INTERNATIONAL CAMPAIGN FOR WOMEN'S RIGHT TO SAFE ABORTION

London, UK

20 October 2018

TO: Simon Harris TD
Minister of Health, Ireland
E-mail: Simon.Harris@oireachtas.ie

Re: Health (Regulation of Termination of Pregnancy) Bill 2018

Dear Mr Harris,
I am the International Coordinator of the International Campaign for Women's Right to Safe Abortion, Steering Committee Chair of the International Consortium for Medical Abortion (2002-2011), and founder editor of Reproductive Health Matters (1992-2015). I have been working for the right to safe abortion for more than 35 years, and have been studying and publishing information on abortion law and policy around the world for many years now.

I have been writing about and reporting what has been happening in Ireland around abortion law reform in our newsletter, which goes to 1,300 members in 120 countries, including going back to what happened to Savita Halappanavar and Ms Y. Last year I read with great excitement the recommendations of the Citizen's Assembly, and then that there would be a referendum, and then that you would do your best to develop a good abortion bill, and a plan for abortion services. I congratulate you for these substantial accomplishments.

I am writing now to comment on the text of the abortion bill you are working on, because I believe you could have written a far better bill, with more emphasis on making abortion accessible, less emphasis on regulation, and one that avoids the need for such a long and arduous review process when women are refused, which is necessary only because you have put the control over the abortion decision in the hands of doctors who may or may not have women's well-being, right to health and right to decide whether and when to have children in mind.

The framing of the bill, right from the word "regulate" in the title, creates a sense of needing to impose controls, even though you say you want to make abortion accessible and woman-centred. I was sorry to see that the text ignores – as if they never existed – the progressive and women-centred Citizen's Assembly's recommendations of January 2017, which called for legal abortion on a wide range of grounds, and most importantly at the woman's request. I urge you to go back to those recommendations and use them to reframe the bill. Those are what the people supported. Those were what led to a Yes vote in the referendum and brought Ireland to where you are today.

I think this bill has you always looking over your shoulder at the opposition, trying to appease them, by giving doctors the heavy hand of control. They won't be appeased. It is women whose needs the bill should be focused on, above all. There is too much in this bill that is restrictive. It is not what a 21st century, woman-centred abortion law and services could and should look like.

Here are my comments and recommendations about specific aspects of the bill:

1. <u>Some history to heed</u> – in Britain, the group of parliamentarians, legal experts, women's rights advocates and health professionals who put together the British 1967 Abortion Act all knew it was not as good a bill as they would have liked. They agreed to it anyway because they believed it would not be hard further down the line to improve on it. Fast forward to today, 51 years later. No one has yet succeeded in improving on the bureaucratic barriers in that law, in spite of many efforts over the years, though this week we are trying again. So I want to encourage you to avoid the same mistake by creating the best possible bill from the start – and ensure the provision of services – for women's sake that you can.

2. <u>Why not take abortion out of the criminal code?</u> In your bill, I'm disappointed to see that even before you define what is a legal abortion, you create an offence of an illegal abortion and provide for heavy prison sentences such as existed under your 2013 law. The trend in abortion law internationally is in the other direction, that is, to remove the offence of abortion from the criminal law altogether. Canada did so in 1988. Sweden, Norway, Belgium, France, Luxemburg, and all but one state in Australia are examples of other countries that have removed abortion from their criminal codes in recent years. They are also countries with the most women-centred abortion laws. Canada has survived with no abortion law at all since 1988, and no one misses it.

3. <u>Where is "abortion at the woman's request"?</u> Section 13, the section covering the great majority of abortions, says an abortion "may be carried out" by a medical practitioner up to 12 weeks LMP. This is a big step forward from an international perspective, because it omits the assumption (left over in many countries from the last century) that for every abortion, hospitals and senior hospital clinicians must be the provider and involved. However, there is nothing in this section about the woman who is seeking an abortion. This is very odd. The wording creates no agency for the woman, no right to an abortion up to 12 weeks if requested, but in effect hands the right to a medical practitioner – who "may" do a termination. How many refusals on the part of medical practitioners do you think would be reasonable for a woman to have to go through before she heads to the airport? My answer to this is "none". I'm sure it is unintentional, but Section 13 does not *require* the public health system or any cadre of health professional or any medical practitioner in Ireland to provide abortion services for those who should have access to them at their own request.

