Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018

Submission to the Public Consultation

from

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Brief bio

Staff profile: http://staffprofiles.bournemouth.ac.uk/display/srowlands
Degrees: MB BS, MD, LLM, FRCGP, FFSRH
I have been active in the field of abortion care since the early 1970s.
I was performing surgical abortions in hospital in the later 1970s.
I was a general practitioner for 17 years.
I was Medical Director of BPAS for almost 3 years.
Subsequently, I have worked in sexual and reproductive healthcare in three different regions in England.
I led the medical termination of pregnancy service in Dorset for 5 years.
I was Secretary of FIAPAC for 4 years.
I was Secretary of the British Society of Abortion Care Providers for 6 years.
I have published more than 110 peer-reviewed papers in the field of SRH.
I was part of delegation invited to Dublin in December 2018 to discuss provision of abortion services with general practitioners.

Language

1. Some who do not identify as women have the capacity to become pregnant. I have attempted in this submission to use gender-inclusive language. The drafting of the 2018 Act has made no such attempt and so technically excludes transgender and non-binary people; this is not compatible with the Gender Recognition Act 2015. It has not been straightforward to write about a country that has Maternity hospitals caring for abortion patients – should these now be called perinatal hospitals?[1] – led by Masters (since 1757), regardless of their gender. Mention of pregnant people is meant to signify that these individuals may include those from the transgender and non-binary community. Additive language is also used so that the language of womanhood is not excluded – it is used alongside gender-neutral language.

Has the 2018 Act achieved what it set out to do?

2. Throughout the 35-year span of the effect of the Eighth Amendment in Ireland, many of those unhappy to be pregnant and wanting an abortion would seek illicit methods of abortion or travel to other jurisdictions, if they had the means. Between 1980 and 1998, more than 170,000 journeys were made from Ireland to Britain for abortion care. More recently, online services have become available. During the 3-year period 2010-2012, Women on Web sent medication to 1,636 individuals on the island of Ireland.[2] It is clear that a highly restrictive law had an extremely negative impact on the quality and safety of women's healthcare and on the social experience of abortion in Ireland.[3-5]

3. The citizens of Ireland voted by a majority for the liberalisation of this restrictive abortion law by repealing the Eighth Amendment. A new law was swiftly drafted and passed. The Explanatory Memorandum to the 2018 Bill was introduced "to give effect to the decision of the people to permit the Oireachtas to make laws governing termination of pregnancy". Among the stated aims of the 2018 Act are the provision and regulation of abortion and the availability of abortion services free of charge. There is no mention of peoples' precise rights under the Act – what they are entitled to – and so there remains some insecurity around decisions being made by those requesting abortion.[6]

4. The 2018 Act never set out to include abortions on socio-economic grounds in the second trimester. It therefore cannot be said to have failed on this basis. Perhaps policymakers need to come clean on this and reiterate this if a revised Act would continue this policy. The public needs to be aware that, unless a person's life is at risk or in cases of severe fetal anomaly, then those who have proceeded into the second trimester, for whatever reason, will be forced to continue their pregnancy or travel overseas. In most countries, the proportion of such pregnancies will be of the order of 1 in 10 of the total.

5. By having the low cut-off of 12 weeks, together with a waiting period, access during the upper end of the first trimester is in practice denied.

6. Under the 2018 Act, unlike laws governing other types of healthcare, doctors taking part in abortion care are still criminalised[4 7] and thus stigmatised.[8 9]

7. The Act has, however, reduced abortion stigma; the issue of abortion is no longer denied and undiscussed. But, stigma is still present among abortion providers[10] and patients.[11] Health professionals need to be supported in their role in normalising abortion.[12]

8. The 2018 Act needs to be scrutinised for its ability to work in practice under real-life conditions. A useful question to ask in this respect is: has the 2018 Act allowed the marginalised in society who previously, mostly, could not travel for abortion[8] to now freely access services within Ireland? This includes, for example, international students, asylum seekers and migrants without documents.

