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

Part 1: Your Details

Section B: For Organisations

Q2: What is the name of your organisation: the Abortion Working Group, convened by the National Women's Council

The Abortion Working Group is a group of civil society organisations and healthcare providers established in early 2019 and chaired by the National Women's Council of Ireland (NWC). The purpose of the Working Group is to provide a space for information sharing and collective advocacy for groups working to ensure safe access to abortion in Ireland.

This is a joint-submission from the following members of the Abortion Working Group: Abortion Access Campaign West, Abortion Rights Campaign; Abortion Support Network; Action for Choice; Alliance for Choice; Amnesty International Ireland; BelongTo; Cairde; Coalition to Repeal the Eighth Amendment; Disabled Women Ireland; Doctors for Choice; Dublin Well Woman Centre; Irish Council for Civil Liberties (ICCL); Inclusion Ireland; Lawyers for Choice; National Collective of Community Based Women's Networks (NCCWN); National Women's Council of Ireland; START Doctors (GP providers of medical abortion in the community); Transgender Equality Network Ireland (TENI); Termination for Medical Reasons; Together for Safety; Union of Students in Ireland (USI); Women's Aid.

Please tick the category that best describes your organisation: Advocacy Body/Special Interest Group
Is your organisation involved in the provision of termination of pregnancy services: Yes - some members of the group provide services.

What is the address of your organisation: National Women's Council, 100 North King Street Dublin 7.

Name and job title: Alana Ryan, Women's Health Coordinator, NWC

Part 2: Your Views

National Women's Council

Introduction

This review marks a critical juncture in progress towards realising the reproductive rights of all: it is a unique and essential opportunity to achieve better care for women and pregnant people.

We must be clear that the focus of this review is to improve our abortion services in line with the HSE's overarching strategic objectives and to bring them in line with WHO guidelines that seek to raise quality standards and provide measurably better and safer healthcare that is accessible to all.

A thorough review of the 'operation of the Act' as set out in Section 1,7 requires recognising and addressing not only aspects of current provision, but also the elements of the legal framework, which jeopardise the health and welfare of service users.

As a group of experts working to improve both access to and experience of reproductive healthcare in Ireland, we are collectively submitting this report as we believe that significant legal changes and practice improvements are required if the Termination of Pregnancy Act is to guarantee equitable, accessible and legal abortion for all women and pregnant people in need.

In the below submission we outline our shared concerns and recommendations. We are keen to work with you to deliver rights-based and women and pregnant person-centred abortion reforms.

Q3(a). To what extent do you agree that the Health (Regulation of Termination of Pregnancy) Act 2018 has achieved what it set out to do?

Strongly Disagree
Somewhat Disagree
Neutral
Somewhat Agree
Strongly Agree

Q3(b). Please provide detail / evidence to support your answer

Please see response below.

Q4(a). Are there parts of the Act which, in your opinion, have not operated well?

Yes
No
Don't know

National Women's Council

Q4(b). If yes, please let us know which section(s) of the Act, and details of the issue(s) it is causing. Please provide detail / evidence to support your answer

1. **Section 23: Criminal Liability**

Section 23: The Act makes anyone who aids or abets abortion outside the specific terms of the Act liable for criminal prosecution. This significantly impacts ability to access and provide care, given that criminal liability carries a prison sentence of up to 14 years for abortions undertaken outside the regulations. While threat of criminalisation affects anyone supporting access to abortion care, it is doctors who are disproportionately impacted.

This sets abortion care apart from other forms of healthcare and suggests that doctors providing abortion care are in some way "inherently less conscientious than other professionals and that the usual regulatory mechanisms of (general) criminal and civil sanctions and professional/fitness to practise oversight are insufficient for these professionals".[1]

This means health professionals, under the threat of prosecution and criminalisation, are essentially forced to police themselves, determining when and whether the statutory criteria for access to care have been met. This criminalisation of healthcare has a chilling effect that undermines clinical judgement and professional expertise, as well as access to needed healthcare.

Recommendation: Decriminalise abortion to remove the chilling effect on doctors and ensure that they can use their clinical judgment to care for patients without fear of prosecution

2. **Section 12: the Mandatory Three-Day Wait**

There is no medical purpose or value to the three-day waiting period. This restriction impedes doctors' ability to provide urgent care when required while also placing additional emotional, logistical, and financial stress on women and pregnant people, particularly those facing additional structural barriers such as disabled people. In practice a three-day wait can become a five day wait if the service users first appointment occurs on a Wednesday and the GP surgery is not open over the weekend.

The World Health Organisation (WHO) has outlined that "[m]andatory waiting periods can have the effect of delaying care, which can jeopardize women's ability to access safe, legal abortion services and has underlined that "[o]nce the decision [to have an abortion] is made by the woman, abortion

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

should be provided as soon as is possible" and without delay. [2] Mandatory waiting periods also lead to discrimination and social inequities as they increase the costs of obtaining lawful abortion, for example through travel costs, particularly where disabled people need specialist transport, and childcare associated with the required additional visit. International human rights mechanisms and treaty monitoring bodies of treaties which Ireland has ratified have consistently criticised states for imposing "medically unnecessary waiting periods" and have called for their removal.[3]

Forcing a woman or pregnant person to wait for care also undermines individual agency and decision-making capacity. The WHO has made it clear that mandatory waiting periods "demean[] women as competent decision-makers" and specified that medically unnecessary waiting periods should be eliminated to "ensure that abortion care is delivered in a manner that respects women as decision-makers."[4]

Recommendation: Repeal the mandatory three days wait period to ensure timely access to abortion care in line with international best practice and to recognise women and pregnant people as competent decision-makers.

