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Abortion Consultation
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16th December 2019

Re: Response to the public consultation on 'A new legal framework for abortion services in Northern Ireland - Implementation of the legal duty under section 9 of the Northern Ireland (Executive Formation etc) Act 2019'

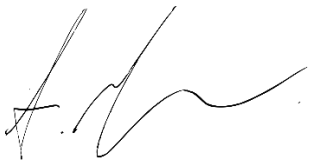
To Whom It May Concern,

This is a response to the Northern Ireland Office's consultation on a new legal framework for abortion services in Northern Ireland, and is submitted by TransgenderNI, a not-for-profit human rights organisation based in Belfast. TransgenderNI exists to promote and support the human rights of trans and gender diverse people in Northern Ireland, including through policy work and service development.

We are the organisation responsible for the running and funding of the Belfast Trans Resource Centre, the only trans community centre in the UK & Ireland, and delivery of consultancy and training services to public authorities on trans inclusion across Northern Ireland. We are members of Transgender Europe and have been expert consultants & contributors on projects at EU/European Commission level and at United Nations level.

This response represents the views of the organisation, as developed through community interaction over the past 24 months in collaboration with other trans community organisations and through our close work with pro-choice movements/organisations in the region.

Yours faithfully,



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Response from TransgenderNI to the Northern Ireland Office's public consultation on *a new legal framework for abortion services* in Northern Ireland

We welcomed the Northern Ireland (Executive Formation etc) Act 2019 being passed earlier this year, mandating the UK Government to provide access to abortion services in line with the UN CEDAW Committee's recommendations in Northern Ireland by 31st March 2020. This legislation decriminalised abortion, repealing sections 58 and 59 of the Offences Against the Person Act 1861, and placing a moratorium on abortion-related criminal prosecutions.

Consent to disclose

We give full and informed consent to the disclosure internally and to the general public of this consultation response in full.

Context for our response

In much of the public discourse throughout our society surrounding access to abortion, the perception is often that only women will benefit from these changes to the law. In reality, many trans and gender diverse individuals who can get pregnant will use these services, and their wellbeing will improve as a result of those services being made available. For many trans men, non-binary and gender diverse people who can get pregnant, pregnancy can be a mental health emergency and can cause the rapid deterioration of an individual's wellbeing. As a result, any services providing reproductive healthcare in the form of medical or surgical abortion will need to be developed with these different needs and experiences in mind.

Where there was an opportunity to take these needs and experiences into account – specifically, in the Section 75 equality screening the Northern Ireland Office chose to undertake on this legislation – the NIO did not to address any potential barriers to accessing abortion services for trans individuals. This was closely mirrored across almost all protected groups under Section 75: no barriers were identified for disabled people, LGB people, racialised groups, or those with dependents. This equality screening was wholly inadequate and did nothing to ensure that barriers to accessing services for those from diverse backgrounds were proactively addressed.

For trans communities to have meaningful access to abortion, this proactivity includes changing the language used when discussing the topic to incorporate and respect diverse experiences. Legislating for 'women and girls' to have access to abortion, and developing services based on this, will result in trans people self-excluding from these services and procuring backstreet abortions or travelling. In a worst-case scenario, the exclusionary language used throughout the consultation document and proposed legislation could be used to explicitly deny trans individuals who have accessed legal gender recognition access to abortion care.

Creating meaningfully accessible abortion in Northern Ireland means legislating for abortion services to be provided in a safe environment, locally, and in a way that ensures the comfort and wellbeing of patients. This must extend to trans individuals. As a result, this consultation response is written specifically from a trans-affirming and

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inclusive perspective, with the aim of ensuring that this legislation is fit-for-purpose for trans communities.

Please note: where brackets have been used, it is for the purposes of ensuring that the language of the question(s) is inclusive of trans identities, bodies and experiences.

