DCEDIY National Strategy on Women and Girls Survey

Research Questionnaire

Detailed response to **Question 15**

by **Irish Family Planning Association (IFPA)**

Contact: Maeve Taylor, IFPA Director of Advocacy and Communications, maeve.taylor@ifpa.ie

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Introduction

About the Irish Family Planning Association (IFPA).

The IFPA is Ireland's leading sexual health charity. We promote the right of all people to sexual and reproductive health information and dedicated, confidential and affordable healthcare services. The IFPA offers a comprehensive range of services which promote sexual health and support reproductive choice on a not-for-profit basis from our clinics in Dublin city centre and Tallaght, and pregnancy counselling services at nine centres nationwide. We also deliver contraceptive training to medical professionals and sexual health training to service providers, young people, parents and community groups. With a strong track record in providing high quality medical, counselling and education services, the IFPA is a respected authority on sexual and reproductive health and rights and is regularly called upon to give expert opinion and advice.

IFPA Vision, Purpose and Mission

The IFPA's Strategic Plan 'Accelerating Sexual and Reproductive Health and Rights' sets out a bold vison, purpose and mission for the organisation for the five-year period, 2024 to 2029.

Vision

A world where everyone has equitable access to the highest standards of sexual and reproductive healthcare and where their sexual and reproductive rights are respected and fulfilled.

Purpose

To champion sexual and reproductive health and rights by providing specialist services, engaging in advocacy and promoting gender equality.

Mission

We provide the highest standards of sexual and reproductive healthcare through our specialist services, focusing on those who experience multiple and intersecting forms of discrimination and ensuring we leave no one behind. We work from a human rights perspective to influence sexual and reproductive healthcare and policy. We work with healthcare professionals, civil society, Irish and international non-governmental organisations and other actors to contribute knowledge and expertise and to strengthen sexual and reproductive health and rights in Ireland and globally.

People living in exceptionally difficult circumstances

The IFPA specialises in providing care to women and girls who are in vulnerable situations which can arise because of myriad factors: youth; isolation, socio-economic hardship and precarity; legal, familial or cultural reasons; intimate partner violence or coercive control; or because of factors relating to a pregnancy, such as underlying health issues or fetal anomaly.

Our team works with a range of state and other agencies to mitigate the multiple and intersecting forms of disadvantage experienced by particularly vulnerable groups, such as minors, including those in care, people within the international protection system, homeless people, and people with disabilities.

We use the term ***people in exceptionally difficult circumstances*** to refer to those service users whose ability to access the healthcare they need is compromised and whose circumstances present barriers to healthcare and for whom a pregnancy is likely to introduce additional stressors into their lives which are already extremely difficult.

This submission is informed by the experiences of our counsellors and medical staff of providing care to this cohort.

Response to Survey Question 15

Q.15 Having gone through the survey, are there any issues that you think should be addressed in the next 5 years that are not currently being addressed?

I. Abortion care

Legislators acknowledged in 2018 that there was no domestic evidence on abortion care in Ireland. They therefore made the appropriate decision to include a review clause in the Health (Regulation of Termination of Pregnancy) Act 2018. The comprehensive, evidence-based review of abortion published in 2023 (the O'Shea Report) highlighted a range of gaps in the provision of abortion under the current legislative framework. The O'Shea report is informed by the abortion care guidance of the World Health Organization (2022) and draws on the 2022 HSE Unplanned Pregnancy and Abortion Care (UnPAC) study.[i]

While there have been improvements in many operational aspects of abortion services in the past year – e.g. 17 of the 19 maternity hospitals now providing care – significant barriers to equitable and accessible abortion services remain. These barriers include ongoing criminalisation, the mandatory 3-day wait, inadequate data collection, uneven geographical coverage, and narrow rigid legal criteria for abortion access after 12-weeks; including the 28-day clause for fatal foetal anomalies. These obstacles have resulted in women and pregnant people being denied timely reproductive health care and, in many cases, being forced to travel abroad.

Recommendations 1 to 6

1. The new strategy should include a range of actions to ensure implementation of the operational recommendations of the 2023 O'Shea report.

2. Full decriminalisation of abortion in line with World Health Organisation (WHO) guidance to remove the chilling effect on healthcare providers, ensuring that they can use their clinical judgment to care for people without fear of prosecution.

