Submission

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

March 2022

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Abbreviations

APG - All Party Oireachtas Interest Group on Sexual and Reproductive Health and Rights

EMA – early medical abortion

FFA – fatal foetal anomaly

FGM – female genital mutilation

FIAPAC - International Federation of Abortion and Contraception Providers

FIGO - International Federation of Gynecology and Obstetrics

HCP – health care provider

HIV - human immunodeficiency virus

ICGP - Irish College of General Practitioners

GP – general practitioner

HSE – Health Service Executive

IFPA – Irish Family Planning Association

IHREC - Irish Human Rights and Equality Commission

LARCs – long-acting reversible contraceptives

MVA - manual vacuum aspiration

PCRS - primary care reimbursement scheme

PPSN - personal public service number

SRHR – sexual and reproductive health and rights

START - Southern Taskgroup on Abortion & Reproductive Topics

STIs – sexually transmitted infections

TM – telemedicine

UNFPA - the United Nations sexual and reproductive health agency

WHO – World Health Organization

About the Irish Family Planning Association

The Irish Family Planning Association (IFPA) is Ireland's leading sexual and reproductive health charity. The IFPA was founded in 1969, by a group of volunteers, mostly young nurses and doctors, who were motivated by the devastating impacts on the health of women and families in Dublin's inner city of the ban on contraception. A 2019 commemorative leaflet, The IFPA at 50, outlines key milestones of the IFPA's role as an advocate and service provider.

Services

The IFPA clinics, which are based in Tallaght, on the outskirts of Dublin and on Cathal Brugha Street in Dublin's inner-city, are at the forefront of reproductive healthcare in Ireland. We also have a network of counselling centres nationwide. IFPA services include: early abortion care, post-abortion care, contraception, specialist pregnancy counselling, cervical screening, vasectomy, menopause check-ups and screening and treatment for sexually transmitted infections (STIs). The IFPA operates Ireland's only dedicated free clinic for women who have undergone female genital mutilation (FGM). We specialise in sexuality education—the IFPA pioneered peer-to-peer sex education in the 1990s and now provides a range of courses for students, parents, health and social care professionals.

Clients

IFPA clients are of all ages and from all walks of life: the IFPA has particular expertise in working with adolescent girls, minors in the care of the State, with women and girls who experience disadvantage, with asylum seekers and migrant women and girls. Most of our clients are either medical card holders or people who are just outside the threshold for the medical card, but whose disposable income is limited and strained.

Contraception

The IFPA provides contraceptive counselling, information and services, including the full range of modern contraceptive methods (hormonal and non-hormonal intrauterine devices (coils), implants, patches, injections, caps, condoms and pills). The IFPA is a specialist provider of long-acting reversible contraception (LARCs); we also provide training in contraception for nurses and midwives.

Clients of our contraception services frequently express the desire to switch to more effective long-acting reversible contraception, but cannot afford the upfront cost of the device and its insertion. The State-funded contraception scheme is extremely welcome in this regard.

Abortion

Our abortion service comprises: the provision of early medical abortion, referral for hospital care, specialist pregnancy counselling, post-abortion medical care and counselling and post-abortion contraception counselling and provision. Our clients include women who are eligible for early medical abortion with the IFPA, and also women who require referral for hospital care (i.e. they are beyond the gestation limit for abortion at primary care level or for other health-related indications.)

We continue to provide peri-abortion care to women and girls who cannot access abortion in Ireland and must travel abroad: i.e. their pregnancies are outside the categories for eligibility for abortion care under the Health (Regulation of Termination of Pregnancy) Act 2018: e.g. the pregnancy is over the 12-week gestational limit (Section 12); or deemed by a hospital not to meet the threshold for termination because of risk to life or health (Section 9) or the definition of fatal foetal anomaly (Section 11). This

service includes: specialist pregnancy counselling, contraception provision and post-abortion medical care and counselling.

Advocacy

Since its foundation, the IFPA has been active as an advocate for the highest attainable standard of reproductive health and for the implementation of the State's obligations under international human rights law. As a respected authority on sexual and reproductive health in Ireland and internationally, the IFPA has addressed numerous Oireachtas Committees, UN human rights bodies, the Citizens' Assembly and Joint Oireachtas Committee on the 8th Amendment. We campaigned for decades for the repeal of the 8th Amendment and the introduction of legal abortion in Ireland. The IFPA supported three women, known as A, B and C to take a case to the European Court of Human Rights. *A, B and C v Ireland*[1] recognised that the State was violating and interfering with women's rights under the European Convention on Human Rights.

International links

The IFPA is a member association of the International Planned Parenthood Federation and is one of 12 organisations across four regions in the IPPF's Globalcare consortium on abortion care. The IFPA provides the secretariat to the All Party Oireachtas Interest Group on Sexual and Reproductive Health and Rights (APG). The APG is affiliated to the European Parliamentary Forum on Sexual and Reproductive Rights. The IFPA is also the Irish collaborating partner of UNFPA, the UN sexual and reproductive health agency.

The IFPA is a member of the European Society for Contraception and Reproductive Health and FIAPAC, the International Federation of Abortion and Contraception Providers.

A note on language

We understand that not all individuals who become pregnant are women and girls – transgender, gender diverse, and non-binary people face significant barriers to sexual and reproductive healthcare, including abortion care. In this submission we use the terms women and girls because our experience of providing abortion services to date has been predominantly to women and girls.

A note on this document

This document has been developed based on the IFPA's submission to the public consultation on the review of the Health (Regulation of Termination of Pregnancy) Act 2018. Our submission has been informed by the inputs of colleagues from the IFPA clinic and counselling teams, internal research on service-user experiences of accessing our abortion service, clinic data and national and international evidence on abortion law, policy and service delivery.

The format of the public consultation was a questionnaire which included nine questions. The IFPA submitted its response to the Department of Health in this format. To make this document more accessible to a wider readership, we have reorganised the presentation of the information we provided. We have not made any substantive changes to the information. However, in some places we have edited the text in the interests of clarity and accessibility.

[1] A, B and C v. Ireland, No. 25579/05 Eur. Ct. H.R. (2010).

Introduction

According to UNFPA—the United Nations sexual and reproductive health agency—50% of all pregnancies globally are unintended[2]. One in every two pregnancies take place in the bodies of people who did not intentionally choose pregnancy or motherhood, who did not want to have a child at that time, in those circumstances, with that partner. As UNFPA unambiguously states, "For these women, the most life-altering reproductive choice- whether to become pregnant or not – is no choice at all". Many unintended pregnancies are celebrated and wanted; however more than 60% of unintended pregnancies end in abortion, because they are unintended and unwanted[3]. The costs borne by women, girls, and their families of an unintended pregnancy can be incalculable.

For women who did not choose to be pregnant, access to abortion care is critical to their health, well-being, and autonomy. UNFPA is clear: access to abortion is about more than providing a health service, it is a statement of how we value women and girls beyond their reproductive capacities. It is about respecting women and girls' right to reproductive choice, bodily integrity, and bodily autonomy.