Our response to the specific consultation questions

Q1: Should the gestational limit for early terminations of pregnancy be:

- Up to 12 weeks gestation
- Up to 14 weeks gestation

Neither

In the consultation document, the reasoning behind this proposal is to ensure that those who are victims of sexual crimes, including rape and incest, are able to access abortion care in a sensitive manner without being forced to evidence their experience of sexual crime.

Trans people of all genders are at a significant risk of experiencing sexual abuse, with around 47% having experienced sexual abuse by a partner/ex-partner[1]. This of course does not take into account those who experienced this abuse from anyone who wasn't their partner, so this figure may not tell the whole story. Henceforth, any provision to ensure access in cases of sexual abuse will need to be in line with the experiences of those trans individuals who experience it as well as cisgender women.

We do not believe that 14 weeks is long enough to ensure that all those who experience pregnancy as a result of sexual crime are able to access reproductive care should they wish to avail of it. Domestic and sexual abuse, reproductive coercion and trauma are incredibly complex issues with unique mental and physical health implications. In many cases, abuse or coercion may make it harder for individuals to access abortion services early in the pregnancy, necessitating provisions to be made to accommodate those individuals.

For trans men and non-binary victims who are also on hormone replacement therapy (HRT) this presents additional complications. Taking testosterone will usually cause changes to an individual's menstrual cycle, and after some time, many find that it can stop menstruation completely. The effect of testosterone on an individual's menstrual cycle varies significantly, with some finding their periods stopped almost immediately and others finding they continued years into taking HRT. For those who aren't on HRT, many choose to access birth control to prevent periods, as they can be a source of significant gender dysphoria.

The reality is that many people only realise that they have fallen pregnant due to a missed period. If an individual's menstrual cycle has already been interrupted by HRT or birth control, there is a chance they will only realise that they are pregnant after the 12/14-week limit has passed, leading to them having to recount their experience of sexual abuse in order to access basic healthcare.

This retraumatisation of individuals simply seeking care can easily be avoided through providing unrestricted access to abortion up until the point of viability (currently 24

[1] 'Out of sight, out of mind? Transgender People's Experiences of Domestic Abuse' (2010): https://www.scottishtrans.org/wp-content/uploads/2013/03/trans_domestic_abuse.pdf

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weeks in the rest of the UK). This will help ensure that no individual of any gender will be forced to travel to Britain for a termination.

Unrestricted early access to abortion services will meet the needs of the vast majority of all individuals seeking terminations. It is vital that this access is guaranteed, so as to ensure that many of the most vulnerable individuals seeking abortions – those who have been victims/survivors of sexual abuse – are able to do so in a way that doesn't retraumatise them or worsen their mental health and wellbeing.

Q2: Should a limited form of certification by a healthcare professional be require for early terminations of pregnancy?

No

Much of the debate surrounding access to reproductive healthcare is revolving around the topic of bodily autonomy: to ensure that those who can get pregnant have full decision-making powers over their desire to continue that pregnancy or access a termination.

Abortion care should be treated as an area of sexual and reproductive health, and as such an informed consent model should be adopted to ensure that those who are pregnant are able to come to a decision on their continuation of the pregnancy without requiring 'permission' from a medical professional to access care.

For the majority of those seeking terminations, this will be carried out in the form of a pill. While we recognise that when a pregnancy is approaching the upper gestational limit verification may be required, requiring this verification in all cases is simply placing an additional barrier to accessing care for vulnerable individuals during what is often a very sensitive and triggering point in their lives.

There is no evidence to suggest that certification adds more safeguards for those who are pregnant, and it has the potential to delay care. This certification process could manifest itself akin to a waiting period for those attempting to access care – something which, in the Republic of Ireland, has led to individuals continuing to be forced to travel to Britain to access basic reproductive care.

Given that abortion is no longer in the realm of criminal law, early access can and should be provided without the requirement for certification by doctors. While this certification may become more necessary closer to the upper gestational limit, the vast majority of abortions taking place will not require it and the individuals accessing care would benefit from having one less barrier to get through.

