Every Woman

Towards Reproductive Health, Choice and Care for All

nwc

National Women's Council

Reproductive health matters at all stages of our lives. It begins before adolescence with sexual health education and continues beyond the years of reproduction with post-reproductive services. Reproductive health is important for all individuals, couples and families in Ireland. We will all need support from reproductive services at some time in our lives.

Reproductive health means complete physical, mental and social wellbeing, not merely the absence of disease, in all matters relating to the reproductive system and to its functions and processes. It combines people's ability to have a satisfying and safe sex life, the capability to reproduce, the freedom to decide if, when and how often to bear children and overall physical health and wellbeing related to our reproductive systems.

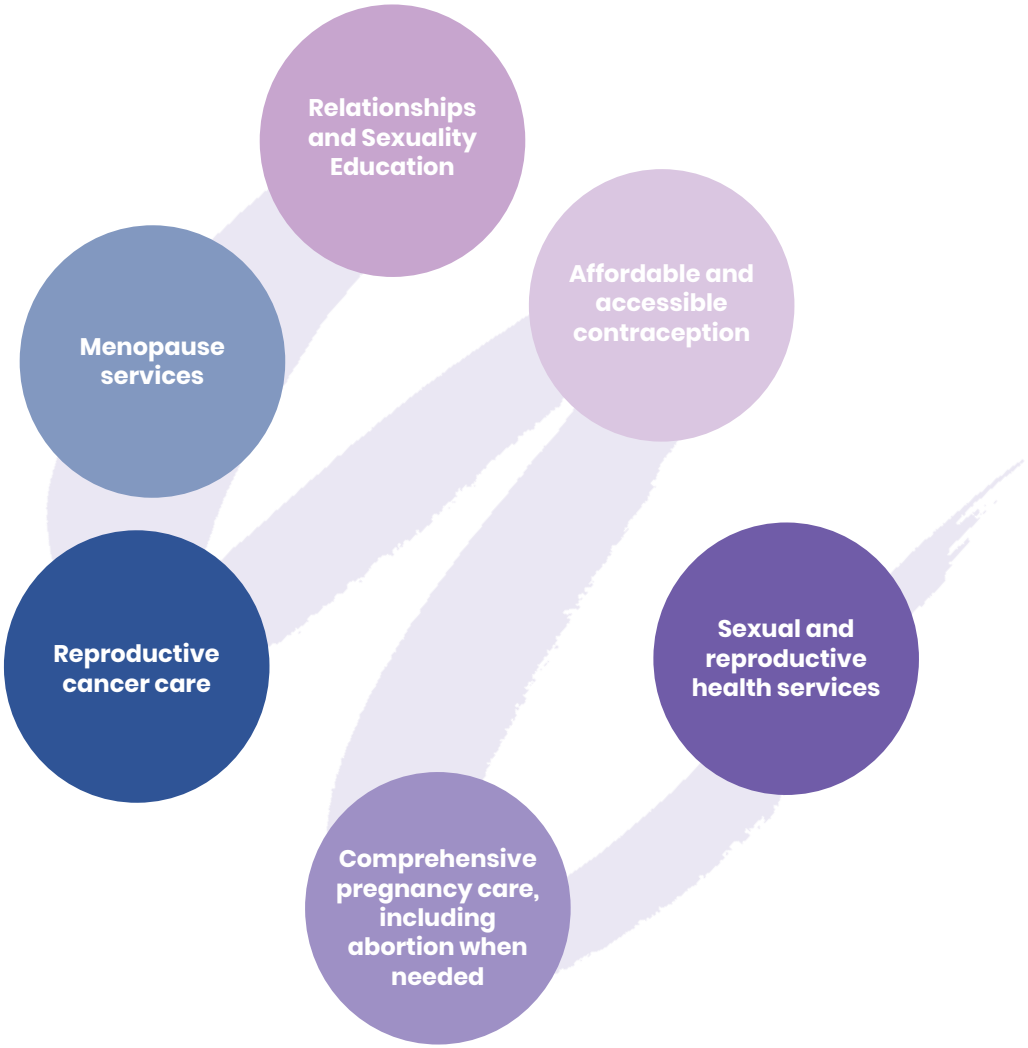
Ensuring a positive transformation in women's health and advancing women's reproductive rights is a priority for the National Women's Council (NWC) under our strategic plan, No Woman Left Behind. NWC's model of reproductive justice is based on the principle of bodily autonomy. Bodily autonomy is a human right, and one which relies on an enabling legal framework, as well as educational and healthcare supports. Structural barriers such as the two-tiered healthcare system, the absence of universal public childcare and limited transport networks, disproportionately disadvantage marginalised women including low-income women, disabled women and women of minority ethnicity, and this can mean some women do not have the same freedom to make decisions around their own bodies and futures. Our reproductive justice model recognises this inequality and is committed to challenging this.

The European Parliament has identified women's sexual and reproductive health rights (SRHR) as being a fundamental issue in *'the achievement of gender equality and the elimination of gender-based violence'* [1] and called upon Member States to ensure that sexual and reproductive health rights are upheld to the highest standard.

'Sexual and reproductive rights (SRR) are recognised as human rights in international and European human rights law and violations of SRHR constitute breaches of human rights.' [2]

European Parliament, Report on the situation of SRHR in the EU, 2022

We believe reproductive healthcare must be grounded in and responsive to the needs of diverse groups and all support must be non-judgmental, evidence-based, and person-centred. Schools, higher and further education, health services and other fora have a responsibility to ensure all women and girls can make informed decisions on sex and reproduction and they should always be seen as equal partners in their care journey. Income should never be a barrier to accessing gold-standard care.



NWC's Every Woman model for reproductive healthcare.

At NWC, we believe the key principles which should underpin all reproductive healthcare services are:

- **Private:** The confidentiality between the doctor and the patient must be protected. All decisions should be private, personal and confidential.
- **Accessible:** Care options should be publicly funded and available to all through the public health system.
- **Comprehensive:** Services should provide for all reproductive health needs of women and girls.
- **High quality:** Services must be evidence-based and comply with best medical practice, standards and safeguards.
- **Adequately funded:** Services should receive appropriate funding that ensures timely access.

Our Focus for 2022–2024

In 2017 the Report of the Joint Committee on the Eighth Amendment of the Constitution recommended enhanced abortion access, a thorough review of sexual health and relationships education and provision of free universal contraception.

Now that abortion has been legalised, we can work to expand and enhance abortion access and finally realise the ancillary recommendations on sexuality education and contraception. This is in keeping with the Government's commitment to advancing women's health, evidenced by the Women's Health Action Plan 2022-23.

The National Council for Curriculum and Assessment is currently developing new Social, Personal and Health Education (SPHE) and Relationships and Sexuality Education (RSE) curricula, the 17–25-year-old scheme of universal contraception has commenced, and we are in the middle of the Review of the operation of the Health (Regulation of Termination of Pregnancy) Act.

