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Abortion Policy - Challenges and Opportunities

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How a society legislates on abortion raises challenging and controversial issues. We are currently conducting pilot work in this area to consider the contrasts in abortion policy globally, nationally and regionally. This has included desk research and discussions with some stakeholder organisations. The pilot work will inform the design of a larger scale project which we are currently seeking funding for. Preliminary findings are reported below.

This Policy Briefing sets out abortion law and policy in Northern Ireland (NI) from its inception to date, setting it within the international context, Great Britain (GB) and the Republic of Ireland (ROI). To contribute to discussion and debate on the prevailing law and policy in NI in this area, this Briefing also examines evidence related to the demand for abortion services in NI, including an analysis of 10 year trends in the profile of those who travel to England and Wales for abortion services, looking at age, marital status and ethnic identity (white Irish/ white British). It also provides analysis of data that is available on those who access abortion services in NI and considers briefly issues related to self-abortion at home. In conclusion, the Briefing identifies issues which will facilitate the development of broader research themes and additional sources of data, thereby enabling a comprehensive consideration of the range of issues impacting on abortion policy.

International context

Although the international community has been concerned with population growth for more than a century, a decisive shift in interest towards sexual and reproductive health took place in 1994. In that year, delegates from more than 179 countries and more than 1200 nongovernmental organisations met in Cairo at the International Conference on Population and Development (ICPD) and agreed a programme of action to improve sexual and reproductive health (UN, 1995). Cairo also marked a major shift in approach with respect to incorporating universally recognised human rights – including women's ability to control their own fertility – into the programme of action (Glasier et al, 2006). The Cairo definition of reproductive health is broad and all-embracing:

> *Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.* (UN, 1995)

The United Nations therefore maintains that individuals should be able to exercise control over their sexual and reproductive lives. This includes the rights to: reproductive and sexual health as a component of overall health; reproductive decision-making (including voluntary choice in marriage, family formation and determination of the number, timing and spacing of one's children and the right to have access to the information and means needed to exercise voluntary choice); equality and equity to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender; and, sexual and reproductive security (including freedom from sexual violence and coercion, and the right to privacy). One of the reasons that the UN is particularly concerned with reproductive health and fertility control is because it has been shown to be central to achieving the Millennium Development Goals (UN Millennium Project, 2005).
Three of the Goals are especially relevant. Millennium Goal 4, to reduce child mortality, and Millennium Goal 5, to improve maternal health, are health-related goals with relatively clear connections to reproductive health. The World Health Organisation (WHO), for example, has estimated that the use of effective contraception by women who want to delay or stop child-bearing can prevent 32% of maternal deaths; and the use of contraception to promote birth spacing is estimated to prevent 10% of infant deaths (WHO, 2011). Millennium Goal 8, to promote gender equality and empower women, also requires women to exercise reproductive control in order to participate in societal and individual developmental activities (WHO, 2011).

According to the WHO, around 21.6 million women experience an unsafe abortion worldwide each year; 18.5 million of these occur in developing countries. 47 000 women die from the complications of unsafe abortion each year, and deaths due to unsafe abortion remain close to 13% of all maternal deaths (WHO, 2011). The WHO's Reproductive Health Strategy thus urges member states to achieve universal access to sexual and reproductive healthcare (Glasier et al, 2006). To achieve this, access to contraceptive services are crucial (Marston and Cleland, 2004; Glasier et al, 2006) but do not provide a complete solution - recent research has shown that many women experiencing an unintended and unwanted pregnancy were using a form of contraception at the time of becoming pregnant (Bury and Ngo, 2009; Bury et al, 2014). Additional global trends that have been observed are that the rate of abortion is often higher in countries where abortion is illegal compared to countries where abortion is available and that safe abortion is not just dependent on legal access but that steps must be taken to address other barriers such as abortion stigma (WHO, 2011). Finally, it is significant to note that the UK is committed to improving reproductive rights globally, as demonstrated in strategies such as A Strategic Vision for Women and Girls (DFIDa, 2014) and its policy on Safe Abortion (DFIDb, 2014).