3. Section 12: the Twelve Weeks Gestational Limit

Abortion care, like all aspects of health care, should be decided in the context of a trusting and supportive doctor-patient relationship, whereby medical needs are met in line with clinical best practice and patient preferences. Rigid gestational time limits inhibit this model of care: the arbitrary nature of the time limit negates consideration of the complexity of personal circumstances and relevant medical evidence. It poses particular difficulty to women and girls who may be marginalised and who do not have ready access to information on abortion care and support in receiving this. For example, the 12-week limit poses particular difficulties for adolescents who face multiple additional barriers including lack of access of information.[5] The HSE's targeted teenage crisis pregnancy website still does not have information on how to access abortion.[6]

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[2] WHO Safe Abortion Guidance: Technical and Policy Guidance for Health Systems (2nd ed. 2012)96-97

[3] See for example, the Committee on the Elimination of Discrimination against Women, Concluding Observations: Hungary, paras. 30-31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); Russian Federation, paras. 35(b)-36, U.N. Doc. CEDAW/C/RUS/CO/8 (2015); Slovakia, paras. 30(c), 31(c), U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); Germany, paras. 37(b), 38(b), U.N. Doc. CEDAW/C/DEU/CO/7-8 (2017); Committee on Economic, Social and Cultural Rights, General Comment 22: The Right to Sexual and Reproductive Health (Art. 12), para. 41, U.N. Doc. E/C.12/GC/22 (2016).

[4] ibid

[5] See Clíodhna Ní Chéileachair, "*No Country for Young Girls: Adolescent Abortion under the Eighth Amendment and the Post–Repeal Landscape",* Kings Inns Law Review Volume V III, 2019.

[6] https://b4udecide.ie accessed on 17 November 2021 and 3 March 2022

It is very concerning that in cases of early medical abortion failure, where the service-user realises they are still pregnant, providers cannot provide further abortion support if the 12 weeks limit has been reached. This means that women who have taken abortion pills with clinical supervision in Ireland, cannot be given further pills in the instance of failed medical abortion and are forced to travel or continue with the pregnancy due to the strict 12-week legal limit.

There was a very narrow margin between members of the Citizens Assembly who recommended that the termination of pregnancy without restriction should be lawful up to 22 weeks (44%) and those who supported the 12 weeks limit (48%).[7] It is the view of this Group that if those same members were presented with the evidence of women and pregnant people's experience of care under the rigid gestational limit in force today, support for the 22 weeks limit would surpass support for 12 weeks.

It is important to remember that the evidence does not support the view that longer gestational limits mean more women and pregnant people accessing care at a later point. Data from England and Wales where the gestational limit is 24 weeks, shows that in 2020, 88% of abortions were performed under 10 weeks. During the same period, abortions performed at 10-12 weeks decreased from 9% in 2019 to 6% in 2020. The percentage performed at 20 weeks and over decreased from 2% in 2019 to 1% in 2020.[8]

Recommendation: Repeal the 12-weeks gestational limit and enable abortion on request up to viability to ensure that no woman or pregnant person is forced to travel abroad for essential reproductive healthcare.

4. Section 22: Lack of Monitoring of Conscience-based Refusal to Provide Care

The Health Act currently allows individual medical practitioners to refuse to provide abortion care on grounds of conscience, except in emergency circumstances such as immediate risk to life or serious harm to health, where they are obligated to provide care.

As a Group, we accept this provision in the Act, not least because women and pregnant people should be confident that they will receive abortion care without judgement, stigma or shame.

[7] First Report and Recommendations of the Citizens' Assembly THE EIGHTH AMENDMENT OF THE CONSTITUTION, 12

[8] UK National Statistics, Abortion statistics, England and Wales: 2020, section 4.9 https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2020/abortion-statistics-england-and-wales-2020

However, we are concerned that the very low number of providers in community and hospital settings is reflective of silent refusal which is not being monitored or recorded appropriately and which is impacting effective operation of the Act.

The Irish Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Professionals is clear that in cases of 'conscientious objection', patients should be informed they have a right to seek treatment elsewhere and doctors must facilitate the transfer of the patient to an alternative provider 'in a safe, effective and timely manner' which makes it 'as easy as possible for the patient'.[9] This is also the position of UN human rights treaty bodies which are clear that regulatory frameworks must include an obligation to refer onwards, with institutional refusal of care unacceptable.[10] The physical and mental suffering arising from refusal of care could amount to torture the UN Committee on Torture has found.[11]

Despite this, research by the Abortion Rights Campaign found that almost one in five survey respondents (19%) were refused care and refused a referral to another doctor (n=26).[12] Similarly, we know that almost three years into implementation, almost half of maternity hospitals have no abortion services, despite there being a positive obligation on publicly funded hospitals to provide this healthcare.

Ensuring that conscience-based refusal of care does not hinder access to essential reproductive health services requires a clear, legal and policy framework and this must be urgently developed. This framework must govern the practice of conscientious objection by healthcare providers with effective oversight. As outlined in para 16 this requires a robust data collection system which can

[9] Irish Medical Council, Guide to Professional Conduct and Ethics, (Amended) 8th edition 2019, para. 49, available at: https://www.medicalcouncil.ie/news-and-publications/reports/guide-to-professional-conduct-and-ethics-for-registered-medical-practitioners-amended-.pdf.