4. <u>Women still have no explicitly stated rights under this bill</u> – This whole bill, in fact, does not give a pregnant woman any rights over the abortion decision, even when her life is so much at risk as to constitute an emergency. Even then, the bill says "a termination may be carried out" and "Where a medical practitioner proposes to carry out…". Do you think this text would necessarily have saved the life of Savita Halappanvar? I'm not so sure, when Catholic health policy is still going to be applied in some hospitals, as happened in her case.

5. <u>Why two doctors?</u> Sections 10 and 12 require two medical practitioners to approve an abortion after the first trimester. These sections put the abortion and the abortion decision into a hospital setting, even though the text does not stipulate this, nor that both doctors must be hospital-based. I can understand why an obstetrician is specified, as pregnancy is their expertise. I assume an obstetrician with expertise in fetal anomaly will be one of the doctors in Section 12.

But these are experts, so why are two professionals actually required? I fear you will just be creating barriers, causing delays, and making abortions later than they need to be. We tried to change the two-doctor requirement in Britain in 2008 because of the years of evidence of the bureaucracy and delay that can occur if there is a problem finding two doctors. This is well known over here. Efforts to try and circumvent the delays, e.g. by asking second doctors to pre-sign approval forms, which had been accepted at the highest level for many years, were suddenly treated as illegal by newly active anti-abortion MPs and civil servants, who attempted to prosecute a number of supportive doctors. Why make the same mistake in Ireland?

The reasoning behind having two doctors that is often put forward is that for ambivalent or nervous doctors, afraid of being criticised for allowing a particular abortion, a second opinion is thought to protect them against accusations that the abortion was not justified under the law. But surely a law that is intended to promote access to safe abortion should seek to support doctors who provide abortions and trust their good faith opinions that an abortion is justified. Just as the law should support and trust women who have unwanted pregnancies and who seek an abortion, so they are able to have the abortion. Doctors will not be asked to look after the child for the rest of their lives if they refuse an abortion. The woman will. Abortion is not a complicated clinical procedure but a simple one and a common one. One in four pregnancies worldwide ends in abortion. Making "approval" uncertain is the imposition of someone else's moral judgment, not a clinical judgment. In my opinion, no one who seeks an abortion should ever be refused. That's what "women-centred" means.

6. This bill is terribly taken up with approval of abortion rather than provision. Who are the medical professionals who must give the approval referred to in this bill apart from obstetricians? Who is allowed to be the one medical practitioner up to 12 weeks LMP (I hear on the grapevine it's GPs but is that all?).

What about the two who are required to approve an abortion after 12 weeks LMP? Who must find them? Is it the woman? Is it her GP? Will GPs and hospitals have to state that they will or will not provide abortions? Will there be a public list? Have you ascertained that there are enough available and willing obstetricians and unspecified other medical professionals, such as fetal anomaly specialists, across Ireland to provide the needed approval?

I fear women beyond 12 weeks LMP will still feel forced to travel if they experience any difficulties getting two doctors' approval, especially if either or both health professionals they see use their power to say no (except in an emergency, of course, but those will be the rarest cases).

7. More positively, it would be so good if primary care professionals were actually mentioned in the bill as recognised medical practitioners able to provide aspiration abortions and medical abortion. Apart from GPs, it is not clear whether you also consider nurses and midwives capable and permitted to do so. The World Health Organization does promote all three of these cadres of health professional to manage first trimester abortions, both aspiration and medical. Moreover, France, the Scandinavian countries and some US states allow midwives and nurse practitioners to manage second trimester medical abortions in an outpatient hospital setting and in freestanding clinics. I urge you to follow in their footsteps.

Specifying GPs, nurses and midwives in the bill would give them status and credibility as providers and make it clear you are seeking to increase the numbers of health professionals willing to manage abortions, thus avoiding the problems that may be created by conscientiously objecting GPs and hospital doctors. The World Health Organization guidance published in 2015 encourages abortions to be managed at primary care level by these mid-level providers as an acknowledgement of how simple and safe (manual) vacuum aspiration and medical abortion are in the first and indeed second trimester of pregnancy today. Why shouldn't family planning clinic doctors and nurses provide abortion care? What about the Well Woman in Dublin, surely they should also be included? They are the first source of what is happening today (I'm old enough to remember!).