The World Health Organization considers strengthening access to comprehensive abortion care as fundamental to good health and well-being and to gender equality.[4]

The review of abortion care in Ireland within the legal framework of the Health (Regulation of Termination of Pregnancy) Act 2018 is a critical opportunity to evaluate the provision of abortion care within the healthcare system and to identify areas of improvement in practice, administration, health promotion and health systems organisation that will bring Ireland closer to providing the highest available standard of reproductive healthcare: i.e. rights-based and patient-centred care that is aligned with the principles of the right to health, as outlined by the UN Committee on Economic, Social and Cultural Rights[5]. This is an inclusive right, meaning it also covers the "underlying determinants of health" which include health-related education and information, and gender equality. Under international human rights law, the obligation to protect and promote rights lies with the State and its officials. The overarching duty of States under Article 12 is to provide healthcare services and facilities which are available, accessible, acceptable to those who need them and of the highest attainable quality.

This report identifies the facilitators of abortion care that should be maintained and enhanced into the future. We document the legal and operational barriers to accessing abortion care, and identify key actions that, in the IFPA's view, are required to enhance the availability, accessibility, acceptability and quality of abortion care and support the realisation of sexual and reproductive health and rights.

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[2] UNFPA. 2022. *State of World Population: Seeing the Unseen- the case for action in the neglected crisis of unintended pregnancy,* pg. 9. Available at https://www.unfpa.org/swp2022

[3] UNFPA, ibid. Pg.11.

[4] World Health Organization (WHO). 2022. Abortion Care Guideline. Available at https://www.who.int/publications/i/item/9789240045163

[5] Committee on Economic, Social and Cultural Rights, General Comment No. 22: On the right to sexual and reproductive health (Art. 12 of the International Covenant on Economic, Social and Cultural Rights), U.N. Doc. E/C.12/GC/22

Context

National and global statistics make it clear that abortion is a common feature of women's sexual and reproductive lives. The successful integration and mainstreaming of abortion care into the Irish public health system further illustrates that abortion is considered routine healthcare by both those who avail of it and those who provide it.

The 2018 Act has had a transformative effect on reproductive rights in Ireland. It has enabled thousands of individuals to access abortion care within local and mainstream healthcare and without cost. The inclusion of a principle of availability of abortion care with no cost to the pregnant woman is a critical indication of the State's interest in reproductive healthcare. Access to abortion on request, that is, on a woman's own indication, is a significant support to bodily autonomy—service users do not have to explain or justify their decision about their pregnancy.

The Act further supports a common sense understanding of the role of sexuality in the lives of young people. The law regarding the age of consent to sex makes clear that State policy is that sexual debut should be deferred to the age of 17. However, law and policy in this regard rarely deter or protect: many children and adolescents engage willingly in sexual intercourse with similar aged partners before the age of 17[6] and many also experience sexual abuse and exploitation. The Act recognises this and prioritises the health needs of this cohort over policy aspirations regarding adolescent sexuality. Access to care is guaranteed to pregnant women and girls, regardless of age, without any special provisions in relation to consent. (This is critical not only to the provision of abortion care, but as a sign of a mature approach to sexuality that could lead the way to a similar grounded and practical approach to contraception and to relationships and sexuality education in Ireland[7]).

The protection of these elements of a patient-centred, rights-based approach to abortion care in law sends an important message about Irish society's understanding of abortion as part of the continuum of essential reproductive healthcare that women, girls and people who can become pregnant need throughout their life-course. The introduction of the 2018 Act led to the rapid normalisation of abortion care and its institutionalisation within the health system through the establishment of an effective community-based model of care, partially supported by hospital-level services. This is now delivered by a cohort of conscientiously committed practitioners in the fields of sexual and reproductive health, general practice and obstetrics and gynaecology.

However, the Act also sends a range of messages about State policy that undermine reproductive autonomy. In echoes of the outdated gender stereotypes and attitudes to women that underpinned the 1861 Offences Against the Person Act and the 8th Amendment, the current legal framework for abortion care provision is a criminal statute. It thereby frames abortion as a moral wrong in a number of significant ways. It treats abortion as a harm deserving of prosecution and harsh punishment on conviction (Section 23). It imposes a medically unnecessary delay between a woman's presentation to a healthcare practitioner and her access to abortion care (Section 12). It excludes most pregnant women from access to abortion after 12 weeks of pregnancy, with limited and narrowly defined grounds for eligibility after that point (Sections 9 and 11). It protects the rights of healthcare practitioners to refuse to provide a time-sensitive healthcare service (Section 20) and creates an environment where many of those who seek and provide this service experience stigma.

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[6] Irish Family Planning Association. 2010. *Annual report.* Available at https://www.ifpa.ie/sites/default/files/documents/annual-reports/ifpa_annual_report.pdf

[7] Bayer and The Irish Family Planning Association. 2020. *Universal, free access to contraception: a framework report.* Available at: https://www.ifpa.ie/app/uploads/2021/10/Framework-report_final-6-5-October-2021-1.pdf

Recommended Actions

The IFPA puts forward the following recommended actions in order to enhance the availability, accessibility, acceptability and quality of abortion care:

- Decriminalise abortion in all circumstances.
- Revise the Act to include a section outlining the international human rights principles that must underpin abortion care.
- Develop a code of practice on respect for reproductive autonomy as a measure of compliance with the Public Sector Duty.
- Retain State-funded access to abortion care on request.
- Retain telemedicine as part of a blended approach to abortion provision and ensure that the expanded service-user choices and support to reproductive autonomy introduced as a pandemic measure are not discarded.
- Retain State-funded access to confidential, non-directive specialist pregnancy counselling for people experiencing an unintended pregnancy or a pregnancy which has become a crisis.
- Remove the 12-week gestational limit and ensure that all those who seek abortion can access this care within Ireland.
- Remove the mandatory waiting period.
- Replace Section 20 with a general provision which requires the HSE to publish an annual statistical report with respect to the incidence of and trends in relation to abortion.
- Establish a data collection system to compile detailed statistics on abortion, including data on geographical availability and refusals of care, to inform the development of abortion services.
- Remove Section 22 from the Act.
- Resource the provision of values clarification and attitude transformation (VCAT) workshops for hospital staff, including staff not involved in the delivery of abortion services.
- Remove Section 25 from the Act.
- Progress Safe Access Zone legislation as a matter of priority in order to ensure that the safety and well-being of patients and staff is protected and their privacy and dignity is respected.
- Take measures to fully mainstream and institutionalise abortion care within the healthcare system including:
    - Create a faculty of sexual and reproductive health to lead a national programme to develop centres of excellence in abortion and in sexual and reproductive healthcare more generally;
    - Develop training programmes for advanced abortion care for complex cases, aimed at midwives, doctors, nurses and foetal medicine specialists;
    - Develop specialist positions and recruitment strategies to ensure the ongoing development and growth of a robust community of abortion care providers into the future.
- Resource the HSE to step up efforts, including outreach, training and capacity building, and provide additional supports to encourage more healthcare providers to participate in the service.
- Ensure that the ultrasound scanning service for community provision of abortion care is available, accessible and of high quality, delivered by staff trained in the ethics of abortion care and including appropriate pathways for minors and other vulnerable groups.
- Widen the grounds for referral from community to hospital provision.

