

Ireland - Review of the operation of the Health (Regulation of Termination of Pregnancy) Act 2018 Public consultation

British Pregnancy Advisory Service response

Introduction

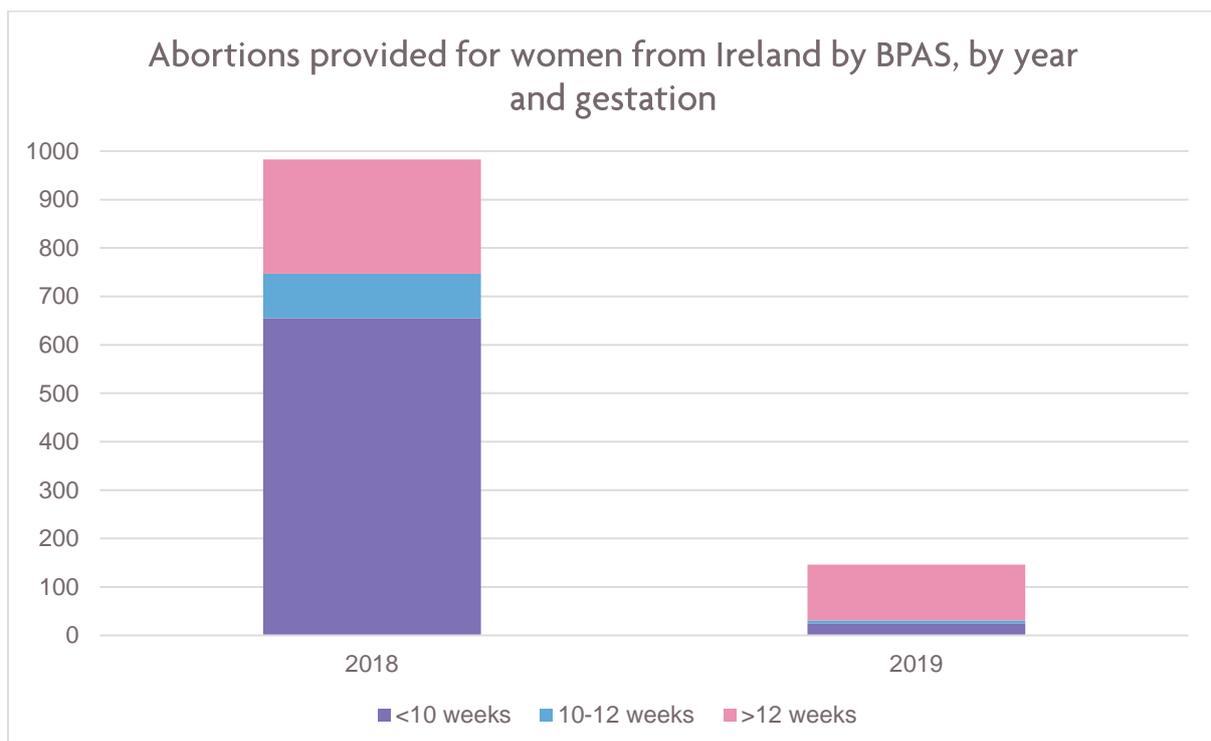
The British Pregnancy Advisory Service (BPAS) is a British reproductive healthcare charity that offers pregnancy counselling, abortion care, miscarriage management, contraception and STI testing to 85,000 women each year. We have long provided care to those travelling to England from Ireland to access abortion care, and continue to provide care and support for women who are unable to access abortion care within their own country.

The BPAS perspective

BPAS has long provided care for women from Ireland. In the aftermath of the introduction of legalised care, the numbers of women being treated by BPAS in England and Wales fell dramatically – from 983 in 2018, to 146 in 2019 as the Act came into force.

Annual figures have varied as a result of the pandemic, but the rate of roughly 3-4 women travelling a week to use BPAS's service has remained broadly true in 2020 and 2021.

Of note is the comparatively small decline in post-12 week abortions. These have fallen by only 50%, compared to a 96% decline in the number of women presenting to BPAS prior to 12 weeks' gestation.



Prior to the change in the law, sizeable numbers of under 18s were being forced to travel for abortion care – nearly 1 a week. This immediately reduced to negligible figures. It remained the case that women aged 25-35 were the most likely to present for care – a figure which is reflected in the number of women presenting for abortion care across England and Wales.

However, the presentation of women over the age of 35 is out of line with domestic presentation – with many more Irish women as a proportion of the total presenting in this age range.

	Under 18	18-25	25-35	35-45	45+	Grand Total
2018	32	314	394	237	6	983
2019	..	39	52	50	..	146

The Health (Regulations of Termination of Pregnancy) Act 2018

BPAS strongly supported efforts to legalise abortion across the island of Ireland, and strongly supported the Repeal the Eighth campaign.

We **somewhat agree** that the 2018 Act has achieved what it set out to do.

It is clear that there has been a precipitous drop in the number of women presenting for routine, early abortions in England – this is a testament to the ability of these women to access care domestically and should be considered a success.

There remains, however, an underlying core of women for whom travel remains a requirement. In our opinion, there are two distinct aspects of provision that lead to this:

- 1) Intentional decisions made at a political level with the understanding that this will result in women continuing to travel (eg a 12-week gestational limit); and
- 2) Shortcomings of care which result in women being forced to travel (eg lack of local availability, lack of specialist care resulting in unsuccessful treatment).