With these three areas of policy reform: abortion, contraception and relationships and sex education, we have a unique opportunity to enable reproductive justice for all women and people who mensturate.

Now is our moment to continue to redress years of secrecy and shame on sexuality and sexual and reproductive health, and to ensure all women and girls have the freedom to make decisions regarding their bodies and their lives.

Expanding Abortion Access

Current Context

Globally abortion is a common healthcare procedure: the WHO has highlighted that six out of ten unintended pregnancies and three out of ten of all pregnancies end in induced abortion.[3]

In Ireland, widened access to safe and legal abortion was only made possible due to the Repeal Referendum. It was a generation defining vote and the message was clear: all women should be able to receive care at home and, with the support of their doctors, make decisions regarding their health. The resounding success for the Yes campaign was a clear statement that no woman should be forced abroad for reproductive healthcare.

However, while constitutional change has enabled access to care in Ireland for many women and this is to be celebrated, there is much unfinished business.

Ongoing restrictions of the new legal framework mean that significant numbers of women and pregnant people continue to find themselves ineligible for care. Between 2019 and 2021, 775 Irish residents were forced to travel to the UK[4] and many others will have travelled to other jurisdictions or taken abortion pills without clinical oversight or support. Aside from the emotional and psychological effects of being denied care in your own country, travelling represents considerable costs for individuals. A survey of people travelling to the UK for abortion services found combined accommodation and travel costs for an individual person can exceed €1000, and the abortion procedure can cost upwards of upwards of €500.[5]

Travel for reproductive healthcare from Ireland is linked to the fact that abortion currently is only available:

- On request up to 12 weeks, with a three-day mandatory waiting period necessitating two GP consultations, as well as a gestational dating scan in some cases.
- After 12 weeks, it is only provided on the grounds of risk to health and fatal foetal anomalies.

Abortions are provided in the community through women's health clinics and GPs up to nine weeks and then in maternity hospitals after nine weeks. The first step to accessing abortion care is through the HSE's dedicated unplanned pregnancy support line My Options which provides the details of the nearest GP provider.

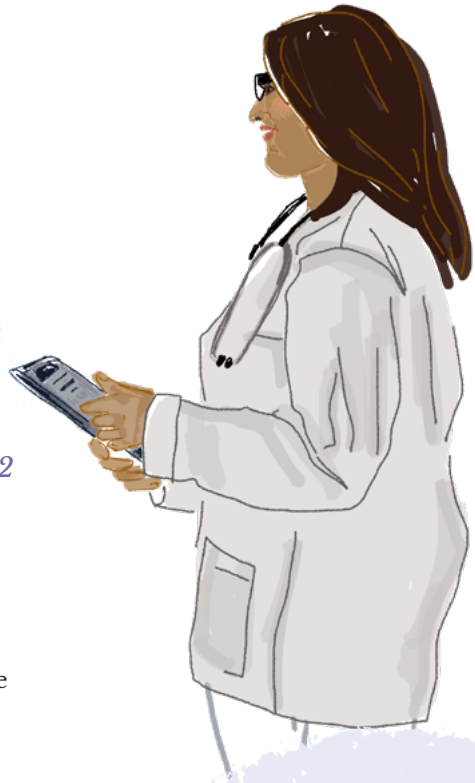
Individual practitioners retain the right to conscientiously object to provide, but they are obliged to refer the service-user on to a practitioner who does provide without delay.

In July 2022, following sustained civil society campaigning and cross-party political work, the Government introduced draft Safe Access Zones legislation and it is hoped that this will be in place around healthcare premises by end of 2023. Safe Access Zones are critically important for enabling healthcare access in dignity, ensuring that all patients, staff, and the wider community are protected from harassment and intimidation.

The Way Forward

Significant legal changes and practice improvements are required if our abortion law is to guarantee equitable, accessible and legal abortion for all women and pregnant people in need.

Instead of creating an enabling legal framework, the law acts as a gatekeeper creating a series of obstacles that prevent access to abortion, disproportionately affecting the most marginalised. This is in direct contrast to the new WHO abortion care guidelines which underline that



'states should take positive steps to secure an enabling regulatory and policy environment to ensure the universal availability, accessibility, acceptability and quality of abortion care.' [6]

WHO Abortion Care Guidelines, 2022

Under our law, anyone who aids or abets abortion outside the specific terms of the Act is liable for criminal prosecution, with a prison sentence of up to 14 years. This means health professionals, under the threat of prosecution, are essentially forced to police themselves, determining when and whether the statutory criteria for access to care have been met.

Using a criminal framework like this is not normative health policy and sets abortion apart from all other aspects of healthcare. The WHO strongly recommends decriminalisation to remove the chilling effect on healthcare providers and this was echoed by the European Parliament which on 9 June 2022 adopted a new resolution that

'urges the Member States to decriminalise abortion and remove and combat obstacles to safe and legal abortion and access to sexual and reproductive healthcare and services.'[7]

European Parliament Resolution 2022/2665, adopted 9 June 2022

Robust opinion data suggests that the Irish public agree - a nationally representative poll from February 2022 found that 71% supported decriminalisation, agreeing that abortion should be treated like any other medical procedure and should not be a matter for criminal law.[8]

Other aspects of our law which inhibit access to care and force women to travel include the 12-week gestational limit, the three-day mandatory wait and the narrow grounds-based approach to care after 12-weeks. The Unplanned Pregnancy and Abortion Care (UNPAC) Study, based on the lived experience of 58 women who accessed care since the enactment of the new legislation in 2019, highlighted criminalisation of service providers, failed medical abortion, the 28-day clause for fatal foetal mortalities and the 3-day wait as areas to consider in the ongoing Abortion Review.[9] The narrow qualifying criteria for access to care for fatal foetal anomalies was given particular attention, with the report underlining that it is causing significant anguish and distress for women. Participants felt that their circumstances had underpinned support for Repeal, yet on needing care, some were found to be ineligible and forced to travel.

Analysis of the UK and Irish abortion data suggests that the 28-day clause created a two-tier system whereby for every three women deemed eligible for care here, two are forced to travel to the UK.[10]

The UN Human Rights Committee has expressed concern over the restrictive nature of Section 11 of the Act which governs care on grounds of fatal foetal abnormality and recommended that Ireland *'take the necessary steps to remove existing barriers and ensure women with foetal abnormality conditions have adequate access to abortion services'*.[11]

Evidence-led legislative reform must be complemented by improved geographical coverage of abortion services. Just one in ten GPs are providing abortion care in the community and only eleven of our 19 maternity hospitals provide full services in line with the law. Outside of our cities the picture is poor, with half of all counties having less than ten GPs offering the service.[12] When we map GP provision against population density it appears that Mayo and Wexford, in particular, may be undersupplied.