- Allocate appropriate resources to expand the availability of surgical abortion, including investment in ambulatory gynaecology and the training of medical staff in both surgical abortion and the ethics of abortion care.
- Establish and communicate a clear policy and set of procedures to govern reimbursement of care for people without Personal Public Service Numbers (PPSNs).
- Undertake more extensive health promotion, in accessible and empowering language, of the rights of and services available to those who need any sexual and reproductive healthcare.
- Increase public awareness of the My Options helpline throughout Ireland.
- Expand the scope of the service to include the provision of information on accessing abortion after 12 weeks.
- Consider the feasibility of offering a booking service to streamline abortion-seekers' experience of accessing abortion care.
- Align the policy approach to contraception access by minors with the approach taken in the 2018 Act[8].

The IFPA also puts forward the following recommendations to advance sexual and reproductive health and rights more broadly:

- Develop a clear and detailed sexual and reproductive health strategy, incorporating the 2018 *Guttmacher–Lancet Commission* definition of sexual and reproductive health and rights.
- Provide universal free access to contraception to all those of reproductive age who wish to avail of it.
- Reform Ireland's relationships and sexuality education curricula to ensure young people's right to holistic, evidence-based, and inclusive sexuality education at all stages of their development.
- Incorporate abortion into the 2023 Women's Health Action Plan as part of the life-course approach to women's health.

Facilitators of abortion access

Model of community-based provision

The availability of State-funded abortion care on a woman's request is a significant advancement in reproductive rights. The focus on early medical abortion (EMA) enabled abortion services to be established quickly across different geographical locations. This community-based model of care delivered through general practice and specialist sexual and reproductive health providers has meant that, for many women, their experience of accessing abortion care has been seamless and straightforward. The combination of medical supervision and home self-management works well and is acceptable to women. And the majority of women are able to access care early – a cohort analysis by the IFPA involving 155 women who accessed our abortion service in 2019 found that 94% of clients were less than 10 weeks pregnant at the time of their abortion[9].

Actions required:

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[8] For example, clarify in policy that a child under the age of 16 years may give a legally valid consent if they are sufficiently mature to understand the nature of the proposed treatment (sometimes referred to as 'Gillick competence', which refers to the UK case, Gillick v Western Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402)

[9] Irish Family Planning Association. 2019. *Annual report.*

- **Retain State-funded access to abortion care on a woman's request and extend access under Section 12 beyond 12 weeks of pregnancy.**

Telemedicine

Community-based provision of early abortion care has been further enhanced by the introduction of remote consultation, or "telemedicine (TM) abortion". This had the effect of protecting access to abortion during the pandemic and reducing the burden on women of arranging childcare and time off work or education to attend multiple appointments in a short space of time. Its introduction has contributed to the recognition of abortion by the State as essential and time-sensitive healthcare.

The provision of TM abortion is supported by a strong international evidence base[10][11] which demonstrates that it has similar outcomes to in-person care. The permanent adoption of TM abortion has also been endorsed by the International Federation of Gynecology and Obstetrics (FIGO)[12], who describe it as a safe and private method that can improve abortion access and reduce exposure to stigma.

Maintaining remote consultation as an option within the abortion care pathway could potentially improve access for a range of individuals, such as those living in rural areas, disabled people, and people with care responsibilities for whom in-person appointments may be logistically challenging. It would give patients more choice in service delivery modality, enabling them to access care in a manner consistent with their needs and preferences. Such an approach would give healthcare providers more flexibility to respond to the differing circumstances of each patient and could contribute to the reduction of geographical access barriers.

Actions required:

- **Retain telemedicine as part of a blended approach to abortion provision and ensure that the expanded service-user choices and support to reproductive autonomy introduced as a pandemic measure are not discarded.**

Availability of specialist pregnancy counselling at no cost to women

State-funded pregnancy counselling began in Ireland when women were denied access not only to abortion care, but to knowledge about abortion services elsewhere. Most abortion clients are very clear about their decision regarding their pregnancy when they present for an appointment. However, the circumstances of unintended pregnancy or pregnancy that has become a crisis are usually complex and women and girls value a safe space to work through the emotional implications.

Counselling provides an opportunity to talk openly and without judgement about the circumstances of the pregnancy and the anxieties and concerns a woman or girl is confronting. Access to counselling is particularly important for those excluded by the law, whether because a foetal anomaly diagnosis was not deemed fatal or because a pregnancy exceeded 12 weeks, but was not considered to involve risk of serious harm to health. This includes women who were still pregnant after their medical abortion was unsuccessful. Specialist pregnancy counselling can be a vital support to vulnerable migrant women, those living in direct provision, minors and women living in situations of coercive control and other

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[10] Endler M, Lavelanet A, Cleeve A, Ganatra B, Gomperts R, GemzellDanielsson K. 2019. "Telemedicine for medical abortion: a systematic review". B*JOG*. 126(9):1094-1102.

[11] Aiken, A., Lohr, P.A., Lord, J, Ghosh, N., Starling, J. 2021. "Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study". *BJOG*. https://doi. org/10.1111/1471-0528.16668. Epub ahead of print

[12] International Federation of Gynecology and Obstetrics. 2021. FIGO Statement: FIGO endorses the permanent adoption of telemedicine abortion services. Available at : https://www.figo.org/FIGO-endor ses-telemedicine-abortion- services.

forms of violence. In these cases, the counsellors' role can involve days of practical and logistical support and liaison with other services to ensure that vulnerable women and girls can access the care they need, in Ireland or in another country.

Specialist pregnancy counsellors play an important role as patient advocates: they act as the go between on behalf of vulnerable clients with medical personnel, Tusla and other agencies, and between Irish women and girls who are forced to travel for abortion and the clinics in the UK and the Netherlands that are still filling that care gap. Increasingly, the IFPA is receiving referrals from Tusla and from UK abortion clinics in relation to minors who need or have accessed abortion care.

Actions required:

- **Retain State-funded access to confidential, non-directive specialist pregnancy counselling for people experiencing an unintended pregnancy or a pregnancy which has become a crisis.**

Choice of provider

Services are provided and resourced at appropriate levels to meet the needs of women and girls and to support providers to deliver quality care. Services are available at primary healthcare level and within the community, rather than exceptionalised. Women and girls have a choice of provider: in principle, they can access care from specialist sexual and reproductive healthcare centres, such as the IFPA, present to their regular GP or obtain contact details for a different GP through My Options. This of course is dependent on local availability of a providing healthcare service.

In late 2018 and 2019, the HSE was proactively seeking ways to support healthcare providers to opt into the contract for abortion care provision. However, the initial impetus and level of contact and availability has decreased since a sufficient critical mass of providers was established. This is of concern as GPs retire and practices change hands. Furthermore, newly qualified doctors, nurses and midwives who are joining the professions are not encountering the level of support that was available three years ago. Similarly, despite initial intensive provision of values-based training on abortion care in late 2018, in collaboration with the World Health Education (Human Reproduction Programme), we are not aware of systematic ongoing provision of such training.