8. It is a major mistake to allow abortion for fetal anomaly only if there is a fatal condition affecting the fetus. In almost all the 69 countries that allowed abortions on this ground up to 2010 (according to research by Reed Boland, Harvard University) the anomalies must be

serious but not fatal.[1] It is only in the last few years that in a few countries (e.g. Chile, Honduras) they have sought to open a tiny space in the law on a very limited set of grounds, including limiting fetal impairment only to fatal cases. I believe this is a policy inspired by Catholic Health Policy, which aims above all to prevent abortions. I think it must be rejected.

I thought you had read the personal stories of women with pregnancies affected by (serious not just fatal) fetal anomalies that changed the status of their pregnancy from wanted to unwanted, an emotionally very difficult transition to have to make. If an anomaly would make the child's life empty of meaning (as with Zika babies, for example) and/or would affect the parents' lives in ways they could not cope with, and/or affect existing children, why would you deny a legal abortion? Again, the likelihood is that many will still be forced to travel to England. Do you really want that to happen?

9. <u>The six sections on review of medical opinion</u> fill almost four pages with complex text laying out the process of review of doctors' decisions, the pages full of bureaucratic and administrative red tape. On the basis solely of numbers of words, it would appear you are more interested in these reviews than anything else. Yet they will not protect women, if that is their aim. Their existence speaks to the lack of protection afforded in this bill right now.

Have you looked at who has second trimester abortions? They are often young or among the most vulnerable women. Do you really want to allow doctors to refuse them an abortion and then force them to challenge the decision in front of a review panel? Why give doctors that kind of power? What if a large proportion of doctors decide to refuse women abortions? What will this bill have achieved? Surely, the inevitable delay, the associated costs and emotional fallout are the last thing you want to introduce. I see this as yet another reason why women will opt to travel to England instead. Scenario: Woman seeks abortion. Two doctors say no. Review panel. Review panel cannot agree among themselves. Another review panel? I'd have gone to England long before I would put myself through that.

10. <u>The three-day delay for an abortion up to 12 weeks LMP</u>. Again, why introduce a delay that has no clinical value and forces the woman to come back for a second appointment?

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[1] "The second most common legal indication for second trimester abortion [after health grounds] is fetal impairment or anomaly. Interpretation of an indication of fetal impairment can pose difficulties. The most significant is a definition of what sort of fetal impairment is sufficiently serious to justify an abortion. This question has been addressed by some government ministries and medical professional associations. For example, in a 2006 position paper, the Netherlands Ministry of Health Welfare concluded that termination of pregnancy after 24 weeks was warranted in cases in which "the unborn child cannot reasonably be expected to survive outside the mother's body" or in which there are "fetal anomalies leading to serious and incurable functional disorders but which might reasonably be expected to have a chance of survival, although mostly a very limited one". In a 2010 report, the UK Royal College of Obstetricians & Gynaecologists (RCOG) advised that a number of factors be considered, including the potential for effective treatment; the probable degree of self-awareness on the part of the child and of the ability to communicate with others; the suffering that would be experienced; the probability of the child being able to live alone and to be self-supporting as an adult; and on the part of society, the extent to which actions performed by individuals without disability that are essential for health would have to be provided by others. The RCOG decided against specifying the types of fetal impairment that justify an abortion, and in fact almost no laws do so, as is also the case with the health indication. Actual wording of the laws varies from country to country. In almost all countries the fetal impairment must be considered serious. For example, in Great Britain and many of its former colonies there must be 'a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped'. In many countries the impairment must also be incurable. In France and a number of its former colonies, and countries influenced by French law, there must be 'a strong possibility that the unborn child will suffer from a particularly serious condition recognized as incurable at the time of diagnosis'. A few countries, such as Israel, Nepal and Slovakia, however, specify neither requirement. Whether these differences in wording make a practical difference or not is unclear." Reed Boland. Second trimester abortion laws globally: actuality, trends and recommendations. Reproductive Health Matters 2010 18;36:67-89.

Women are not children who need to be *made* to wait in case they change their minds. Women who are uncertain can ask someone they trust for help to decide. It has always been the case that some women decide against an abortion, having booked an appointment. But if they are uncertain, they can create their own "delay" by booking for the following week if they wish. Or they can take the pills home and not take them until they are ready (if you allow that, of course, which I hope you will in line with progressive policy, e.g. in the USA). A delay period was imposed in France and Belgium in the previous century. Both have dropped it as a bad idea. France only imposed a delay to stop women from neighbouring countries from crossing the border to get abortions (a long time ago now).

Is there any medical treatment in which men are required to wait for three days before receiving it, in case they change their minds? If not, this delay period is a form of discrimination on the grounds of sex. There is absolutely no clinical or other justifiable reason for it.