9. The Act overall has resulted in a step change in the situation in Ireland, making abortion potentially widely available to most of those requesting it. The challenge for service managers and clinicians in implementing such a fundamental change of approach to so-called crisis pregnancies should not be underestimated. From a long-established culture of not facing the problem and exporting it overseas to being asked to take care of all abortion requests from day 1 was a tall order. General practitioners (GPs) have taken on a large share of the workload, more so than in any other country that I am aware of. Hospital-based services experienced significant 'teething troubles' in the early months after the Act came into force.[13 14] Gynaecologists in some cases have been hamstrung by conservative hospital management. Clinicians who wish to invoke conscientious objection are totally free to do this without having to argue their case.

10. An annual number of abortions of 8,072 would be predicted based on a population of 1.01 million women aged 15-44 years and an abortion rate of 8 per 1,000 women aged 15-44 (half the rate of Britain). This is likely to be an underestimate of the need. The numbers of abortions being performed in Ireland (just under 7,000 per annum – Table 1) is therefore not fully meeting the needs of women and pregnant people. There are still pregnant people travelling to England and Wales, the Netherlands and some other countries. Of the 375 individuals who travelled to England and Wales in 2019 (Table 1), 74% were beyond the first trimester. The Abortion Support Network continues to assist some of these tragic cases.[5]

    Between 2006 and 2013, 1,500 people accessed abortion in the Netherlands.[15] Other destinations included Belgium and Spain.

Table 1 The interface with Britain

Year	Abortions reported in Ireland	Abortions on Irish citizens reported in England & Wales
2018	32	2,879
2019	6,666	375
2020	6,577	194*

Sources:
https://www.gov.ie/en/search/?q=termination+of+pregnancy
https://www.gov.uk/government/collections/abortion-statistics-for-england-and-wales

* The figure shown for 2020 is low partly due to severe difficulties with travelling due to the COVID-19 pandemic.

11. In summary, within the constraints of the Act, abortion appears to be being regulated reasonably fairly and efficiently and services are available in many geographical areas, including more rural ones. Stigma has been reduced. Compared to the previous situation, improvements are obvious. However, there is still some considerable way to go in achieving proper access at all gestations.

Parts of the Act which <u>have not</u> operated well

12. The Act applies only to women. As mentioned in paragraph 1, this is not compatible with the Gender Recognition Act 2015. Transgender and non-binary people face ongoing concerns that they could be denied access to abortion care.[16]

13. Abortion regulation should be based on human rights and evidence.[17]

14. The Act falls short of human rights standards. The Act is neither person-centred nor rights-centred.[16] Grounds-based laws restrict access to abortion; WHO recommends abortion on the request of the pregnant person and without gestational limits.[17]

15. Criminalisation is incompatible with the design and provision of an agency-maximising law on abortion.[16-18] Professional regulation, existing criminal law and the law of tort are all sufficient to regulate abortion.[19]

Abortion on request in earlier pregnancy

16. The GP service ceases at 9 weeks and hospitals can provide abortions for a futher three weeks under section 12. It seems that GPs are meeting the demand for the gestations they can provide for but that there are not enough hospital appointments for the 9 - 12 week gestational age band.[5] This may be because hospitals are having to cover catchment areas outside their normal region for the nine 'non-providing' areas, due to basic pressures of work, to lack of planning/financing or because there are no well-defined care pathways.

17. There appears to be a complete absence of planning for surgical abortion. This is not offered at all at under 9 weeks' gestation. Beyond 9 weeks, it does not seem that an individual has any possibility of making a personal choice on having a surgical procedure. Patient experience of abortion care in hospitals has been overwhelmingly negative.[11] Overall, there is a complete lack of choice of method to all women who meet the conditions for section 12.

18. Despite the WHO recommendation that there should not be gestational restrictions, it is acknowledged that this will likely be a step too far for those deliberating on abortion law in Ireland. The 12-week gestational limit for abortions in 'early pregnancy' laid out in section 12(1) has, in my opinion, been set too low. It has resulted in a *de facto* gestational limit of 9 weeks, laid down in clinical guidance.[7] Vacuum aspiration can be safely performed at up to 13 or 14 weeks and dilatation and evacuation at higher gestations. In my opinion, the early pregnancy category should be renamed 'abortion at the request of a woman or pregnant person' and the limit should be extended to 20 weeks as specified in the 2020 law in New Zealand; or failing that to 18 weeks as has long been the case in Sweden; or failing that to 16 weeks as is now the case in France; or failing that to 14 weeks, as in Belgium, Germany, the Isle of Man, Luxembourg and Spain.[20]

19. The Act does not make provision for those who receive care within the 12-week limit but for whom the procedure fails to terminate the pregnancy.[8 16] If the diagnosis of continuing pregnancy is made at after the 12-week limit, according to current interpretation of the law, the pregnant person cannot be treated in the jurisdiction and has to travel overseas for a uterine evacuation. This situation is inhumane. The wording needs to be clarified that the gestation specified in the law relates to the date on which treatment is initiated, so that clinicians can treat complications arising later on confidently and locally.