Access to 24/7 emergency medical advice

My Options is a significant support to service-users and providers, as women may find it difficult to identify a provider without this helpline. The provision of the 24/7 emergency nurse helpline number is a critical element. It is extremely reassuring to providers that they can provide a number for out-of-hours medical back-up.

Free, local access to abortion care as a support to women who present with a degree of uncertainty

Anyone seeking an abortion is required to have two appointments with a doctor, but can have as many appointments as they wish. People can also consult nurses and specialist pregnancy counsellors, including through My Options. In the IFPA's experience, the small cohort that ultimately decides to continue the pregnancy and either parent or consider adoption, frequently have multiple appointments with IFPA doctors and specialist pregnancy counsellors while they are thinking through their decision. Before legalisation, once a flight and a clinic appointment were booked, childcare organised, time off work negotiated, it was much harder to turn back, take more time and reconsider the decision. The

availability of local services at no cost is a significant support to the small proportion of individuals who present to IFPA services uncertain whether abortion is the right decision for them. Enforced delay through the legally imposed waiting period only serves to stigmatise, frustrate and stress those who experience an unintended pregnancy or pregnancy which has become a crisis, it does not help with decision making.

Appropriate resourcing

The payment to healthcare providers for abortion care is at the appropriate level to ensure that sufficient time can be allocated for the appointments to provide all necessary information, take medical histories and provide contraception counselling, if desired. This is as important in the context of telemedicine as face-to-face care, as providers find they need to spend additional time providing information during remote consultations.

Professional education

Professional education has been provided free to healthcare providers by the Irish College of General Practitioners (ICGP) and Southern Taskgroup on Abortion & Reproductive Topics (START) doctors: this is a necessary support for those who have been providing from the beginning and those who subsequently opt in.

The role of midwives

The role of midwife coordinators in providing hospitals is a particularly important element in ensuring quality access to abortion care. These midwives are available by mobile phone; they are committed, competent and are essential to the management of referrals to hospitals. However, their importance highlights the insufficiently institutionalised nature of too many of the supports within hospitals for abortion care: their role, knowledge and competence are such that any absences at short notice, e.g., sick leave or family leave, which can't be covered by other personnel cause enormous problems.

Growing expertise and peer-to-peer support

The growing confidence and skill of the community of committed abortion care providers and the provision of peer-to-peer support have been exceptional. From the IFPA's experience and participation in various networks, we see this growing skill level result in fewer referrals to emergency and other hospital services, as the skill set of primary healthcare practitioners develops. Yet the effectiveness of such informal networks is unsustainable as a pillar of essential healthcare. The Covid-19 pandemic and the cyber-attack on the HSE have shown the vulnerability of well-established elements of the health system: the reliance on a cohort of committed providers and peer networks exchanging WhatsApp messages must be replaced with robust systems, such as training, centres of excellence, a national quality assurance framework and a code of practice for respect for patient choice and reproductive autonomy.

Actions required:

Take measures to fully mainstream and institutionalise abortion care within the healthcare system including:

- **Create a faculty of sexual and reproductive health to lead a national programme to develop centres of excellence in abortion and in sexual and reproductive healthcare more generally;**

- **Develop training programmes for advanced abortion care for complex cases, aimed at midwives, doctors, nurses and foetal medicine specialists;**
- **Develop specialist positions and recruitment strategies to ensure the ongoing development and growth of a robust community of abortion care providers into the future.**

Legal barriers to accessing abortion care

Failure to secure the right to reproductive autonomy

The IFPA is of the view that the Act insufficiently secures the right to access abortion, frames abortion as a harm and gives unnecessary legal protection to practitioners who decline to provide abortion because of personal or religious beliefs. We have made suggestions for amendments to the legislation to correct this. We are of the view that the best way to rebalance the Act in favour of its general respect for reproductive autonomy is to decriminalise abortion and to include a preamble or principles provision that explicitly sets out the human rights norms that underpin the rights and entitlements of those seeking abortion. Such a provision should make explicit an individual's right to access quality abortion care in a timely manner, free from discrimination and in a manner that respects and upholds their human rights. This is a more appropriate framing of the law than criminalisation and would bring Ireland into line with the prevailing trend of recently reformed abortion laws in, for example, Spain and Portugal, which centre human rights and place a duty on the State to ensure equitable access to abortion care.

Specifically, we propose the inclusion in legislation of a summary of rights on which the Guttmacher Lancet Commission definition is based:

Achieving sexual and reproductive health depends on realising sexual and reproductive rights, which are based on the human rights of all individuals to:

1. have their bodily integrity, privacy and personal autonomy respected
2. freely define their own sexuality, including sexual orientation and gender identity and expression
3. decide whether and when to be sexually active
4. choose their sexual partners
5. have safe and pleasurable sexual experiences
6. decide whether, when and whom to marry
7. decide whether, when and by what means to have a child or children, and how many children to have
8. have access over their lifetimes to the information, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence.

A similar summary is included in the 2022 World Health Organization Abortion Care Guideline[13].

Actions required:

- **Revise the Act to include a section outlining the international human rights principles that must underpin abortion care.**
- **Develop a code of practice on respect for reproductive autonomy as a measure of compliance with the Public Sector Duty.**

[13] World Health Organization. 2022. *Abortion Care Guideline.* Pg. 8

Criminal liability (Section 23)

Human rights standards require the decriminalisation of abortion because of the impact on maternal health: i.e. when abortion is criminalised, and women and girls are thereby denied a critical form of healthcare and social support, foreseeable risks of mental distress and suffering result.[14] Moreover, the framing of abortion in terms of criminality, rather than essential healthcare, is at odds with the views of Irish citizens, as evidenced by the discussions and recommendations of the Citizens' Assembly in 2017 and the outcome of the 2018 referendum, and the comprehensive exit poll conducted at the time.[15]

Criminal liability creates a 'chilling effect' for medical practitioners. Doctors, in particular, are acutely aware of the potential impacts on their professional and personal lives, and the extensive delays before any resolution, of complaints to the Medical Council or the Gardaí.[16] According to the World Health Organization, the chilling effect of fear of criminal prosecution can lead health workers to deny abortion even in cases where it is legal. Evidence further shows that criminalisation does not impact the decision to have an abortion or prevent women from having abortions. Rather, it simply "limits access to safe and legal abortion and increases recourse to unlawful and unsafe abortion."[17]

Actions required:

- **Decriminalise abortion in all circumstances.**

Enforced delay (Section 12)

Most people who access abortion care do so early in pregnancy. The IFPA knows from our services that they have generally thought deeply about their options and decided that parenting is not the right thing for them at this time. Clients of our services who are unsure about their decision, or need more time, will make this clear to a nurse or doctor, who are well versed in the medical ethics on informed consent. Specialist pregnancy counselling provides an additional layer of support. To require every single woman to wait three days after seeing a doctor, for no medical reason, before she can begin her abortion is a denial of women's agency and autonomy and implies distrust of women's capacity to make rational decisions in pregnancy.