11. You said the referendum was a resounding affirmation of support for the right of women to make choices about their lives. Indeed, it was, and it's great that you think so. You said: "It was a reaffirmation of the primacy of equality in our modern democracy and it was also a call for us to do more… More on women's health, women's equality, more on continuing to shape an inclusive and equal society." But this bill does not do that. This bill is about giving the medical profession, whether gynaecologists, fetal medicine specialists, or GPs total control over women's abortion decisions and their access to abortion care.

12. WHO says: Use of routine pre-abortion ultrasound scanning is not necessary. On 24 September it was reported that resources for abortion services, including improved ultrasound scanning services in maternity hospitals, would be included in this year's budget because of this bill. Does that mean you think every woman seeking an abortion must have an ultrasound scan? An article on 25 September appears to clarify that you were talking about scans for fetal anomaly, and that these would not be available in time for a January roll-out. That is a quite different picture. I hope you will clarify this as it matters a lot.

Many older abortion providers, especially senior gynaecologists, still insist on a scan before every abortion. This practice is out of date, yet in England, ultrasound is still a routine part of pre-abortion care. The World Health Organization said in 2012: "Use of routine pre-abortion ultrasound scanning is not necessary." (page 6) The RCOG's *The Care of Women Requesting Induced Abortion*[2] said the same, and explained that its routine use pre-abortion to date the pregnancy became entrenched following the introduction of medical abortion, which was originally (but is no longer) associated with a strict gestational time limit.

13. On 27 September, it was reported that the Irish Family Planning Association and the Well Woman Centre, who already have the expertise to provide first trimester abortions expressed frustration that they have been left out of meetings between the Department of Health and medical experts and left out of plans to provide access to abortion in Ireland. And yet, if you want to provide woman-centred services, these are precisely the service providers who can teach everyone else in the country how to do it!

14. On 28 September (International Safe Abortion Day), you said that Catholic crisis pregnancy centres would lose state funding if they refused to give information to women about abortion. But these centres try to talk women out of having abortions (scare them, guilt trip them, and tell them lies about lack of safety, cancer risk and lifelong regret). This raises several questions: why do such groups receive state funding to begin with? Has anyone ever assessed their "services" for accuracy of information provided or perceived value on women's part? Why would you want an anti-abortion organisation to advise women who are seeking an abortion? You have said you want to create safe access zones – isn't this contradictory? Why allow them to "advise" women with your funding to do so? Please don't.

[2] Royal College of Obstetricians and Gynaecologists, 2011, 52.

They do not provide unbiased information or support. Women seeking abortions don't need them.

15. Conscientious objectors: let them be – On 5 October, you said you would meet medical colleges because some doctors were calling for the new legislation to protect conscientious objectors. Here is my proposal: do not force any anti-abortion health professional to participate in abortion care – for the same reason that pregnancy crisis centres should not be allowed (let alone forced) to provide (anti-)abortion counselling for women. Medical professionals who are against abortion should not be allowed anywhere near abortion services, and that is what they also want. Instead, I recommend following what Sweden has done. They have employment contracts that specify that any health professional who accepts a job in which involvement in abortions is a contractual obligation must participate. If they refuse, they lose their job. Anyone who does not want to do abortions is told they cannot accept a position where abortion is provided or may be necessary, even if only on an emergency basis. Thus, participation vs. non-participation becomes a contractual issue, not a moral one. Had this been in place in Savita's hospital, she would still be alive today. It cannot be applied retrospectively, but it means that in the future, no one anti-abortion can become an obstetrician-gynaecologist or a midwife, for example, unless their contract excludes them from doing abortions. It also obliges you to ensure these services are provided by others. This makes abortion a women-centred service, guarantees them access, and also allows professional non-participation.

16. What the best 21st century, woman-centred services should look like – If a lot of health professionals claim conscientious objection, you are going to need nurses and midwives to manage abortions, as well as willing GPs and clinics like the Well-Woman. But in any case, that is what the best 21st century, woman-centred services should look like – abortion as a primary care service for the great majority of women. Go to France, Belgium, Sweden, Norway. Abortions are mostly very early, and almost all are nurse or midwife-led. Many abortions which are not home-based are provided in freestanding clinics, not in hospitals at all. Or they are heading in that direction.