Strong Public Mandate for Abortion Care.

The public mandate to provide abortion at home has consolidated and strengthened over time. Nationally representative public opinion data from February 2022 shows that support for access to care at home has increased since 2018.

80% agree no woman in Ireland should still have to travel abroad to access abortion care

71% agree abortion should be treated like any other medical procedure and should not be a matter for criminal law

79% agree doctors should be trusted to provide abortion care based on professional judgement and clinical best practice

85% agree all individuals accessing and providing abortion care should be protected from threats, harassment and abuse from anti-abortion protests

67% agree any person on the island of Ireland should be able to access abortion free of charge

Source: Opinions Market Research Omnibus Feb 2022, base: n=863, margin of error: +/-3.34%

Abortion services in Ireland

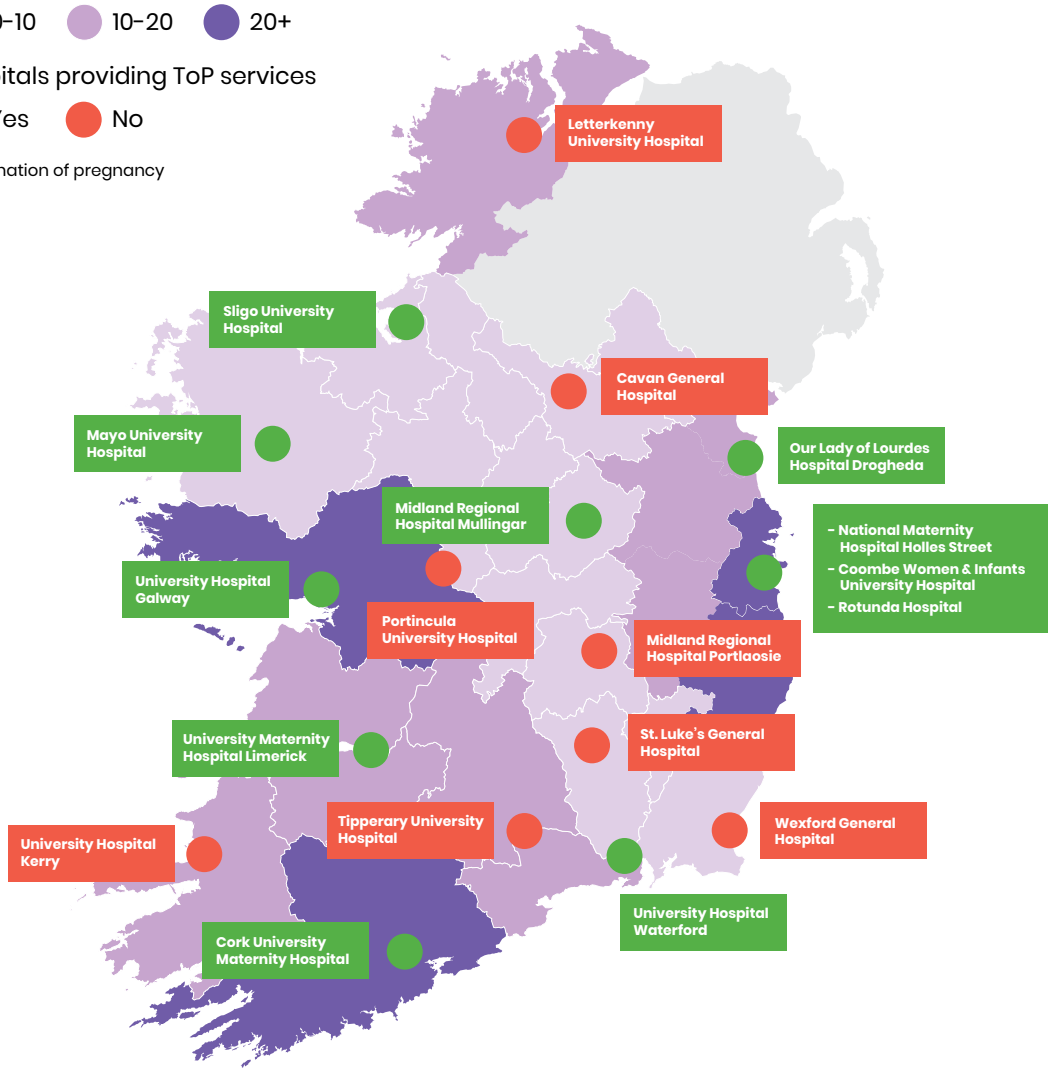
GPs contracted to provide ToP* services by country

0–10 10–20 20+

Hospitals providing ToP services

Yes No

*Termination of pregnancy



Source: HSE data provided to the National Women's Council, March 2022.

From working with healthcare providers in our Abortion Working Group, we know that some of the reasons for poor primary coverage are:[13]

- the lack of local maternity hospitals providing back-up support: GPs' ability to serve the needs of women locally requires a smooth referral pathway into hospital-based care
- the absence of Safe Access Zones to ensure all staff are guaranteed protection from harassment and abuse in providing healthcare to the community
- the ongoing criminalisation of abortion within our legal framework which has a significant chilling effect on healthcare providers.

The reality of poor coverage is an increased burden on service users, and this can make access to care within the tight 12-week timeframe all the more challenging. Research by Dr Lorraine Grimes and the Abortion Rights Campaign suggests service users are having to travel considerable distances - 30% of respondents reported travel of 4-6 hours to access abortion care. This is likely to have a disproportionate adverse effect on the disabled community, those simply reliant on public transport, those with child care and care-giving responsibilities, women in situations of domestic abuse who do not have freedom to leave the house, and lone parents without childcare.

In response to the demands of the COVID-19 pandemic on healthcare delivery, a telemedicine or remote access to abortion care was introduced and continues to be in place. This is evidence-based and in line with international standards and now forms part of our revised model of care.

Is Ireland's abortion law compliant with the 2022 WHO Guidelines?