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Q3: 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 [person], or any existing children or [their] family, greater than the risk of terminating the pregnancy, be:

- 21 weeks + 6 days gestation
- 23 weeks + 6 days gestation

The consultation document reveals little about the process through which physical and mental health would be assessed. In some jurisdictions, these criteria have been interpreted conservatively by service providers, leading to heavy restrictions being put in place for accessing abortion into the 2nd term.

MENTAL HEALTH

In Northern Ireland, there is a mental health crisis within trans communities. Statutory mental health services are often inaccessible or unsuitable for trans people, with medical professionals simply not having the cultural competency or training to adequately support these individuals.

For those individuals seeking access to transition-related-healthcare, there is a requirement for 'relatively stable psychological health' for a period of six months before doing so. As a result, trans people often misreport their mental health, and are unable to access support due to a fear that doing so would jeopardise their position either on the waiting list for Gender Affirming Services or within those services themselves.

This presents a potential barrier to accessing care, and may result in trans individuals in the second trimester self-excluding from NI services and being forced to travel for fear of information about their mental health being shared with the Gender Affirming Services without their consent.

Further, there is a body of evidence suggesting that many health professionals are not adequately trained in mental health[2] generally, not to mention the nuances of mental and physical health within trans contexts. Many of our service users have attested to feeling as though their GP, counsellor or psychiatrist has little to no understanding of the complexities and nuances of health and wellbeing within trans communities. This includes the asking of invasive or inappropriate questions, not knowing what a trans person is or simply not respecting their identity.

With the lack of clarity being provided on the assessment process for mental health related terminations, coupled with the already existing barriers to accessing culturally competent mental health care, we reiterate our belief that unrestricted access to abortion up to the point of viability (24 weeks) is the best practice approach to ensuring that no one is forced to travel to Britain to access a termination, as stated in our response to Q1. This approach would go some way to ensuring that the barriers to accessing 2nd trimester abortions for trans people are meaningfully mitigated.

[2] Participation and the Practice of Rights (2019) 'Counselling - A Vital Tool: Equipping GPs With Mental Health Expertise' https://www.pprproject.org/sites/default/files/documents/%23123GP%20Report%20FINAL_0.pdf

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PHYSICAL HEALTH

Within trans communities, mental and physical health are often inextricably linked. Trans people's ability to access reproductive care has a significant impact on how they perceive their bodies, and can mitigate some gender dysphoria that many trans people experience.

Pregnancy can have a detrimental impact on how a trans person's physiology is perceived by others, which may lead to worsening mental health and an increased likelihood of self-harm, suicidality, and generally self-destructive behaviour. Thus, pregnancy can have an impact on mental and physical health in equal measure for trans people.

Further, due to the absence of anomaly testing at 12 weeks, many risks to physical health are not detected until the 20-week scan. This scan can often be subject to delays due to scheduling issues and the overburdened nature of our health service. If an anomaly is detected, a referral to the Foetal Medicine Unit may be required, alongside further tests and scans which could potentially take up to another week to 10 days. If there are any issues with the testing process, or if any tests need to be repeated, this can cause further delays.

The pressure caused by the imposition of a hard deadline on the provision of abortion means that pregnant people who experience these complications within the pregnancy may not have the time to fully consider all the information and come to a decision, or may feel pressured to rush this decision. Hence, the provision of abortion after 24 weeks in these cases is essential to ensuring that no one is left without care, forced to undergo a 'backstreet abortion' or travel elsewhere for termination.

Placing hard limits on healthcare is never the answer; individual cases will always stretch any boundaries or limits arbitrarily chosen by policymakers. Ensuring the appropriate provision of care, based on the individual situation at whatever point which they have reached in their pregnancy and not revolving care around these arbitrary lines is the only way to provide best practice reproductive healthcare.

