Stakeholder submission to the 53rd session of the UNHRC Universal Periodic Review, 2026

April 2026

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53rd session, November 2026

Stakeholder submission by: Irish Family Planning Association (IFPA)

The Irish Family Planning Association (IFPA) is a leading not-for-profit provider of reproductive and sexual healthcare, information and counselling. We provide specialist services through our Dublin-based clinics, nationwide counselling network and education and training service. The IFPA receives state funding to provide free services to marginalised and low-income communities.

A consistent voice of challenge against legal and policy barriers to contraception and abortion care access, the IFPA advocates for reproductive autonomy and the progressive realisation of the right to the highest attainable standard (availability, accessibility, acceptability, and quality–AAAQ) in sexual and reproductive healthcare.

Founded in 1969, the IFPA is a member association of the International Planned Parenthood Federation (IPPF) and is the Irish collaborating partner of UNFPA, the UN agency for sexual and reproductive health. Over many years, the IFPA has submitted shadow and stakeholder reports to a range of UN treaty bodies, mandates and special rapporteurs; and to the Committee of Ministers of the Council of Europe in relation to a ruling of the European Court of Human Rights.

The IFPA is an independent non-governmental organisation with charitable status.

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Key words: right to health, family planning; right to abortion; children: adolescents' right to bodily autonomy and confidentiality; access to sexual and reproductive health services; gender equality; right to bodily autonomy; gender equality; stigma and discrimination, asylum/refugee /immigration; equality and non-discrimination.

Introduction

0.01 This report is submitted by the Irish Family Planning Association, a leading advocate for sexual and reproductive health and rights in Ireland, and expert provider of contraception and early abortion services. The IFPA delivers an accredited contraception foundation course for medical professionals; is represented on the National Termination of Pregnancy Service Improvement Group; and operates Ireland's only dedicated free treatment service for women who have been subjected to female genital mutilation (FGM).

0.02 This report is based on principles of international human rights law and best healthcare practice. It draws upon the IFPA's expertise and clinical experience, analysis of anonymised clinic data and qualitative research with key stakeholders, as well as our clinical team's day-to-day experience of the impacts of barriers to access to reproductive healthcare.

Summary of IFPA priority focus

0.1 Recommendations of previous UPR cycles regrading sexual and reproductive health and rights focused on abortion care and access to reproductive healthcare more generally.

0.2 2nd cycle: France: take all necessary measures to ensure full respect for sexual and reproductive rights–partially implemented.

0.3 3rd cycle: Iceland, Canada, Netherlands, Austria and Denmark: remove barriers to access to abortion, including those faced by migrant and other marginalised groups–not implemented.

0.4 This submission provides evidence of non-implementation of these recommendations and highlights select issues for scrutiny during the fourth UPR cycle:

(1) Abortion: remaining legal and policy barriers to access leave pregnant women ineligible, abandoned by the healthcare system and forced to access abortion care outside Ireland.

(2) Contraception: free contraception is limited to 17- to 35-year-olds; ineligible age-groups may struggle to pay for the long-acting methods most effective for controlling fertility; lack of clarity in the law regarding consent to medical treatment compromises adolescents' access and confidentiality.

(3) Female genital mutilation (FGM): increasing demand and inadequate resources impact access to timely treatment for those who have been subjected to FGM.

1. ABORTION

Overview

1.01 The introduction of abortion care services in January 2019[i] was transformative for reproductive health, wellbeing and autonomy in Ireland. As expected with a new service, uptake has increased year-on-year.

1.02 Abortion care on request up to 12 weeks of pregnancy is widely available in primary healthcare settings, without charge, and with no requirement to give reasons. However, a mandatory three-day waiting period applies before a pregnancy can be terminated, beginning with a doctor consultation rather than initial contact with a healthcare service.[ii] Abortion is also available in cases of risk "to the life, or of serious harm to the health, of the pregnant woman"[iii]; emergency[iv]; and fetal anomaly likely to lead to the death of the foetus before or within 28 days of birth.[v] Practitioners have a legal right to refuse care due to personal beliefs.[vi] The act includes a criminal offence of intentionally ending the life of the foetus outside the Act terms; while a pregnant woman is exempt from liability for termination of her own pregnancy, anyone who assists her outside the provisions of the act risks prosecution and a harsh sentence.[vii]

1.03 Most of the need for abortion care in Ireland is now fulfilled, however, restrictions in the law preclude meeting the need in full. Additionally, recommendations to Ireland within the 3rd UPR cycle, including calls for the statutory review of the abortion law[viii] to focus on expanding access and reducing barriers, have not been implemented.