3. Remove the medically unnecessary mandatory three-day wait period to ensure timely access to abortion care.

4. Review the 12-weeks gestational limit to ensure women and pregnant people are not timing out of care and forced to travel abroad for essential reproductive healthcare.

5. Appoint a HSE Primary Care Lead for Termination of Pregnancy to address current gaps in training, guidance, and data collection in relation to abortion care at the community level.

6. Take all possible measures, including policy and law reform, to ensure that women and girls in exceptionally difficult circumstances and who are affected by multiple and intersecting forms of disadvantage have equitable access to abortion care.

Specialist pregnancy counselling

The review of "crisis pregnancy" counselling services in Ireland undertaken in 2023, four years after the introduction of abortion care in Ireland was very timely. As the review noted, the term "crisis pregnancy" is outdated and comes from a time when abortion care was illegal and stigmatised. The term may be associated with an erroneous view that the role of pregnancy counselling is support with decision-making. The term does not encompass the range of emotional and psychosexual needs that arise in practice within the service (e.g. infertility, tokophobia, post-natal depression, gender-based violence). The limitations of the terminology have implications for the ability of service provision to provide care that is truly needs-led.

Moreover, section 4(i) of the regulation that established the mandate of the HSE Sexual Health Programme (SHP) (known until recently as the SHCPP and formerly known as the Crisis Pregnancy Agency)[ii] must be reframed. The regulation defines the functions as:

(a) To reduce the number of crisis pregnancies by the provision of information, advice and contraceptive services.
(b) To *reduce the number of women with crisis pregnancies who opt for abortion* by offering services and supports which make other options more attractive.
(c) To provide counselling services, medical services and such other health services for the purpose of providing support, after crisis pregnancy as may be deemed appropriate by the Crisis Pregnancy Programme.

Paragraph (b) reflects the legal position imposed by pre-2018 legislation and by article 40.3.3 of the Constitution and is at odds with current public policy in relation to abortion care, which is now part of mainstream healthcare and available from GPs. All three stated functions are out of alignment with contemporary understanding of access to reproductive healthcare as essential to women's health, well-being and bodily autonomy.

Recommendations 7 to 12

7. Include actions to promote and support the service currently termed "crisis pregnancy counselling" as part of an overall strategy to integrate all aspects of abortion care into mainstream healthcare. We recommend the term "specialist pregnancy counselling" and that reference be made to "unintended pregnancy" and "pregnancy that has become a crisis".

8. Reframe the role of the HSE Sexual Health Programme (SHP) within the wider context of sexual and reproductive health andrevise terminology to reflect this, including by removal of language on reducing the number of women with crisis pregnancies who opt for abortion and reframing the functions of the SHP in terms of fulfilling rights and supporting choices with regard to abortion and contraception.

9. Specialist pregnancy counselling is an area of mental health that requires significant expertise. Complex cases frequently require engagement with a range of healthcare professionals in addition to GPs, including medical social workers, midwives and perinatal mental health teams in hospital settings. However, there are no formal referral pathways from specialist pregnancy counselling into hospital perinatal care.

10. Introduce measures, including referral pathways, to ensure integration of specialist pregnancy counselling services into maternity and pregnancy care more generally.

11. Support the ongoing development of skills within the sector through the provision of advanced training by appropriately experienced practitioners of pregnancy counselling.

12. Take measures to combat the activities of disingenuous/rogue agencies, including by promoting legitimate counselling services and by accelerating the process of regulation of counselling through Corú.

II. Contraception

With the free scheme introduced in 2022 the state recognised that access to contraception is so obviously a public good that the state, rather than the user, should bear the cost. In the IFPA's view, the limitation of the scheme to defined age-groups is inherently inequitable, as many women and girls for whom an unintended pregnancy would be a significant crisis are excluded from the scheme and

therefore at higher risk. The ineligibility of those under 17 is particularly problematic, as they are unlikely to be able to pay for contraception and a pregnancy is highly likely to adversely affect these young people's well-being, education and career prospects in multiple ways and increase their vulnerability to ongoing disadvantage.

