National Women's Council of Ireland
Comhairle Náisiúnta na mBan in Éirinn

Response to the Health (Regulation of Termination of Pregnancy) Bill

October 3, 2018

NWCI welcomes the opportunity to respond to the Health (Regulation of Termination of Pregnancy) Bill 2018 (henceforth "the Bill"). Our submission is based on extensive research, direct account of women's personal testimonies and over thirty years of policy development in the area of women's reproductive health.

We believe the effect of our abortion laws should be two-fold: (1) to ensure safe, equitable, accessible and legal abortion for women, and (2) to institutionalise women's autonomy over reproductive decision-making. In this respect, NWCI calls for the following to be included in the Bill:

Principles that inform the legislation

1. A Preamble would serve as a reminder for future generations of the long fought for changes to protect women's health. It would further serve to reflect Ireland's past restrictive abortion laws and the legacy of how women have been treated in Ireland.

Scope of providers of care

2. Ensure a wider range of healthcare professionals can provide, or be involved in the provision of abortion care. Currently, the Bill only enables service provision by doctors. Nurses and midwives provide highly skilled, complex care in other areas of Irish healthcare, including in maternity units which are increasingly led by midwives and nurses, with doctors on-call.

Medical Decision Making & Assessing Risk

3. Ensure the legislation enables medical decision-making in the best interests of women. Doctors must be empowered to feel confident in their interpretation and application of any new abortion law, so that they (or their legal advisers) do not adopt needlessly cautious interpretations of provisions.

Conscientious Objection

4. Protection for women in the case of conscience-based refusals of care (so-called 'conscientious objection') requires a clear, legal and policy framework, governing the practice of conscientious objection by healthcare providers, coupled with an effective oversight and complaint mechanism for women.

Notification & Data Collection

5. Data collection is necessary to ensure good quality care. Routine monitoring is essential to inform service development in the interests of women (numbers per region; gestation; method; location; etc.) In establishing a new system it is essential that data collected enables monitoring of national distribution of abortion provision and incidences of refusal of care.

Safety Zones

6. Speedy introduction of legislation providing for safety zones which are necessary outside maternity hospitals and primary care centres to protect women and their healthcare providers.

Principles that inform the legislation

1. Preamble

NWCI is calling for the legislation to include a Preamble. Inclusion of a Preamble would act as a reminder for future generations of the importance of the enactment of the legislation, outline the purposes and processes which led to the enactment of the legislation and communicate the shared intention of the legislation, namely, that abortion care is a private and personal matter for women in consultation with their doctors. It would further serve to act as a reminder of Ireland's past restrictive abortion laws and the legacy of how women have been treated in Ireland.[1]

Recalling the time, effort and dedication that the Citizen's Assembly put into their deliberations and recommendations;

Recalling the Joint Oireachtas Committee on the Eighth Amendment of the Constitution's clear recognition of the complexity of decisions in pregnancy and that these decisions are private and personal, never political;[2]

Recalling the countless personal stories and testimonies as recounted by women, parents and families;

Recalling that on 25th May 2018, 1,429,981 people said 'Yes' to a more compassionate Ireland where a woman can make her own decisions in pregnancy and access abortion if she needs it here in her own country.

Scope of providers of care

2. Ensure a wider range of healthcare professionals can provide, or be involved in the provision of abortion care. Currently, the Bill only enables service provision by doctors. Nurses and midwives provide highly skilled, complex care in other areas of Irish healthcare, including in maternity units which are increasingly led by midwives and nurses, with doctors on-call.[3]

(i) Scope of 'Medical Practitioner', section 2

The Bill precludes a model where nurses or midwives could undertake specialist training and develop an equal competence with doctors to take responsibility for aspects of abortion care in non-complex cases.[4] Since 2003, the WHO has recommended that such care is provided at the lowest appropriate level of the healthcare. According to Best Practice in Comprehensive Abortion Care (Royal College of Obstetricians and Gynaecologists) a range of providers, including nurses and midwives are competent to deliver these services safely in a number of settings. Nurses and midwives provide highly skilled, complex care in other areas of Irish healthcare, including in maternity units which are increasingly led by midwives and nurses, with doctors on-call. Engagement of nurses and midwives within the provision of these services would support early access to care and reduce waiting times for women.