The World Health Organization is clear that there is no health rationale for mandatory waiting periods: its 2012 guidance described these as demeaning women as decision-makers. The revised 2022 guidance highlights that the logistical challenges of completing a mandatory waiting period can mean that some women must disclose their pregnancy to others, "even though international human rights law requires States to ensure that [sexual and reproductive health] services are provided in a way that ensures privacy and confidentiality".[18] Yet Irish law forces every single woman who has an abortion before 12 weeks to wait for three days, regardless of her circumstances. It forces doctors to impose a delay in the care pathway for no reason related to women's health, even when that delay pushes her past the gestational limit.

Actions required:

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[14] Erdman, N.J., Cook, R.J. 2020. "Decriminalization of abortion :A human rights imperative". *Best Practice & Research Clinical Obstetrics and Gynaecology* 62 (11e24) https://doi.org/10.1016/j.bpobgyn.2019.05.004

[15] Citizens' Assembly. 2017. *First Report and Recommendations of the Citizens' Assembly: The Eighth Amendment of the Constitution.* Available at: https://2016-2018.citizensassembly.ie/en/The-Eighth-Amendment-of-the-Constitution/Final-Report-on-the-Eighth-Amendment-of-the-Constitution/Final-Report-incl-Appendix-A-D.pdf

[16] Taylor, M. 2015. "Abortion Stigma, A Healthcare Provider's Perspective", in A. Quilty, S. Kennedy, and C. Conlon (eds), *The abortion papers Ireland: Volume 2* (Cork: Attic Press), p 218.

[17] World Health Organization. 2022. *Abortion Care Guideline*. 10 Section 2.2.1, pg. 24–25

[18] World Health Organization. 2022. *Abortion Care Guideline*. Section 3.3.1, pg. 41–42.

- **Remove the mandatory waiting period.**

Operation of the 12-week gestational limit (Section 12)

The inflexibility of the gestational limit and the waiting period creates unnecessary anxiety for women and healthcare providers and has resulted in some women being denied access to care. In the IFPA's analysis of 2019 data, a significant minority of clients (5%) were close to or just over the legal gestational limit of 12 weeks. Navigating complex referral pathways under the pressure of a rigid legal cut-off point is a very stressful experience for both women and healthcare providers. In some instances, despite best efforts, it was not possible to arrange care within the time limit. Two women in the sample group subsequently travelled to Britain for abortion care because their pregnancies exceeded 12 weeks.

Furthermore, in cases where a medical abortion has failed and the pregnancy remains viable after the 12-week limit, no further intervention is permitted, even though treatment commenced within the gestational limit and involved the administration of medication with teratogenic potential. Women in these circumstances are forced to travel abroad to complete their abortion care.

The rigidity of the gestational limit can also cause significant anxiety for women and additional burdens on services in circumstances where women have a positive low-sensitivity pregnancy test post-abortion. The risk of not discovering an ongoing pregnancy until after 12 weeks results in women attending for additional blood tests, appointments which they must take time off work or education or arrange childcare to attend and appointments for which service providers are not reimbursed. In the absence of this legal constraint, women in these situations could simply delay taking their pregnancy test or take a repeat test some weeks later.

Actions required:

- **Remove the 12-week gestational limit and ensure that all those who seek abortion can access this care within Ireland.**

Limited access to abortion beyond 12 weeks (Sections 9 to 11)

There are many reasons why a wanted or unintended pregnancy becomes a crisis: for example, relationships end, family or other supports do not emerge, economic circumstances change, other crises intervene. Furthermore, there are many reasons why some girls and women do not know that they are pregnant within 12 weeks—if they are using contraception, for example, or have irregular periods, or are young, or believe they are post-menopausal. The inflexible gestational limit undermines access for many women and girls who already experience multiple forms of exclusion, disadvantage and vulnerabilities: minors, asylum seekers, women in abusive relationships and those experiencing addiction or homelessness. Many women and girls who need abortion are denied access to care because of the gestation limit, resulting in some continuing a pregnancy against their wishes, in circumstances where they have well-founded concerns about the impact of continuing a pregnancy on their future. Longitudinal research has found that women who sought but were denied access to abortion experienced serious negative consequences, such as poorer physical health, increased economic hardship and more difficulty extricating themselves from situations of domestic violence, when compared with women who were able to access this care.[19] Others are forced to travel abroad to access essential healthcare. They experience significant physical, financial and psychological burdens.

[19] Greene Foster, D. 2020. The Turnaway Study: ten years, a thousand women, and the consequences of having--or being denied--an abortion. Scribner, New York

Forced travel from Ireland during the Covid-19 pandemic involved heightened stress, anxiety, insecurity and expense. Between 2019 and 2020, at least 569 women travelled outside Ireland to access care[20].

The 2018 Act provides for termination of pregnancy for fatal foetal anomaly (FFA) but excludes many severe and complex foetal anomalies from its definition. Diagnosing conditions as fatal foetal anomalies in accordance with Irish legislation is complex, as many anomalies in isolation may not be considered an FFA, but when combined are potentially fatal[21]. Foetal medicine specialists must make a distinction in the care of pregnant women between fatal and severe in the context of very complex cases that results in some women being “ostracised” when they are then required to travel for termination of an anomaly that is “not fatal enough”.

The 2018 Act draws an artificial bright line between termination of pregnancy as compassionate healthcare in defined cases where death can be expected within 28 days and the same procedures as criminal acts in all other cases of foetal anomaly. This requires doctors to act as gatekeepers for the law and to apply rigid legal formulae to medically complex cases that involve women’s health and severe foetal anomalies.

The IFPA knows from our services that women experience stress, anxiety and trauma when a devastating diagnosis of foetal anomaly is compounded by delay and uncertainty as to eligibility for a termination of the pregnancy in Ireland.

The impact of these provisions, in the absence of a provision guaranteeing access to care for the women and girls the Act is designed to serve, or a set of guiding principles based on sexual and reproductive health and rights, frames abortion in the law as essentially different from and exceptional to other health interventions.

Actions required:

- **Remove the 12-week gestational limit and ensure that all those who seek abortion can access this care within Ireland.**

Obstruction, provider bias and refusal to provide healthcare based on personal beliefs (Section 22)

Professional guidance for doctors, nurses and midwives sets out a robust system for the management of situations where a healthcare provider’s personal or religious beliefs may infringe upon patient access to healthcare. Professional ethical guidance places clear obligations on objectors to ensure transfer of care in ways that are sensitive, patient-centred and aligned with values of equality and respect[22].

The inclusion of Section 22 sets abortion care apart from other forms of healthcare and suggests that doctors providing abortion care are in some way “inherently less conscientious than other professionals and that the usual regulatory mechanisms of (general) criminal and civil sanctions and

[20] Department of Health and Social Care UK.2021. National Statistics: Abortion statistics for England and Wales: 2020. Published 10 June 2021. https://www.gov.uk/government/statistics/abortionstatistics-for-england-and-wales-2019
Department of Health and Social Care UK. 2020. National Statistics: Abortion statistics for England and Wales: 2019. Published 11 June 2020. https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2020

[21] Power S., Meaney, S., O’Donoghue K. 2021. ”Fetal medicine specialist experiences of providing a new service of termination of pregnancy for fatal fetal anomaly: a qualitative study”. *BJOG*. 128(4):676- 684.