The findings of the Irish Health Behaviour in School-aged Children (HBSC) Study, 2022 underscore the need for expansion of the scheme to younger teenagers. The report found a decrease among 15- to 17-year-olds who report using a condom and an increase in those who report using no contraception at last sexual intercourse. Overall, 25% of 15 to 17-year-olds reported that they have ever had sexual intercourse, which remains broadly unchanged from 2018 (25%). However, of those who reported having had sex; 34% said that they or their partner used no contraception at last sexual intercourse, an increase of 12% from 2018.[iii]

While a budgetary allocation has been made for the inclusion of 16-year-olds, the Minister has said that he has been advised that legislation is needed to extend the free scheme to younger age groups.[iv] However, no legislative proposals have yet been published. We understand that such legislation would resolve the unclear legal status of prescribing contraception to under 17s and the fact that the law is silent on whether under 16s are capable of consenting to medical treatment or need the consent of their parents.

The stated position in the current HSE National Consent Policy is that the key consideration in prescribing contraception to minors is the best interests of the child. Young people's health should be a national priority. The UN Committee on the Rights of the Child and the Committee on Economic, Social and Cultural Rights have issued guidance on adolescents' right to access reproductive healthcare. Moreover, the Committee has repeatedly criticised the State for failing to ensure young people's rights to access sexual and reproductive healthcare.

Action to address these issues was recommended by the Law Reform Commission in 2011, which urged that the Gillick principles and Fraser Guidelines, which are derived from a 1985 UK House of Lords ruling[v], be given legislative status.

Since 2011, the UN Committee on the Rights of the Child and the UN Committee on Economic, Social and Cultural Rights have issued guidance on adolescents' right to access reproductive healthcare which reflects a more rights-based approach than that of the House of Lords in the Gillick case, is in line with the children's rights provisions of the Constitution and is therefore to be preferred.

International human rights law and adolescent sexual and reproductive health

The United Nations (UN) Committee on Economic Social and Cultural Rights (CESCR) and the UN Committee on the Rights of the Child (CRC) have provided guidance on the interpretation of children's right to health. This includes the right to control one's health and body, including sexual and reproductive freedom to make responsible choices[vi] and universal access to a comprehensive package of sexual and reproductive health interventions[vii]. The CRC has criticised the tendency to treat adolescents as incompetent and incapable of making decisions about their lives and has emphasised the need for States to support the right of a child who is able to demonstrate sufficient understanding to make autonomous decisions[viii].

The World Health Organisation (WHO) has summarised States' obligations under human rights law to provide contraceptive services to adolescents[ix] as follows:

–States are obliged to adopt legal and policy measures to ensure access of all individuals, including adolescents, to affordable, safe and effective contraceptives[x].

—*Adolescents should have easy access to modern methods of contraception, including short-term and long-acting reversible methods, and such access must not be hampered by providers' conscientious objections*[xi].

—*Contraceptive information and services, including emergency contraception, as part of sexual and reproductive health services, should be free, confidential, adolescent-responsive and non-discriminatory, and barriers to services such as third-party authorization requirements should be removed*[xii].

Furthermore, the CRC recommends that States consider the introduction of a legal presumption that adolescents are competent to seek and have access to preventive or time-sensitive sexual and reproductive healthcare[xiii].

Recommendations 13 to 15

13. Bring Irish law into line with international human rights law by removing the requirement of parental or other third-party consent from adolescents' access to contraception; ensure that adolescents' right to confidentiality in access to healthcare is guaranteed; develop targeted adolescent friendly health promotion and information campaigns.
14. Introduce legislation to resolve the legal barrier to extension of the free contraception scheme all adolescents under 17; promote adolescent responsive contraception care including by providing healthcare professionals with training and guidelines on provision of contraception care to adolescents.
15. Extend the free contraception scheme to all those living in Ireland who wish to use modern methods of contraception, regardless of age or residence status.

For those who are eligible, the scheme is working extremely well, however there are issues with supplies of non-hormonal intra-uterine devices: there is currently only one copper coil (Ballerine) available within the scheme.

Recommendation 16

16. Ensure availability of a full range of quality modern methods, including non-hormonal devices, to women and girls who are eligible under the scheme.

III. Primary healthcare provision of SRH

The World Health Organisation promotes the vision of universal health coverage (UHC), i.e. that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship.[xiv] To deliver on this promise, countries need to have strong, efficient and equitable primary health care systems which can ensure that SRH needs are identified, prioritized and addressed in an integrated way within the community; that there is a robust and equipped health and care workforce; and that all sectors of society contribute to confronting the environmental and socio-economic factors that affect health and well-being.

