Submission on the General Scheme of a Bill to Regulate the Termination of Pregnancy

20 August 2018

The Abortion Rights Campaign (ARC) is an all-island grassroots movement for choice and change. Since 2012 we have been raising awareness and advocating for change to Ireland's abortion laws. We organise the annual March for Choice, which last year saw over 40,000 people take to the streets of Dublin to demand free, safe and legal abortion access for all who need or want it. ARC was a founding member of the "Together For Yes" campaign which secured a resounding Yes vote in the recent referendum to repeal the 8th Amendment. We aim to ensure that the health and dignity of all reproductive rights-holders in Ireland are protected in line with international best practice and human rights standards.

Introduction

The General Scheme of the Health (Regulation of Termination of Pregnancy) Bill represents the Government's plan to give effect to the will of the Irish electorate, as expressed in the referendum of 25th May 2018. In this referendum 66.4% of people voted to repeal the 8th Amendment and thereby pave the way for legal abortion. The referendum result proved what ARC has long known - that Ireland is truly pro-choice. The level of engagement in the campaign was overwhelming, particularly among young people and women. The public discourse during the campaign reflected people's understanding of abortion as a healthcare issue that should be addressed through progressive patient-centred legislation, not criminal sanctions.

The repeal of the 8th means that we now have the opportunity and responsibility to introduce world-class abortion services. In this document ARC sets out the key principles that should underpin the modern abortion legislation that Ireland needs. We call for a system of free, safe, legal abortion that respects bodily autonomy, accessibility, accountability and evidence. These principles are based on international standards and our own experience representing the many directly affected by the 8th Amendment, and give rise to the following policy recommendations:

- dedicated lines of funding for abortion care
- patient choice of healthcare provider and procedure
- patient-centred care without refusal of care ("conscientious objection")
- safe access zones to protect patients, providers, and the public
- no waiting periods, which are not medically necessary
- full decriminalisation of abortion

We welcome the opportunity to meet with Government representatives about our recommendations.

1. Free, Safe and Legal Abortion

ARC fights for free, safe, legal abortion care. We believe that free, safe and legal access to abortion services is the only model that supports meaningful choice in pregnancy-related healthcare.

Central to this framework is the principle of bodily autonomy. All individuals have the right to make their own decisions about what happens to their bodies during pregnancy, including the right to choose and refuse medical treatment, such as abortion care, antenatal care and birth care. Any abortion legislation must reflect each pregnant individual's right to agency and bodily integrity, as well as their rights to privacy and freedom from cruel, inhuman and degrading treatment. Other principles that are central to putting free, safe, and legal abortion care into practice include the legal and practical accessibility of services, accountability and transparency in service provision, and a commitment to evidence-based regulation of services.

ARC strongly urges the Government to harmonise the proposed abortion legislation with the Gender Recognition Act 2015 by making it explicitly inclusive of transgender and non-binary people, who can and do become pregnant and avail of abortion. This can be done by using the words "person" or "person who is pregnant" rather than "woman" throughout the legislation, or at minimum defining "woman" to encompass anyone of any age who can become pregnant. In keeping with this recommendation, and while acknowledging that the majority of abortion services are required by women and girls, we predominantly use gender-neutral terms throughout this submission.

2. Accessibility

Fundamentally, abortion must be accessible to all who need it. Therefore, abortion law should be non-discriminatory and should clearly address any barriers people may face when trying to access an abortion. In line with national policy on other aspects of pregnancy-related care, abortion should be made freely available without any time limits or gatekeepers. Accessible abortion is good for public health: the World Health Organisation (WHO) has found that deaths and illnesses decline dramatically where there are few restrictions on access to safe abortion.[1] ARC's position - reinforced by best medical practice internationally - is that abortion should be available as early as possible and as late as necessary.

Free, local services

Because cost should never be a barrier to accessing healthcare services, we advocate for abortion as part of the public health system. If abortion services are only available through private healthcare providers or at a cost, then poor and low-income people could be prevented from accessing care. Removing financial barriers also allows people to access abortions earlier. Research from the United States demonstrates that costs are a significant barrier to abortion access.[2]

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[1] World Health Organisation (2012) "Safe abortion: technical and policy guidance for health systems." Legal and policy considerations - Key messages. Geneva: World Health Organisation, p.8.

[2] Jerman, J. and Jones, R. (2014) "Secondary Measures of Access to Abortion Services in the US, 2011-2012: Gestational Age Limits, Costs, Harassment", Women's Health Issues.

