the regulatory bodies responsible for regulating the medical professions and healthcare services, [15] just as they would be for any other treatment.

Allowing abortion to be regulated in this way, without imposing additional legislative restrictions, will ensure that clinical best practice and cost efficiency are not obstructed by legislation which was developed on the basis of outdated evidence.

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

If you answered 'no', what alternative approach do you suggest?

As we have stated above, UNISON believes that decisions with regards to the location of services and the healthcare professionals who provide them should be informed by

[12] Sheldon, S. (2015). The Decriminalisation of Abortion: An Argument for Modernisation. Oxford Journal Of Legal Studies, 36(2), 334-365. doi: 10.1093/ojls/gqv026
[13] Ibid.
[14] UK Government (2019). *Abortion statistics*.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/808556/Abortion_Statistics__England_and_Wales_2018__1_.pdf.
[15] These include the Nursing and Midwifery Council, the General Medical Council, the Pharmaceutical Society of Northern Ireland and the Regulation and Quality Improvement Authority.

clinical evidence and should be subject to existing regulation. Therefore we see no reason to specify a requirement in law for provision within acute sector hospitals. Over time it is possible that as abortion procedures become safer in such circumstances, such provision may be made available outside of acute sector hospitals. To ensure that provision is responsive to these changes, we believe it should be directed by clinical evidence subject to appropriate levels of oversight and regulation.

Do you think that a process of certification by two healthcare professionals should be put in place for abortions after 12/14 weeks gestation in Northern Ireland?

Alternatively, do you think that a process of certification by only one healthcare professional is suitable in Northern Ireland for abortions after 12/14 weeks gestation?

If you answered 'no' to either or both of the above, what alternative provision do you suggest?

Our response to both questions above is no.

In our view requiring certification by a healthcare professional is clinically unnecessary and provides no additional safeguards for pregnant people or doctors.[16]

The provision of medical and surgical treatments, including abortion, is carefully regulated. The independent regulators of the healthcare professions, as well as the independent regulators of healthcare services, ensure that all medical and surgical procedures, including abortions, are performed in safe, appropriate locations, by appropriately qualified professionals adhering to best clinical practice. Where practice falls outside of regulations, regulatory bodies retain the authority to take action against the individual or service responsible, for example by imposing restrictions on,

[16]Select Committee on Science and Technology. (2007). *Twelfth Report*. Retrieved 27 November 2019 from https://publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/104507.htm.

or cancelling their registration. In our view, no additional form of oversight is necessary of justified in the case of abortion.

Requiring certification by a healthcare professional is likely to cause unnecessary barriers to access. In England, Wales, and Scotland the requirement that two doctors certify the need for an abortion is known to have caused delays in access to abortion services. These delays occur where women struggle to make prompt GP appointments or where they face negative attitudes and struggle to get a referral.

The regulatory system for abortion in Northern Ireland should avoid implementing clinically unnecessary, obstructive and administratively burdensome requirements for certification, and instead aim to facilitate access and timely treatment. Ensuring access and timely treatment is particularly important where time limits are placed on the availability of abortion, to ensure procedural delays do not interfere with women's ability to access legal, safe abortion services. Timely access can also lead to a decrease in adverse events.

In light of the evidence discussed above, the recently published NICE guideline on Abortion Care recommends a system of self-referral. A system of self-referral not only reduces the likelihood of delays but could improve women's experiences by allowing them to avoid stigma and negative attitudes when requesting an abortion.[17] A system of self-referral also presents the least burdensome system in terms of administration and cost. UNISON recommends that this approach, which is founded on the best available evidence, is taken in Northern Ireland.

[17] NICE Abortion Care (2019) https://www.nice.org.uk/guidance/ng140/chapter/Recommendations#making-it-easier-to-access-services

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?

If you answered 'no', what alternative approach do you suggest?

UNISON agrees that there should be central collection of abortion data, subject to strict confidentiality protections, to ensure future services are fit for purpose. However, we do not believe that a new notification process is required here and believe that this data can be collected through existing systems for recording procedures in Northern Ireland.

We do not wish any additional notification process which will impose unnecessary legal or administrative burdens or create additional cost burdens on the health and social care system.

We are also mindful for the potential for such data to be misinterpreted and misused by those who do not wish to see the law around access to abortion reformed. If the Government wishes to legislate for such a notification process, which we oppose, it must be accompanied by strong legal guarantees that data will be safely anonymised. Given that pregnant people may fear being stigmatised as a result of accessing a termination their right to privacy must be strictly upheld.

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?

If you answered 'no', what alternative approach do you suggest?

Do you think any further protections or clarification regarding conscientious objection is required in the regulations?

If you answered 'yes', please suggest additional measures that would improve the regulations

UNISON recognises that healthcare professionals have a right to conscientious objection. However it is vital that this right be balanced against the rights of pregnant people to access services without discrimination.