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Q4: Should abortion without time limit be available for foetal abnormality where there is a substantial risk that:

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

It is imperative that, in these difficult cases, pregnant people are treated with compassion and given all the options to make an informed choice at their own pace.

In our responses to previous questions, we have explored why abortion should be provided after 24 weeks. In cases of foetal abnormality, these can be some of the most difficult, complex and sensitive cases, and can be an incredibly emotionally turbulent time for the pregnant person.

For the majority of pregnant people, pregnancies that have continued into the third trimester are usually ones which they intend to bring to term. Accessing abortion late in that process will usually be an incredibly difficult decision to make, brought about by an incredibly difficult situation. It is important that this decision is not made even harder by the potential of having to travel, as many continue to do in the Republic of Ireland, due to their restrictive definition of what foetal abnormalities are covered by these provisions.

It is vital to note here that the CEDAW committee requires the availability of abortion after 24 weeks in both cases of fatal *and* serious foetal abnormality; not just fatal, as is the case in the Republic of Ireland.

This question also raises concerns about disability discrimination, and a lack of public awareness – and even awareness in the medical profession – of the reality of being disabled in Northern Ireland.

There is a distinct need for healthcare professionals to be better educated on many conditions and able to provide balanced information about the implications this may have on quality-of-life, thus empowering the pregnant person to make a truly informed decision.

Further, having meaningful choice in continuing or not continuing a pregnancy where there is a foetal abnormality is often dependent on the level of state support available for families with disabled children. The current UK government has been consistent in its opposition to the human rights of disabled people, cutting living allowances for disabled people of all ages and letting support services suffer without investment. If families are to have genuine choice in these situations, our society and our state needs to value and meaningfully support disabled people within it.

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Q5: Do you agree that provision should be made for abortion without gestational time limit where:

- There is a risk to the life of the [pregnant person] greater than if the pregnancy were terminated?
- Termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant [person]?

Access to abortion without time limits to protect the life of the pregnant person is global best practice, and is accepted in almost every country in the world.

Often, misinformation around the 'dangers' of abortion masks the reality that the risks of continuing a pregnancy are often higher than the risks of accessing a termination. In cases where a continuation of pregnancy would cause grave harm, this may be the best course of action for some individuals.

We reiterate our concern that healthcare professionals in Northern Ireland have limited understanding of trans health, especially mental health, and ensuring that those who do need access to late-stage abortions for these reasons are actually able to is imperative. This requires proactive work to improve understanding of mental and physical health for trans people, as well as mental health for anyone accessing abortion.

This is just as prevalent, if not more so, in the psychiatric profession, where trans individuals often face pathologizing treatment by mental health professionals. It should be noted that these professionals are not required to be involved in the assessment of this criteria in other countries. In Kenya, for example, it is recommended that determination of danger to 'life or health' is carried out between a trained healthcare professional in consultation with the patient.

Ensuring that this determination is accessible to trans people, and any others who get pregnant, requires an approach that affirms the individual's needs, wants and experiences, and works with them to come to conclusion about the best approach for the patient. This should not take the form of a formal psychiatric assessment.

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Q6: 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?

Abortion care should be treated like all other forms of sexual and reproductive healthcare and should be framed within an informed consent model.

This model will not require care to be delivered by doctors; indeed, early medical abortion provision in many countries is led by nurses and midwives – including in Scotland – which may be a better use of staffing resources. This approach has been recommended in the NICE guidelines[3] published earlier this year, as well as in WHO guidance[4].

Nurse-led early medical abortion care is possible here in Northern Ireland; it would go some way to ensuring that access is provided across rural areas, with a flexible model of care appropriate for this region.

This will require a body of staff that is trained and competent in the provision of abortion care. A training programme should be developed in collaboration with women's civil society and trans community organisations, should include a dedicated session on supporting trans communities in their work and in accessing abortion care, and should be inclusive of trans experiences throughout. Only through healthcare providers being knowledgeable on trans needs and experiences will abortion care be truly accessible to our communities.