Review of the operation of the 2018 act

1.04 Since the previous UPR, the legally required review of the 2018 Act has taken place. The final report by the independent Chair of the review, barrister Marie O'Shea BL, (hereafter "the O'Shea report")[ix] was endorsed by the Oireachtas (parliament) Health Committee after its publication in 2023. The report emphasises that the Act is "not aligned with Ireland's human rights obligations" and recommends legal reforms. While legislation was enacted in 2024 to prevent targeted harassment of those accessing abortion care, no other reforms have followed.

1.05 In July 2025, CEDAW made recommendations to Ireland to ensure culturally sensitive sexual and reproductive health services for all women; implement the O'Shea recommendations; consider fully decriminalizing abortion and abolishing the waiting period; and combat stigma and conscientious objection among medical personnel."[x]

Outstanding law and policy gaps and flaws

1.06 Narrowly defined fetal anomaly grounds (see para 1.2) result in the ostracism of women whose pregnancies do not meet the criteria, forcing them to travel out of State for care. Fetal medicine specialists report difficulties in determining whether a given diagnosis falls within the Act. Moreover, the legislation can be restrictively interpreted in instances where hospitals fear criminal prosecution or adverse media exposure.[xi, xii]

1.07 A national study[xiii] commissioned by the State's Health Service Executive for the review of the 2018 act describes the "mental anguish" caused to women by the protracted testing process required for

termination for fetal anomaly, and the uncertainty and delay caused by overly cautious approaches within hospitals.

1.08 The O'Shea report criticised the unfairness of the "rigid, arbitrary restriction" in the law that excludes women whose pregnancies involve "complex, severe life-limiting anomalies" yet might survive 28 days by mere days or weeks. The report found it "highly likely" that eligible cases are wrongly refused due to difficulty assessing whether death will occur within 28 days.[xiv] The report called for the government to review the fetal anomaly provision and consider alternative grounds.[xv] This has not occurred and the law continues to cause anguish, imposing significant financial and emotional burdens on pregnant women and their families. Media reports of such cases make clear that the distress is compounded by the uncertainty and ultimate denial of a service introduced following a popular vote.[xvi] Commenting on one such case, Taoiseach Micheál Martin committed to examine the O'Shea review in consultation with the Minister for Health.[xvii]

Mandatory waiting period

1.10 The three-day mandatory waiting period for early abortion care under section 12 is imposed on everyone who needs early abortion: doctors have no discretion to waive the waiting period for any reason. This is contrary to best international practice as set out by standard-setting bodies such as the World Health Organization, which considers mandatory waiting periods to be unjustifiable barriers, with no health-related rationale.[xviii]

1.11 The imposition of a delay on every person who seeks abortion care is unjustifiable and patronising. Standard medical practice and ethical guidance on informed consent is that healthcare providers encourage patients to take additional time if that is what they need. A mandatory waiting period in the law implies that women would otherwise take unconsidered decisions and doctors would ignore signs of uncertainty or rush someone into a termination. There is no evidence for either scenario. However, we know from our clinical experience that the delay causes stress and harm to women.

1.12 The IFPA has published a cumulative four-year data set (2021-24) which shows that 98% of clients who were subjected to the imposed delay of a mandatory waiting period proceeded to have an abortion.[xix]

Restrictive 12-week gestational limit

1.13 Healthcare providers have no discretion to waive the gestational limit, regardless of a woman's circumstances, including if they are timed out of care by the waiting period or a failed medical abortion. The gestation cut-off also denies care to women whose physical or mental health conditions in pregnancy are not deemed of "serious harm to health", and in cases where a person is unaware of their pregnancy until too late. There is no legal option if parenting is not in the best interest of a girl or woman because of personal, family, relationships, financial, employment, accommodation, health, age, asylum status, or other life situations.

1.14 The O'Shea report recommended legislative amendment to overcome barriers associated with the mandatory three-day waiting period, delays in the health system or failed medical termination of pregnancy. The IFPA supports this recommendation and further advocates for the removal of all barriers to access to abortion care.[ix]

Conscientious objection and stigma

1.15 The O'Shea and UNPAC reports found that exercise of "conscientious objection"[xx] results in gaps and delays in care and experiences of stigma, including because of ancillary personnel who may feel entitled to express disrespectful views, despite not being covered by the section.[xxi, xxii] Professional ethical guidance obliges refusing practitioners to actively ensure continuity of care and minimise distress their decision may cause a patient.[xxiii] The WHO recommends that access to and continuity of abortion care be protected against barriers created by conscientious objection.[xxiv]