Health (Regulation of Termination of Pregnancy) Act 2018	Recommendations from the WHO Abortion Care Guidelines, March 2022	WHO Remarks and Rationale
Section 23 It is a criminal offence for anyone to support access to or provide an abortion outside the scope of the law, carrying a sentence of up to 14 years.	**Recommendation 1** Recommend the full decriminalisation of abortion	Decriminalisation means removing abortion from all penal/criminal laws, not applying other criminal offences (e.g. murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors. Decriminalisation would ensure that anyone who has experienced pregnancy loss does not come under suspicion of illegal abortion when they seek care.
Section 12 Abortion is available up to 12 weeks on request.	**Recommendation 3** Recommend against laws that prohibit abortion based on gestational age limit.	The evidence demonstrates that gestational age limits, are "associated with increased rates of maternal mortality and poor health outcomes." Evidence shows that "adolescents, younger women, women living further from clinics, women who need to travel for abortion, women with lower educational attainment, women facing financial hardship and unemployed women" are disproportionately harmed by gestational age limits.
Section 12 There is a 3-day mandatory waiting period for access to care under 12 weeks	**Recommendation 6** Recommend against mandatory waiting periods for abortion.	Evidence does not establish any benefits of mandatory waiting periods. It shows that such waiting periods delay access to abortion, sometimes to the extent that available abortion methods are restricted. Mandatory waiting periods may result in the continuation of pregnancy, "especially among women with fewer resources, adolescents, younger women, those from racial or ethnic minorities and those who need to travel further for an abortion.
Sections 9–11 After 12 weeks, abortion is only available on the grounds of fatal foetal anomalies and risk to maternal life and health	**Recommendation 2** Recommend against laws and other regulations that restrict abortion by grounds. Recommend that abortion be available on the request of the woman, girl or other pregnant person.	Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person.
Section 22 Medical practitioners are not obliged to carry out abortions if they object due to their personal beliefs, known as conscientious objection.	**Recommendation 22** Recommend that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection	Conscientious objection continues to operate as a barrier to access to quality abortion care. It is critical that States ensure compliance with regulations and design/organise health systems to ensure access to and continuity of quality abortion care.

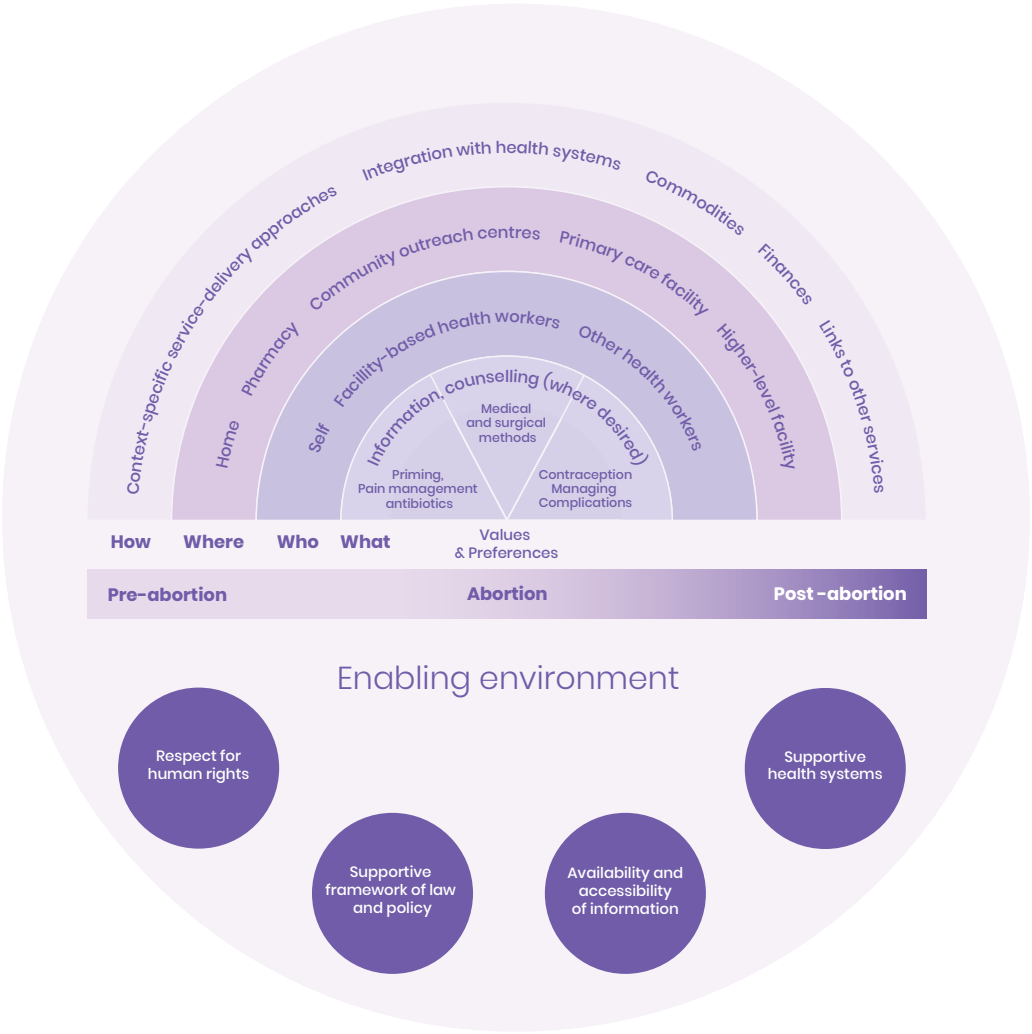


Figure: Conceptual framework of the WHO Abortion Care guideline, March 2022.

Recommendations

— To address legal barriers to access, we need:

- Full decriminalisation of abortion so doctors can provide care based on clinical judgement and professional expertise
- Removal of the 3-day mandatory wait and review of the 12-week gestational limit so abortion is accessible to all on request
- Removal of the 28-day mortality clause for fatal foetal anomalies so compassionate care can be provided at home in Ireland

These changes are all in line with the 2022 WHO guidelines on abortion, the gold standard in clinical best practice and medical evidence.

— To address regional barriers to access, we need:

- Early medical abortion to be understood as a core part of primary care, with additional HSE resources deployed as required.
- Maternity hospitals to be mandated to provide the service in line with the law. Where necessary, new medical appointments should be fast-tracked to address any gaps in service provision and the necessary resources should be made available to address infrastructural challenges.
- All healthcare staff working in primary and hospital settings should be supported to come on board through provision of comprehensive training in abortion care, beginning in undergraduate, and access to continuous professional development and values clarification workshops in the workplace.
- Safe Access Zones legislation to be enacted to give healthcare staff assurance that in stepping up to provide a vital service they will be protected from harassment or intimidation

For a full list of recommendations: see our Abortion Working Group's submission to the Abortion Review.

Delivering Universal Free Contraception

Current Context

Universal free contraception is a public health initiative with transformative potential. It is fundamental to reproductive health and rights and critical for achieving gender equality, reducing poverty, protecting against adverse health conditions and prevention of unplanned pregnancies. Different forms of contraceptives can also form part of the management and treatment of medical conditions such as polycystic ovary syndrome (PCOS) or endometriosis.

In Budget 2022, in a landmark decision, Minister for Health Stephen Donnelly began the introduction of universal free contraception starting with the 17-25 age cohort. The law was amended to enable the free scheme to be introduced from September 2022 and roll-out is through the GP and women's health clinic network. This progress was built upon in Budget 2023 with additional investment to extend the age cohort to 16-30 year olds, in line with the Programme for Government commitment to a 'phased' roll-out of universal free contraception.