Q7: 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?

Due to gendered perceptions of pregnancy and abortion care, accessing dedicated abortion services may be an uncomfortable experience for many trans folks.

The flexible provision of care is essential for ensuring access for many underserved groups, including trans people, disabled people and those in rural areas, Local access for early term medical abortion, managed through a primary care facility such as sexual and reproductive healthcare clinics and GP surgeries, is necessary in Northern Ireland to ensure access across the region. For patients with complex needs – i.e. requiring general anaesthetic – facilities should be scaled up appropriately.

[3] https://www.nice.org.uk/guidance/ng140/chapter/Recommendations
[4] https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf?sequence=1

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Further, in England, Scotland, and Wales, misoprostol has been cleared for home use, providing more options for pregnant people to make decisions over their surroundings, This will have a particular benefit for trans people seeking abortions; as previously mentioned, accessing dedicated clinics can be a sensitive and uncomfortable experience for many, so providing home access for early-term medical abortions would have a significantly positive impact on access. This would also improve access for those in rural areas, and is a common-sense approach to reducing reliance on dedicated services already under strain from funding cuts.

Where required and requested, dedicated counselling services should be provided, including for those with unintended pregnancies or ambivalent feelings, victims of sexual abuse and for people post-termination.

As mentioned previously, any medical professionals involved in providing abortion care must be trained on supporting trans individuals to ensure positive experiences across the board.

Q8: Do you agree that terminations after 22/24 weeks should only be undertaken by health and social care providers within acute sector hospitals?

No

The decision on where to carry out an abortion procedure is one that should be made in a clinical setting, not in legislation.

While it is highly likely that procedures taking place after 22/24 weeks will be in these hospitals, making this a legally mandated restriction has the potential to stigmatise those accessing abortion and the procedure itself.

Q9: 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?

No

Requiring a process of certification for abortion care treats it distinctly from other areas of healthcare, places barriers to accessing care, and is rooted in criminal law that is no longer applicable in NI.

In Great Britain, the certification process is required due to abortion regulations being rooted in criminal law. Since abortion has been decriminalised in Northern Ireland, a certification process is not necessary. There is a distinct lack of clinical evidence suggesting this process improves the safety of patients accessing care or provides any clear benefit to abortion services. Indeed, often certification creates a barrier to accessing care and can lead to delayed treatment.

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Abortion care should be treated as part of sexual and reproductive healthcare, and an informed consent model should be used.

For trans individuals accessing care, discussing pregnancy and going through a process of certification can be an extremely uncomfortable experience. As mentioned previously, pregnancy can be a dysphoria-inducing process for many trans men and non-binary people. Placing an arbitrary delay and additional barrier to accessing abortion care in the form of certification would have a negative impact on access for and experiences of trans patients in these services, and would simply prolong a process that may be having a distinct negative impact on their mental and physical health.

Further, there is no evidence in favour of requiring more than one healthcare professional to certify a patient accessing abortion care. Healthcare professionals work in multidisciplinary teams across the health service in NI; requiring more than one to certify would be an unnecessary administrative burden and would further stretch resources in the health service.

If the decision is made to implement a certification process – which, we stress, will negatively impact access and contribute to the stigmatisation of abortion – it is vital that this process only relies on one healthcare professionals. Requiring two would impact care in rural areas, and would do nothing but delay care and worsen experiences for patients.

Q10: 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

Trans-inclusive data collection on abortions performed is part of good governance, can help inform policymakers and improve access to services.

However, it is important that this notification process is not separate and distinct, and should be no different to the notification process in similar services. Exceptional notification processes have been used in some countries, for instance the United States, as part of over-regulation of abortion service providers and as a strategy to negatively impact access.

Ensuring that this data collection is mindful and inclusive of the identities and experiences of trans men and non-binary individuals who may be accessing abortions is also essential for maintaining the accuracy and usefulness of this data.