<u>GB context</u>
The legal framework for abortion in England, Wales and Scotland is the 1967 Abortion Act. This Act, as amended by the Human Fertilisation and Embryology Act 1990, permits abortion up to 24 weeks in specific circumstances (when two doctors agree that continuing with the pregnancy would be more harmful to the physical or mental health of the pregnant woman or any existing children of her family than if the pregnancy was aborted). After 24 weeks an abortion is permitted if it is necessary to save the woman's life; or it will prevent grave, permanent injury to the physical or mental health of the

pregnant woman; or there is a substantial risk that if the child were born it would suffer from serious physical or mental anomalies. When these conditions are not met, the law on abortion is still governed by the 1861 Offences Against the Person Act. In law, at no gestational point do women have the right to an abortion on request. In addition, abortions must be carried out in a hospital or a specialist licensed clinic.

Current Debates on Legislative Reform: England, Scotland and Wales

The 1967 Abortion Act was developed in a context where public opinion was more ambivalent about abortion than today. In 1983, 37% of people surveyed thought that women should be allowed to decide if they wanted an abortion. The figure now is 62% (Park et al, 2013). This reflects, amongst other things, the changing social context of abortion, in particular, the changing position of women, as well as medical advances. Making progress with respect to women's equality relies upon the ability to make choices about pregnancy and childrearing. All the main political parties in Britain make provision for legal abortion, supported by health policy (DoH, 2013). It is increasingly accepted by practitioners that the provisions of 1967 Act are out of touch with best practice in abortion care (Lee, 2013). Medical advances in the abortion field, and a significant body of research on women's abortion experiences could lead to continual improvements in provision (Hoggart, 2015). Specific provisions of the Act that prevent this are: the requirement for two doctors to authorise each abortion; women being prevented from home-administration of early medical abortion; and, nurses and midwives not being permitted to perform an abortion. These changes underpin debates around decriminalisation of abortion, in general, and removal of abortion from the context of the 1861 Offences Against the Person Act, in particular. In October 2014, at a meeting at the House of Commons, doctors, lawyers and abortion practitioners began a campaign to reform Britain's abortion law, in effect to regulate abortion as any other clinical procedure. The Law Commission is currently reviewing the terms of the 1861 Act.

One final area of debate is the issue of women from one area of the UK (Northern Irish women) needing to travel and pay for their abortion in England. Many consider this inequitable. Cases of abortion for fatal foetal anomaly cause particular concern. Two emerging issues from the pilot (mentioned in the introduction to this Policy Briefing) are: citizenship, and compassionate healthcare. One abortion provider said:

> *The thing that always strikes me about these women is that they are faced with this awful dilemma. They have a planned pregnancy that hasn't turned out as expected and they are dealing with the shock and upset of that and then when they are looking for medical help they find that they can't get that help and that people are not helpful, and they have to start making arrangements and talking to people about all this really emotional thing and trying to arrange flights and hotels. It just seems so awful that they have to face this other dilemma and come to England and have to terminate for a much wanted pregnancy, away from home, away from the support of family. It always upsets me that they've got this one big problem and then it's added to.*

ROI Context

Abortion in ROI was historically governed by the 1861 Offences Against the Person Act, a hangover from Ireland's time as part of the British Empire. Similar to NI, access has been limited; whilst data on abortions are not published by the Irish government, evidence presented at a government hearing referred to around 30 legal abortions being carried out per year. In contrast, 3,750 travelled to England to access abortions in 2014. Despite several high-profile cases, most notably the X case in

1992 and the Savita Halappanavar case in 2012, alongside calls from international human rights bodies, the Irish government failed to enact liberal reform (Bloomer and O'Dowd, 2014). The most recent legislation, The Protection of Life During Pregnancy Act 2013, has been criticised by those who seek a more liberal approach to abortion access. They point out that it places several hurdles in the way of a person seeking an abortion, and limits access to those whose life is at risk (Fletcher, 2014). Others, however, who opposed its introduction argued that the law was too liberal.