Minister Donnelly committed during debate on the Health (Miscellaneous Provisions) Act in July to examine legal change to ensure that under 17s can also access free contraception in the Autumn of 2022 and this will require legal advice. Extension of the scheme to older age cohorts will be straightforward and can be delivered through regulation and investment in future budgets.

The public contraception scheme challenges the culture of silence and helps shift the dial from individual onus to collective responsibility. It is a clear recognition by the State that contraception is fundamental to reproductive rights and the full realisation of gender equality and requires Government investment and support.

The Way Forward

The ability to choose if or when to have children is a core bodily autonomy issue, forms part of basic healthcare, and is not a radical proposal. We need sustained investment and political commitment to ensure women of all ages can benefit.

An examination of the legal changes to enable young women under the age of consent to access the scheme will be necessary. Provision of free contraception with appropriate medical support is a public health intervention which, alongside robust relationships and sex education, mitigates the risk of teenagers facing a crisis pregnancy or sexually transmitted infection. In England, where the age of sexual consent is 16, GPs are still able to provide free contraception to teenagers under this age provided strict guidelines are followed, there are no safeguarding concerns, and where it is clinically appropriate.[14] This approach suggests that it is possible to retain a legal age of sexual consent, while also ensuring that teenagers in need are able to access appropriate medical support.

Similarly, we must see scheme extension to older age-ranges. Risk of unplanned pregnancy does not end at 30 and with the significant rise in living costs,[15] and 40% of lone parents currently experiencing difficulty making ends meet,[16] there is an urgent need to ensure that older women are not priced out of the most effective forms of contraception such as Long Acting Reversible Contraceptives (LARCs) which require a significant upfront investment.

Research by the Dublin Well Woman Centre found cost and accessibility of contraception remain relatively constant drivers of choice across the age ranges, demonstrating that these barriers are not specific to younger women.[17] International evidence indicates those with fewer resources often use contraception inconsistently[18] or don't use the most effective method of contraception because they cannot afford it.[19] Research with a sample of young women in Ireland has also indicated that when the cost barrier is removed, women would change contraception type, with many stating a preference for LARCs.[20]

Recent analysis of data from the abortion care roll-out based on 475 women service-users, the majority of whom were over 25, found that two-thirds were not using contraception.[21]

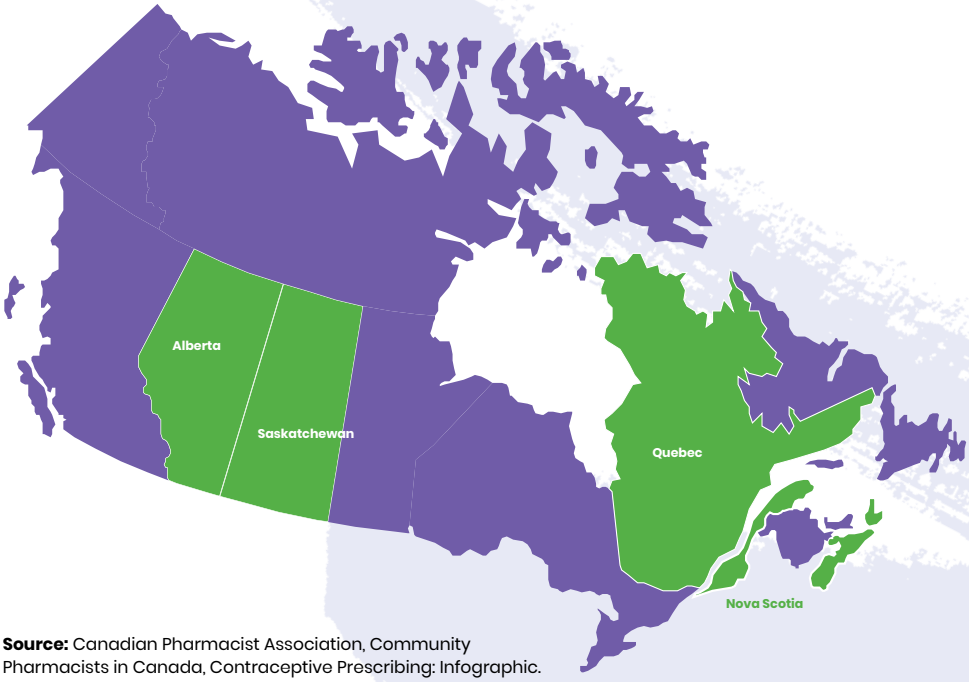
Additionally, almost one fifth of pregnancies in 26 to 35 year-olds are reported as crisis pregnancies according to HSE research.[22] This underlines the urgent need to remove barriers to contraception for older age cohorts to improve take up and reduce risk of unplanned pregnancy.

Research also shows high levels of misunderstanding and misconceptions about contraception. Investment in universal contraception must be matched by a comprehensive information campaign to dispel myths and which is tailored to diverse target age range.

Finally, in keeping with the reproductive justice model, we must also examine accessibility and health equity. Accessibility of contraception[23] was identified as a significant issue in the Report of the Working Group on Access to Contraception in 2019[24] and the biggest barrier to contraception identified by service users was a lack of access to services in their locality. Barriers to access stemmed not only from issues in geographical coverage, but also arose from wait-times for appointments and limited or inflexible opening hours of services. Related to this, it is worth noting that not all GPs are able to provide LARCs, with GPs reporting a lack of the appropriate skills or training required for LARC insertion procedures.[25]