Waiting period

20. The three-day waiting period specified in section 12(3) and 12(4) is a harmful barrier to access.[21] Mandatory waiting periods contravene the World Health Organization Abortion Care Guideline[17] and fail to comply with international human rights standards.[21] The Irish Council for Civil Liberties confirmed the 2018 Act to be non-rights compliant.[22] Waiting periods cause delay and can push those requesting abortion beyond gestational limits. They undermine women's agency and autonomous decision-making ability. The presence of a waiting period in the 2018 Act and more generally is disliked by clinicans[7] and pregnant people[11 21] alike. The waiting period constitutes an undue barrier to access and should be repealed.[11] It should be noted that waiting periods have recently been repealed in Jersey[23] and the Netherlands[24] on the basis of failure to comply with international human rights standards.

Fetal anomaly

21. There are still fetocentric remnants in the Act.[6] A woman or pregnant person's life should come first at all gestations. There is no gestational limit when an abortion is performed on the grounds of fetal anomaly (FA) in Belgium, France, Germany, Guernsey,[25] the Isle of Man, Lithuania, Luxembourg, the Netherlands and the UK. Section 9(1)(b), which puts a limit at fetal viability, should be removed from the Act.

22. Section 11 of the 2018 Act is clearly in breach of international human rights standards. The drafting of the Act qualifying FA as having to be 'fatal' has created major difficulties, as was predicted. The wording in British law 'if the child were born, it would suffer from such physical or mental impairment as to be seriously disabled' is one which is known to have operated humanely and without difficulty for more than 50 years and is now operational in Northern Ireland too.

23. Tertiary-level Fetal Medicine Units are well-established in Dublin, Cork, Galway and Limerick. The 2018 Act has not worked well either for those with pregnancies suspected of fetal anomaly or the professionals responsible for their management. Section 11 allows abortion only in cases of FA which are likely to lead to the death of the fetus within 28 days of birth. But, it has been shown that the majority (58%) of cases of FA in Ireland cannot be classified as fulfilling the grounds of the 2018 Act.[26] Consequently, a majority of cases of FA in the Ireland must travel to another jurisdiction; 81 such women travelled to England in 2019.[27]

24. In Northern Ireland, a Private Member's Bill recently introduced was fortunately defeated. This law would have allowed abortion for FA only if the death of a fetus were to be likely during or shortly after birth. The arguments against such restrictive wording were eloquently set out in evidence submitted to the Northern Ireland Assembly Health Committee consultation by several professional bodies, including the British Society of Abortion Care Providers (at Appendix 3 of their report).[28]

25. The current situation is immensely distressing for those whose fetus is abnormal[16] and for those professionals caring for them. Those whose fetal condition is 'not fatal enough'[11 29] are forced to travel – this is inhumane. Fetal medicine specialists are dealing with an odd law that forces them to live with the 'chilling' effect of criminalisation if they make a judgement about a baby's longevity after birth that turns out to be longer than 28 days.[14] This can be disturbing for these specialists, sour relationships with colleagues such as neonatologists and be a highly distressing experience for those going through such pregnancies.

26. There has already been a case in which a pregnant person with a severe FA was refused abortion and forced to travel.[16 30] Despite two consultants having initially said that the anomaly would fit the grounds of section 11, later on a formal letter from the Coombe Hospital following a MDT meeting stated that the criteria were not fulfilled. It cannot be overemphasised how distressing this must have been for the couple concerned and how this has an unsettling ripple effect through society.