NI evidence related to the demand for abortion services

Access to abortion in NI is governed by the 1861 Offences Against the Person Act and case law which allows abortion in circumstances where the woman's life is in danger or the pregnancy poses a "real and serious, permanent or long term" risk to her health and well-being (Bloomer and Fegan, 2014). Data collated by the Health and Social Care Trusts indicate that during the reporting periods 2006/07 to 2014/15 an average of 39 abortions were carried out per year on NHS premises (Table 1 below). The majority of these were carried out on women aged 30+. Whilst data is collated on other variables such as which health trust the abortion was carried out in and country of origin the small numbers within each category are not sufficient for statistical analysis (DHSSPSNI, 2016).

Table 1: Abortion Data for NHS Northern Ireland – Age profile

Year	24 & Under	25 – 29	30 & Over	Total
2006/07	7	15	35	57
2007/08	12	9	26	47
2008/09	9	8	27	44
2009/10	6	9	21	36
2010/11	7	10	26	43
2011/12	8	4	23	35
2012/13	14	11	26	51
2013/14	4	8	11	23
2014/15	3	7	6	16

Those unable to obtain an abortion on the NHS obtain abortions by other means. In significant numbers they travel to private clinics in England, whilst others access the abortion pill (also referred to as medical abortions) from internet-based providers such as Women on the Web and Women Help Women, in order to self-abort at home (Bloomer and O'Dowd, 2014). Unknown numbers obtain medical abortions (up to 9 weeks 4 days gestation), within the current legal framework, from Marie Stopes International in its sexual health clinic in Belfast. The cost of accessing abortion ranges from £70 from internet providers to £600–£2000 for those who travel to England (this includes clinic fees and flights/ ferry costs: fpani et al, 2010). Such costs create a significant burden to women with low incomes and can also lead to delays in obtaining an abortion, thereby increasing costs. The challenge in providing an explanation for their absence from home in instances where the abortion remains a secret is faced by all women, but more so for those from poorer backgrounds (Rossiter, 2009).

An analysis of 10 years of data provides insight into the age, ethnicity and marital status of those who travel to England. This data is provided to the Department of Health (England and Wales) by abortion providers throughout its jurisdiction. This data is thought to be an under-representation of all who travel, as they may for various reasons not wish to disclose their home address. Over the period

2005 to 2014 an average of 1075 residents per year travelled from Northern Ireland to England to obtain an abortion (this ranged from a peak number of 1343 in 2007 to 802 in 2013.

As detailed in chart 1 a wide range of ages travel to obtain abortions in England. The most common ranges being typically within the categories of 20-24 and 25-29. Teenagers represent less than 20% of all those who travel. In terms of marital status (chart 2) the majority of those who travel are in a relationship (married / civil partnership / with partner).