On 4 October, although your proposed legislation provides for termination of pregnancy up to 12 weeks without any restriction or justification as to reason, you said doctors would be asked to refer women between 9 and 12 weeks LMP to an obstetrician, because the "international evidence and advice [you] have received indicate that GPs should refer women to the care of consultant obstetricians in hospital environments". That's not correct. It would not be supported by the World Health Organization; ask them. Mid-level providers can provide medical abortion pills at primary level for women to use at home until 10 weeks LMP. That's the current US Food & Drug Administration policy. And they also manage medical abortions all through the second trimester. A skilled mid-level provider can do vacuum aspiration until 12-14 weeks in a day clinic. Obstetricians are still needed for D&E and complicated cases, e.g. some fetal anomaly cases and some women's health conditions but that's all.

On 16 October, an Irish news report said women will be able to get medical abortion pills direct from GPs or from a hospital doctor and "will not have to fill a prescription in a pharmacy". But the role of pharmacies for obtaining medical abortion pills is becoming central in many countries, especially in the global south, where women cannot count on seeing a health professional. Please consider your rural areas and don't write off the role of pharmacies.

Please also look at the use of telemedicine for providing medical abortion pills, which has become a highly popular service provided by the Tabbot Foundation across Australia,[3] and also in four states in the USA. Trained pharmacy workers have been shown in Nepal to be

[3] Tabbot Foundation, https://www.tabbot.com.au/

safe providers of medical abortion pills that women use at home. If they can do that in one of the world's poorest countries, they can do it everywhere. That is how safe early medical abortion is. Medical abortion pills can be used at home up to ten weeks, first trimester aspiration abortion takes only a few minutes.

An alternative proposal

I do hope you will reconsider your bill in its entirety, and submit a much simpler bill along the following lines, using Sweden's law as a model: Abortion is available there on request up to 18 weeks and on a range of grounds, including fetal impairment, rape, sexual abuse, risk to health and mental health, and economic and social reasons, after 18 weeks. It is not in the criminal law. Queensland in Australia has just last week decriminalised abortion and passed a law allowing abortion on request up to 22 weeks.

If you want to expand the list of grounds the Irish way, you could use the recommendations of the Citizens' Assembly – they cover everything.

But please don't give doctors the control over women's decision, eliminate the review boards, and eliminate the three-day delay. Make abortion a nurse/midwife/GP led service at primary care level for women up to 14 weeks of pregnancy. Offer training to these cadres. Canada has an excellent medical abortion pill online training course, for example. Start with medical abortion pills (training is very simple) and launch training for manual vacuum aspiration. Arrange for women to have antenatal screening for fetal anomalies as early as possible (contact Antenatal Results and Choices in London for information) and in cases where abortion is complicated or needs to be by D&E, yes, involve experienced obstetrician-gynaecologists. But note that in Sweden, nurses and midwives manage second trimester medical abortions. They do not do D&E because there are so few cases that the doctors could not keep up the necessary skills.

Some reading

Health worker roles in safe abortion care and post-abortion contraception, by Bela Ganatra, WHO. Lancet Global Health, 2015. (Summary)
https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(15)00145-X/fulltext

Health Worker Roles in Safe Abortion Care and Post-Abortion Contraception. World Health Organization, 2015.
http://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf;jsessionid=A33EAC938E5292116A0369A47CAE4D04?sequence=1

Competency in Facilitation of Abortion-Related Care/ Essential Competencies for Basic Midwifery Practice 2010, revised 2013. Pages 18-19.
http://www.safeabortionwomensright.org/wp-content/uploads/2016/05/ICM-Essential-Competencies-for-Basic-Midwifery-Practice-2010-revised-2013.pdf

From: Contraception, Medical Abortion Special Issue Feb 2018

Editorial: Medical abortion pills have the potential to change everything about abortion
https://www.contraceptionjournal.org/article/S0010-7824(17)30532-2/fulltext

What if medical abortion becomes the main or only method of first-trimester abortion? A roundtable of views
https://www.contraceptionjournal.org/article/S0010-7824(17)30371-2/fulltext

Efficacy of medical abortion prior to 6 gestational weeks: a systematic review
https://www.contraceptionjournal.org/article/S0010-7824(17)30438-9/fulltext

Medical abortion can be provided safely and effectively by pharmacy workers trained within a harm reduction framework: Nepal
https://www.contraceptionjournal.org/article/S0010-7824(17)30436-5/fulltext

I wish you the very best going forward. Many thanks for your attention.

With kind regards,

Marge Berer

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International Coordinator

INTERNATIONAL
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RIGHT TO SAFE
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