[10] See, e.g., CEDAW, General Recommendation No. 24: Article 12 of the Convention (Women and Health), para. 11, U.N. Doc. A/54/38/Rev.1, chap. I.; CEDAW, Concluding Observations: Hungary, para. 31(d), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); CRC, Concluding Observations: Slovakia, paras. 41(f), U.N. Doc. CRC/C/SVK/CO/3-5 (2016); Human Rights Committee, General Comment No. 36, para. 8, U.N. Doc. CCPR/C/GC/36 (2018); Committee on Economic, Social and Cultural Rights, General Comment No. 24, para. 21, U.N. Doc. E/C.12/GC/24 (2017); Human Rights Committee, Concluding Observations: Colombia, paras. 20, 21, U.N. Doc. CCPR/C/COL/CO/7 (2016).

[11] Committee against Torture, Concluding Observations: Poland, paras. 33(d), 34(e), U.N. Doc. CAT/C/POL/CO/7 (2019).

[12] Abortion Rights Campaign and Lorraine Grimes. Too Many Barriers: Experiences of Abortion in Ireland after Repeal. Sept. 2021.

then be used for enforcement. Service users should also be aware that complaints regarding individual doctors can be made to the Irish Medical Council.

Recommendation a: The Act should replace the phrase 'conscientious objection' with the more accurate 'conscience-based refusal to provide care' as the effect of this action is in essence refusing to provide a healthcare service, protected by law, to a patient

Recommendation b: The Act should replace the phrase "as soon as may be" to "immediately" and should include wording to the effect that care is transferred immediately to another provider who is not an objector and who is able to perform the procedure immediately. The transfer of care must be done in such a way that does not cause any additional geographic, financial, accessibility or temporal obstacles for a person seeking abortion services.

Recommendation c: The Act should be amended to include a clause which obliges all medical practitioners to preregister as an objector with reasons if they wish to refuse care, i.e. it should be an opt-in to refusal, rather than the status quo.

Recommendation d: The Act should be amended to include wording such that all medical practitioners must be obligated to record abortion requests, whether care was provided and where the service-user was referred onto in the case of conscience-based refusal of care. This should be monitored by the Irish Medical Council to ensure compliance and failures to adhere to guidelines around swift referrals should lead to sanctions.

5. Section 11: Termination for Medical Reasons

There are significant problems with access to abortion care post-12 weeks on the grounds of fatal foetal anomaly laid out in Section 11.

In Ireland, just 97 of a total of 6577 abortions provided in 2020 have been on the grounds of fatal foetal anomaly.[13] Since the Act was introduced in January 2019 the percentage of Irish women seeking abortion in the UK under Ground E of the Abortion Act 1967 ('That there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped') has increased substantially. It was initially 3% in 2018 but now accounts for 32% of all Irish residents who had to travel in 2020. It should be noted that Irish grounds allowing termination of pregnancy where fatal foetal abnormality has been detected have no direct comparison under UK

[13] Department of Health, Second Annual Report on Notifications in accordance with the Health (Regulation of Termination of Pregnancy) Act 2018, June 2021

law; while this means that we cannot give exact figures for those prevented from accessing abortion services in Ireland in this situation, our best sources of data indicate that people experiencing pregnancy with FFA diagnoses comprise a significant proportion of those accessing abortion under Ground E of the UK Abortion Act**.** Last year alone, 63 women and pregnant people travelled as they were not able to access care in Ireland, despite the risk to their health of travelling during a pandemic.[14] This suggests that for every three women who are able to access care at home, another two are forced to travel to the UK – we do not know how many more will have had to travel to other European countries.

These are women or pregnant people who made the decision to end a wanted pregnancy under very difficult circumstances and are then being let down by Irish legislation which has been found to be inconsistently applied, highly restrictive and in contravention of the UN Ruling on the Mellet V. Ireland and Whelan V. Ireland cases respectively. No such limit as "a condition affecting the foetus that is likely to lead to the death of the foetus either before, or within 28 days of, birth." was cited in the ruling.

The 28-day limit in Section 11 has led to a two-tier nature of abortion provision in which parents are in the unenviable position of hearing that their baby's condition is not fatal enough. The decision to end a wanted pregnancy is unnecessarily complicated and restricted by an arbitrary deadline by which the foetus must be expected to die, by an adversarial medical system, and a process that excludes the wishes or circumstances of the parents in this situation.

Recommendation: Repeal the 28-day limit and enable abortion on request up to viability to ensure that no woman or pregnant person is forced to travel abroad for essential reproductive healthcare.

6. Section 9: the Definition of Health

Another area which has not operated well is access to care post-12 weeks on the grounds of risk to health. In 2020, of the 6577 abortions provided, just 20 procedures were carried out due to a risk to life or health under the grounds set out in section 9 of the Act and only 5 due to a risk to life or health in an emergency situation under section 10.[15]

[14] UK National Statistics, Abortion statistics, England and Wales: 2020, https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2020/abortion-statistics-england-and-wales-2020

[15] Department of Health, Second Annual Report on Notifications in accordance with the Health (Regulation of Termination of Pregnancy) Act 2018, June 2021

This suggests that "risk to the life, or of serious harm to the health" is interpreted within a highly conservative framework that denies women or pregnant people a role in reproductive decision-making and prevents medical professions from exercising clinical judgement in the best interests of their patients.