Chart 1 Age profile - Northern Ireland residents who travel to England

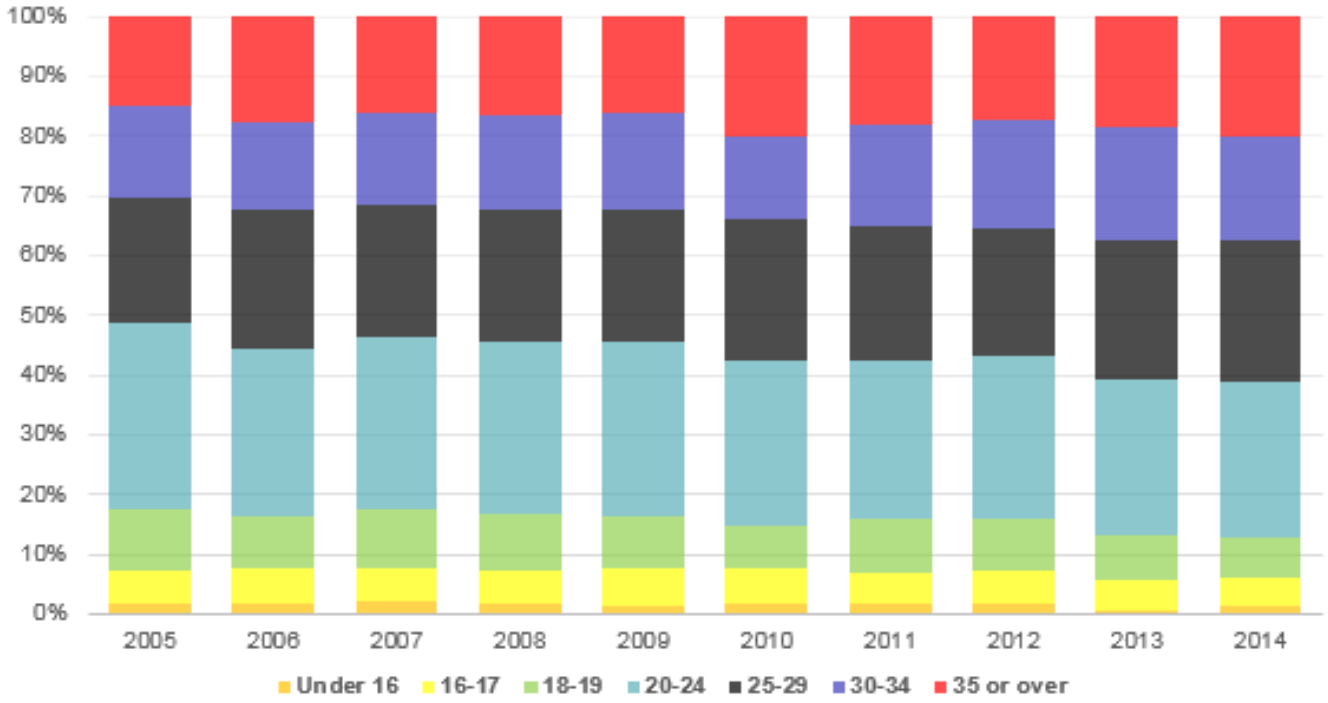

Chart 2 Marital status - Northern Ireland residents who travel to England

In terms of ethnicity (chart 3) the category white / Irish is typically the most frequent ethnic group chosen, with white/ British in second place (note: data on ethnicity was not available for 2014 due to data protection issues).

The majority of abortions carried out in clinics in England on residents of Northern Ireland are within the time period of 3-9 weeks gestation, with overall almost 90% within 12 weeks gestation. Prior to the time period of this study the figures were noticably lower for the earlier gestation time. This change in earlier gestation times is ascribed to the increasing availability of information on abortion services and financial support from Abortion Support Network, reducing the burden on lower income families to gather funds for travel and clinic costs.

Cases with later gestation times typically include those who have received a diagnosis of fatal foetal anomaly. Families supported by Abortion Support Network (ASN) in these situations include the following:

> "A *couple who had received a diagnosis of fatal foetal anomaly, but could not tell their parents or anyone in their family about the pregnancy. The couple have a child with a genetic disorder and were terrified of having a second child with the same condition. The couple had no money but were able to borrow £150, the rest of the costs were donated by ASN."*
>
> *"In another case a couple pregnant with twins with fatal foetal anomalies needed support. They tried everything to receive care in NI because they wanted to have a funeral for their babies and also because they were concerned about the possibility of an underlying genetic condition and wanted to bring the babies' home for an autopsy so they could be aware for future pregnancies. This couple were very young and even though they had the support of their families they were barely able to raise £100"* (author interview with ASN, 2016).

Families who wish to have a burial or cremation (or an autopsy) after an abortion in England are also faced with the task of having to organise how they can bring the foetal remains home. This might

include using specialist services (at a cost of approx. £400), a parcel courier or as some have done, bringing the remains home themselves, in their hand-luggage if flying, or in a car if travelling by ferry (author interview with ASN, 2016). Those wishing to have an autopsy conducted in Northern Ireland have no clear pathway to request this, resulting in clinic staff liaising with local health settings in Northern Ireland to arrange tests or tests being conducted in England, which the families would have to pay for. The challenges faced by families in these circumstances are highlighted in the following case:

> *I remember one particularly difficult case where the couple wanted testing and the hospital in Belfast had agreed to do the tests but the timing of the couple's flight getting into Belfast meant they would miss the mortuary opening hours. I had to call several people at the hospital to try and find somewhere suitable for the couple to bring the baby. In the end I spoke to a midwife, who suggested the couple bring their dead baby "up to the labour ward". She was lovely but just didn't think that through. Of course I highlighted how asking a couple who had just lost their baby to bring the remains up to the labour ward might be seen as cruel, that maybe we could arrange for someone to go and meet the couple somewhere else in the hospital would be a great kindness* (author interview with BPAS, 2016).