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Q11: 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?

Robust guidance on conscientious objection is already applied through the codes of practice of medical governing bodies. Building this into the legislation treats abortion differently to other medical procedures, despite clear existing guidance.

The General Medical Council, Nursing Midwifery Council and Royal College of Nursing have provided clear and robust guidance on conscientious objection, which can easily be applied in a clinical setting without the need for this to be written in the legislation. This guidance is clear that conscientious objection cannot apply in an emergency situation where there is a risk to life or a risk of serious deterioration in the health of the patient.

Access in emergency situations may have a disproportionate impact on trans people, who, due to the additional discomfort of pregnancy for many trans people and an inability to access mental health care, may be seeking terminations at a crisis point. There is also a risk of conscientious objection being used against trans people disproportionately due to previously held transphobic views amongst medical practitioners.

Q12: Do you think any further protections or clarification regarding conscientious objection is required in the regulations?

It is vital that staff who have a conscientious objection are supported in not providing abortion care, not least to ensure that pregnant people have a positive experience accessing care without receiving treatment from those who don't support their decision.

It is also vital, on the other side of this, that staff who are committed to providing abortion care are also supporting in doing so and protected from discrimination from colleagues, harassment or intimidation by protestors and anti-abortion groups/individuals, as well as defamation and malicious communications online or elsewhere.

While freedom *of* religion is important, so to is freedom *from* religion; it is vital that those seeking terminations are able to do so free from religious dogma. The provision of training is essential to ensure healthcare professionals know what a conscientious objection entails, how to raise one and the limits of them, in line with existing guidance.

Where a healthcare provider has a conscientious objection, this should be raised before dealing with patients and measures should be put in place to ensure a continuation of care and no delays for patients attempting to access terminations.

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Q13: Do you agree that there should be provision for powers which allow for an exclusion or safe zone to be put in place?

Yes

It is vital that those seeking terminations are able to do so free from harassment, intimidation or traumatisation by anti-abortion protesters.

In the campaign for access to abortion, those supporting bodily autonomy and basic human rights have been labelled 'murderers', 'baby-killers', amongst a tirade of other cruel and demeaning personal attacks. Many of these campaigners have previously had an abortion themselves. In addition to this, incredibly graphic, manipulative and potentially traumatising images have been put on public display by anti-abortion activists.

While activists and campaigners have unfortunately come to expect this vitriol, the same should never have to be said for those who are either accessing healthcare or providing it. Exclusion zones are a proactive way to ensure the safety and wellbeing of all staff and service users accessing abortion care, as well as those using reproductive healthcare clinics to access any other type of care.

In Northern Ireland, there is a long and storied history of protests and harassment occurring outside reproductive healthcare settings. This includes Brook NI (now Common Youth) who provide sexual health education and testing, the Family Planning Association (now Informing Choices NI) and the near constant presence of protesters outside the Marie Stopes clinic more recently. In the example of the Marie Stopes clinic, a clinic escort service had to be established to protect patients from harassment and intimidation.

Not only is this vital for the safety and wellbeing of patients and staff, it is also a widely supported policy. In 2017, the Belfast City Council voted in favour of a motion calling for exclusion zones at reproductive healthcare facilities. Imposing exclusion zones is a common sense approach to ensuring positive experiences accessing healthcare.

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Q14: Do you consider there should also be a power to designate a separate zone where protest can take place under certain conditions?

No

The existence of an 'exclusion zone' implies that anyone outside this zone is free to protest. There is no need for a specific protest zone.

There is the potential that this 'protest zone' will simply displace the problem, while encouraging those who wish to oppose access to basic healthcare and human rights to continue protesting. This could create endless protests, endless intimidation and endless traumatisation not just for those currently seeking terminations but also those who have had them in the past and those providing reproductive care.

Upholding the right to freedom of speech should not come at the expense of the health and wellbeing of individuals seeking access to basic reproductive care.