Parts of the Act which <u>have</u> operated well

<u>Remote consulting</u>

27. By not being too prescriptive, the Act has allowed discretion to conduct any consultations deemed appropriate remotely through the pandemic.[31] This is considered to be best practice.[17] Section 12 does not specify the type of premises or the precise means of communication between practitioner and pregnant person, which is helpful. The Health Minister confirmed that the wording "having examined' in section 12 covered remote consultations. Ireland was one of the only jurisdictions to be able to permit remote consultations for abortion without the introduction of emergency regulations. This recognition by the government that abortion is essential and time-sensitive healthcare has been widely praised.[32] Excessive regulation of EMA in the UK has been heavily criticised by legal scholars.[33]

28. Studies conducted since the onset of the pandemic have categorically shown the benefits of remote consultations which are generally relevant and not just pandemic-specific.[34]

29. For the avoidance of doubt, there should be some additional words in section 12 stating that remote consultations via video-link, telephone or other electronic means are equally as valid as face-to-face ones and the mechanism of communication can be determined freely by the health professionals providing the care. This then ensures that the facility cannot then be removed, as has been annnounced in England with effect from 30 August 2022.[35]

30. Also, I understand that the 'Home Care Pack' is still subject to collection from a health care facility,[32] with no option for it to be delivered to the recipient of the abortion care. This rather undermines the benefits of remote consulations.

The operation of the legislation

31. It should be acknowledged that to have the opportunity for review of the law at three years laid down in section 7 is as a result of enlightened drafting. This is most welcome.

32. International human rights standards dictate that concrete action must be taken by states to guarantee the quality of abortion care in line with WHO safe abortion guidelines and ensure that it is available and accessible in practice.[36] All legal, policy, financial and other barriers that impede access to abortion care should be removed.

33. One of the main drivers for the Act was to prevent women and pregnant people from having to travel abroad. This has only been partially achieved. There are still dozens of pregnant people with/without escorts travelling to other jurisdictions each year because of the 12-week gestational limit, because of almost non-existent surgical options or because of the unnecessarily restrictive wording in section 11 on fetal anomaly.[5]

34. The Act restricts those authorised to perform abortions to doctors. Consideration should be given to widening permitted professionals to midwives and nurses too. There is strong support for this from the international body of midwives.[37] Such a facility was enshrined in South Africa's Choice on Termination of Pregnancy Act 1996. The most well-established and high-quality system of midwife-delivered/led abortion care has existed in Sweden since 2009.[38] France followed suit in 2016. The facility is also contained within the Isle of Man's Abortion Reform Act 2019.

35. The 2018 Act restricts signatories to medical practitioners in contrast to the legislation in Northern Ireland and Isle of Man. It would seem much more progressive to emulate these two neighbouring jurisdictions and allow a signatory to be any medical professional, be it doctor, midwife or nurse.[39] [40] This allows more flexibility in the provision of services.

36. The requirement in cases of risk to life or health of a pregnant woman (section 9) and in cases of severe fetal anomaly (section 11) for two doctors to provide certification is too onerous. In my opinion, one signatory is sufficient, as is the case in the jurisdictions of Northern Ireland, the Isle of Man and Guernsey.[25]

Conscientious objection

37. Section 22 on conscientious objection (CO) is too broadly worded, allowing any health professional an opt-out.[8] CO has caused some distressing situations at the primary care level.[11] International human rights standards prohibit institutional refusals to provide abortion care,[36] so any trace of this as an underlying cause of lack of services in the nine 'maternity' hospitals having no abortion services would need to be rooted out.[5] In my view, those on the ground in the catchment areas of these nine hospitals need to make an assessment of the ease with which residents in these areas can access abortion so that this can be fed into this review. Human rights standards also require that CO is overseen and monitored so as to ensure adequate staffing with those willing and able to provide services at all times within a reasonable geographical reach.[17] [36] [41] As an example, CO is not permitted in New Zealand if it would 'unreasonably disrupt' services.[9] I have not seen any evidence that these type of obligations are being met. Section 22 needs some revision in relation to these points to ensure the necessary structures are in place to ensure compliance. A formal complaints procedure has been recommended for those who experience refusal of care and a disciplinary procedure as redress for harm caused.[11]