[22] Medical Council of Ireland, 2021. *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (Amended), 8th edition revised.
Dublin: Medical Council of Ireland. 2019. *Code of Professional Conducts and Ethics for Registered Nurses and Registered Midwives*. NMBI: 2014; updated 2021: https://www.nmbi.ie/NMBI/media/NMBI/Code-of-Professional-Conduct-and-Ethics.pdf?ext=.pdf

professional/fitness to practise oversight are insufficient for these professionals” [23] In the IFPA’s view, Section 22 disproportionately values the personal beliefs of individual healthcare practitioners over the decisions, needs and perspectives of pregnant women.

We do not know of cases where women and girls have been prevented from accessing abortion because of the actions of healthcare providers who object to abortion. However, it is our view based on clients’ experiences in other settings, that the inclusion of Section 22 creates an environment wherein some providers feel free to act in ways that stop short of obstruction, but cause significant emotional distress, delays and stigma to women accessing abortion care in Ireland. Outside of the established abortion care pathways via the primary care system to the participating hospitals, women may encounter disdain, judgement and delay. Some healthcare professionals feel entitled to openly, in public hospital corridors, question or criticise women’s choice of abortion or use of contraception. Within the care pathway, some women also experience disrespectful or harassing treatment because of their decision not to continue a pregnancy; or have experienced delay, fragmented care pathways and substandard services because they have encountered objecting or biased healthcare practitioners. We have provided support and counselling to women and girls in these situations.

Within some hospitals, lack of institutional support and inadequate provision for the implementation of abortion services, as well as provider bias or obstruction on the part of some members of staff, are causing immense stress to the committed and conscientious providers who are determined to ensure access to safe abortion services.[24] [25]

In the IFPA’s view, treatment of abortion seekers that conveys a clearly stigmatising message and undermines the right of women to be treated with dignity regarding their decision about their pregnancy is unacceptable from the perspective of international human rights law and professional ethics. It also contravenes the “public sector duty”, i.e. the statutory obligations under Section 42 of the Irish Human Rights and Equality Commission (IHREC) Act 2014, which requires public bodies to promote equality and protect human rights.

However, the inclusion of a right to refuse to provide care in abortion legislation, in the absence of an over-arching right of access and recognition of reproductive autonomy privileges the views of objecting healthcare practitioners over the considered choices of women, girls and pregnant people.

Action required:

- **Remove Section 22 from the Act.**
- **Resource the provision of values clarification and attitude transformation (VCAT) workshops for hospital staff, including staff not involved in the delivery of abortion services.**

Poor data collection (Section 20)

National-level data about the abortion service provides information only on total abortion numbers, abortions per month, and service-user county of residence. The notifications do not include any information about the women who access care, other than their county of residence. Data collected by this notification process has no public health rationale and is insufficient to inform service delivery. As such it constitutes an administrative burden for healthcare providers without any inherent value to

[23] Donnelly, M. and Murray, C. 2019. “Abortion care in Ireland: Developing legal and ethical frameworks for conscientious provision”. Ethical and Legal issues in Reproductive Health. Available at: https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/ijgo.13025?af=R

[24] Mishtal, J., Duffy, D., Chavkin, W., Reeves, K., Chakravarty, D., Grimes, L., Stifani, B., Horgan, P., Murphy, M., Favier, M., and Lavelanet, A. 2021. *Policy Implementation – Access to Safe Abortion Services in Ireland Research Dissemination Report*. April 23. UNDPUNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), pg.18-23.

[25] World Health Organization. 2012. *Safe abortion: technical and policy guidance for health systems.* 2nd edition §3.5. Available at: http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf

assessing quality in this area of healthcare. The Medical Council registration number of the medical practitioner who certified the termination must be provided on each notification, which must be sent directly to the Minister for Health. No other area of healthcare in Ireland is subject to this kind of reporting mechanism. The data collected in the legal notifications system has no clinical merit but rather seems to operate only to perpetuate abortion stigma and inhibit the normalisation of this aspect of reproductive healthcare. In its 2012 guidance, the WHO notes that effective processes for monitoring, evaluation and quality assurance and improvement are vital for ensuring good quality abortion care. The 2022 guideline reinforces this principle and notes a range of health systems considerations, including integration of indicators for quality abortion care into health management of information systems and population outcome monitoring, which includes collection and disaggregation of data[26]. There is no need for the types of data collected to be stipulated in legislation. This could hinder the development of information gathering systems going forward and prevent data on abortion being collected in line with best practice. Guidelines could elaborate on the details of the information required for annual reporting.

Actions required:

- **Replace Section 20 with a general provision which requires the HSE to publish an annual statistical report with respect to the incidence of and trends in relation to abortion.**
- **Establish a data collection system to compile detailed statistics on abortion, including data on geographical availability and refusals of care, to inform the development of abortion services.**

Stigmatisation of specialist pregnancy counselling (Section 25)

In light of the positive role of specialist pregnancy counselling within the abortion care pathway, it is jarring in the extreme that the only reference to counselling in the 2018 Act is in Section 25, which retains an offence which was included in the now repealed Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995. This Act was enacted explicitly to enforce the 8th Amendment, with respect to information. The retention of this section in the 2018 Act relates to no risk of which the IFPA is aware and serves only to stigmatise specialist pregnancy counsellors, who may be inferred to exclusively pose a risk of somehow profiting from abortion care in unethical ways.

Actions required:

- **Remove Section 25 from the 2018 Act.**

Operational barriers to accessing abortion care

Failure to provide safe access zones

The failure to deliver on the political commitment to introduce safe access zones has left abortion seekers and healthcare providers vulnerable to intimidation and harassment by fringe anti-abortion groups who seek to obstruct women's access to a legal, State-funded service and stigmatise those seeking and providing abortion. IFPA patients and staff have been subjected to multiple incidents of harassment. The nature of these activities has varied, but includes: prayer groups or "vigils"; individuals approaching women with leaflets as they try to leave or enter clinics; attempts to engage women in "sidewalk counselling"; display of graphic or religious imagery; verbal harassment of service users and staff; physical assault; solo and group protests. These activities have declined significantly at IFPA clinics

[26] World Health Organization. 2022. *Safe Abortion Guideline*. Pg.18.

since the onset of the Covid-19 pandemic. However, evidence gathered by the Abortion Rights Campaign and Together for Safety indicates that anti-abortion campaigners continue to protest outside maternity hospitals and GP surgeries.[27] A study of abortion care providers' experiences carried out by a research team at the National Maternity Hospital found that 15% of providers experienced a verbal threat or attack related to their abortion work.[28]

Actions required:

- **Progress Safe Access Zone legislation as a matter of priority in order to ensure that the safety and well-being of patients and staff is protected and their privacy and dignity is respected.**