When determining risk to health, medical professionals should be empowered to apply the WHO's definition of 'health' which is understood as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This would allow 'health' to be interpreted contextually and to take account of the person's wider circumstances and social wellbeing and would permit doctors to take account of the woman's or pregnant person's own assessment of relevant risks to their life/health, or of the severity of a foetal diagnosis.

Recommendation: Amend to the Act to define health using the World Health Organisation (WHO)'s definition: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

Q5(a). Are there parts of the Act which, in your opinion, have operated well? Yes

Q5(b). If yes, please let us know which section(s) of the Act, and details of how it has operated / its benefit(s). Please provide detail / evidence to support your answer.

7. Section 12 delivery through telemedicine

One aspect of the Act which has operated well is delivery of early medical abortions through telemedicine. Uneven geographical coverage underlines the need to continue to build and develop the telemedicine option for early medical abortions. We were pleased that Minister Donnelly recognised that the new model of remote consultation for abortion services was positive and committed to it being continued post-covid19.[16]

A robust body of international peer-reviewed research confirms that this is a safe and effective approach to health care that is highly acceptable to women who require abortion.[17] Emerging

[16] Stephen Donnelly TD, Minister for Health, Written Answers 13 July 2021 [28446/21]
[17] For example, see M. Endler, A. Lavelanet, A. Cleeve, B. Ganatra, R. Gomperts, K. Gemzell-Danielssona "Telemedicine for medical abortion: a systematic review" *BJOG: An International Journal of Obstetrics and Gynaecology.* 126 (9) 2019: 1194-1102. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.15684 and public health guidance Royal College of Obstetricians and Gynecologists (3 June 2020) Coronavirus (COVID-19) infection and abortion care – information for health professionals. Version 3.

evidence gathered since the Health (Regulation of the Termination of Pregnancy) Act 2018 took effect reinforce these findings, and clinicians have expressed hope that remote care can continue.[18] Data collected from Irish service users since 2019 highlights several advantages including not having to take time off work or education, perceived greater privacy, reduced risk of Covid19, as well as not having to arrange childcare or other care or incur transport costs.[19] It has been particularly welcomed by the disabled community who can face additional challenges attending in-person appointments. It is likely to also be particularly important for women experiencing domestic abuse who may not have the freedom to leave the house if they are being subjected to coercive control.

Going forward it is critical that women and pregnant people retain the option of remote consultation for early medical abortion if this is their preference and clinically appropriate. Consideration should also be given to amending the legal framework to enable the delivery of abortion pills by post as is available under the British Pregnancy Advice Service.[20] This would ensure that the service user does not face additional challenges to collect the pills from GPs or women's health clinics in instances where they have opted for fully remote consultation.

Recommendation: Maintain and enhance the telemedicine option for early abortion care so that all women and pregnant people can avail of remote consultation and pill delivery if this is their preference and clinically appropriate.

8. My Options, although challenges remain

MyOptions is the national free helpline where women and pregnant people looking for an abortion can call and receive the name and phone number to specific providers near them. The WHO research highlights that although some people are still unaware of this service, service users typically report positive experiences of MyOptions and service-providers consider it a well-functioning service.[21] Research by the Abortion Rights Campaign does however highlight that while participants

https://www.rcog.org.uk/globalassets/documents/guidelines/2020-06-03-coronavirus-covid-19-infection-and-abortion-care.pdf

[18] A. Mullaly, T. Horgan, M. Thompson, C. Conlon, B. Dempsey, M.F. Higgins, Working in the shadows, under the spotlight – Reflections on lessons learnt in the Republic of Ireland after the first 18 months of more liberal Abortion Care, Contraception (2020), doi: https://doi.org/10.1016/j.contraception. 2020.07.003

[19] Spillane A, Taylor M, Henchion C, Venables R, Conlon C. Early abortion care during the COVID-19 public health emergency in Ireland: implications for law, policy, and service delivery. *Int J Gynecol Obstetr*. 2021; 154(2): 379– 384

[20] See BPAS, Pills by Post – Abortion Pill treatment at home: https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/remote-treatment/ accessed 27 October 2021

[21] Mishtal, J., Duffy, D., Chavkin, W., Reeves, K., Chakravarty, D., Grimes, L., Stifani, B., Horgan, P., Murphy, M., Favier, M., and Lavelanet, A. 2021. "Policy Implementation – Access to Safe Abortion Services in Ireland

mostly commended the counsellors as supportive and non-judgemental, there were issues with some counsellors being rude or "cold".[22] This research also revealed that some service users had thought My Options would book appointments for them and faced challenges with non-providers when booking appointments directly.

NWC is also aware that service users who do not have a PPS number rely on the support of specialist NGOs working with the migrant community rather than being able to access PPS application support through My Options directly. Similarly, where women or pregnant people are almost at, or just over 12 weeks, and undocumented, there is no formal support with visa processes and women and pregnant people must again rely on the support of NGOs working with the migrant community if they have to travel to access care.