Safe Access Zones

38. The Act did not include provision for Safe Access Zones (SAZs). This deficiency is present in many abortion laws around the world. Protests have continued outside health facilities in at least ten counties in Ireland.[42] This has had a negative impact on patients.[11] As in Northern Ireland and other jurisdictions, provision for SAZs has been shown in practice to be necessary. It has been in the process of being dealt with separately in the Seanad Éireann. Senator Paul Gavan's Safe Access to Termination of Pregnancy Services Bill passed its Second Stage in November 2021[43] and has now reached its Fourth Stage.[44] In the debate, Senators Paul Gavan and Lynn Boylan

proposed the Bill which had been drafted by Together for Safety; a further 10 Senators spoke in favour of the Bill and two spoke against. The Minister for Health, Stephen Donnelly TD, said that the government would draft its own Bill, to be introduced at the lastest by March 2022. He is committed to this in the Women's Health Action Plan (Action 9).[45] Until this separate SAZ legislation has been passed, this review needs to keep in mind that it is essential that SAZs are incorporated into the law in Ireland. It should be noted that the Isle of Man 2019 abortion law has an integral section on SAZs.[40]

39. Northern Ireland has been forced to consider such supplementary legislation due to the similar intensity of protests north of the border. Clare Bailey MLA introduced an Abortion Services (Safe Access Zones) Bill into the Northern Ireland Assembly and this passed its Consideration Stage on 2 March 2022.[46] The Committee for Health supported the Bill with a recommendation that SAZs extend between 100 - 250 metres from entrances/exits to the premises. Their Report is a useful summary of all the considerations that are needed when bringing forward SAZ legislation. Professional organisations submitted written evidence supporting the establishment of SAZs which is available at Appendix 3 of the report, including from BSACP and the RCM. This Bill successfully passed its Final Stage on 24 March 2022.

40. Protests in Scotland continue too, with seven hospitals/clinics being repeatedly targeted by protestors. In a debate at Holyrood in November 2021, Gillian Mackay MSP formally announced her plans to bring forward a Members' Bill on Abortion Clinic Buffer Zones with 150 metre zones.[47] Ten MSPs spoke in favour of SAZs, generally backing a national legislative approach; one MSP spoke against SAZs. Subsequently, Scottish Ministers have decided to commission research into protests before making a final decision on how to proceed.[48]

41. New Zealand recently passed SAZ legislation with zones of up to 150 m.[49]

Services provided under the Act

42. Effective monitoring and evaluation are essential for measuring quality of and trends in abortion care.[17] These need to be better developed in Ireland.

43. Like most abortion laws, that in Ireland steered well clear of referring to ultrasound scanning, in contrast to 17 US States that mandate it. Ireland broke with ritualistic pre-abortion investigations entrenched in the UK and elsewhere before the pandemic. Selective scanning has been shown not to compromise safety.[34 50 51] WHO recommends against ultrasound scanning as a prerequisite for providing abortion services.[17] Ultrasound scanning was advised in Ireland only in certain instances well defined in clinical guidelines; this progressive system has proved to work well in practice. However, a capacity issue has arisen in relation to scanning facilities for those in whom it is indicated. Outsourcing of ultrasound scanning has on occasions resulted in lengthy journeys and significant delays.[5] It has been recommended that the Health Service Executive (HSE) review its scanning contracts to ensure they are unbiased, accurate and provide value for money.[11]

44. The HSE did an good job setting up all necessary mechanisms to operate services. MyOptions appears to be a humane and efficient system for first contact. However, detailed assessment of its working has shown some deficiences that need to be remedied.[11 16 52]

45. Despite initial feelings that there would be an unwillingness and reluctance due to lack of relevant training,[53] GPs have stepped up remarkably and provided excellent services;[54] this has made early medical abortion (EMA) available in most counties. START doctors were drafting guidelines and planning service delivery immediately after the Referendum result (https://startireland.ie). Eleven per cent of all GPs have now registered with the HSE to provide abortion care in their practices.[5] This is a sizeable proportion and has enabled EMA to be delivered in the community at a practice not far distant from a person's residence due to the impressive conscientious commitment[8] on the part of GPs, using their internal networks in a relatively small country. It is a far higher proportion than that in Australia, Canada, France and the USA, where there are also traditions of GP provision. Despite all this effort, there are still abortion 'deserts' such as Sligo where there are no providers.[5]

46. Two organisations provide abortion services, apart from GP-based services. These are the IFPA and Dublin Well Woman Centre. There is scope for an expansion of community-based EMA services outside general practice to increase choice of setting. Such centres could also provide manual vacuum aspiration (MVA) services.