We therefore welcome the Cabinet's recent commitment to free abortion care for all.[3] Abortion law and regulation should make clear how the Government intends to provide universal access to abortion, especially for those already financially disadvantaged, for example people living in direct provision or those without control of their own finances, such as people experiencing domestic violence.

Equally, no one should be constrained in their choice of provider or choice of procedure because of their socioeconomic status. For example, people with medical cards must be able to access abortion care from any practice, not just the GP to which their card is registered. Widening the scope of medical practitioners who can provide abortion services - to include, for example, midwives and nurses - would ensure that they are more accessible to those who need them.[4] Similarly, where either a surgical or medical abortion is suitable for the patient, they should be able to choose either type of procedure without charge.

Accessible service also means local service. Statistics from the UK show that people from every county of Ireland have been forced to travel for abortion care every year.[5] The strength and breadth of the "Yes" vote also reflected the fact that abortion access is not a uniquely urban or rural issue. The State has a duty to ensure that medical practices providing abortion are available within a given radius, so that people do not have to travel long distances for healthcare. We have seen in our own recent history and in other jurisdictions that inadequate local abortion access disproportionately impacts those who lack financial resources, have caring responsibilities, are in controlling relationships, or have mobility issues. It also creates a postcode lottery scenario where people living in certain parts of the country are significantly geographically disadvantaged.

Barrier-free access

When people face barriers to abortion care, they tend to have later abortions - a significant potential problem under the proposed General Scheme, which limits the timeframe for abortion and would force people to travel. Planned Parenthood has identified three main factors which result in pregnant people seeking abortions after the first trimester:

1. Financial constraints – 36% of those having abortions after the first trimester reported that they needed time to raise the necessary funds.[6] This impacts low-income and young people in particular.[7]
2. Provider shortage – in 2011, 89% of U.S. counties lacked an abortion provider. As such, people are forced to travel to access services and experience significant delays.[8]

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[3] "Cost will not be barrier to accessing abortion, ministers agree", Irish Examiner, 10 July 2018.
[4] Berer, M. (2009) "Provision of abortion by mid-level providers: international policy, practice and perspectives". Reproductive Health Matters Journal, 87, 58-63 www.who.int/bulletin/volumes/87/1/07-050138/en/
[5] Abortion Statistics, England and Wales. www.gov.uk/government/collections/abortion-statistics-for-england-and-wales
[6] Finer, L.B. et al. (2005) "Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives." Perspectives on Sexual and Reproductive Health, 37(3), 110–8.
[7] Jones, R.K. and Finer, L.B. (2012) "Who has second-trimester abortions in the United States?" Contraception, 85(6), 544-51.
[8] R.K. Jones and J. Jerman (2014) "Abortion Incidence and Service Availability in the United States, 2011." Perspectives on Sexual and Reproductive Health,46(1). http://www.guttmacher.org/pubs/journals/ psrh.46e0414.pdf

3. Legal barriers – for example, mandatory waiting periods impose significant delays on those seeking abortion - often longer than initially intended. For example, a study in the U.S. found that the "three day" waiting period translated to, on average, an eight day wait in practice, because of logistics and the lack of available appointments.[9]

The Government can avoid the first problem by fulfilling its promise to make abortion available without cost to patients. However, the Government must take action to avoid the other two problems. First, medical providers in every county must be supported to include abortion care in their services. Second, the Government itself must remove the significant legislative barrier to access currently proposed: a medically-unnecessary three-day waiting period. Barriers to abortion access will only serve to undermine the law and endanger the welfare of abortion-seekers. They will force some in Ireland to travel abroad for care, as if the 8th had never been repealed, or to order pills online instead of receiving a doctor's care.

ARC opposes all time limits on abortion access because they are arbitrary and often harm pregnant people by placing undue constraints on their healthcare choices. In particular, the proposed restriction on access to abortion on request beyond 12 weeks of pregnancy will severely impact many people. It should be noted that 12 weeks of pregnancy is around 10 weeks since conception, which is a relatively short time period, especially for people with an irregular menstrual cycle or those who were not expecting to become pregnant. We would urge the Government to remove time restrictions which will act as barriers to the pregnant person's right to abortion care.

Policy-makers should put in place all necessary measures to ensure access for marginalised groups, including minors, transgender people, members of minority ethnic communities, people with disabilities, people living in abusive relationships, people living in direct provision, undocumented migrants, people who require translation services, prisoners and sex workers. Regular proactive engagement with marginalised groups is imperative to ensure that their voices are heard and their needs are met by the health service.