My Options currently provides translation services and offer interpreters for 240 different languages, as well as Irish Sign Language Interpretation, however its services are not yet fully accessible to all who need them; for example, Easy-to-Read information has yet to be provided and information available via the text-based service is restricted. The drive to develop an inclusive service is to be welcomed and progress could be built on by ensuring translators and ISL interpreters are continuously available to ensure the initial call is swiftly followed by a same-day call with an interpreter, expanding the text-based service and ensuring accessible versions of information are made available as a priority. Provision must also be made for women and pregnant people who have English as an additional language and who require care, but who do not feel comfortable asking a friend or family member to call My Options on their behalf.

Going forward, the service needs greater visibility if it is to reach all those in need of abortion, given significant numbers still do not know it is available or that abortion care is available on request to 12 weeks with no need to give a reason or explain this personal decision.

Recommendation a: Invest in nationwide promotion of MyOptions through traditional and digital media to ensure everyone knows this is the first step towards accessing abortion in Ireland.

Research Dissemination Report," April 23. UNDPUNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), Department of Sexual and Reproductive Health and Research, World Health Organization, 20 Avenue Appia, 1211 Geneva, Switzerland. Pp. 1-37

[22] Abortion Rights Campaign and Lorraine Grimes. Too Many Barriers: Experiences of Abortion in Ireland after Repeal. Sept. 2021.

Recommendation b: Ensure that interpretation and translation services are readily accessible and that service users in need of these supports receive them without delay given the time sensitive nature of abortion care.

Recommendation c: Ensure that information provision through the MyOptions service is made fully accessible as close to point-of-contact as possible, including the provision of alternative formats for information on the MyOptions website.

Recommendation d: Explore feasibility of having MyOptions as a booking service rather than just an information line.

Q6. Are there any further comments you would like to make on the operation of the legislation? Please provide detail / evidence to support your answer, where possible.

9. Address regional gaps in abortion services in the community and hospital network

At present, just 1 in 10 GPs are providing abortion services in Ireland, meaning just one third of GP surgeries offer early medical abortions. Freedom of information requests seen by the National Women's Council from February 2022 show that of the 405 GPs who are early medical abortion providers, just 246 are currently listed through My Options – the others only provide services to their existing patients and will not take referrals. This is very concerning as it indicates the actual pool of providers for the general public is just 7% of the overall GP population.

Data shared with NWC by the HSE as of March 2022, shows that half of counties have less than 10 GPs offering the service currently – in some counties it could be as low as one GP per county as the data was provided in a 0-10 range rather than the total number. Indeed only four out of 26 counties have a well-developed community network of providers: Dublin, Cork, Galway and Wicklow. Although abortion providers are very committed, limited coverage is therefore a significant barrier to accessing abortion.

The reality of poor nationwide coverage is a heightened burden on women and pregnant people. For disabled women and pregnant people, these burdens are especially arduous when multiple appointments are necessary within the restricted time frame of the mandatory waiting period. Research by the Abortion Rights Campaign found that almost one third of survey respondents who accessed abortion in Ireland since 2019, travelled between 4-6 hours for this healthcare.[23] Travel barriers were also highlighted as a particular area for concern in the WHO policy implementation

[23] Abortion Rights Campaign and Lorraine Grimes. Too Many Barriers: Experiences of Abortion in Ireland after Repeal. Sept. 2021.

report, with a particularly adverse impact on women in rural Ireland and in Direct Provision centres.[24]

It is critical that the provider strand of the Review process pays particular attention to the issue of geographical coverage to better understand and address the barriers inhibiting medical professionals from taking up abortion care. GPs have highlighted the threat of anti-abortion activities is potentially the biggest impediment to a new provider in areas which do not yet have adequate provision as it is in those areas that protests have had a disproportionately significant impact. [25] As such it is difficult to disentangle the urgent need for Safe Access Zones legislation from the issue of poor geographical coverage. Similarly, we know that GPs want the support and back up of local maternity hospitals and so a failure to mandate service delivery in each maternity hospital has real consequences for bringing more GPs on board as providers in the community.

Looking at coverage for care post-9 week, it is deeply concerning that three years into the roll-out of the services, only 10 of our publicly funded maternity hospitals are providing full abortion care in line with the law. While individual consultants can object to providing abortion services under the Health Act, this should not lead to an absence of provision outright. The WHO research highlights that as well as conscience-based refusal of care, there are significant challenges in delivery of the service due to infrastructural limitations including difficulties in accessing hospital operating theatres and shortage of providers. Covid-19 has compounded these challenges and created an additional barrier to scheduling procedures. The WHO research team recommends that uncomplicated procedures in the late first and second trimester can be more safely provided in ambulatory outpatient settings.[26] Moving abortion care to outpatient gynaecological settings would reduce pressure on acute services and may make the service more accessible to patients.

[24] Mishtal, J., Duffy, D., Chavkin, W., Reeves, K., Chakravarty, D., Grimes, L., Stifani, B., Horgan, P., Murphy, M., Favier, M., and Lavelanet, A. 2021. "Policy Implementation – Access to Safe Abortion Services in Ireland Research Dissemination Report," April 23. UNDPUNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), Department of Sexual and Reproductive Health and Research, World Health Organization, 20 Avenue Appia, 1211 Geneva, Switzerland. Pp. 1-37

[25] National Women's Council, Accessing Abortion in Ireland: Meeting the Needs of Every Woman May 2021

[26] Mishtal, J., Duffy, D., Chavkin, W., Reeves, K., Chakravarty, D., Grimes, L., Stifani, B., Horgan, P., Murphy, M., Favier, M., and Lavelanet, A. 2021. "Policy Implementation – Access to Safe Abortion Services in Ireland Research Dissemination Report," April 23. UNDP-UNFPA-UNICEF-WHOWorld Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), Department of Sexual and Reproductive Health and Research, World Health Organization, 20 Avenue Appia, 1211 Geneva, Switzerland. Pp. 1-37.