The ultimate result is that **the abortion law in Ireland is both designed and operated in a way which maintains a system of exporting women and their care to England.**

Shortcomings in operation

Yes there are aspects of the law that have not operated well – or, that is to say, aspects of the law which provide a fundamental barrier to women in accessing their reproductive rights. These aspects were clear from the commencement of the Act, and have only been proven by its continued operation.

Specifically, the parts that have not worked well are:

- Section 11 – Condition likely to lead to the death of foetus
- Section 12 – Early pregnancy
- Sections 13-17 – Review of decisions.

Foetal anomaly

The matter of age and increases in the presentation of older women indicates that there may be a link to established surveillance data (NCARDRS, 2019) which shows that the rate of genetic congenital anomalies in women over 40 years is almost 9 times higher relative to women under 20 years.

Given the law in Ireland regarding severe fetal anomaly, it is highly likely that some of these older women are presenting in England as a direct result of the law in Ireland.

As a provider, we know that women present to us wanting to end a pregnancy as a result of an antenatal diagnosis, but with no recourse to that care within Ireland. These women have often experienced substantial delays and engagement with clinicians within Ireland as part of the decision and review process related to the fatal fetal anomaly provision. As a result, they have to pay to access care away from home, in order to make the decision they want about their own pregnancy and own lives.

The law must be changed to enable the provision of abortion on the grounds of severe foetal anomaly.

Early pregnancy

In a speech made in January 2018, the then-Health Minister, Simon Harris, said:

We need now to seek to build a society which accepts our own challenges and addresses them honestly, maturely and openly. One which does not seek to deny reality or to outsource it to another country. One which does not reject women at the most vulnerable moments in their lives.

As shown by the BPAS figures above, this goal has not been realised. The numbers of women who continue to travel over the gestation of 12 weeks has fallen by only half. More than 2 women a week continue to travel from Ireland to England to access a termination that their country has declined to provide.

This is not an ‘honest, mature, and open’ management of these women’s needs.

In order to deliver truly holistic care that women continue to access regardless of domestic provision, **the law must be changed to make post 12-week abortions accessible within Ireland, such as along the lines of regulations in Northern Ireland.**

Review of decisions

It remains BPAS’s position that the decision on abortion is one best made between a woman and her medical team. A complicated review process in order to ensure that the woman meets one of a small number of exceptionally tight criteria causes distress, delay, and results in care that falls far short of best practice.

Women should be able to choose and access a doctor and medical team who support their decision, and should not be required to go through repeated layers of bureaucracy to exercise their medical rights.

Positives of operation

BPAS is not well-placed to describe the operation of services for women within Ireland, but we have been involved in the training of GPs and continue to provide care for women who travel.

Despite the 12-week limit, we believe that the precipitous decline in the number of women travelling at the earliest gestations indicates that, by and large, women are able to access routine care.

We support provision in primary care in conjunction with expert teams at hospitals – but believe that additional guidance should be given to GPs regarding the treatment of complex cases to prevent inadequate care and delayed referral.

Further aspects of operation

Telemedicine

We are writing this response days after the Westminster Parliament made the home use of mifepristone and misoprostol a legal right in the first ten weeks of pregnancy.

This will embed the provision of telemedical abortion care in law – enabling women to access fully remote services through the postage of abortion medication.

This method of provision has been in place for two years, and the [largest study of telemedical abortion care in the world](#) has found it to be safe, effective, accessible, and preferred by women. It has also recently been made permanent in the USA by the Food and Drug Administration, and in France.

Although the Irish government announced telemedical abortion early on in the pandemic, it is our understanding that this was solely regarding teleconsultation – and that women (or a nominated party) are still required to collect medication in person from a GP surgery.

We believe that the government should be clear that the method of consultation and method of provision of medication are **not covered by the Act**, and that doctors (and indeed pharmacists operating under prescription instructions) are able to provide abortion medication in the same way as any other medication – including via post.

This will improve access to women who live further distances from participating GPs, and reduce inequalities of provision between regions.

Safe access zones

BPAS strongly supports the implementation of safe zones around abortion clinics and hospitals at the earliest available opportunity. We fully support the current Safe Access to Termination of Pregnancy Services Bill 2021.

As an abortion provider, we have thousands of accounts from women of the impact that this type of activity has on them as they access care. Although presence, prayer, watching women can seem innocuous to observers, women experience this as harassment, and routinely report **alarm, distress, and fear** as a result of the presence.

We are aware that one of the largest international organisations – 40 Days for Life – is currently targeting at least one clinic in Ireland. They routinely target c.14 clinics across Great Britain, and once they establish a foothold, they continue to present for 80 days a year with increasing degrees of intensity.

The decision to do nothing is not a neutral one. **Standing by as harassment continues gives a free pass to these groups at the expense of women's health and rights.**

“The protesters were praying loudly and trying to engage me in conversation as I was on my way into the clinic. There were about 6 of them and they had plastic fetuses and graphic posters. They shouted at me when I wouldn't stop to speak to them. It made me so upset. I was so tired because I had travelled from Ireland and had been awake all night. I didn't need to see their posters or have them pray for me. It was none of their business but I was worried they were filming me. One had held his phone up and I don't know if he took my picture.”

– Irish client, attending a clinic in Manchester