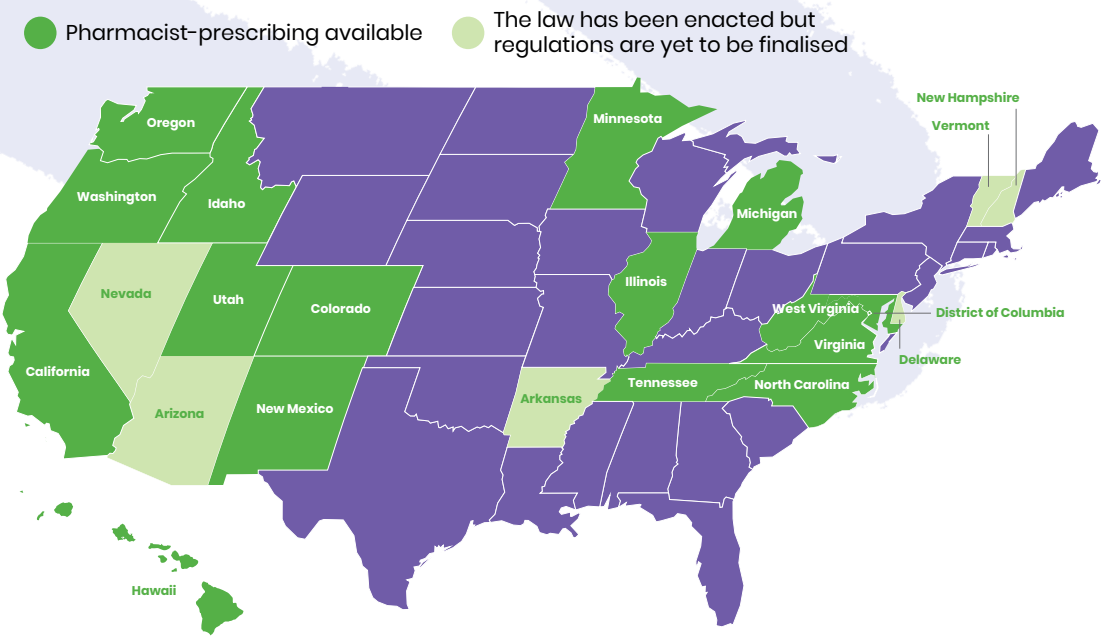
An important measure which could promote access to contraception is reclassification of oral contraception to over-the-counter use for adult women. Pharmacist prescribing is supported by the 2019 WHO guidelines which note that medical eligibility screening by pharmacists can reduce risk and safeguard service-users.[26] This has already been safely introduced in other countries such as the US and Canada. Policy analysts writing in the WHO Bulletin have noted *'increasing access by establishing sound, affordable and effective regulation of over-the-counter contraceptives could help reduce unintended pregnancies and improve maternal health'*.[27]

Pharmacist contraceptive prescribing across Canada



Source: Canadian Pharmacist Association, Community Pharmacists in Canada, Contraceptive Prescribing: Infographic.

Pharmacist contraceptive prescribing across the US



Source: Guttmacher Institute, Pharmacist Prescribed Contraceptives: State Laws and Policies, September 2022

Use of our pharmacist network as well as our GPs could help to ensure we reach all women and people who menstruate and enable equal access to reproductive healthcare.

How much would universal contraception save the State?

Unplanned pregnancies carry significant costs to the individual, but also to the State.

In 2018, Public Health England (PHE) undertook a robust cost-benefit analysis to estimate the Return on Investment (ROI) for publicly funded contraception in England using the latest available evidence and data.

The study population was women of child-bearing age (15 to 44 years old) in England and the economic analysis focussed on determining the number of pregnancies each year that are averted as a result of universal contraception and estimating the direct and indirect costs to the State if these were not adverted. The analysis included a time horizon of one year, five years and ten years, and found a significant ROI on publicly funded contraception: £9 for every £1 invested over 10 years. From a healthcare perspective, the ROI is £1.51 for every £1 spent after one year, reflecting the high savings from averted unplanned pregnancy and birth costs.

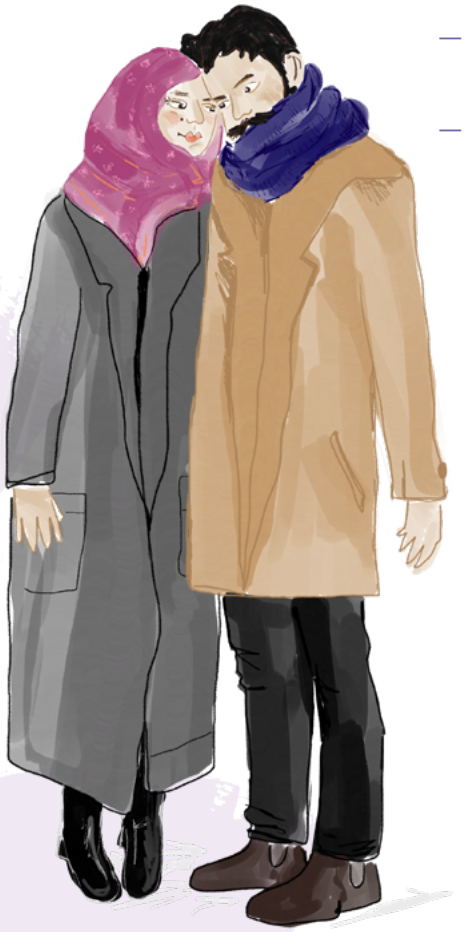
The economic model included healthcare costs such as birth costs, abortion costs, miscarriage costs, ongoing child health care costs, and the non-healthcare costs included education costs, welfare costs, children in care costs, housing support etc.

Source: *Public Health England (2018) Contraception: Economic Analysis Estimation of the Return on Investment (ROI) for publicly funded contraception in England*

Recommendations

To ensure all women and people who menstruate have real contraceptive choice and bodily autonomy, we need to:

- Extend universal, free contraception so women have meaningful choice and access to the most effective forms with investment in Budget 2024 and 2025 to ensure universal coverage by the end of this Government term.
- Ensure that adolescents have access to the scheme through their GPs using appropriate safeguards; consideration should be given to adapting the existing NHS England model of free contraception provision to under 16s, which uses the Fraser guidelines and Gillick competence test, to the Irish context.
- Invest in additional GP training and support on fitting and aftercare for Long Acting Reversible Contraceptives
- Review current classification of oral contraceptives to enable pharmacist prescribing for adults. Pharmacists should receive appropriate training and be required to outline the pros and cons of all forms of contraceptives including Long Acting Reversible Contraceptives to support service-user knowledge and informed shared-decision making. Use of medical screening tools as per WHO guidelines should also be mandatory.
- Support telemedicine for contraceptive consultations to broaden reach and increase uptake
- Develop a nationwide public information campaign to promote awareness and uptake of the extended scheme
- Include information on the effectiveness and suitability of all forms of contraceptives on the updated objective sexuality education curriculum in secondary schools.



Developing Comprehensive Relationships and Sexuality Education

Current Context

Relationship and sexuality education (RSE) is a vital source of information about sexuality, sexual health and healthy relationships and helps young people when making safer future sexual health decisions, such as when to initiate sex and protecting themselves against STIs. It is also core to establishing gender equality norms in personal relationships. Comprehensive relationships and sexuality education focuses on delivering evidence-based and age-appropriate information, while also providing a crucial opportunity to enable children and young people to develop life skills as well as foster positive attitudes and beliefs.[28]

Schools are typically reflective of the dominant social norms around gender and gender stereotypes.[29] The role parents and carers play in supporting RSE at home is of great importance, nonetheless the provision of incremental, inclusive and objective sexuality education in schools from an early age also minimises the possibility of children and young people being vulnerable to conflicting and damaging information from their peers, the internet or other sources[30]

> 'The need for full access to CSE (comprehensive sex education) in all primary and secondary schools is now most urgent than ever as there is growing misinformation surrounding sexual and reproductive health and rights (SRHR)'[31]
>
> *European Parliament, 2022, Report on the situation of SRHR in the EU*

The National Council for Curriculum and Assessment (NCCA) has begun work on updating the primary school, junior cycle and senior cycle Social, Personal and Health Education (SPHE) and RSE curriculums. The new curricula will be rolled out for junior cycle on September 2023, senior cycle in September 2024 and primary school in 2025.