Pregnant women forced to travel abroad to access care

1.16 If a pregnancy is ineligible for abortion in Ireland, the resulting options are to access services abroad or forced parenthood. Not everyone can travel. Marginalised groups–including minors, those in state care, women experiencing abuse, those living in poverty, and people with travel restrictions–face barriers, with non-citizen residents disproportionally affected. Bureaucratic hurdles can delay passports and visas and derail clinic bookings–increasing the complexity, cost and emotional stress involved. Sometimes a pregnant person in need of urgent care must restart the process from the beginning. Others may be forced to give up because of legal and other barriers to international travel.[xxv]

1.17 The state provides no financial supports for women in these situations, but signposts the Abortion Support Network (ASN), as a source of assistance.[xxvi] While acknowledging the vital support it has provided to some of our clients, it is unacceptable that following the 2018 referendum, women living in Ireland, especially those in international protection, have to rely on a UK-based charity.

Criminal liability

1.18 The stigmatising and chilling effects of criminal law in the context of reproductive healthcare have been highlighted by a range of treaty bodies, by the WHO and in the O'Shea report. The latter acknowledges that criminalisation of abortion is stigmatizing *per se*, framing it as "an immoral and aberrant act". Risk of criminal liability is heightened for hospital doctors whom the law forces to predict whether termination will avert a serious risk to health[xxvii] or life, or whether a fetal anomaly will cause death before or within 28 days of birth.[xxviii] O'Shea emphasises that this has led to overly cautious, risk-adverse decision-making that tends towards refusing care. Colleagues working in fetal medicine and abortion care in hospitals consistently highlight this as major impediment to their ability to provide appropriate healthcare.

1.19 Coerced abortion could be prosecuted as assault under pre-2018 criminal law, with the pregnancy loss considered a serious aggravating factor.[xxix] In the IFPA's view, such an approach would more appropriately focus on gender-based violence and the harm, loss, and violation of autonomy and bodily integrity caused to the pregnant woman.

Recommendations

a) Fully decriminalise abortion so that healthcare providers can care for people without the chilling effect of fear of prosecution

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

c) Remove all legal barriers to access abortion care and ensure that women and pregnant people neither experience stigma nor are forced to travel abroad for abortion care

2. CONTRACEPTION

2.01 Since 2022, the State has introduced a free contraction scheme which has widened access to the most effective contraceptives for those eligible within the 17- to 35-year-old age range. This supports gender equality as (1) it removes a cost that disproportionately falls on women and (2) decentres financial considerations from this healthcare decision, empowering those eligible to consider of the full range of options and make meaningful, informed decisions.

2.02 The free scheme excludes younger girls and older women, whose contraceptive needs are no less pressing. In 2024, 71% of the IFPA's provision of hormonal coils (IUS), copper coils (IUCD), implants and injections was for clients eligible under the free scheme. Free fittings were also available to clients with medical cards (available to families below a defined income threshold). However, many clients had to pay out-of-pocket as they did not qualify for either scheme.

2.03 The exclusion of under-17s from the free contraceptive scheme means that younger adolescents who lack financial means or parental supports may not be able to avail of contraception and may be at higher risk of unintended pregnancy than those aged 17 and older. The 2025 CEDAW concluding observations recommended both expanding the free contraception scheme to include women at all ages and marginalised groups of women[xxx]; and the inclusion of age-appropriate information on modern contraception and sexual consent in school curricula.[xxxi]

2.04 The National Sexual Health Strategy (NSHS) 2025–2035 commits to expand the free scheme "until all women aged 17-55 are eligible for free contraception."[xxxii] The NSHS also commits to "scope and develop" legislative supports prior to supporting access to free contraception for under-17s. However, it does not commit to a timeframe to resolve the legal barriers to access.

Recommendations

d) Ensure the expansion of the free contraception scheme to everyone of reproductive age who needs it.
e) Accelerate the development of legislative supports to address all current legal barriers so that under-17-year-olds can be included in the free contraceptive scheme and that their autonomy, privacy and confidentiality are protected.
f) Ensure primary and secondary curricula include age-appropriate comprehensive sexuality education.

3. ACCESS TO TREATMENT FOR SURVIVORS OF FGM

3.01 The state funds the IFPA's FGM treatment clinic–Ireland's only specialist service for the treatment of women who have been subjected to FGM. This allows us to deliver medical and psychological care to women and adolescent girls who have been subjected to this harmful practice. The service is free for FGM survivors, who can access expert medical care, specialist counselling and onward referral for surgical interventions.