47. Clinical guidelines in Ireland limit EMA to 69 days[54] and, as there are no real surgical options, this means that women who reach 10 weeks are in effect barred from abortion in Ireland, despite the law allowing an upper limit of 12 weeks.

48. It is noted that abortion services are only provided in ten of the nineteen 'maternity' hospitals in Ireland.[5] It is impossible as an out-of-country observer to comment on underlying reasons for this, for instance how much it is due to CO. But this inequality of service provision makes for geographical/access problems for those living in the catchment areas of the nine non-providers. It is well-known that such inequalities have an intersectional effect such that they have a disproportionately negative impact on marginalised persons and communities: for example, those on a low income, migrants, asylum seekers and travellers.[5 16] Such inequalities have been compounded during the pandemic. All this does not look like reproductive justice.[9]

49. There is a gross lack/absence of surgical abortion as an option. This deprives service users of choice at all gestations. Ratios of medical: surgical abortion greater than 80% should trigger enquiry; it usually means that abortion practices are supply/provider-driven rather than user-driven.[55] This is a major failure of implementation of the Act on the part of the Department of Health. It is imperative to design and fund the necessary pathways as a matter of urgency.

50. A full range of contraceptive options and sterilisation should be available to commence as soon as clinically appropriate after abortion.[5 11 17] Although it has been announced that contraception will be free for those aged 17 - 25,[45] this is clearly an ageist policy. Contraceptive services do not need to be referred to in the law; clinical guidelines suffice.

Recommendations

The law itself

51. The Act should be reviewed generally in terms of its ability to rectify the relevant parts about which criticisms have been made on human rights grounds.[4 16 56] The 12-week gestational limit, mandatory waiting period and extremely narrow grounds for access to abortion at gestations higher than 12 weeks all fail to meet international human rights standards.[57]

52. The Act should be reviewed because of its basic ability to criminalise all those professionals who provide abortion care and serious consideration given to decriminalisation.

53. The mandatory waiting period should be removed from the law; sections 12(3) and 12(4) should be repealed.

54. The gestational limit for abortion on request should be extended beyond 12 weeks. It needs to be specified that notification is only once per pregnancy and that any complications ensuing (including continuing pregnancy) are legitimately dealt with at whatever subsequent gestation the complication is diagnosed at.

55. In case of risk to a pregnant person's life, there should be no gestational limit applied.

56. The section on fetal anomaly should be revised to include *any* serious anomaly. All reference to the ability of the anomaly to result in the death of the fetus within a certain length of time should be deleted. There should be no gestational limit applied.

57. The conscientious objection section of the Act should have specific requirements for oversight and monitoring as well as complaints and disciplinary procedures.

58. There should be provision for Safe Access Zones.

59. Nurses and midwives should be authorised to perform abortions, in addition to doctors.

60. Nurses and midwives should be authorised signatories, in addition to doctors.

61. There should not be any section of the Act that requires more than one signatory.

62. It should be clarified that clinicians can use their discretion about the use of face-to-face and remote consultations.

Services provided under the law

63. Monitoring and evaluation of abortion services need to be developed.

64. Some identified deficiencies in the MyOptions system should be remedied by the HSE.

65. National care pathways are needed so that primary, secondary and tertiary level abortion care work seamlessly.

66. There needs to be real surgical abortion option availability.

67. A full range of contraceptive options and sterilisation should be available.

68. There should not be a county in Ireland without any abortion service provision.

69. It is not tenable that any large gynaecological department has a complete absence of abortion provision. Admittedly, dealing with this problem may make a little time, but concrete plans should be put in place to remedy this.

70. Community-based early medical abortion and manual vacuum aspiration services outside a general practice setting should be set up, not only in Dublin.

71. Data collected need to be more expansive. A basic requirement would be some gestation band data and procedures split into medical and surgical. Age-bands and ethnicity would also be helpful.

Note

This submission does not contain any personal, confidential of commercially sensitive information. I am happy for my complete submission to be made public.

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