Amend the definition of medical practitioner to refer to "such other healthcare practitioners as may be defined by the Minister from time to time" to ensure that future changes in policy and practice in healthcare regarding, for example, the roles of midwives and nurses, would not require legislative change.[5]

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1 For example, a Preamble appears on legislation in force in South Africa: The Choice on Termination of Pregnancy *Act*, 1996 (*Act* No. 92 of 1996).

2 https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_the_eighth_amendment_of_the_constitution/reports/2017/2017-12-20_report-of-the-joint-committee-on-the-eighth-amendment-of-the-constitution_en.pdf

3 See IFPA Policy considerations in relation to abortion care in the context of the General Scheme of a Bill to Regulate Termination of Pregnancy (25 June 2018), para 3.1.

4 World Health Organization (2015) Health worker roles in providing safe abortion care and post-abortion contraception. Available at: http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en

5 See IFPA Policy considerations in relation to abortion care in the context of the General Scheme of a Bill to Regulate Termination of Pregnancy (25 June 2018), para 3.1.

Medical decision making & assessing risk

3. Ensure the legislation enables medical decision-making in the best interests of women. Doctors must be empowered to feel confident in their interpretation and application of any new abortion law, so that they (or their legal advisers) do not adopt needlessly cautious interpretations of provisions.

(i) Offences, section 5; and Offence by Corporate body, section 6

Healthcare providers are routinely trusted to make decisions about their patients' health. Abortion should not be seen as a medical procedure so unique that it requires a whole new approach cemented in legislation. What is essential is that women have control over their reproductive decision-making and medical professions can exercise clinical judgement in the best interests of their patients.

Given the existence of the Non-Fatal Offences Against the Person Act 1997, NWCI questions creating additional criminal offences that may trigger a 'chilling effect' by forcing healthcare providers to consider their own best interests rather than that of their patients, overcomplicating the practical delivery of abortion care.

Delete sections 5 and 6.

(ii) Risk to life or health, section 10 and Risk to life or health in an emergency, section 11

While legislation is intended to provide legal certainty, both to women and their healthcare providers, it is important that certainty of the law does not hinder clinical flexibility; healthcare providers need space to exercise clinical judgement in the best interests of their patient.

Applying a legal standard of risk to a medical determination of actual risk is not practical nor within the best interests of a patient. The test for determining risk is overly complicated, as two medical practitioners must certify in their 'reasonable opinion', which they must make in 'good faith' that there is either a risk to life or 'serious harm' to health, that the foetus has not reached 'viability' and it would be 'appropriate' to terminate in order to avert that risk.

The assessment of the pregnant woman's health must take into account her actual or reasonably foreseeable environment. The legislation should include an obligation on the part of the assessing practitioner to show that they have taken account of the woman's own assessment of relevant risks to her life/health and the impact of continued pregnancy on her current and future health.

Delete the reference to 'serious harm to the health' and replace with 'harm to the health' in sections 10 and 11.

Amend section 10(2) to state that a termination may be carried out whether a recognised healthcare provider reasonably believes that the abortion is appropriate to avert a risk to life or health of the woman, and they have consulted at least one other provider who also reasonably believes that the abortion is appropriate. In considering whether the abortion is appropriate, a registered medical practitioner must have regard to— (a) all relevant medical circumstances; and (b) the woman's current and future physical, psychological and social circumstances.

(iii) Early pregnancy, section 13

Healthcare providers need space to exercise clinical judgement in the best interests of their patient. Women need space to make decisions that are best for them and their health. Rigid legal standards and language will directly serve to weaken doctors' decision making capacity and by default undermine women's access to appropriate healthcare.

We must ensure that barriers to care are not created for women who due to geographic accessibility, domestic abuse, disability or other reasons may have difficulty accessing multiple appointments. The

Bill makes provision for a 3-day waiting period prior to termination. The start of this 3-day period should be triggered at initial contact with a healthcare provider.

To prevent the needless development of hard case case-law flexibility should be provided for around challenging cases. Such an approach would ensure that a woman should not be denied access to the abortion she needs because of factors beyond her control.

Amend section 13(2)(b) to state that the 3 day waiting period is triggered from initial contact with the healthcare provider.

Insert a new subsection (5) into section 13 that recognises that there may be challenging circumstances beyond the control of the woman, which may have delayed her accessing the procedure within 12 weeks, and that she should not be denied access to the abortion she needs because of factors beyond her control.