NI Policy development

Since its inception in 1998 until 2015 the Northern Ireland Assembly has held four major debates on abortion (Hansard 2000, 2007, 2013, 2015) These sessions have centred on the issue of legal reform or policy issues such as guidelines for medical staff. The use of evidence is largely absent from such debates, this includes high quality reliable data such as that considered above, from the Department of Health (England and Wales) on those who travel, research on preventing crisis pregnancies and abortion (Bury, 2009; Marston and Cleland, 2003; Raymond and Grimes, 2012; WHO, 2011) and expert opinion from health providers. Instead, earlier debates exhibited examples of abortion myths (such as negative health risks) whilst more recent debates centred on presenting women seeking abortion as 'vulnerable' and in need of protection. Competing views are evident: prevalent within the Assembly debates are recurring themes of religiosity and stigma about abortion (Pierson and Bloomer, forthcoming). In contrast, the fpani has sought to improve access to abortion in Northern Ireland by lobbying for guidelines for health professionals to enable them to interpret the law on abortion on a consistent basis; arguing that the absence of guidelines has resulted in the denial of abortions which could have been provided even under Northern Ireland's very restrictive laws. This campaign led to the launch of a judicial review in 2001 and a long legal battle resulting in the first draft guidelines being issued some years later in 2007. The most recent draft guidelines issued in 2013 were widely criticized by health professionals and, it is argued by campaigners, later led to the denial of abortions on grounds of fatal foetal abnormality (FFA). One woman who made her story public, Sarah Ewart, had to travel to England to obtain an abortion from a private provider and pay substantial costs for doing so (Bloomer and O'Dowd, 2014).

The proposed legal reform by the Department of Justice, which followed such cases, recommended allowing abortion on grounds of FFA (DOJ, 2015). A judicial review published in late 2015 concluded that abortion should be permitted on grounds of FFA and rape/incest, noting that to force women to travel in such circumstances would place them under greater stress. The judgement also noted the restrictions had a detrimental impact on those from poorer backgrounds and that the inordinately slow progress in publishing guidelines was indicative of how politicians in Northern Ireland dealt with contentious issues (NIQB96, 2015). Both the Attorney General and Minister for Justice lodged appeals against the judicial review in January 2016, with the Minister of Justice stating that the

absence of "legal certainty" could lead inadvertently to abortion on demand. Alongside the need for clear policies and legislation, there is also evidence that training for health professionals does not meet their needs (Steele, 2009) with medical students seeking abortion training from outside core provision (Medical Students for Choice, 2015).

Conclusion

This Policy Briefing considered evidence from a pilot study exploring issues related to abortion policy globally, nationally and regionally. The research highlights the need to improve access to abortion in NI. It notes that the lack of progress on legal reform has led advocates and campaigners to take legal action though this will likely impact on only a small number of cases. The evidence indicates that continued restrictions on access are experienced unequally as those with low incomes have to fund travel and other costs alongside abortion costs, if they travel out of Northern Ireland or access the services of Marie Stopes International in Belfast (if they fit within the current legal framework and fulfil the requirements for a medical abortion). The alternative for others is to access the abortion pill from online providers and self-abort at home.

In summary, Northern Ireland presents as a classic case of legal restrictions on accessing abortion not halting abortion, but displacing it to another jurisdiction or contributing to abortions being conducted away from a healthcare setting.

To move forward research should inform: assessing access to and knowledge of contraceptives; provision of appropriate training for health professionals; guidance for health professionals; legal reform; and programmes to challenge stigma.

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