3. Accountability

The State has a responsibility to ensure that abortion is safe and accessible to all who need it. The State must take proactive measures to ensure that there is a sufficient number of willing and qualified providers in every area of the country, particularly in rural regions, and that prospective patients can easily locate providers in their area. The Department of Health is ultimately accountable for the availability and quality of abortion-related services across Ireland.

No refusal of care

ARC believes that refusal to provide care, or so-called "conscientious objection", must not be a barrier to pregnant people trying to access abortion. Evidence from other jurisdictions has shown that one of the biggest barriers to abortion access is the refusal of medical practitioners to provide care. Under the General Scheme, medical practitioners are permitted

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[9] Roberts, S. (2016) "Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women" Wiley Online Library, 28(4),179. https://onlinelibrary.wiley.com/doi/epdf/10.1363/48e8216

to refuse to care for patients on grounds of conscience, except in emergency situations. We believe this falls short of what is required to protect patients. This stance is shared by the WHO, who have identified *all* forms of "conscientious objection" as barriers to safe abortion. [10] Refusal of care on conscience grounds undermines standards of medical best practice by preventing patients from receiving accurate and unbiased information regarding treatment options, and by inhibiting their ability to access such treatment when needed. The ability of medical practitioners to object to *any* medical procedure on grounds of conscience violates the medical ethical principle of "do no harm" and is detrimental to the health and wellbeing of the people medics are supposed to serve.[11]

Furthermore, the inclusion of an option to refuse care on grounds of conscience within the legislation frames abortion as a moral rather than medical issue. This is likely to contribute to institutional and internalised stigma among both patients and service providers, and creates a culture where medical practice is not based on objective medical evidence or the right of every individual patient to determine their own choices. In countries like Italy, the refusal to provide care has become widespread, due in large part to "convenient objectors" who claim conscientious objection but are often simply unwilling to provide this service for other reasons. The result of this practice is that, although abortion in Italy is technically legal, it can be practically impossible to access, with more than 70% of providers (rising to 90% in southern parts of the country) refusing to provide abortion care.[12] Indeed, one woman had to visit 23 hospitals in order to obtain an abortion.[13] Refusal of care on conscience grounds was implicated in the tragic death of Valentina Milluzzo in Southern Italy in 2016.[14]

The UN CEDAW (Convention on the Elimination of all Forms of Discrimination Against Women) Committee has specified that "[i]f health service providers refuse to perform [reproductive health] services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers."[15] However, the Center for Reproductive Rights has emphasised that such measures are typically ill-defined and unenforced, and as such systemic abuse is rampant.[16]

Not all legal systems recognise a right to object to or refuse care. For example, abortion cannot be refused on grounds of conscience in Sweden or Finland. This is in keeping with

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[10] World Health Organisation (2016). "Factsheet: Preventing Unsafe Abortion." http://www.who.int/mediacentre/factsheets/fs388/en/

[11] Truong, M. and Wood, S.Y. (2018) "Unconscionable: when providers deny abortion care." International Women's Health Coalition. https://iwhc.org/resources/unconscionable-when-providers-deny-abortion-care/

[12] "Italy's far right uses Irish vote to boost anti-abortion campaign", The Guardian, 19 May 2018. https://www.theguardian.com/world/2018/may/19/italys-far-right-use-irish-abortion-referendum-to-boost-pro-life-campaign

[13] "Italy's far right uses Irish vote to boost anti-abortion campaign", The Guardian, 19 May 2018. https://www.theguardian.com/world/2018/may/19/italys-far-right-use-irish-abortion-referendum-to-boost-pro-life-campaign

[14] "Police launch inquiry into death of woman 'refused' an abortion by Sicilian doctors", The Guardian, 23 October 2016. https://www.theguardian.com/world/2016/oct/22/italy-death-miscarriage-abortion-doctors-refuse-procedure

[15] CEDAW Committee General Recommendation 24 on women and health (1999), para. 11.