3.02 Demand for treatment has grown by over 300% since 2021, with 223 appointments fulfilled in 2024 alone. This increase primarily reflects a growing population from countries where FGM is prevalent and from where people continue to flee due to ongoing political insecurity, conflict and a severe climate crisis. This includes those from Somalia, Sudan and Sierra Leone. Many of the women we

see carry significant trauma from their country of origin or migration journey; most are also seeking international protection.[xxxiii]

3.03 The level of demand means it is no longer sustainable that one service should be the sole national focal point for primary-care FGM treatment. It is unacceptable that people must travel from across Ireland to access a Dublin-based service. Without dedicated funding, other primary care providers cannot be expected to fill the significant nationwide gaps in FGM treatment. The development of a network of state-funded FGM treatment services is urgently needed. In its 2025 periodic review, in this regard, the CEDAW recommended that (1) care and support services for FGM survivors are integrated into mainstream healthcare and (2) the number of specialised clinics is increased.[xxxiv]

Recommendation

g) Take all measures, including financial, to expand and support the provision of expert services outside of Dublin for the treatment of those who have undergone FGM.

Citations

[i] Health (Regulation of Termination of Pregnancy) Act 2018
[ii] Section 12 of the 2018 act.
[iii] Section 9
[iv] Section 10
[v] Section 11
[vi] Section 22
[vii] Section 23
[viii] Section 7 of 2018 act required a review of the operation of the act within 3 years of its commencement.
[ix] O'Shea, Marie. February 2023. The Independent Review of the Operation of the Health (Regulation of Termination of Pregnancy) Act 2018 [Hereafter: the O'Shea report]
[x] UN CEDAW July 2025 Concluding observations on the eighth periodic report of Ireland; para 42(d) CEDAW/C/IRL/CO/8
[xi] Power S, Meaney S, O'Donoghue K. *Fetal medicine specialist experiences of providing a new service of termination of pregnancy for fatal fetal anomaly: a qualitative study*. BJOG 2020: page 3-4; Available at: https://doi.org/10.1111/1471-0528.16502.
[xii] O'Shea report. Op cit. Section 8.3, p.62
[xiii] Conlon et al. July 2022. The Unplanned Pregnancy and Abortion Care Study: http://hdl.handle.net/2262/101813
[xiv] O'Shea report. Op cit. Section 8.3, p.62
[xv] O'Shea report. Op cit. Section 1.2, p.22
[xvi] McCullough, D. (2026) 'One woman's story of facing a fatal foetal anomaly in pregnancy', *RTÉ Radio 1*. RTÉ. https://www.rte.ie/radio/radio1/clips/22589206/.
[xvii] Finn, C. (2026) *Taoiseach commits to Examining Review into Ireland's abortion law three years after publication*, *TheJournal.ie*. Available at: https://www.thejournal.ie/irelands-abortion-law-review-6975218-Mar2026/.
[xviii] Word Health Organisation. 2023. Abortion care guideline, 2nd ed, page 8
[xix] Annex 1: Briefing on the IFPA Mandatory Waiting Period Research 2021-24
[xx] Section 22 of the 2018 act. This term is used in the legislation and by the WHO. However, the IFPA prefers the terms "refusal of care based on personnel beliefs."
[xxi] O'Shea report, op. cit. s.12
[xxii] The O'Shea report notes that not all countries permit conscientious in provision of abortion care, e.g. Sweden, Finland, Iceland, Czech Republic.
[xxiii] Irish Medical Council. 2024. Guide to Professional Conduct & Ethics for Registered Medical Practitioners (9th edition) https://www.medicalcouncil.ie/news-and-publications/publications/guide-to-professional-conduct-and-ethics-for-registered-medical-practitioners-2024.pdf

[xxiv] WHO op. cit. page 10
[xxv] Insert ref to IFPA annual report
[xxvi] Response to a parliamentary question October 2024:
https://www.oireachtas.ie/en/debates/question/2024-10-17/328/
[xxvii] Section 9, 2018 act
[xxviii] Section 11, 2018 act
[xxix] Section 5 of the Non-fatal Offences against the Person Act 1997: causing serious harm, carries a similar maximum sentence to s.23 of the 2018 act.
[xxx] CEDAW op. cit. para 40 (b)
[xxxi] CEDAW op. cit. para 36 (c)
[xxxii] Department of Health. 2025. National Sexual Health Strategy 2025-2035
[xxxiii] IFPA annual report, op. cit. page 14
[xxxiv] UN CEDAW July 2025 Concluding observations on the eighth periodic report of Ireland (para 26 e) CEDAW/C/IRL/CO/8