The Citizens' Assembly on Gender Equality (2021) recommended that all school curriculum reviews should:

a. Promote gender equality and diversity

b. Explicitly cover gender power dynamics, consent and domestic, sexual and gender-based violence – both online and offline – within the revised Relationships and Sexuality curriculum.[32]

Redevelopment of the curricula has also coincided with the publication of the Third National Strategy on Domestic, Sexual and Gender-Based Violence (DSGBV). One of the key actions under the Strategy is overhaul of the relationships and sexuality education curricula in schools. This is an essential intervention in the prevention of gender-based violence. Good quality relationships and sexuality education enables children and young people to recognise and identify harmful to abusive behaviour and make disclosures of abuse. It also allows students to critically engage with some of the harmful norms which lead to violence against women and girls.

The Strategy contains several actions relating to schools under the prevention pillar, including actions on education and referral information for teachers. The plan commits to implementing these actions alongside interventions in schools to address and challenge male violence and crucially recognises the importance of this work being supported by a whole of school approach to enable schools to be free from gender-based violence. The plan also includes a commitment to delivering awareness and education programmes to young people who are no longer in school, are in informal education settings and/or are in state care.

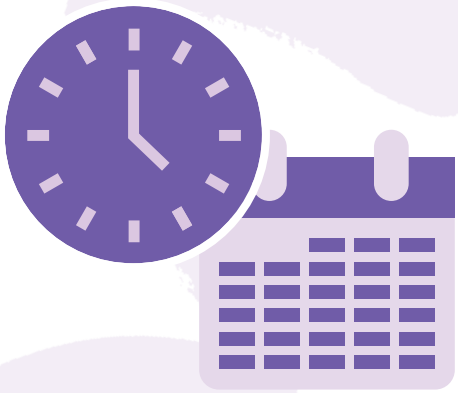
The Way Forward

The Government has a responsibility to uphold the rights of children by supporting the provision of comprehensive sex education for all students. Ireland has ratified the Convention on the Rights of the Child and this includes the right of the child to health (Article 24) and the rights to protection from sexual exploitation and abuse (Articles 34 and 35). Article 19 upholds the State as being responsible for taking all appropriate educational measures to protect the child from *'physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse'*.[33]

The UN Committee on the Rights of the Child has recognised *'severe lack of access to sexual and reproductive health education'* [34] in Ireland and recommended a more comprehensive provision of relationships and sexuality education for adolescents.[35]

To facilitate this, comprehensive relationships and sexuality education should begin and be developed and built on each year within the educational environment. The WHO recognises that informal sexuality education already begins at an early age when children start to learn about their own bodies and the differences in people's bodies.[36] All schools regardless of religious ethos or fee-paying status have a responsibility to support this and standardise learning for all young people. It is critical that the emotional, physical and social changes which accompany puberty are discussed and age-appropriate and accurate information on sexuality and reproductive health is provided. This information should account for gender equality. As part of this, myths around different contraception types should be dispelled, and students should be supported to understand that there are choices with regard to pregnancy, with information on all options, including abortion care considered.

Key to this will be ensuring that relationships and sexuality education is delivered objectively and independent from the religious ethos of schools. Currently, Boards of Management develop school policies on relationships and sexuality education and they must uphold the ethos of the school.[37] In addition, teachers are legally obliged to uphold the ethos of the school under Section 37(1) of the Employment Equality Act. The UN Human Rights Committee has raised concerns about this and recommended amending the Act in a way that bars all forms of discrimination in employment in the fields of education and health. The State is requested to provide information on the implementation of this recommendation by July 2025.[38]



In addition to developing young people's knowledge of reproductive health,

the new curriculum is an important opportunity to present sexuality in a positive way, teaching children and young people how to develop relationships based on consent, mutual respect and equality.

There is a real opportunity to challenge the detrimental impact of pornography, cyberviolence, and intimate image abuse on young peoples' conception of gender equality and consent, as well as the harmful messages children and young people receive in the media which can distort understandings of what a mutually respectful and fulfilling relationship is.

One of the core objectives of relationships and sexuality education is prevention of sexual violence, exploitation and abuse,[39] in addition to supporting disclosure of experiences of abuse.[40] This overarching aim must be reflected in our curriculum re-development process.

In Ireland, 26% of women have experienced physical or sexual violence since the age of 15[41]

- SPHE network (2018)

and women with disabilities are four times more likely to experience sexual violence.[42] Gender-based violence is associated with an increase in the likelihood of teenage pregnancy and sexual health problems, early school leaving, physical and mental health difficulties and post-traumatic stress symptoms.[43] The Committee on the Rights of the Child has recommended Ireland take measures to raise awareness of and foster responsible sexual behaviour, with particular attention to boys and men[44] and this should be a key consideration in the curriculum update.

Sexuality education which is only delivered through a single programme is insufficient to prevent gender-based violence. In order for sexuality education to be effective, it must be embedded objectively across the school to ensure students are hearing consistent information across different sources. Programmes that link sexuality education in schools with community youth services are particularly important for reaching marginalised young people, including those who are not in school.[45]

Good sexuality education requires thorough teacher education for all teachers across the education system. This must be standardised to ensure equitable delivery of sexuality education across all schools, regardless of whether they are privately owned or State-funded. The recent TEACH-RSE study is the first of its kind in Ireland to explore teacher professional learning and development regarding sexuality education. 62% of student teachers who took part in the survey for this study indicated that their perceived preparation to teach sexuality education during their teacher education was 'Worse' (34%) or 'Much Worse' (28%) when compared to training in other subject areas[46].

Six in ten student teachers say their training for RSE was worse than in other subject areas.

Source: Teach-RSE study 2021

Studies have found that inclusion of sexuality education training within teacher education colleges bolstered teachers' confidence in providing sexuality education.[47] In addition, teacher education which includes critical self-reflection on one's own belief systems and experiences in society can support teachers to understand how social norms influence identity and behaviour. This has been identified as a gap within existing teacher education programmes as well as practical teaching experience of sexuality education topics.[48]

Young women's experience of intimate relationship abuse

3 in 5 young people have experienced, or know someone who has experienced, intimate relationship abuse

71% agree abortion should be treated like any other medical procedure and should not be a matter for criminal law

51% of young women affected experienced the abuse under the age of 18.

Of the young women who had suffered abuse, 1 in 2 experienced online abuse

1 in 3 young women never spoke to anyone about the abuse they experienced.

Source: *Women's Aid (2022) Too Into You Campaign Research*

How can we make the new RSE and SPHE curricula a success?