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Our response to the Section 75 Equality Screening

It is our view that the equality screening conducted by the NIO for this new legislative framework was wholly inadequate, taking into account almost no issues impacting equal access to abortion services for marginalised groups and suggesting no measures by which to mitigate them.

The purpose of Section 75 of the Northern Ireland Act is to ensure that any policies, practices or services provided by the government and/or public authorities have equal access, equality of opportunity and promote good relations. Section 75, in spirit and in words, exists to improve the quality of life for all people in Northern Ireland. The screening undertaken by the Northern Ireland Office failed in every possible way to do so.

Where the equality screening did provide information was almost solely on the impact these services may have on those holding differing religious or political beliefs on the morality of abortion itself. This very clearly does not fulfil the Office's duty under Section 75 of the Northern Ireland Act to ensure equal access to services for the protected characteristics listed in the legislation.

The NIO has taken the further decision to undergo an Equality Impact Assessment (EQIA) on religious and political grounds following the result of their deeply flawed Section 75 screening process. Given the conclusions reached on the impact to those with differing political or religious beliefs on abortion, it is worrying that the decision was made to go ahead with a further impact assessment on these grounds. This appears to be a political decision, rather than one rooted in the need to improve access for marginalised groups.

Had a more thorough and appropriate screening process been adopted, the needs and experiences of marginalised groups affected by these legislative proposals may have been taken into account sooner, and proactively addressed at the initial stages of the consultation. Unfortunately, due to the obtuse and inappropriate route this screening process has taken, we are concerned that the views and needs of these groups will not be taken into account in the development of legislation or services governing the provision of abortion.

In collaboration and consultation with trans communities in our services, as well as civil society orgs representing different Section 75 groups across NI, we have provided an alternative screening below.

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Racialised Groups

The equality screening stated that there was 'no evidence to suggest that there are differing needs, experiences or priorities between individuals of different racial groups.'

In reality, many migrants, asylum seekers, refugees, and others from racialised groups living in Northern Ireland struggle to access mainstream healthcare services due to issues with ID, documentation, and/or for fear of the 'hostile environment' policy adopted by the UK government and enforced within our healthcare settings.

Racialised people are not a homogenous group with the same needs, experiences or circumstances. The legal status of those seeking healthcare may differ, calling into question their ability to access services forced to comply with the UK Government's hostile environment policy. The repercussions for those attempting to access healthcare will be massively dependent on this legal status: some may be fearful of deportation or providing information which could potentially be used to impact their legal status.

Further, there are differing barriers around language, unconscious bias amongst healthcare staff, and social stigma related to accessing abortion. These tangible and societal barriers to accessing care must be proactively tackled and mitigated in order to ensure truly accessible abortion provision. This provision must be mindful of the additional needs and sensitivities that some of the most vulnerable groups of people seeking terminations will experience, with many racialised groups experiencing human trafficking and sexual violence at disproportionate levels.

As with every other group considered under Section 75, there is a need to ensure that healthcare providers are adequately trained and knowledgeable on the needs and experiences of racialised groups, including migrants and refugees.

Pregnancy for trans people

The equality screening failed to identify any needs of trans people seeking terminations. On the grounds of gender, it stated that 'women will benefit' from the provision of abortion services, despite trans people being included under Section 75.

Throughout both the equality screening and the consultation document, those who will be affected by the introduction of a legal framework for abortion (i.e. those who have the capacity to become pregnant) are referred to solely as 'women and girls'. As we have already outlined, this is not inclusive or respectful of the needs and experiences of many trans men and non-binary people who can get pregnant and who may need access to abortion services.

Not only will this put trans communities off responding to the consultation, but if this approach is maintained through the legislation as well as the commissioning and development of services, it will create significant barriers to trans people accessing abortion care.

We have outlined areas which will disproportionately affect trans people accessing abortion, including disproportionate rates of sexual and domestic violence, poverty and homelessness. Our responses on the provision of local services, certification by medical

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professionals, term limits and the cultural competency of medical professionals are particularly important for trans individuals.