In the IFPA's view, the provision of sexual and reproductive healthcare (SRH) at the community level should be a priority of the new strategy. Currently, many people have no option but to travel long distances within Ireland to access hospital or other specialist services to avail of SRH that could be better provided at local primary healthcare facilities. The burden of the geographical inequity in relation to distribution of services falls most heavily on those who are disadvantaged.

There is a need for more centres across Ireland that can provide the full range of SRH services, as well as training and capacity building, and policy development support. Such centres should provide

accessible referral pathways from GP services for complex cases which may be overly burdensome within a busy general practice.

As emphasised in the UNPAC report, there is currently an over-reliance on the goodwill of champions of particular areas of SRH to provide training and to deal with more complex cases and provide peer support. These champions frequently provide such supports on their own time and access training at their own expense. This is not sustainable for quality, ongoing health-service development. There is a need to foster the development of a community of practice and promote research and innovation. In this context, while the role of doctors is emphasised in the 2018 act and the model of care for early medical abortion, the expansion of the roles of nurses and midwives within abortion care provision would enhance the capacity of primary healthcare providers of the service.

Recommendations 17 to 20

17. In order to support the capacity of general practice and to foster the development of specialist skills in sexual and reproductive healthcare (SRH) throughout primary care, the strategy should include an action to identify and resource leading primary health care specialist providers of SRH in each of the healthcare regions.
18. Initiate a faculty of sexual and reproductive health. Such an institution should be tasked with ensuring that Ireland has sufficient numbers of providers who are trained in the provision of care for both routine and complex contraception, menopause and abortion care, as well as other areas of SRH.
19. Provide subsidised training and education in key areas of SRH, including abortion, contraception and menopause.
20. Enhance the role of nurses by providing advanced training in SRH for nurses and midwives.

V. Equity in access to healthcare

Equity in healthcare access is a major challenge, related both to out-of-pocket costs of healthcare and the difficulty of accessing a GP in contexts where GMS lists are full. National or population-based programmes are necessary but not sufficient to ensure equitable access.

The recently published 2024 UNFPA State of World Population report, *Interwoven Lives, Threads of Hope: ending inequalities in sexual and reproductive health and rights*[xv] outlines the impacts of multiple and intersecting forms of discrimination on the most marginalised and vulnerable in all societies. The report makes clear that barriers to healthcare fall fastest for those who are more affluent, educated and privileged. The groups that have benefitted the most from population-based programmes are those that had the fewest barriers to begin with.

Among the most marginalised women and girls who seek to access sexual and reproductive healthcare in Ireland are unaccompanied minors, people who are undocumented, and people whose residence status is precarious or subject to an international protection process. The requirement of presenting a PPSN as evidence of residence can be an insurmountable hurdle for people in these situations. Denial of free services can leave such women and girls at higher risk of unintended pregnancy.

Recommendation 21

21. Remove the requirement to present a PPSN when accessing sexual and reproductive healthcare.

The cost barrier in relation to menopause care

The existing structures for menopause care offer an encouraging example: however, these services are inadequate to meet the demand for menopause care and there is a need for training of GPs to enhance their capacity to deal with moderately complex cases.

The announcement on October 2nd that Hormone Replacement Therapy (HRT) will be free for all women experiencing menopause from January 2025 is very welcome and continues a very positive trend of recognising the inequitable burden on women of paying for reproductive healthcare out-of-pocket. The free HRT scheme is based not on age, but on the experience of symptoms. The IFPA welcomes its inclusiveness. However, it is regrettable that only the HRT itself is covered by the scheme for now, and women will still have to pay dispensing fees and fees for a consultation with a doctor. These costs will remain onerous for many women.

Recommendation 22

22. Extend the free scheme for access to hormone replacement therapy to include the doctor consultation and the dispensing fee.

The cost barrier in relation to vasectomy care

Access to vasectomy under the GMS should also be improved to enhance the reproductive options available to men and also to decrease the health and financial burden on those women who may be using contraception not because of choice, but due to the high cost of vasectomy.

Recommendation 23

23. Immediately increase the number of GMS providers of vasectomy and take steps to introduce a free scheme for access to vasectomy.

Promoting equity

The development of a quality assessment framework aligned with the principles of the right to health, and taking into account the social determinants of health, as outlined in international human rights law, would support the identification of actions to promote equity across the health service.