Conscientious objection

4. Protection of women in the case of conscience-based refusals of care (so-called 'conscientious objection') requires a clear, legal and policy framework, governing the practice of conscientious objection by healthcare providers, coupled with an effective oversight and complaint mechanism for women.

(i) Conscientious objection, section 23

No woman should be faced with refusal of lawful abortion care.

There is considerable concern about the potential for conscientious objection to reduce access to services.[6] The framework for conscientious objection must respect the rights of the pregnant woman and protect women from disapproval from medical providers with objections. For conscientious objection to work there must be a referral system that comes under the guarantee of access. This will ensure that each woman gets a safe and timely service. NWCI recommends establishment of a central online and telephone hub which could direct women to available services (particularly necessary in a system allowing conscientious objection), provide out-of-hours medical support and access to crisis pregnancy counselling by telephone or face-to-face, where requested by the woman.

It also has to be clear that objections (which protect an individual's conscience) cannot apply to institutions. This may require a provision obliging healthcare authorities to organise services in a manner that ensures women have timely access. There is a further need to protect healthcare providers who provide termination services. Respect for self-determination and integrity are applicable not only to providers who decide that their belief precludes them but also to those who decide to provide termination. [7]

Establish a central online and telephone hub which could direct women to available services (particularly necessary in a system allowing conscientious objection), provide out-of-hours medical support and provide access to crisis pregnancy counselling by telephone or face-to-face, where requested by the woman.

Delete "as soon as may be" from section 23(3) and replace with a specific time frame to ensure timely referral.

[6] Irish Catholic Bishops' recently published Code of Ethical Standards for Health Care "No healthcare facility or practitioner should provide, or refer a patient for, an abortion, i.e. any procedure, treatment or medication whose primary purpose or sole immediate effect is to terminate the life of a foetus or of an embryo before or after implantation. Such procedures, treatments and medications are morally wrong because they involve the direct and deliberate killing of, or a direct lethal assault on, an innocent human life in the earliest stages of development "(2.24)

[7] The below proposals are generally modelled on Norway's Regulations for the Implementation of the Act dated 13 June 1975 No. 50 concerning Termination of Pregnancy, with Amendments in the Act dated 16 June 1978 No. 66, cf. sec. 12 of the Act, sec. 15-17. See also See detailed discussion Chavkin W, Swerdlow L, Fifield J. Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study. *Health and Human Rights*. 2017;19(1):55-68.

Insert a new subsection to oblige medical providers to register their refusal with relevant health care authorities, and refer women seeking abortion services to another medical practitioner able to perform the service within a short time.

Insert a new subsection to oblige health care institutions to notify health care authorities on a quarterly basis as to the number of registered medical practitioners with conscientious objections as well as the number of medical practitioners willing to perform abortions.

Insert a new subsection to prohibit health care institutions adopting policies or practices to facilitate refusal of abortion care.

Notification & data collection

5. Collection of data and routine monitoring is essential to inform service development in the interests of women (numbers per region; gestation; method; location; etc.) In establishing a new system it is essential that data collected enables monitoring of national distribution of abortion provision and refusals of care.

Monitoring the national distribution of abortion provision and conscientious objection would facilitate the meaningful evaluation of the service access. Most countries that provide legal abortion services gather statistics on the incidence of abortion and publish annual reports. Gathering such data allows the improvement of service delivery and supports good public health outcomes amongst those who access termination of pregnancy.[8]

Amend section 21 to provide for collection of necessary data, particularly national distribution of abortion provision and to ensure that conscience-based refusal of abortion care is recorded to enable monitoring of the operation of refusal of care.

Safety zones

6. Speedy introduction of legislation providing for safety zones which are necessary outside maternity hospitals and primary care centres to protect women and their healthcare providers.

We understand that there will be a separate piece of legislation to introduce safe access zones to prevent women being intimidated or harassed when seeking these services. We call for its publication as a matter of urgency.

NWCI welcomes the opportunity to comment on the Bill and is available to provide further information or clarity as required. We will continue to work with the Department of Health, HSE and healthcare providers throughout the legislative process to ensure that women have access to high-quality, women-centred abortion care in Ireland.

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[8] For extensive commentary and analysis of this area see IFPA Policy considerations in relation to abortion care in the context of the General Scheme of a Bill to Regulate Termination of Pregnancy (25 June 2018), section 4.