Age

While there was some information provided on age as a potential factor, the equality screening did not provide any details on measures that will be taken to ensure minors have access to vital reproductive healthcare services.

For under 18s, especially for those in abusive or dangerous living situations, access to abortion can be lifesaving. Access to this lifesaving care can be called into question due to a lack of agency provided to young people in those kinds of situations. There has been no information provided in the NIO's equality screening as to what measures will be put in place to ensure confidentiality and access to services for minors who are in abusive or dangerous situations, which - if handled poorly - could put young people's lives at risk.

This is, again, particularly pertinent for trans young people, who are at heightened risk of abuse and parental coercion, as well as young people in care who often have their agency to make decisions over their own bodies removed from them.

Disabled people

The equality screening stated that 'It is not expected that this section 75 category will be affected in a major way' by the implementation of this legislative framework for abortion services.

Disabled people face a significant number of barriers to accessing services which, coupled with negative attitudes towards disabled people within wider society, Often, attitudes towards the sexuality of disabled people means that their sexual health needs are often ignored at both a familial and societal level. There is a distinct lack of a person-centred approach being taken to cater for the needs of each disabled individual attempting to access sexual and reproductive healthcare.

Previously in this response, we raised the need for healthcare professionals to be more educated on different conditions and more broadly on how to support and respect disabled people within their care. With many disabled people reporting that they are treated as a disability rather than a person within healthcare services, it is vital that this work is done proactively to improve inclusion for this group.

Given the complete lack of any recognition of the needs, experiences, or barriers to accessing care for disabled people, we urge the Northern Ireland Office and the Department of Health to engage and partner with civil society organisations and community groups led by disabled people to meaningfully and proactively address these needs.

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Persons with dependants

Many of those currently seeking abortions abroad find themselves struggling to cover the costs of childcare and/or making alternative arrangements for their dependants - as has been consistently raised throughout the campaign for access to abortion with the UK Government, the Northern Ireland Office and the Secretary of State.

While the move to more localised services will massively benefit those with dependents, there may still be barriers to accessing care if proactive work is not done to mitigate these. Childcare costs, travel implications and the locality and flexibility of abortion provision are all factors in whether or not a person with dependants will be able to access a termination. While some of these factors were addressed in the consultation, none have been directly explored in tandem with their impact on access for those with dependants; something that would've been pretty fitting for an equality screening to do.

The lack of consideration of their needs and wants within this equality screening - including providing localised services across Northern Ireland, alongside support with alternative care arrangements for dependants – is not compliant with Section 75 and causes great concern amongst those who fight for free, safe, legal and local access to abortion for all who need it.

Sexual Orientation

The equality screening fails to recognise any particular impact of this legislation on those with differing sexual orientations, again displaying a lack of awareness of a raft of issues affecting LGB+ individuals.

The CEDAW report which the Northern Ireland (Executive Formation etc) Act 2019 referred to highlighted the particular need to provide abortion in cases where the pregnancy is a result of a sexual crime. Many lesbian, bisexual and non-heterosexual individuals experience sexual and domestic violence at much higher rates than the wider population. This is especially relevant for lesbians, for whom 15% of pregnancies are as a result of forced sex in comparison to 1% of heterosexuals according to a 2018 US study by the Guttmacher Institute of people who had had an abortion. These findings are likely to be similar here in Northern Ireland.

There is also a worldwide trend of disproportionate levels of adolescent pregnancy amongst lesbian and bisexual people. There may be many reasons for this – whether it be lesbian & bisexual teenagers being more sexually active or adventurous, disproportionate levels of sexual violence, or more unplanned sex without contraception. This highlights the need for comprehensive, LGBT-inclusive relationships and sexuality education to be rolled out across Northern Ireland, in compliance with the recommendations contained within the CEDAW report.

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