Recommendation a: Adequate early abortion care needs to be guaranteed in every county in Ireland. This should be understood as a core part of the primary care offer and therefore should be addressed as a key service priority with additional HSE resources deployed as required.

Recommendation b: Maternity hospitals cannot be permitted to conscientiously object to providing services directly or indirectly through failure to provide services. 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.

10. Support Service User Choice: Enable Elective Surgical Care

The World Health Organisation's analysis found that abortion services in maternity hospitals vary significantly and choice of surgical care is not consistently offered.[27] Research carried out by the Abortion Rights Campaign also highlights that a significant minority of service users did not have the type of abortion they wanted and/or were unsure if the type they received was in line with their preference.[28] Individuals reported why they would prefer surgical care, such as the swift nature of the process and a belief that it was less visceral, but faced particular challenges in access to elective surgical care.[29] This is despite the clinical guidelines highlighting that the woman's choice should be considered when determining what type of abortion is provided 'even at earlier gestations'.[30]

Recommendation: Ensure that service user preference is respected when determining the type of abortion to be provided.

11. Address the absence of Safe Access Zones

All women and pregnant people should be guaranteed access to confidential, private and respectful care. Yet, nationwide, anti-abortion activities outside of hospitals, clinics, and GPs surgeries are occurring throughout the country on an almost daily basis. These activities constitute intimidation and

[27] Mishtal, J., Duffy, D., Chavkin, W., Reeves, K., Chakravarty, D., Grimes, L., Stifani, B., Horgan, P., Murphy, M., Favier, M., and Lavelanet, A. 2021. "Policy Implementation – Access to Safe Abortion Services in Ireland Research Dissemination Report," April 23. UNDPUNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), Department of Sexual and Reproductive Health and Research, World Health Organization, 20 Avenue Appia, 1211 Geneva, Switzerland. Pp. 1-37

[28] Abortion Rights Campaign and Lorraine Grimes. Too Many Barriers: Experiences of Abortion in Ireland after Repeal. Sept. 2021.

[29] Ibid, 37

[30] Irish Institute of Obstetricians and Gynaecologists, Interim Clinical Guidelines: Termination of Pregnancy Under 12 Weeks, December 2018, 17

harassment of service-users: as well as chanting, groups sometimes use distressing images, and props, such as small coffins and white crosses.

There is strong evidence that the anti-choice activities, as they currently occur, are adversely affecting women and pregnant people's ability to access health care, including abortion care, freely and without interference[31]. There is strong evidence that the anti-abortion activities have a profoundly distressing, stressful and traumatizing effect on people as they access their healthcare providers[32]. There is strong evidence that health care providers are also adversely affected[33] and that the protests have a chilling effect on provision of services[34], which has resulted in large parts of Ireland not having local access to care. This constitutes a considerable barrier[35] for women and pregnant people and requires urgent Government action on Safe Access Zones, as was promised in 2018.

The Safe Access to Termination of Pregnancy Bill 2021[36] is a draft Bill put forward by Together for Safety "to protect the free and unencumbered access to facilities providing legal termination of pregnancy services; protect individuals providing or facilitating legal termination of pregnancy services from harassment". It establishes a zone of 100 meters around a designated premises in which communication about abortion cannot take place and provides Gardai with grounds on which to move individuals/ distressing pictures. As a Group we support this Bill and call for Government to progress it. It is vital that Government recognises that 100 meters is the minimum acceptable level of protection needed for service providers, service-user and the community as whole.

Recommendation: Government should support the cross-party Safe Access Zones Bill currently going through the Seanad and ensure it progresses swiftly, with no further delays.

12. Regulate rogue pregnancy agencies

[31] The Impact of Anti-abortion Protest on Women Accessing Services - A Rapid Evidence Assessment. Oireachtas Library & Research Service. (2019)
[32]Greene Foster, D. 2013. Effect of Abortion Protesters on Women's Emotional Response to Abortion. *Contraception*. 81(1) 81-87. Cozzarelli, C. Major, B. Karrasch, A, Fuegen, K. (2000) Women's Experiences of and Reactions to Abortion Picketing. *Basic & Applied Social Psychology*, 22(4), 265-275.
[33]Dempsey, B., Favier, M, Mullally, A, & Higgins, M.F. (2021) Exploring providers' Experiences of Stigma following the Introduction of More Liberal Abortion Care in the Republic of Ireland. *Contraception.*104(4) 414-419
[34]Accessing Abortion in Ireland: Meeting the Needs of Every Woman. National Women's Council and Dr. Sinead Kennedy (2021)
[35] Too Many Barriers: Experiences of Abortion in Ireland After Repeal. ARC and Dr Lorraine Grimes. (2021)
[36] Safe Access to Termination of Pregnancy Bill 2021. Clionadh Ni Cheilleachair: drafter of the Private Members Bill

Rogue agencies continue to spread biased information surrounding abortion care and target women and pregnant people who may not realise the information offered isn't HSE approved and comes from an anti-choice agenda. While research into the HSE's MyOptions service suggests it has been largely well-received by those accessing abortion care, awareness of this service remains poor meaning women and pregnant people are liable to be tricked by well-targeted google ads for rogue pregnant agencies or community-based rogue agency volunteers. It is vital that regulation of rogue agencies is considered as part of the Review Process to ensure smooth operation of the Health Act.