Uneven and inequitable distribution of services

For those who are legally entitled to access abortion care, serious geographical disparities in provision frequently deny them locally accessible care. Only 10 of Ireland's 19 maternity units are providing the full range of abortion services and there has been no increase in the number of providing hospitals since the first year of service provision. In the IFPA's view, this contravenes the IHREC "public sector duty", i.e. the statutory obligations of public bodies, such as hospitals, to promote equality and protect human rights. The absence of hospital services and associated referral pathways in some areas has been identified as a reason for non-provision by GPs.[29] An estimated 1 out of every 10 GPs currently provides an early medical abortion service.[30] The lack of hospital service provision is a significant barrier to GPs offering the service, particularly in rural areas where there is no hospital back-up in case of emergency. For example, a woman living in Donegal would have to make a 400km round trip to access abortion care in a hospital. There is an over-reliance, particularly at the hospital level, on individual committed healthcare providers to ensure that the service is maintained on a day-to-day basis. This is unsustainable in the short-term and, from a health systems perspective, fails to safeguard the availability, accessibility, acceptability to users and the overall quality of abortion care into the future.

While it is well documented that only one in every 9 or 10 GPs is providing abortion care, there is no reliable data on the reasons for non-provision. The lack of such data masks the range of complex, health system-based reasons for non-provision and creates a stigmatising impression that those GPs who do not provide have personal objections to abortion. It is hoped that the forthcoming research commissioned by the Department of Health into provider experience of abortion care will provide nuanced and useful information about ways in which more GPs can be supported to opt into the provision of abortion care.

Actions required:

- **Resource the HSE to step up efforts, including outreach, training and capacity building, and provide additional supports to encourage more healthcare providers to participate in the service.**

[27] Grimes, L., and Abortion Rights Campaign (ARC). 2021. *Too Many Barriers: Experiences of Abortion in Ireland After Repeal*. Available at: https://www.abortionrightscampaign.ie/facts /research/

[28] Dempsey, B., Favier, M., Mullally, A., and Higgins, M. 2021. "Exploring providers' experience of stigma following the introduction of more liberal abortion care in the Republic of Ireland", Contraception, 104, pg.416. Available at: https://pubmed.ncbi.nlm.nih.gov/33864811/

[29] Mishtal et al., Pg.16

[30] Ryan, V. 2020. "All GPs signed-up for abortion services not constantly available" Irish Medical Times. 1 April 2020. https://www.imt.ie/uncategorised/gps-signed-abortion-services-notconstantly-available-01-04-20

Inadequate access to ultrasound scanning

The HSE contracted a private provider to deliver ultrasound scanning for the community-based model of abortion care. It is the IFPA's experience that this provider did not undertake appropriate training of staff in the ethics of abortion care or develop appropriate information materials for abortion seekers accessing their scanning service. IFPA clients have reported experiencing judgmental behaviour and feeling stigmatised in this environment. One woman stated that the screen with the foetal image was turned towards her and the volume of the heartbeat monitor was turned up.

We have been made aware that the service level agreement with this provider does not include the provision of gestation dating scans to under-16s. The absence of this pathway was not communicated by the HSE to community providers and the restriction was only discovered by IFPA staff in the circumstances of a referral of a minor. It is unacceptable that this limitation of the role of the private provider was not clearly communicated, and a clear care pathway developed for minors in such circumstances.

Furthermore, the IFPA has experienced a number of cases recently in which our clients' access to scanning was delayed with no communication to their treating healthcare practitioner, which caused immense stress and anxiety to both the pregnant woman and the doctor and nurse-midwife involved. Such delays have the potential to put patients outside the legal gestational limit for abortion care.

Actions required:

- **Ensure that the ultrasound scanning service for community provision of abortion care is available, accessible and of high quality, delivered by staff trained in the ethics of abortion care and including appropriate pathways for minors and other vulnerable groups.**

Limited availability of surgical abortion

The majority of women accessing abortion receive early medical abortion. While the evidence supports this method as acceptable to women, the right to receive accurate information about all treatment options and choose the method most suited to the individual is central to reproductive rights. Furthermore, for some individuals – such as asylum seekers living in the direct provision system and homeless women – 'home' may not be a suitable place to self-manage an abortion. At present, cases such as these are not eligible for hospital referral.

Several hospitals do offer choice of method between medical and surgical abortion, however this is not the case in all facilities and, in practice, most women availing of abortion care in Ireland are not routinely offered a choice between medical and surgical abortion. Even in situations where a medical abortion has been unsuccessful, some hospitals do not offer surgical management and women are prescribed additional doses of mifepristone and misoprostol.

A policy implementation study by the World Health Organization found that hospitals providing the full range of abortion methods are "uncommon"[31]. Contributing factors include a lack of trained or willing providers and competition for operating theatre time. Regarding the latter, hospital-based practitioners who participated in the study identified the need for ambulatory gynaecology facilities to address this problem. In order to increase the availability of surgical abortion, the WHO recommends: shifting away from the use of general anesthesia for uncomplicated procedures, both to lower risk and to reduce use of scarce theatre time and personnel resources; and moving into ambulatory care, establishing manual

[31] Mishtal et al, pg.1-37

vacuum aspiration (MVA) and suction curettage as clinical norms[32][33]. The study further recommends expanding the cohort of medical practitioners who can deliver abortion care to include midwives and nurses. Section 2 of the 2018 Act restricts the definition of medical practitioners to doctors only.

Actions required:

- **Widen the grounds for referral from community to hospital provision.**
- **Allocate appropriate resources to expand the availability of surgical abortion, including investment in ambulatory gynaecology and the training of medical staff in both surgical abortion and the ethics of abortion care.**

Onerous procedural requirements for undocumented people

In early 2019, when abortion services were being set up, HSE guidance to the IFPA was that proof of residence such as a student card, letter or other indication of residence in Ireland should be accepted from people without personal public service numbers (PPSN) and that the usual reimbursement by the HSE would apply in these cases. More recently, the primary care reimbursement scheme (PCRS) has declined to reimburse on this basis, and the IFPA has had to absorb the costs from its income from fees by non-medical card clients of other services. This failure to establish a robust system of reimbursement for treatment provided to people who do not have PPSNs is unfair and inequitable—some providers decline to provide services to this cohort, which includes students who have chosen Ireland as a place to undertake third level education, undocumented migrants, women who have fled violent relationships and minors. The failure to clearly communicate HSE policy in this regard has caused delay, stress, anxiety and time-wasting to both service users and providers.

Actions required:

- **Establish and communicate a clear policy and set of procedures to govern reimbursement of care for people without PPSNs.**

Public Awareness

The IFPA knows from our services that many women and girls who present for care are aware that abortion care is available, but are unclear about many aspects of the legal framework. Some are unaware of the mandatory three-day wait or the gestation limit. Others assume that they will be required to explain or justify their reasons for deciding not to continue their pregnancy—and are extremely relieved to learn that abortion is available on their own indication, without any requirement to establish grounds before 12 weeks of pregnancy.