Monitoring the implementation of the right to the highest attainable standard of health care is a critical aspect of addressing inequalities. The new strategy should adopt an ambitious and visionary human rights-based approach: 2024 marks 30 years since the International Conference on Population and Development (ICPD) took place in Cairo in 1994. The ICPD's landmark Programme of Action (PoA), adopted by 179 governments, including Ireland, recognised the importance of sexual and reproductive health and rights as critical to health and wellbeing. Ireland's statement at the UN gathering which marked this milestone made a renewed commitment to advance the ICPD agenda.[xvi]

A human rights-based approach should be prioritised: this would make reference to the norms of international human rights law, the guidance standards of the World Health Organisation, including its abortion care guidance. It should be aligned to the most up to date definition of sexual and reproductive health and rights, namely, that proposed by the 2018 Guttmacher Lancet Commission, which in turn draws on numerous international and regional agreements, and on international human rights treaties and principles, and reflects an emerging consensus on the services and interventions needed to address the sexual and reproductive health needs and bodily autonomy of all individuals.[xvii]

Recommendations 24 and 25

24. In line with a human rights-based approach, the Sustainable Development Goals and the associated goal of universal health coverage, the new Strategy should include actions to promote access to healthcare and the realisation of the rights of those furthest behind, i.e. those who experience multiple and intersecting forms of discrimination and disadvantage.

25. Development of a quality assessment framework aligned with the principles of the right to health as outlined in international human rights law, and taking into account the social determinants of health, which support the identification of actions to promote equity across the health service.

A 2024 report by UNFPA, the UN agency for sexual and reproductive health, makes clear that too few countries are collecting data on sexual and reproductive health needs and barriers; fewer still are disaggregating data by factors known to contribute to neglect, discrimination and marginalization, factors including culture, ethnicity, "race", caste, language, religion, disability status, HIV/AIDS status, migration status, sexual orientation and gender identity.[xviii]

Without a proper system of data collection at national level in relation to abortion, contraception, FGM and other areas of SRH, Ireland lacks a robust evidence base which can support monitoring of the successes and shortcomings of these critical services. This hampers the development of future initiatives. We have raised this issue in relation to abortion care, pregnancy counselling and contraception (previous sections) and with regard to the provision of treatment for women who are subjected to FGM (below).

Recommendation 26

26. A system for national data collection across all areas of SRH should be developed in light of current service needs, informed by the social determinants of health, and capable of capturing data relevant to national service planning and design, including, but not limited to asylum status, use of interpreters, socio-economic factors, experience of gender-based violence, disability.

VI. Female genital mutilation (FGM)

FGM is the cutting, injuring or closing of the external female genitalia, or other injury to the female genital organs, for no medical reasons. FGM is a human rights violation and a form of gender-based violence most commonly carried out on young girls between infancy and age 15. It has no health benefits. It can cause excruciating pain and severe bleeding in the immediate aftermath and often leads to long-term physical and psychological issues, including infection, infertility and post-traumatic stress disorder. Many girls and women who have been cut also face childbearing complications, including postpartum haemorrhage, stillbirth and infant mortality.

It has been estimated that 10,000 women and girls living in Ireland have experienced FGM. Since 2014, the IFPA has been operating Ireland's only dedicated expert primary healthcare service for the treatment of women who have been subjected to the extremely harmful practice of FGM. This is funded by the HSE. The service includes a referral pathway to secondary care (Rotunda Hospital) for surgical assessment and intervention (deinfibulation). Since 2022, the IFPA has seen an unprecedented increase in demand for our service: in 2023, we provided 241 FGM appointments (medical and psychological). This represents a 338% increase on 2021 appointments (55). The increase in client numbers has been accompanied by an increase in complexity, as most women presenting to the service are newly arrived asylum seekers. Uncertain legal status, limited or no English and the absence of family and community support networks mean that FGM clients are a highly vulnerable population, who experience particular difficulties as they try to navigate the unfamiliar health, social protection, public transport and international protection systems in Ireland.

A single service is not sufficient to meet the needs of this large and highly vulnerable population. The new strategy should include dedicated actions to address the increasing demand for treatment of women and girls who have been subjected to female genital mutilation (FGM). We recommend a range of measures below to address the deficit in care provision for those who have been subjected to FGM.

Recommendations 27 to 32

27. Appoint a national clinical lead for FGM treatment services in primary care to provide guidance and support for appropriate service expansion around the country.