Recommendation: Amend the Act to ensure it includes regulation of rogue pregnancy agencies which spread false and misleading information to those in need of abortion services.

13. Address the additional barriers faced by the migrant community and Northern Irish residents

An Irish address and PPS number are required to access abortion in Ireland.[37] This creates barriers for asylum-seekers, migrants, undocumented individuals and those temporarily resident in Ireland. Women from Northern Ireland can access abortion services in the Republic, but they have to pay a fee (up to €450) plus travel and, in some cases, accommodation.[38] Removal of PPS number requirements is critical for redressing inequalities and would help ensure that the most marginalised in society can access essential reproductive healthcare.

Recommendation: Remove the requirement for an Irish address and PPS number to ensure all those in need of abortion care can access it without additional obstacles.

14. Recognise trans and non-binary service-users

Trans men, intersex and non-binary people can also become pregnant and may face additional specific barriers in accessing abortion services. While the Interpretation Act 2005 extends provision of abortion under the Health (Termination of Pregnancy) Act 2018 to these groups, the original language of the Act can inadvertently instantiate the erroneous idea that abortion care is only for women and this should be amended.

Recommendation: The Health (Termination of Pregnancy) Act should be amended to ensure trans inclusivity. The Act should include gender inclusive language throughout, i.e. women and pregnant

[37] See Health Service Executive, "Before Having an Abortion" https://www2.hse.ie/conditions/abortion/abortion-methods/before-having-an-abortion.html accessed 28 October 2021.
[38] Alliance for Choice (2020) 'Up to 12 weeks access in Ireland'. https://www.alliance4choice.com/ up-to-12-weeks-access-in-ireland

persons. This is important as non-binary people currently have no means of legally affirming their gender under Irish law.

15. Insert a Rights-Respecting Preamble

It is our collective opinion that in its current form, the Act does not frame abortion as an essential reproductive health right which all women and pregnant people are entitled to. While making the above changes will go some way towards ensuring that the needs of women and pregnant people are more robustly recognised within the legal framework, we also feel the opening needs to be revised to instantiate this idea. This new preamble would help balance the Act towards women and pregnant people's autonomy and honour core principles of equality and respect for service users.

Recommendation a: Open the legislation with a statement that the purpose of the legislation is to ensure rights-respecting access to abortion care. For example: Guarantee of access (a) The Minister for Health shall ensure that women and pregnant people may access abortion care in accordance with the terms of this Act in a safe and timely manner. The Minister shall be responsible for the provision and regulation of abortion care to the highest attainable standards. (b) Access to abortion care, including to related sexual and reproductive healthcare before and after an abortion, shall not be impeded on discriminatory grounds, including on grounds of race, sex, religion, national or ethnic origin, marital or family status, immigration status, sexual orientation, age, or other social status. (c) In making any decision under the Act, or in providing medical care and services under this Act, the provisions shall be interpreted in the manner most favourable to achieving positive health outcomes for the woman and pregnant person, and to the protection of their rights.

Recommendation b: Amend the long title of the Bill to reflect its character as a more enabling, rather than limiting provision. Specifically, rephrase the long title as: "An Act to ensure that women and pregnant people may have equitable access to abortion care in a safe and timely manner, and at no cost, and for that purpose to amend [relevant legislation as currently listed]."

Q7. Do you have any comments about services provided under the Act? Please provide detail / evidence to support your answer, where possible

16. Establish robust data collection to monitor service provision

Publicly available data on Ireland's abortion service is sparse, detailing only the number of terminations, the grounds under which the termination was provided, and the county or place of

residence.[39] In order to better understand the current operation of the Termination of Pregnancy Act, a national abortion database should be created that requires medical professionals to record not only each abortion provided but also the wait time between when the abortion request was first made and the abortion. Medical providers should also be obliged to record refusals of care on the grounds of conscience and detail the service they referred the woman or pregnant person onto. We believe enhanced data collection, particularly around the issue of conscience-based refusal is key for mitigating risks and barriers to service users. As the Institute of Obstetricians and Gynaecologists in Ireland has stated, abortion is "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible. The consequences of being unable to obtain an abortion profoundly impact a person's life, health, and well-being".[40]

Transparency, supported by monitoring and oversight, on refusal of care would help to lower the risk that the service users face unnecessary delays in accessing essential healthcare and also enable good governance.

Recommendation: Expand the current publicly available abortion dataset to include wait times, recording of refusal of care and referral onwards.