Actions required:

- **Undertake more extensive health promotion, in accessible and empowering language, of the rights of and services available to those who need any sexual and reproductive healthcare.**

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[32] Mishtal et al, p. 23

[33] Grimes, L., O'Shaughnessy, A., Roth, R., Carnegie, R., Duffy, D. 2021. Analysing MyOptions: experiences of Ireland's abortion information and support service. *BMJ Sexual and Reproductive Health:* 0:1–5. doi:10.1136/bmjsrh-2021-201424

My Options

My Options facilitates access to abortion care six days a week. The service includes referrals for counselling if requested by a service-user, medical advice after hours, and an interpreting service. Research conducted on abortion-seekers' experiences of the service found that many had a positive, helpful, and compassionate experience. However, others noted a lack of clarity from My Options about the scope of its service and a lack of information on accessing abortion after 12 weeks. The fact that the service does not arrange appointments was seen as a source of frustration for abortion-seekers, many of whom found the process of contacting GPs stressful and time-consuming. Separate research by the WHO found that there is insufficient awareness of the service: about half of service users in their study did not contact My Options because they were not aware that My Options is the national referral service in Ireland[34][35].

Actions required:

- **Increase public awareness of the My Options helpline throughout Ireland.**
- **Expand the scope of the service to include the provision of information on accessing abortion after 12 weeks.**
- **Consider the feasibility of offering a booking service to streamline abortion-seekers experience of accessing abortion care.**

Advancing sexual and reproductive health and rights

Abortion is part of a continuum of sexual and reproductive health services that should be considered as part of an overall sexual and reproductive health strategy. The strategy should adopt a life-cycle approach to sexual and reproductive health, including:

- Comprehensive sexuality education;
- Counselling and services for the full range of modern contraceptives, including emergency contraception;
- Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care;
- Abortion services;
- Prevention and treatment of HIV and other sexually transmitted infections;
- Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence;
- Prevention, detection and management of reproductive cancers, especially cervical cancer;
- Information, counselling and services for subfertility and infertility;
- Information, counselling and services for sexual health and well-being throughout the life cycle.

The 2018 *Guttmacher–Lancet Commission on Sexual and Reproductive Health and Rights* developed a new, integrated definition of sexual and reproductive health and rights that should form the basis of an overall sexual and reproductive health strategy:

"Sexual and reproductive health is a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. A positive approach to sexuality and reproduction recognises the part played by pleasurable sexual relationships, trust and communication in promoting self-esteem and overall well-being. All

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[34] Grimes, L., O'Shaughnessy, A., Roth, R., Carnegie, R., Duffy, D. 2021. Analysing MyOptions: experiences of Ireland's abortion information and support service. BMJ Sexual and Reproductive Health: 0:1–5. doi:10.1136/bmjsrh-2021-201424

[35] Mishtal et al., pg.14

individuals have a right to make decisions governing their bodies and to access services that support that right"[36].

Actions required to advance sexual and reproductive health and rights more broadly:

- **Develop a clear and detailed sexual and reproductive health strategy, incorporating the 2018 *Guttmacher–Lancet Commission* definition of sexual and reproductive health and rights.**
- **Provide universal free access to contraception to all those of reproductive age who wish to avail of it.**
- **Reform Ireland's relationships and sexuality education curricula to ensure young people's right to holistic, evidence-based, and inclusive sexuality education at all stages of their development.**
- **Incorporate abortion into the 2023 Women's Health Action Plan as part of the life-course approach to women's health.**

Conclusion

Ireland has made important progress towards the realisation of sexual and reproductive health and rights. The introduction of State-funded abortion care on request is a significant step towards a truly patient-centred, rights-based approach to reproductive healthcare. The community-based model of care broadly supports locally accessible services so that the burdens associated with the need to travel, take time off work or education, or arrange childcare in order to access abortion care are reduced.

This model has been further strengthened by the addition of telemedicine, which has broadened women's choices and enhanced the ability of medical practitioners to deliver essential, time-sensitive healthcare.

The design of services supports choice of provider: in principle, people can access care from a specialist sexual and reproductive healthcare centre, such as the IFPA, or attend their regular GP, or obtain contact details for a different GP through My Options. Other critical supports, including specialist pregnancy counselling and a 24/7 medical helpline, are also available without cost.

However, the legal framework creates significant challenges for the operation of abortion services, both in its provisions and in its influence on the wider healthcare environment within which people access abortion.

The Act disproportionately values the personal beliefs of individual healthcare practitioners over the decisions, needs and perspectives of pregnant people. Other provisions serve only to perpetuate abortion stigma. The criminalisation of abortion frames this healthcare service as a moral wrong in a number of significant ways. It treats abortion in certain circumstances as a harm deserving of prosecution and harsh punishment on conviction and creates a chilling effect for medical practitioners. In the absence of an explicit guarantee of access, the Act's recognition of the right to refuse to provide abortion care on grounds of personal beliefs undermines reproductive autonomy.

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[36] Starrs, A.M., Ezeh, A.C., Barker, G., Basu, A., Bertrand, J.T., Blum, R., Coll-Seck, A.M., Grover, A., Laski, L., Roa, M., Sathar, Z.A., Say, L., Serour, G.I., Singh, S., Stenberg, K., Temmerman, M., Biddlecom, A., Popinchalk, A., Summers, C., Ashford, L.S., 2018. "Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher– Lancet Commission". *The Lancet* 391, 2642–2692

A rigid 12-week gestational limit causes stress and anxiety and results in the denial of care for many women. The inflexible, paternalistic mandatory waiting period creates unnecessary delays, demeans women as decision-makers and restricts reproductive autonomy. These provisions, combined with limited, narrowly defined grounds for abortion access after 12 weeks, mean that many women continue to leave the country to access care, enduring physical, emotional and financial burdens in the process. Others are forced to continue a pregnancy against their wishes, in circumstances where they have well-founded concerns about the impact of continuing a pregnancy on their future.

In addition to the legal restrictions, a range of barriers frustrate access for many, particularly those who experience added vulnerabilities, such as minors, asylum seekers, homeless women and disabled women. These barriers include an uneven and inequitable geographical distribution of both community- and hospital-level abortion services, a lack of availability of surgical abortion, inadequate scanning services, onerous procedural requirements for undocumented people and low public awareness about the availability and accessibility of abortion services.

It is now three years since the establishment of abortion services. There is significant evidence from abortion seekers and healthcare providers who have sought and provided care under the legal framework about the facilitators and barriers to abortion care. There is also a set of international best practice standards and guidance on human rights compliance in abortion provision, most recently the 2022 World Health Organization *Abortion care guideline*. The review of the Health (Regulation of Termination of Pregnancy) Act 2018 is a critical opportunity to address the many legal and operational barriers that remain. It is equally important that the current strengths of the abortion service and the elements that support reproductive autonomy and rights are carefully scrutinised, and that a health systems approach to the ongoing development and long-term sustainability of this essential health service is identified so that the availability, accessibility, acceptability and quality of abortion care is safeguarded into the future.

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