We would particularly highlight the following with regards to conscientious objection in relation to abortion:

- Nurses, midwives and nursing associates must at all times keep to the principles contained within the NMC Code. Paragraph 4.4 of the Code states that nurses, midwives and nursing associates who have a conscientious objection must tell colleagues, their manager and the person receiving care that they have a conscientious objection to a particular procedure. They must arrange for a suitably qualified colleague to take over responsibility for that person's care.

- Paragraph 20.7 of the Code requires nurses, midwives and nursing associates to make sure they do not express their personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way. This expression may be in any format including though the use of social media. Paragraph 20.10 of the Code states that nurses, midwives and nursing associates must use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times.

- In England, Scotland and Wales, Section 4 of the Abortion Act 1967 permits healthcare professionals to refuse to participate in any abortion treatment to which he or she has a conscientious objection, provided the treatment is not necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant person.

- The scope of this right has been clarified by the Supreme Court in *Greater Glasgow Health Board v Doogan and another* [2014] UKSC 68. The Supreme Court here held that 'participating' under section 4 meant actually taking part in

the process of treatment for termination of pregnancy. The course of treatment to which conscientious objection is permitted by section 4 is the whole course of medical treatment bringing about the termination of the pregnancy. It also includes the medical and nursing care which is connected with the process of undergoing labour and giving birth. But the ordinary nursing and pastoral care of a patient who has just given birth was not unlawful before the Abortion Act 1967 and thus not made lawful by it. 'Participate' means taking part in a hands-on capacity: actually performing the tasks involved in the course of treatment. Thus whilst the Supreme Court identified that some tasks carried out by the Labour Ward Co-ordinators who had raised the conscientious objection in the case would be within the scope of section 4, others would not be. Accordingly, healthcare professionals do not have a legal right to claim exemption from giving advice or performing the preparatory steps to arrange an abortion. Thus, all healthcare professionals should be prepared to care for women before, during and after a termination in a maternity unit under obstetric care.

- The current UK Government Guidance for Healthcare Professionals in Northern Ireland on Abortion Law and Terminations of Pregnancy (October 2019) recognises conscientious objection, but requires healthcare professionals raising such an objection to direct women to the appropriate advice and services.

UNISON is content that the conscientious objection provision should reflect the above understanding of practice in England, Wales, and Scotland. We do not think that any further protections or clarification regarding conscientious objection are required in the regulations.

Do you agree that there should be provision for powers which allow for an exclusion or safe zone to be put in place?

If you answered 'no', what alternative approach do you suggest?

Do you consider there should also be a power to designate a separate zone where protest can take place under certain conditions?

If you answered 'no', what alternative approach do you suggest?

Women and healthcare workers should be able to access services and their places of work without fear of intimidation or harassment.

Such harassment can cause significant distress and upset for women and their families and can negatively impact on staff wellbeing. Such protests interfere with rights to private and family life and enhance the stigma surrounding abortion.

UNISON fully supports the concept of exclusion zones in principle. This will be particularly important in Northern Ireland, where provision of abortion services is likely to be spread across a range of services.

We do not support the creation of separate zones where protest can take place under certain conditions. We believe that this would place a disproportionate emphasis on the rights of those seeking to protest compared to those accessing services. If it is concluded that an exclusion zone is required, it will be on the basis that the protest is inherently one which brings the risk of causing intimidation, harassment or distress. A separate zone for protest would simply undermine the concept of creating a safe space for staff and service users.

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

Trans Men and Non-Binary People: Throughout the consultation document, as well as the equality screening itself, those who may require access to abortions are referred to solely as 'women and girls', leading to the exclusion of many transgender men and non-binary individuals and the potential exclusion of those groups in any services

developed. While the majority of those accessing abortion will identify as women and girls, these services nevertheless must be accessible to all, especially considering the acute mental health impacts of pregnancy on many transgender men and non-binary people. The exclusion of those whose legal documents, physiology and/or expression may be gendered differently from the specific wording of the legislation will lead to the creation of barriers to accessing abortion services. Therefore, the legislative framework - as well as any services developed from that framework - must be inclusive and mindful of those experiences directly in the language used, and be developed in collaboration with trans civil society organisations to ensure all needs can be met within these services.

CONCLUSION

Given the concerns highlighted within this submission UNISON would welcome a clear commitment on the part of the NIO to engage with us and other relevant stakeholders in respect of these proposals. We anticipate a detailed response to our comments which demonstrates that they have been given proper consideration. We believe that direct engagement is the most valuable form of engagement in relation to these proposals.

For further information, please contact:

John Patrick Clayton, Policy Officer – j.clayton@unison.co.uk

Telephone – 028 90270190

UNISON, Galway House, 165 York St, Belfast, BT15 1AL