17. Improve training and professional development of providers

The lack of trained healthcare providers is a significant barrier to safe abortion care in Ireland. The current delivery of abortion care largely restricts service provision to doctors. The World Health Organisation recognises that Early Medical Abortions (EMAs) can be provided at primary care level by nurses and midwives.[41] Nurses and midwives provide highly skilled, complex care in other areas of Irish healthcare, including in maternity units which are increasingly led by midwives and nurses, with doctors on-call.[42] Research has shown that nurses and midwives can provide abortion as safely as physicians and extending legislation to include them in provision of service increases access to abortion.[43]

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[39]Department of Health, NOTIFICATIONS IN ACCORDANCE WITH SECTION 20 OF THE HEALTH (REGULATION OF TERMINATION OF PREGNANCY) ACT 2018, June 2021

[40] See Institute of Obstetricians and Gynaecologists, COVID-19 infection Guidance for Maternity Services. May 2020. Retrieved from https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2020/05/COVID19-pregnancy-Version-4-D2-final.pdf

[41] WHO (2015) Health worker roles in providing safe abortion care and post-abortion contraception http://apps.who.int/iris/bitstream/handle/10665/181043/WHO_RHR_15.15_eng.pdf?sequence=1

[42] National Women's Council, Accessing Abortion in Ireland: Meeting the Needs of Every Woman May 2021 https://www.nwci.ie/images/uploads/15572_NWC_Abortion_Paper_WEB.pdf

[43] Mainey, L., O'Mullan, C., Reid-Searl, K., Taylor, A. & Baird, K. (2020) 'The role of nurses and midwives in the provision of abortion care: A scoping review', *Journal of Clinical Nursing*, 29(9-10), pp. 1513-1526.

While we know that there are many dedicated and hard-working health practitioners who provide high quality care, research also suggests some women and pregnant people's experiences of care when accessing abortion have been poor, with some receiving judgement and lack of compassion from medical practitioners and staff.[44] A holistic understanding of abortion care must be provided through dedicated training and professional development for all healthcare staff to ensure compassionate experiences of care for all those accessing abortion services. The WHO research has shown that values clarification workshops are very valuable and recommend their ongoing use.[45] Senior staff within hospital and GP settings play a leadership role in shaping the delivery of care and should inculcate a culture of respect for service users seeking abortion across the wider team, including reception and administrative support staff.

Recommendation a: Ensure that midwives and nurses have sufficient training to enable them to deliver Early Medical Abortions thus widening access to care and supporting better geographical coverage.

Recommendation b: Abortion should be fully integrated into all aspects of the medical, nursing and midwifery undergraduate and postgraduate curriculums and all staff, including administration and reception staff, should receive mandatory values clarification workshops.

18. Advance Reproductive and Sexual Health Rights: Contraception and Sexuality Education

In considering roll-out of services under the Health Act, we must also recognise deficiencies in Ireland's approach to reproductive healthcare more broadly and take this opportunity to address the two inter-related issues of universal access to contraception and the development of a modern Relationships and Sexuality Education (RSE) curriculum. These are key gaps in our reproductive healthcare which are significantly related to abortion care in Ireland and all three should be seen as critical issues, as the Joint Committee on the Eighth Amendment of the Constitution noted.

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[44] Abortion Rights Campaign and Lorraine Grimes. Too Many Barriers: Experiences of Abortion in Ireland after Repeal. Sept. 2021.https://www.abortionrightscampaign.ie/wp-content/uploads/2021/09/Too-Many-Barriers-Report_ARC1.pdf

[45] Mishtal, J., Duffy, D., Chavkin, W., Reeves, K., Chakravarty, D., Grimes, L., Stifani, B., Horgan, P., Murphy, M., Favier, M., and Lavelanet, A. 2021. "Policy Implementation – Access to Safe Abortion Services in Ireland Research Dissemination Report," April 23. UNDPUNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), Department of Sexual and Reproductive Health and Research, World Health Organization, 20 Avenue Appia, 1211 Geneva, Switzerland. Pp. 1-37

While we welcome the announcement of free contraception for 17-25 year olds, we recognise that reproductive health justice can only be delivered by fully removing the cost barrier across the whole of the reproductive age-range. Roll-out must also enshrine the key principle of choice across the board so all women and people who menstruate have access to a range of contraceptives including LARCs. The ability to choose if or when to have children is basic reproductive healthcare and as such universal contraception should be provided across primary care, family planning clinics, pharmacies and hospitals, accompanied by appropriate information on suitability and advantages of different methods.

Along with universal access to free contraception, inclusive and rights-based sex education must be prioritised. Comprehensive school-based sexuality education provides young people with the knowledge and skills to navigate the world around them, ensuring they have access to accurate information and a platform for discussing key issues in a safe and supportive environment. This is of fundamental importance for reproductive health and bodily autonomy. International evidence suggests that adolescent girls are more likely than older women to self-induce an abortion or seek abortion services from untrained providers, they are less knowledgeable about their rights concerning abortion and post-abortion care and can take longer than adult women to realise they are pregnant, leading to later term abortions which carry more risk.[46]

Recommendation a: Expedite the Programme for Government commitment to 'develop inclusive and age-appropriate RSE and SPHE curricula across primary and post-primary levels, including an inclusive programme on LGBTI+ relationships', ensuring that current work on the SPHE curriculum is complemented by reform of primary and senior cycle curricula.

Recommendation b: Deliver universal free contraception across the whole of the reproductive age range, with the State covering the cost of all forms of contraception and consultations with medical professionals.

Q8. Prior to this consultation what was your awareness of the Act?

Not aware of any provisions of the Act
Aware of some provisions of the Act
Aware of most provisions of the Act
Aware of all provisions of the Act

Q9. Do you consent to your submission being released by the Department of Health?

[46] M.F. Fathalla (2020) "Safe abortion: The public health rationale" Best Practice & Research Clinical Obstetrics and Gynaecology 63

Yes

Yes, some parts may be released

No, it contains personal or confidential material