28. Develop a new funding model aimed at GPs who specialise in women's health, in addition to women's health and family planning clinics, i.e. healthcare providers who already possess a skillset relevant to the care of women who have experienced FGM.
29. Provide training for providers of treatment to those who have been subjected to FGM in the clinical aspects, but also areas of cultural competence and cultural awareness.
30. Develop clear referral pathways to psychological supports for healthcare providers who care for FGM survivors. In the IFPA's extensive experience, there is significant demand for counselling, including psychosexual therapy, amongst FGM survivors.
31. Develop national clinical guidelines for FGM treatment in primary care and therapeutic guidelines for working with FGM survivors (however such development should not be a precondition to service expansion).
32. Establish FGM contact points in all 19 maternity hospitals, as recommended in the 2019 Guidance for hospital management of FGM.[xix] This should be prioritised: the IFPA is only aware of two hospitals (Rotunda, CUMH) where an FGM referral pathway exists.

Need for multiagency and multisectoral strategy development and governance.

Responsibility to address FGM cuts across the health, social care, social protection and justice sectors. There is a need for a whole-of-government approach. However, to date, efforts to tackle the practice in Ireland have been led for the most part by NGOs. The State has largely confined its role to the enforcement of the Criminal Justice (Female Genital Mutilation) Act 2012 and providing financial support to NGOs and multilateral agencies to work on FGM both at home and abroad. Policy formation and implementation are fragmented and there is no overarching accountability structure to ensure an effective and coordinated response to FGM by the various State bodies, agencies and government departments that have a role in addressing this harmful practice.

Recommendation 33

33. Establish a government-led interagency committee, with representation from key government departments, State agencies, NGOs and women and men from affected communities. This committee should be tasked with responsibility for the development of a national-level framework or strategy with appropriate resourcing, including funding, to combat FGM across key areas.

VII. Ireland's international policy on sexual and reproductive health and rights (SRHR)

Ireland's international policy on SRHR has developed considerably in recent years, following the publication of *A Better World, Ireland's Policy for International Development*, in 2019. A sexual and reproductive health and rights (SRHR) initiative, promised in the policy, was approved by Tánaiste Micheál Martin in September 2023, recognising that SRHR is necessary to secure better health outcomes for women and men, and, is a precursor to full gender equality. The new initiative expands Ireland's efforts to reduce unmet need for modern contraception; reduce adolescent birth rates; and increase the number of countries that guarantee access to sexual and reproductive health care, information and education.

The initiative sets out a bold ambition for SRHR in Ireland's international engagement, at the policy, programme, bilateral and multilateral levels. It is critical that implementation of the initiative is monitored and that adequate funding is allocated.

Moreover, the initiative underscores the need for attention to SRH in crisis settings. The UN has identified a minimum intervention service package (MISP) for sexual and reproductive health (SRH) in crisis situations: crucial, lifesaving activities required to respond to the SRH needs of affected

populations at the onset of a humanitarian crisis, which are often overlooked with potentially life-threatening consequences. It is critical that this approach is taken by Irish Aid.

Recommendations 34 to 40

34. The government should allocate funding and ensure appropriate programmes and policies are in place to deliver on the commitments in the new initiative to scale up action to reduce unmet need for contraception amongst adolescent and young women, including by funding SRH supplies.
35. Take measures to ensure that SRHR, specifically the MISP, are integrated into Ireland's responses to humanitarian emergencies and crisis settings,.
36. Ensure that resources are dedicated to greater support for comprehensive sexuality education, which is identified in the initiative as a priority intervention, and ensure funding for partners such as UNFPA, UNESCO, and WHO, along with the Global Fund to Fight AIDS, TB and Malaria, the International Planned Parenthood Federation, and the Population Council.
37. Publish the SRHR on the website of Irish Aid.
38. Ireland should take a more visible leadership role as a champion of SRHR in key UN-led intergovernmental forums and processes, such as the Commission on the Status of Women, the Commission on Population and Development, the UN General Assembly, UN Human Rights Council, and the World Health Assembly.
39. Recognising the long road to reform of repressive laws that impeded and violated sexual and reproductive rights in Ireland, the government should create support and fund the advocacy work of groups and organisations in its priority aid countries and in Ireland that campaign for the sexual and reproductive health and rights of all globally.
40. Ensure that SRHR is mainstreamed into all future Irish Aid and international policies.

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