Essential building blocks	How does the evidence support this?
Focus on prevention of gender-based violence	
Sexuality education must be designed and delivered with the key objective of prevention of gender-based violence and abuse and providing the opportunity for disclosures of abuse.	A systematic review of school-based education programmes for the prevention of child sexual abuse found that those who received education on sexual abuse were more knowledgeable about it, more likely to report and make disclosures of abuse and less likely to engage in self-blame.[49] Research suggests that introducing concepts related to gender identity and gender norms from an early age has the potential to prevent harmful gender stereotypes.[50]
Champion positive sexuality and reproductive rights	
Presenting sexuality in a positive light and teaching students about sexual health in an age-appropriate way, including provision of information on contraception and abortion.	Evidence shows that sexuality education does not increase sexual activity, sexual risk-taking behaviour or STI/HIV infection rates.[51]
Equip teachers with the necessary knowledge and skills	
Teachers who are confident and trained in presenting all topics covered in the curriculum requires sufficient initial teacher training and ongoing professional development.	A study in Finland showed that effective sexuality education was successful due to the motivation, attitudes and skills of teachers, and the ability to employ participatory teaching techniques.[52]
Guarantee objective delivery, unfiltered by religious ethos	
Sexuality education must be implemented according to the programme and without influence from the religious ethos of the school to ensure equitable provision for all students.	UNESCO highlights the importance of remaining true to the programme to ensure the success of relationships and sexuality education. Deviations from the programme can result in an asymmetry between students' learning outcomes and undermine the prevention of abuse and gender-based violence.
Provide dedicated, regular, time-tabled lessons	
The duration and intensity of sexuality education is a critical factor in how effective it is. Adequate time and space to teach sexuality education must be allocated to increase its efficacy.[53]	UNESCO has recommended a spiral-curriculum approach which includes timetabled lessons and highlighted that programmes that offer 12 or more 50-minute sessions, and sometimes 30 or more sessions, have shown positive results.
Integrate topics in a whole-school approach which is linked to community interventions	
It is essential that sexuality education does not take place in isolation and must be embedded in a whole of school approach. This must be linked to the broader social context by implementing community interventions.	UNESCO has stated that sexuality education in schools is most impactful when implemented as part of multi-component interventions, such as linking programmes in schools with community-based services for children and young people.

Recommendations

To develop comprehensive RSE which prioritises mutually respectful and fulfilling relationships, sexual health & well-being and the prevention of gender-based violence across primary and secondary schools we must:

- Ensure that comprehensive, age-appropriate, gender-sensitive relationships and sexuality education that is inclusive of the experiences of marginalised young women and girls is embedded across all curricula and school policies as part of a whole-school approach.
- Include topics on gender stereotypes, intimate partner abuse, positive body image, understanding female anatomy, consent, positive sexuality and healthy relationships, social media, the harms of pornography and reproductive health through the life cycle in the new SPHE and RSE curriculum. This should be assessed by continuous learning and treated with equal importance as core subjects.
- Ensure that relationships and sexuality education is delivered objectively and without influence from the religious ethos of the school by amending Section 37 (1) b of the Employment Equality Act in a way that bars discrimination in employment in the field of education and 15-2(b) of the Education Act to remove the requirement for Boards of Management to legally uphold the religious ethos of the school when developing RSE policies
- Include comprehensive training on sexuality education in initial teacher training for all teachers and ensure resources are available to facilitate continuous professional development so that teacher education is not treated as a one-off event. Existing training resources must be updated to reflect the new SPHE and RSE curriculums for primary school, junior cycle and senior cycle.
- Invest in community-based programmes for young people which integrate relationships and sexuality education for children and young people who are not in school.
- Enhance cross-departmental and inter-agency collaboration to ensure relationships and sexuality education is embedded across the wider education system and community programmes.
- Strengthen the links between school and home by providing parents, carers or guardians with information on the contents of the sexuality education programme including resources used by schools, in order to support them in continuing the conversation at home.

Conclusion

Great strides have been made in achieving reproductive rights for women in Ireland in recent years. The success of Repeal has led to thousands of women being able to access abortion care at home after years of secrecy and shame. This was followed by the introduction of free contraception beginning with 17-25 year olds which marks an important step towards gender equality. The success of these programmes will be supported by an up-to-date and modern sexuality education programme in schools.

Government commitment to women's health and wellbeing is notable through the Women's Health Action Plan and the comprehensive Third National Strategy on Domestic, Sexual and Gender-Based Violence.

These are achievements which should be celebrated. However, this is a crucial time to build upon these advances. All three policy areas of contraception, abortion and relationships and sexuality education, should be considered as key components of an integrated model for reproductive health which is grounded in bodily autonomy for all women and girls.

Ongoing barriers to abortion mean that women are still traveling to access abortion care. To address this, an enabling legal framework which is complemented by practice improvements is required to increase accessibility of abortion services. The ongoing Abortion Review is a unique and critical opportunity to achieve this. Research suggests that some abortion service users are not using contraception and rates of unintended pregnancies remain high. The cost of contraception has been prohibitively high for many. It is therefore essential that we expand the universal free contraception scheme to reduce the number of unintended and crisis pregnancies and enable all women to access the type of contraception which works for them without concern of cost.

Universal access to quality reproductive health services must be built on a foundation of comprehensive sexuality education to all children and young people to provide them with the right tools to make choices about their own reproductive health. A modern curriculum which recognises and responds to the pressures young people are facing is also a key part of a public health approach to supporting the development of mutually respectful and fulfilling relationships, sexual health & wellbeing and the prevention of gender-based violence.

NWC's model for reproductive healthcare is grounded in the complexity and diversity of women's lives and ultimately seeks to ensure all women have choices. We need an integrated model to safeguard and promote women's health at every life stage and ensure all women have control and autonomy over their own lives. We must ensure that women have the requisite information and access to care from adolescence onwards and that they are treated as equal partners in the delivery of their healthcare.

Women's reproductive rights can only be fulfilled if these key areas of relationships and sexuality eductaion, contraception and abortion are understood as being interconnected and interdependent. It is therefore essential that responsibility for this is supported by cross-departmental cooperation. We are at a critical juncture in the advancements to improve these areas and ensure inclusive policies for all women. It is vital that we act upon this opportunity for change and achieve a rights-based model for reproductive healthcare. We cannot do this alone. We seek your support for advancing reproductive and sexual health education and services for women and girls in Ireland.

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Acknowledgements

We gratefully acknowledge the funding provided by HSE Health and Wellbeing which enabled us to undertake this work.

We also acknowledge the work of Fay White, NWC Women's Health Officer and Alana Ryan, NWC Women's Health Coordinator in the development and production of this pamphlet.

October 2022

Be a champion for women's reproductive and sexual health

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