[16] Center for Reproductive Rights (2012) "Abortion opponents undercut council of Europe resolution on conscientious objection." http://reproductiverights.org/en/press-room/abortion-opponents-undercut-council-of-europe-resolution-on-conscientious-objection

the principle of patient-centred care, which puts the rights and needs of the person seeking treatment first.[17] We would encourage the State to adopt a similar approach in Ireland. Research has shown that a commonly-cited reason for refusal of care on conscience grounds among medical professionals is fear of stigma and ostracism from peers, rather than genuine personal moral distress.[18] A "patient first" approach, with active de-stigmatisation of abortion and thorough education and training for medical professionals, could significantly reduce the problem of medical practitioners refusing to engage in abortion provision. Training in abortion provision should include giving medical professionals ample opportunity to voice their concerns, learn from international best practice and address their own values and perceptions. The work of the Citizens' Assembly, the Joint Oireachtas Committee on the Eighth Amendment of the Constitution (JOC), and Together for Yes have shown that when provided with accurate information and given an opportunity to ask questions, people tend to adopt a pro-choice position. Providing medical practitioners who intend to refuse care with a similar forum could be a constructive means of opening a dialogue and helping medical professionals become comfortable with the idea of providing reproductive health services.

The education and support discussed above should be extended to all workers involved in abortion care, including nurses, midwives, pharmacists and others, who each have a role to play in ensuring abortion is truly accessible.

Safe access zones

The State's responsibility to ensure safe abortion access includes ensuring that safe access zones are in place around medical practices and clinics to prevent individuals from being harassed by anti-choice campaigners.[19] Safe access zones are needed for both patients and healthcare professionals. The lack of safe access (or "buffer") zones around abortion clinics in countries like the US and the UK has been shown to have a detrimental effect on people seeking abortions, on the staff working at clinics and also on local residents. In a large survey conducted in the UK, people going into clinics felt that anti-choice protesters were invading their privacy and stigmatising their healthcare decisions.[20] In Canada, both patients and staff said they experienced distress and harassment at the hands of anti-choice protestors.[21]

In April 2018, Ealing Council became the first local authority in the UK to introduce a Public Spaces Protection Order outside of an abortion clinic. Anyone who violates this order is

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[17] "Italy's far right uses Irish vote to boost anti-abortion campaign", The Guardian, 19 May 2018. https://www.theguardian.com/world/2018/may/19/italys-far-right-use-irish-abortion-referendum-to-boost-pro-life-campaign

[18] Freedman, L. et. al (2010) "Obstacles to the integration of abortion into obstetrics and gynecology practice". Perspect Sex Reprod Health, 42(3) 146.

[19] Sister Supporter "Evidence Pack: calling for a Public Spaces Protection Order on Mattock Lane". http://www.lag.org.uk/?fileid=-17475

[20] Hayes, G. and Lowe, P. (2015) "'A Hard Enough Decision to Make': Anti Abortion Activism outside Clinics in the Eyes of Clinic Users" Aston University. http://www.aston.ac.uk/EasySiteWeb/GatewayLink.aspx?alId=256682

[21] "NDP to consider legislating buffer zones around abortion clinics", Edmonton Journal, 10 March 2018. http://edmontonjournal.com/news/politics/ndp-to-consider-legislating-buffer-zones-around-abortion-clinics

liable to criminal prosecution.[22] Ireland has the opportunity to proactively create and enforce safe access zones outside all places where abortion care is provided and ensure that people's medical decisions are treated with confidentiality and respect. ARC is pleased that the Cabinet agreed in principle to create safe access zones, and we look forward to reviewing the details as soon as they become available.[23]

Transparency

The State also has a responsibility to ensure that abortion care is properly funded under the public healthcare system with dedicated lines of funding - so that it is not vulnerable to arbitrary cutbacks - and to ensure that healthcare professionals receive appropriate ongoing training to equip them with the knowledge and skills needed to support patients who decide to end their pregnancy.

Additionally, it is essential that good, clear public health data is collected on abortion service provision. We encourage the State to collect data on the number of providers in each county in order to identify any gaps that need to be addressed.

In order to assess how well the legislation is working overall and to ensure that it is not having negative unintended consequences for pregnant people, we recommend that an independent review of the legislation (similar to that undertaken for the Gender Recognition Act 2015) take place within 12 months of its effective date. Considering abortion regulation without the shadow of the 8th Amendment is a paradigm shift in the way Ireland considers healthcare legislation; a periodic review would allow for the impact of legislation to be properly considered and adapted to suit the needs of pregnant people in Ireland.

4. Evidence-based Care

Abortion legislation and regulation must be evidence-based, as is the case for laws concerning any other medical procedure. Research from around the world demonstrates that abortion restrictions are often arbitrary or ideologically motivated.[24] [25]

No medically unnecessary barriers

There is no evidence that waiting periods are medically necessary or have any impact on a pregnant person's decision. Numerous studies in places where mandatory waiting periods are in effect - such as states in the U.S. - have shown that women and pregnant people are certain of their decision to have an abortion.[26] In fact, evidence on waiting periods has consistently found that their only impact is to create practical and psychological hardship for

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[22] " Ealing Council's cabinet members have taken the decision to implement a Public Spaces Protection Order (PSPO) around the Marie Stopes clinic on Mattock Lane, Ealing", Ealing Council, 10 April 2018.
https://www.ealing.gov.uk/news/article/1760/ealing_introduces_first_uk_safe_zone_outside_abortion_clinic
[23] "Cost will not be barrier to accessing abortion, ministers agree," Irish Examiner, 10 July 2018.
[24] World Health Organisation (2012) "Safe abortion: technical and policy guidance for health systems. Second edition." Geneva: World Health Organisation
[25] Guttmacher Institute (2013) "TRAP Laws Gain Political Traction while Abortion Clinics - and the Women they Serve - Pay the Price".
https://www.guttmacher.org/gpr/2013/06/trap-laws-gain-political-traction-while-abortion-clinics-and-women-they-serve-pay-price
[26] Guttmacher Institute (2018) "Waiting Periods for Abortion."
https://www.guttmacher.org/evidence-you-can-use/waiting-periods-abortion

pregnant people and that they have no basis in medical best practice.[27] People who face disadvantage in society may find it difficult or impossible to make multiple trips to access abortion care and in this way a needless waiting period could effectively strip them of their right to access abortion. Based on the evidence, France repealed its waiting period in 2015.[28] The WHO and the American College of Obstetricians and Gynecologists, as well as the JOC, oppose waiting periods.[29] Additionally, the Citizens' Assembly did not recommend waiting periods to the State.

Equally, it is crucial that medically extraneous practices (such as mandatory ultrasound scans to date pregnancy) are not introduced, as these are costly, onerous, and unnecessary.[30] For those having medical abortions, evidence suggests that it is preferable to allow the pregnant person to take the second pill at home.[31]

Full decriminalisation

The continued criminalisation of those who assist a pregnant person to obtain an abortion outside of the provisions of the bill is also at odds with medical best practice and wider international evidence, which advocates for the full decriminalisation of abortion.[32] We have already witnessed the chilling effect that criminalisation of abortion has on medical practitioners.[33] We are deeply concerned that having a 14-year prison sentence on the statute books (a troubling legacy of the Protection of Life During Pregnancy Act (PLDPA)) will result in medical professionals interpreting the law unduly conservatively and in doing so endanger the health and lives of patients. In addition, this criminalisation could impact other people who may assist an abortion-seeker, for example their parent or partner. We do not believe this is in the spirit or intention of the law. Therefore, we urge the State to enact legislation which ensures that no one is dissuaded from providing care or assistance to a pregnant person for fear of prosecution.

Related to this, vague terminology that defies medical evidence should be deleted from the legislation. While ARC opposes all gatekeeping criteria in line with the principle of bodily autonomy, we are especially troubled by the phrase "risk of *serious* harm to health" in the proposed legislation. We have reason to be concerned that if faced with unclear regulations

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[27]World Health Organisation (2012) "Safe abortion: technical and policy guidance for health systems. Second edition." Geneva: World Health Organisation.
[28] Berer M. (2015) "Abortion Law and Policy Around the World: In Search of Decriminalization. Health and human rights."
[29] World Health Organisation (2012) "Safe abortion: technical and policy guidance for health systems." Geneva: World Health Organisation", p.78, p. 94; American College of Obstetricians and Gynecologists, Committee Opinion no. 613, "Increasing Access to Abortion" (2014); JOC proceedings of 13 December 2017.
https://data.oireachtas.ie/ie/oireachtas/debateRecord/joint_committee_on_the_eighth_amendment_of_the_constitution/2017-12-13/debate/mul@/main.pdf;
[30] Bracken H. et. al (2011) "Alternatives to routine ultrasound for eligibility assessment prior to early termination of pregnancy with mifepristone–misoprostol." BJOG,118,17–23.
[31] Thornton, J. (2018) "Allow English Women to take Medical Abortion Pill at Home, say Doctors." BMJ 361, k2879. https://www.bmj.com/content/361/bmj.k2879
[32] World Health Organisation (2012) "Safe abortion: technical and policy guidance for health systems. Second edition." Geneva: World Health Organisation, p.8.
[33] "Abortions were Denied to Women at Suicide Risk", The Times, 20 June 2017
https://www.thetimes.co.uk/article/abortions-refused-after-several-suicide-bids-xlxq0k8r7

and potential criminal sanctions, healthcare professionals may feel forced to interpret the law conservatively and impose overly stringent conditions on people with physical and mental health conditions. We have already seen this under the existing PLDPA.[34] For example, the Abortion Support Network reported in 2017 that women who had attempted suicide more than once were denied abortions. Due to the lack of official reporting on refusals we cannot determine if this occurrence was widespread or if it may have contributed to any pregnant person dying from suicide. Numerous medical experts testified before the JOC that risks can escalate quickly and doctors should be able to use their clinical judgment and expertise to care for their patients. Ambiguous terms in law and regulation are bound to cause confusion, and healthcare professionals may therefore deny care to those who need it. The JOC accepted this expert advice, and recommended that risk not be fixed in legislation.[35]

Additionally, for those whose cases end up before a review committee, there is a danger of repeating the current situation - where even those who meet the criteria for an abortion under the PLDPA feel compelled to travel rather than subject themselves to an onerous, invasive and potentially fruitless review.[36] [37] If a review process is required, it must be timely, transparent and sensitive to the needs of the person seeking an abortion.

Another vestige of criminalisation that should be eliminated from the legislation is found in the proposed definitions. By defining “termination of pregnancy” as the “intentional ending of the life of a foetus” the legislation evokes a criminal offence and in turn stigmatises the very medical care the Government is seeking to introduce.[38] An alternative definition could be “an induced abortion.”

Clinical guidelines and training

We anticipate that the clinical guidance produced as part of this legislation will provide more specific detail regarding abortion provision in Ireland. Reproductive rights-holders, especially people from groups that may experience particular difficulty accessing care, should have a role in reviewing and drafting guidelines, and the Oireachtas should also review draft guidelines before they are finalised.

Finally, it is crucial that evidence-based practice informs the ongoing training of medical professionals involved in the delivery of abortion care. In Canada, where abortion pills are dispensed in a primary care setting, a community of practice forum has been established. The forum is a space for providers from across the world who are involved in abortion provision to ask questions and gain access to robust and accurate information.[39] We would encourage medical practitioners to take advantage of these resources.

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[34] Amnesty International (2016) “Ms.Y’s Case: Denied a Lawful Abortion in Ireland.” https://www.amnesty.ie/ms-ys-case/
[35] JOC (2017) “Final Report”, p. 8, par. 2.13.
[36] Irish Family Planning Association “A Health and Rights Approach to Abortion in Ireland”. https://www.ifpa.ie/sites/default/files/ifpa_submission_to_the_citizens_assembly.pdf
[37] O’Keane, V. (2017) “Risks to Mental Health of Pregnant Women”. https://www.oireachtas.ie/en/debates/debate/joint_committee_on_the_eighth_amendment_of_the_constitution/2017-10-25/3/; Proceedings of the JOC 25 October, 2017.
[38] Enright M. et. al (2018) “Position Paper on The Updated General Scheme of the Health (Regulation of Termination of Pregnancy) Bill 2018” https://lawyers4choice.files.wordpress.com/2018/08/position-paper-1.pdf
[39] CAPS CPCA (2018) “Canadian Abortion Providers Support.” https://www.caps-cpca.ubc.ca/index.php/Main_Page

Conclusion

We urge the Government to focus on the following principles in the development of legislation to regulate the termination of pregnancy:

Bodily Autonomy: The law should be centred on the pregnant person's right to choose or refuse treatment. Abortion care should be patient-centred at all times.

Accessibility: The Government should maximise practical access to abortion and work to ensure no barriers to access are erected, intentionally or unintentionally. Abortion care should be publicly funded through dedicated lines, universally accessible, locally available and easy to find.

Accountability: The State and service providers should be accountable to the public. The overall workings of the law and the outcomes of the services implemented should be independently reviewed. The State and medical bodies should ensure that any clinical guidance drafted is made available for consultation with rights-holders who may be directly affected by the legislation. In addition, service providers must not be permitted to block access to abortion by refusing to provide care on grounds of conscience.

Evidence: Abortion regulation must be based on international best practice. Barriers such as mandatory waiting periods - which cause harm and are not based on medical evidence - have no place in this legislation.

ARC welcomes the opportunity to discuss the General Scheme and is available to provide further information if needed. ARC is committed to working with Government ministers, legislators and healthcare professionals throughout the legislative process to attain full realisation of reproductive rights in Ireland.

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